The Institute is especially grateful to our outstanding Seminar Chairperson(s) for providing the necessary leadership, organization, and supervision that has brought this program into a reality. Indeed a debt of gratitude is particularly due our articulate and knowledgeable faculty, without whose untiring dedication and efforts this seminar would not have been possible. Their names are listed on the brochure for this program and their contributions to the success of this seminar are immeasurable.

I would be remiss if I did not extend a special thanks to each of you who are attending this seminar and for whom the program was planned. All of us hope your attendance will be most beneficial as well as enjoyable. Your comments and suggestions are always welcome.

February, 2017

Tangela S. King
Interim Director, ICLE
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Materials Were Not Submitted for the Following Presentations at the Time of Printing/Duplication:

YOU HAVE TRIED YOUR SOCIAL SECURITY CASE AND WON. HOW DO YOU GET PAID?
Sarah White, Westmoreland, Patterson, Moseley & Hinson, LLP, Gordon

CHANGES AFFECTING REGION IV ODAR
Hon. Patrick Nagle, Chief Administrative Law Judge, Office of the Chief Administrative Law Judge, Office of Disability Adjudication and Review, Falls Church, VA
Multiple Sclerosis

Neil S. Lava
Emory University
Atlanta, Georgia
Multiple Sclerosis

Neil S. Lava, MD

Multiple sclerosis is a neurological disease in which the immune system attacks areas of the brain and spinal cord causing neurological symptoms. This is a lifelong disease that can cause very significant difficulties although some patients can have mild symptoms. It is the leading cause of disability in young adults.

It is thought that people are born with a genetic predisposition to develop multiple sclerosis. Other risk factors include exposure to Epstein-Barr virus, low vitamin D, smoking and being overweight. If a patient has the right risk factors it is possible that their immune system will then start its lifelong attack on the central nervous system. The disease usually occurs between ages 15 and 50 and is seen more commonly in women. Interestingly, men’s disease tends to be a bit more aggressive.

The most common form of multiple sclerosis is relapsing remitting multiple sclerosis. In this form of the disease patients will experience a neurological symptom that will last for a period of time and then disappear. They can be symptom free for long periods of time before having their next event. Over time these patients can become secondarily progressive and have more and more difficulty functioning in daily life. A small percentage of patients have primary progressive disease where they develop a neurological symptom and gradually worsen over many years.

Because any area of the brain or spinal cord can be affected, patients can have many different neurological symptoms. Commonly impairment of vision, optic neuritis, is a frequent presenting symptom. We can also see sensory symptoms with numbness and tingling or even nerve type pain. Patients can have weakness of extremity and difficulty with muscle stiffness (spasticity). Bowel and bladder symptoms are seen commonly. Difficulty with coordination can occur. Cognitive problems can also arise along with fatigue which can become quite devastating and impair the patient’s ability to function.

Early on in the disease patients tend to do fairly well but as the years pass they are at risk to accumulate more deficits and have more difficulty functioning. Probably the 2 most common reasons that cause patients to stop working are cognitive problems and fatigue (or a combination of both).

Before 1993 there were no medications to treat and change the natural history of multiple sclerosis. In 1993 the first of many immune system therapies came to market and over the years we have been able to change the natural history of this disease. Now patients are taking much longer to develop progressive disease and tend to have fewer, less severe attacks. Unfortunately there is still not a “cure” for this disease but extensive research continues worldwide to try and stop this aggressive neurological disease.
Objectives

- Understand the natural history of MS
- Be familiar with the theories for MS Etiology
- Be familiar with MS treatments
- Appreciate the life changes necessitated by this disease
Multiple Sclerosis

The leading cause of (non-traumatic) disability in young adults

There are several historical accounts of people who lived before or shortly after the disease was described by Charcot and probably had MS. A young woman called Halldora, who lived in Iceland around the year 1200, suddenly lost her vision and mobility, but after praying to the saints, recovered them seven days after. Saint Lidwina of Schiedam (1380–1433), a Dutch nun, may be one of the first clearly identifiable MS patients. From the age of 16 until her death at 53, she suffered intermittent pain, weakness of the legs, and vision loss—symptoms typical of MS. Both cases have led to the proposal of a ‘Viking gene’ hypothesis for the dissemination of the disease.

Augustus Frederick d’Este (1794–1848), son of Prince Augustus Frederick, Duke of Sussex and Lady Augusta Murray and the grandson of George III of the United Kingdom, almost certainly suffered from MS. D’Este left a detailed diary describing his 22 years living with the disease. His diary began in 1822 and ended in 1846, although it remained unknown until 1948. His symptoms began at age 28 with a sudden transient visual loss after the funeral of a friend. During the course of his disease, he developed weakness of the legs, clumsiness of the hands, numbness, dizziness, bladder disturbances, and erectile dysfunction. In 1844, he began to use a wheelchair. Despite his illness, he kept an optimistic view of life.

Another early account of MS was kept by the British diarist W. N. P. Barbellion, nom-de-plume of Bruce Frederick Cummings (1889–1919), who maintained a detailed log of his diagnosis and struggle with MS. His diary was published in 1919 as The Journal of a Disappointed Man (Wikipedia).
Demographics of MS

- **Age of onset**: 15 to 50 years
- **Gender**: 70% women
- **Geography**: Incidence increases with distance from equator
- **Incidence**: 8,500 to 10,000 new cases per year
- **Prevalence**: 400,000 in U.S.

Gender Differences in MS

- 3:2 ratio women to men
- Men develop first symptoms at later age
- Men more likely to develop chronic progressive form of disease

Geography of MS

- High Frequency - >300 per 100,000
  - Northern Europe, Northern United States, New Zealand, Southeast Australia
- Medium Frequency - 5-30 per 100,000
  - Northern Scandinavia, Central USSR, Southern Europe, Australia
- Low Frequency - <5 per 100,000
  - Asia, Tropics

Figure 1. Total Number, Prevalence and Incidence of MS
Risk Factors for Multiple Sclerosis

- **EBV** – risk 15x with EBV in childhood & 30x in adolescence or later
- **Smoking** – risk 1.5 for smokers compared to nonsmokers
- **Low Vitamin D** – using cod liver oil during age 13-18 reduced the risk of developing MS (also supports adolescence as important period of susceptibility)
- **Obesity** – higher BMI in women in adolescence and young adulthood had younger onset MS. Also disability progression was 8x higher in obese patients compared to normal BMI.
- **Gut Microbiome** – can worsen or improve MS symptoms. Vit D increases ruminococcaceae (anti-inflammatory). Women with MS higher # of Enterobacteriaceae family compared to controls
Genetic Prevalence of MS

- 10 X increase for MS if direct relative affected
- Higher prevalence in identical twins
- Variability in severity of disease in twins and affected relatives

Potential Triggers for Multiple Sclerosis

- Infectious agent
- Environmental factors
- Abnormal immunologic response

MS = multiple sclerosis
Common Symptoms of MS

- Bladder and bowel problems
- Cognitive difficulties
- Depression
- Fatigue
- Visual difficulties
- Muscle rigidity or stiffness
- Numbness and tingling
- Pain
- Weakness or poor coordination

Course of disease in MS

1. Relapsing-remitting
2. Primary progressive
3. Secondary progressive
4. Progressive relapsing

Diagnosis

- Clinical
- MRI

Multiple Lesions in time and space
Laboratory Diagnosis

- Cerebrospinal Fluid Evaluation
  - increased immunoglobulins in the CNS, separation into oligoclonal bands

- Evoked potentials
  - visual evoked potentials (VEP)-response to flashing lights
  - brainstem auditory evoked potentials (BAEP)-stimulation of hearing
  - somatosensory evoked potentials (SSEP)-stimulation of peripheral nerves

- Imaging-MRI studies
Serial Monthly Enhancing Lesions

Brain atrophy can occur early in the course of MS. In patients with RRMS and only mild-to-moderate disability, significant cerebral atrophy may develop over 1 to 2 years. The course of cerebral atrophy in MS appears to be influenced by the presence of enhancing lesions.

RRMS = relapsing remitting multiple sclerosis
### 2010 Revised McDonald MS Diagnostic Criteria

Diagnosis of MS requires elimination of more likely diagnoses and demonstration of dissemination of lesions in space (DIS) and time (DIT).

<table>
<thead>
<tr>
<th>CLINICAL (ATTACKS)</th>
<th>LESIONS</th>
<th>ADDITIONAL CRITERIA TO MAKE DX</th>
</tr>
</thead>
<tbody>
<tr>
<td>2 or more</td>
<td>Objective clinical evidence of ≥ 2 lesions or objective clinical evidence of 1 lesion with reasonable historical evidence of a prior attack</td>
<td>None. Clinical evidence alone will suffice; additional evidence desirable but must be consistent with MS</td>
</tr>
<tr>
<td>2 or more</td>
<td>Objective clinical evidence of 1 lesion</td>
<td>DIS; OR await further clinical attack implicating a different CNS site</td>
</tr>
<tr>
<td>1</td>
<td>Objective clinical evidence of ≥ 2 lesions</td>
<td>DIS; OR await second clinical attack</td>
</tr>
<tr>
<td>1</td>
<td>Objective clinical evidence of 1 lesion</td>
<td>DIS OR await further clinical attack implicating a different CNS site AND DIS; OR await second clinical attack</td>
</tr>
<tr>
<td>0 (progression from onset)</td>
<td>One year of disease progression (retrospective or prospective) AND at least two of: DIS in the brain based on ≥1 T2 lesion in periventricular, juxtacortical or infratentorial regions; DIS in the spinal cord based on ≥2 T2 lesions; or positive CSF</td>
<td></td>
</tr>
</tbody>
</table>


### Paraclinical Evidence in MS Diagnosis

#### Evidence for Dissemination of Lesions in Space (DIS)
- ≥ 2 T2 lesion in at least two out of four areas of the CNS: periventricular, juxtacortical, infratentorial, or spinal cord
- Gadolinium enhancement of lesions is not required for DIS
- If a subject has a brainstem or spinal cord syndrome, the symptomatic lesions are excluded and do not contribute to lesion count

#### Evidence for Positive CSF
- Oligoclonal IgG bands in CSF (and not serum) or elevated IgG index

#### Evidence for Dissemination of Lesions in Time (DIT)
- A new T2 and/or gadolinium-enhancing lesion(s) on follow-up MRI, with reference to a baseline scan, irrespective of the timing of the baseline MRI
- Simultaneous presence of asymptomatic gadolinium-enhancing and non-enhancing lesions at any time

---


These diagnostic criteria were developed through the consensus of the International Panel on the Diagnosis of MS. See cited articles for details. Funding through National Multiple Sclerosis Society (USA) and European Committee for Treatment and Research in MS; additional support from the Multiple Sclerosis International Federation and MS Ireland.

National Multiple Sclerosis Society (USA)/Professional Resource Center: 733 Third Avenue, New York, NY 10017-3288
http://www.nationalMSsociety.org/PBC. MD_info@nmss.org
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Progression of Untreated MS

- Subclinical
- Mono-symptomatic initial demyelinating event
- Relapsing-Remitting
  - Clinically definite MS
- Secondary Progressive
  - Relapse

- Level of disability
- Accumulated MRI lesion burden
- Acute (new and Gd+) MRI activity
- Cognitive dysfunction
- Brain volume
- Relapses

Gd = gadolinium.

Components of Multiple Sclerosis Pathogenesis

- Inflammation
- Demyelination
- Axonal Loss

Demyelination and Axonal Degeneration in MS

A. Normal myelinated axon

B. Acutely demyelinated axon

C. Chronically demyelinated axon

D. Degenerated axon

Conduction restored by increase in density of sodium channels

### Drugs for Relapsing MS

<table>
<thead>
<tr>
<th>SC</th>
<th>IM</th>
<th>SC</th>
<th>SC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Betaseron</td>
<td>Avonex</td>
<td>Rebil</td>
<td>Copaxone</td>
</tr>
</tbody>
</table>

- Type: IFN, IFN, IFN, GA
- Dosage: 250 µg, 30 µg, 44 or 22 µg, 20 mg
- Frequency: Alternate Days, Once Weekly, Thrice Weekly, Daily
- Primary Trial: 2 years, 2 years, 2 years, 2 years
- Total Follow-Up: 5 years, 2 years, 4 years, 8 years

SC: subcutaneous; IM, intramuscular; IFN, interferon; GA, glatiramer acetate.
*Partial six-year data available
†10-year data being analyzed

**Table:**

<table>
<thead>
<tr>
<th>Agent/Ganglioside ☸</th>
<th>Proposed/Mode</th>
<th>Side-Effects</th>
<th>Warning/Precaution</th>
</tr>
</thead>
<tbody>
<tr>
<td>Betaseron (Caviterm)</td>
<td>promotes anti-inflammatory and immunomodulatory activity mediated by NO pathway</td>
<td>flushing, GI symptoms, moderate pain, rash, allergic reactions</td>
<td>Symptomatic supportive care, injection site pain, rash, allergic reactions</td>
</tr>
<tr>
<td>Gilenya (Ocrevus) 0.5 mg PO daily</td>
<td>interacts with lymphocytes, preventing aggregation of gangliosides</td>
<td>headache, depression, fatigue, paraesthesia, gastrointestinal disorders</td>
<td>Myelosuppression and severe skin reactions</td>
</tr>
<tr>
<td>Gilenya (Ocrevus) 2 mg PO daily</td>
<td>interacts with lymphocytes, preventing aggregation of gangliosides</td>
<td>headache, depression, fatigue, paraesthesia, gastrointestinal disorders</td>
<td>Myelosuppression and severe skin reactions</td>
</tr>
<tr>
<td>Gilenya (Ocrevus) 5 mg PO daily</td>
<td>interacts with lymphocytes, preventing aggregation of gangliosides</td>
<td>headache, depression, fatigue, paraesthesia, gastrointestinal disorders</td>
<td>Myelosuppression and severe skin reactions</td>
</tr>
<tr>
<td>Gilenya (Ocrevus) 10 mg PO daily</td>
<td>interacts with lymphocytes, preventing aggregation of gangliosides</td>
<td>headache, depression, fatigue, paraesthesia, gastrointestinal disorders</td>
<td>Myelosuppression and severe skin reactions</td>
</tr>
<tr>
<td>Gilenya (Ocrevus) 15 mg PO daily</td>
<td>interacts with lymphocytes, preventing aggregation of gangliosides</td>
<td>headache, depression, fatigue, paraesthesia, gastrointestinal disorders</td>
<td>Myelosuppression and severe skin reactions</td>
</tr>
<tr>
<td>Gilenya (Ocrevus) 20 mg PO daily</td>
<td>interacts with lymphocytes, preventing aggregation of gangliosides</td>
<td>headache, depression, fatigue, paraesthesia, gastrointestinal disorders</td>
<td>Myelosuppression and severe skin reactions</td>
</tr>
<tr>
<td>Gilenya (Ocrevus) 25 mg PO daily</td>
<td>interacts with lymphocytes, preventing aggregation of gangliosides</td>
<td>headache, depression, fatigue, paraesthesia, gastrointestinal disorders</td>
<td>Myelosuppression and severe skin reactions</td>
</tr>
<tr>
<td>Gilenya (Ocrevus) 30 mg PO daily</td>
<td>interacts with lymphocytes, preventing aggregation of gangliosides</td>
<td>headache, depression, fatigue, paraesthesia, gastrointestinal disorders</td>
<td>Myelosuppression and severe skin reactions</td>
</tr>
<tr>
<td>Gilenya (Ocrevus) 35 mg PO daily</td>
<td>interacts with lymphocytes, preventing aggregation of gangliosides</td>
<td>headache, depression, fatigue, paraesthesia, gastrointestinal disorders</td>
<td>Myelosuppression and severe skin reactions</td>
</tr>
<tr>
<td>Gilenya (Ocrevus) 40 mg PO daily</td>
<td>interacts with lymphocytes, preventing aggregation of gangliosides</td>
<td>headache, depression, fatigue, paraesthesia, gastrointestinal disorders</td>
<td>Myelosuppression and severe skin reactions</td>
</tr>
<tr>
<td>Gilenya (Ocrevus) 45 mg PO daily</td>
<td>interacts with lymphocytes, preventing aggregation of gangliosides</td>
<td>headache, depression, fatigue, paraesthesia, gastrointestinal disorders</td>
<td>Myelosuppression and severe skin reactions</td>
</tr>
<tr>
<td>Gilenya (Ocrevus) 50 mg PO daily</td>
<td>interacts with lymphocytes, preventing aggregation of gangliosides</td>
<td>headache, depression, fatigue, paraesthesia, gastrointestinal disorders</td>
<td>Myelosuppression and severe skin reactions</td>
</tr>
</tbody>
</table>

**MS Coalition SC**
TABLE 1. MS DRUGS IN PHASE III/IV DEVELOPMENT

<table>
<thead>
<tr>
<th>Agent</th>
<th>Developer/Marker</th>
<th>Proposed or Known MOA</th>
<th>Delivery</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alemtuzumab</td>
<td>Genzyme</td>
<td>Targets CD52 antigen expressed on B and T lymphocytes; Slows down immune response, possibly by interfering with T cell activation and movement across blood-brain barrier</td>
<td>IV, SC</td>
</tr>
<tr>
<td>BG-12 (dimethyl fumarate)</td>
<td>Biogen, Inc.</td>
<td>Uregulates Th2 response, immune-modulatory</td>
<td>PO, SC</td>
</tr>
<tr>
<td>BiBR17 (PEGylated interferon beta-1a)</td>
<td>Genentech</td>
<td>Slows down immune response, possibly by interfering with T cell activation and movement across blood-brain barrier, including suppressive T cells</td>
<td>SC</td>
</tr>
<tr>
<td>Daclizumab High Yield Process (DAC-IYP)</td>
<td>Biogen, Inc.</td>
<td>Limits T cell expansion by blocking signaling of cytokine IL-2</td>
<td>IM, SC</td>
</tr>
<tr>
<td>fingolimod (Galeno)</td>
<td>Novartis</td>
<td>Sphingosine-1-phosphate receptor binder; prevents lymphocytes from exiting lymphatic tissue</td>
<td>PO</td>
</tr>
<tr>
<td>Clazanam peptide acetate (Copaxone), New formulation</td>
<td>Teva</td>
<td>Peptide copolymer synthesized to mimic myelin basic protein, induces shift from Th1 to Th2</td>
<td>SC</td>
</tr>
<tr>
<td>Laquinimod</td>
<td>Teva</td>
<td>Immunomodulatory; Slows down immune response, possibly by interfering with T cell activation and movement across blood-brain barrier, and inducing suppressive T cells</td>
<td>PO, IM</td>
</tr>
<tr>
<td>Methylprednisolone</td>
<td></td>
<td>Closes damaged blood-brain barrier, reducing inflammation in CNS</td>
<td>PO, IV</td>
</tr>
<tr>
<td>NUF100 (recombinant human interferon beta)</td>
<td>Nurion Biotech</td>
<td>Slows down immune response, possibly by interfering with T cell activation and movement across blood-brain barrier, and inducing suppressive T cells</td>
<td>SC</td>
</tr>
<tr>
<td>Ocnelizumab</td>
<td>Chugai</td>
<td>Binds to CD20 antigen on B cells and induces B-cell lysis; Slows down immune response, possibly by interfering with T cell activation and movement across blood-brain barrier, and inducing suppressive T cells</td>
<td>IV, SC</td>
</tr>
<tr>
<td>Teriflunomide (HMR1726)</td>
<td>Sanofi-Aventis</td>
<td>Modulates responses of T-cells within the immune system by impairing DNA synthesis; Also studied for clinically isolated syndrome.</td>
<td>PO</td>
</tr>
</tbody>
</table>
Expanded Disability Status Scale (EDSS)

- Ordinal scale (range 0 - 10) measuring disability in 0.5 increments
- Most widely accepted measure of disability in patients with MS
- Reflects impact of disease on neurological function

Progression to disability—EDSS steps

- 9.0 - 9.5 = Completely dependent
- 8.0 - 8.5 = Confined to bed or chair; self-care with help
- 7.0 - 7.5 = Confined to wheelchair
- 6.0 - 6.5 = Walking assistance is needed
- 5.0 - 5.5 = Increasing limitation in ability to walk
- 4.0 - 4.5 = Disability is moderate
- 3.0 - 3.5 = Disability is mild to moderate
- 2.0 - 2.5 = Disability is minimal
- 1.0 - 1.5 = No disability
- 0 = Normal neurologic exam
MS and Disability

Fifteen years after diagnosis:

- **80%** of patients have functional impairment
- **50%** of patients are unable to walk
- **70%** of patients are unable to continue working

Principles of management

- Manage symptoms
  - fatigue
  - spasticity
  - pain
  - bowel, bladder
  - memory loss and affective disorders
  - swallowing problems
- Psychological and emotional support
- tremors
- visual changes
- sexual problems
- speech disorders
- balance and mobility dysfunction
**Fatigue in MS**

- Reported by 75%–97% of patients with MS\(^1\)-\(^5\)
- 66% of 309 patients with MS experienced fatigue daily\(^3\)
- Most patients with MS say fatigue is their worst or one of their worst symptoms\(^2\)
- Underrecognized and underdiagnosed


---

**Cognitive Dysfunction in MS**

- Occurs in 43%-65% of patients with MS
- Often under recognized or misdiagnosed as depression, stress, or personality disorder
- Contributes significantly to unemployment, accidents, impairment of daily function, and loss of social contacts
- Strongly related to the extent of lesion burden and brain atrophy

MS = multiple sclerosis
Progression of Cognitive Dysfunction in MS

- The evolution of cognitive dysfunction in early onset MS was assessed over 10 years in 45 consecutive inpatients and outpatients.
- Of 37 patients who were not cognitively impaired on initial testing, only 20 remained so by the end of the 10-year follow-up.
- The proportion of patients who were cognitively impaired over the 10-year period increased from 26% to 56%.
- Of 25 patients with only mild or moderate cognitive impairment, 17 had to modify or discontinue their work.

Cognitive Dysfunction Related to MS

<table>
<thead>
<tr>
<th>Function</th>
<th>Signs of Impairment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Verbal/visual memory</td>
<td>Forgetfulness</td>
</tr>
<tr>
<td>Attention</td>
<td>Tendency to be easily distracted</td>
</tr>
<tr>
<td>Information processing speed</td>
<td>Problems performing multiple tasks</td>
</tr>
<tr>
<td>Executive function (problem solving)</td>
<td>Problems performing tasks quickly</td>
</tr>
<tr>
<td>Visuospatial dysfunction</td>
<td>Difficulties in solving thought problems</td>
</tr>
<tr>
<td></td>
<td>Rigidity in solving problems</td>
</tr>
<tr>
<td></td>
<td>Impaired visual perception, recognition, and construction</td>
</tr>
<tr>
<td></td>
<td>Difficulty completing task requiring hand-eye coordination</td>
</tr>
</tbody>
</table>

Indicators of Cognitive Dysfunction in MS

- Need for help in activities of daily living
- Unemployment in the absence of physical disability
- Mood disorders other than depression
- Withdrawal from usual social activities
- Changes in personality
- MRI showing focal atrophy and high total lesion load

MRI = magnetic resonance imaging
Multiple Sclerosis in the 11th Circuit and the 7th & 10th

Larry Christensen  
Law Office of Burgess & Christensen  
Marietta, Georgia
Multiple Sclerosis in the 11th Circuit and the 7th & 10th

I prepared for this seminar by surveying all of the cases in the 11th Circuit in which MS was a factor in the decision and to see how MS was evaluated. Then I looked at the decisions in the Georgia, Florida and Alabama District Courts to see how MS was treated at those levels. The results were interesting.

At the 11th Cir.: five denials were upheld.

In the U.S.D.C. Ga. Eight of the nine denials were affirmed
Congratulations to Chuck Martin

In the U.S.D.C. Ala. Eight of the nine denials were affirmed.
Here congratulations are due to Michael Booker

In the U.S.D.C., Fla. I included 28 cases in these statistics. There 5 or 6 cases in which MS was merely mentioned but not substantively discussed. Of the 28 cases 16 denials were reversed and 11 of those were in the Middle District; 3 in the Northern District and 2 in the Southern District.

From this I first concluded that there was a more virulent strain of MS existing in the Middle District of Florida. Doctor Lava corrected my conclusion.

But as I read those cases from the Middle District it became clearer what was happening. [And congratulations to Sarah Bohr for educating the Middle District]

Consequently I surveyed the cases in the 7th and 10th Circuits as points of comparison.

At the 7th Circuit I was surprised to learn that of the 6 denials of benefits, 5 denials were upheld and only 1 denial reversed and remanded.
Nonetheless I still thought I had cracked the code (why are cases reversed and remanded) so I looked a little deeper into the decisions of the Illinois, Indiana and Wisconsin District Courts. There I found:

In the Illinois U.S.D.C. there were 30 MS cases. 22 denials were reversed and 8 were affirmed.

In the Indiana U.S.D.C. there 46 MS denials of which 25 denials were reversed: some for payment of benefits and some for further consideration of the record, and, 21 denials were upheld.

In the Wisconsin U.S.D.C. Westlaw turned up 12 denials of which 9 were reversed and remanded, and 3 denials were upheld.

By this time I was thinking that I was right in finding the key to the reversals and I decided to cross-check my theory against the 10th Circuit.

At the 10th Circuit there were 14 denials of which 12 denials were upheld and 2 were reversed. My theory was not looking good. So, I went to the U.S.D.C.s in the 10th Circuit and found as follows:

Colorado: 10 MS denials; 8 reversals and 2 affirmances. Things are looking up.

Kansas: 11 MS denials; 5 reversals and 6 affirmances.

Oklahoma: 10 MS denials; 8 reversals and 2 affirmances.

Utah: 4 MS denials; 2 reversals and 2 affirmances.

New Mexico & Wyoming: -0- MS cases on appeal. Maybe the SS practitioners in those states know something about their FDCs that I don’t.

Nonetheless, the trend in Colorado, Kansas, Oklahoma, Illinois, Indiana,
Wisconsin and the Middle District of Florida is fairly clear. Those district court judges are not reluctant to call an ALJ’s work product to task. (Let me note for the record that some of my best friends are ALJs.------ Some aren’t. )

What the 7th and the 10th Circuits have in common are three cases. In the 10th Circuit there is the case of Allen v. Barnhart (copy in its entirety in your handout) and in the 7th Circuit, the case of Spiva v. Astrue and Golembieski v. Barnhart.

In Allen, the 10th circuit case, turned on whether 100 jobs constituted a “significant number” of jobs for purposes of denying benefits.

We recognize that ... as a court acting within the confines of its administrative review authority, we are empowered only to “review the ALJ's decision for substantial evidence” and, accordingly, “we are not in a position to draw factual conclusions on behalf of the ALJ.” Drapeau v. Massanari, 255 F.3d 1211, 1214 (10th Cir.2001) ...This brings us to the Appellee's final line of defense—the principle of harmless error...Any attempt to save the decision, by finding that the one job Allen concededly can do constitutes significant work, usurps the ALJ's primary responsibility to determine that question in light of the various case-specific considerations....

Then in Spiva v. Astrue, 628 F.3d 346, Judge Posner unloaded on the Commissioner and the U.S. Attorney’s argument saying that “The district court defended the ALJ's decision as a determination based not on the grids but on the
VE's identification of specific jobs in response to the ALJ's inquiries incorporating Allen's RFC and associated limitations. This facially more creditable rationale for the decision risks obscuring the important institutional boundary preserved by the admonition that courts avoid usurping the administrative tribunal's responsibility to find the facts. Second, to the extent a harmless-error determination rests on legal or evidentiary matters not considered by the ALJ, it risks violating the general rule against post hoc justification of administrative action recognized in *SEC v. Chenery Corp.*, 318 U.S. 80, 63 S.Ct. 454, 87 L.Ed. 626 (1943) and its progeny.

Without some analysis, nowhere to be found in the administrative law judge's opinion, we note that:

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explained that someone of Golembiewski's age, education, and work experience would be able to work based on “selective placement.”

Here the ALJ found Golembiewski's testimony—including his complaint that in 1998 he suffered weekly seizures and pain so severe that he could not sit or stand comfortably for more than five minutes—less than credible ... because he observed Golembiewski sitting for 40 minutes at the hearing. [Here the 11th Cir. admonition against “sit and squirm jurisprudence” was noted} The Commissioner's response is problematic ...because the general principles of administrative law preclude the Commissioner's lawyers from advancing grounds in support of the agency's decision that were not given by the ALJ. See SEC v. Chenery Corp., 318 U.S. 80, 93–95, 63, Steele, 290 F.3d at 941; Pinto v. Massanari, 249 F.3d 840, 847–48 (9th Cir.2001); Fargnoli v. Massanari, 247 F.3d 34, 44 n. 7 (3d Cir.2001). So the Commissioner's effort to pinpoint parts of the ALJ's decision that support the credibility finding is unhelpful.

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Other courts will say: not my job! YOU tell us why the claimant’s testimony is not consistent with the medical record, and be specific. YOU tell us why the evidence favoring the claimant’s bid for disability benefits is out weighed by the evidence of the non examining, non treating physician so we have some idea that you have read and even considered the record.

But we don’t practice in Colorado or Indiana or maybe even the Middle District of Florida. So what is the “take away?”

I would NOT request the treating physician (say Doctor English in the Case) to fill our a RFC or other summary of the patient’s medical situation. If the ALJs in our Circuit want to deny the claim they will most certainly go behind the doctor’s report into the medical evidence and say that the report is not entitled to any weight because it is contrary to the physician’s medical notes and contrary to the thrust of the medical record in general.

What we have begun doing is to ask the physician to QUANTIFY his terms. For example if the notes say that the patient has symptoms of MILD ataxia, or
OCCASIONALLY has trouble with distorted vision, or SOMETIMES experiences cognitive dissonance, does that mean that these symptoms are generally present but at the level of non obstructive background noise. OR does it mean QUANTITATIVELY that 2 or 3 days per month my patient reports significant trouble with balance and tremors which compromises her ability to stand w/o an assistive device or grasp and handle objects effectively, and 1 or 2 days per month my patient reports blurred with vision and cannot read the newspaper or use her computer, or 1 or 2 days per month my patient reports severe trouble with memory and thinking and forgets her “to do” list. These do not appear to happen all on the same day and s/he has several days per month symptom free and so I have described this as mild or mild to moderate. If it were moderate to severe or severe to extreme then she would encounter these symptoms many more days per month. And there is your question to the VE between: I want you to assume that during 4 & 7 days per month ..... 

I know that not getting an RFC from your TP is heresy, but in our Circuit and in our District Courts it won’t work. Symptoms have to be quantified. We are hoping that this will help us down the line when we find ourselves at the AC or in FDC.
Multiple Sclerosis in the 11th Circuit and the 7th & 10th

I prepared for this seminar by surveying all of the cases in the 11th Circuit in which MS was a factor in the decision and to see how MS was evaluated. Then I looked at the decisions in the Georgia, Florida and Alabama District Courts to see how MS was treated at those levels. The results were interesting.

At the 11th Cir.: five denials were upheld.

In the U.S.D.C. Ga. Eight of the nine denials were affirmed
Congratulations to Chuck Martin

In the U.S.D.C. Ala. Eight of the nine denials were affirmed.
Here congratulations are due to Michael Booker

In the U.S.D.C., Fla. I included 28 cases in these statistics. There 5 or 6 cases in which MS was merely mentioned but not substantively discussed. Of the 28 cases 16 denials were reversed and 11 of those were in the Middle District; 3 in the Northern District and 2 in the Southern District. [And congratulations to Sarah Bohr for educating the Florida Courts.]

From this I first concluded that there was a more virulent strain of MS existing in the Middle District of Florida. Doctor Lava corrected my conclusion. But as I read those cases from the Middle District it became clearer what was happening. Consequently I surveyed the cases in the 7th and 10th Circuits as points of comparison.

At the 7th Circuit I was surprised to learn that of the 6 denials of benefits, 5 denials were upheld and only 1 denial reversed and remanded.

Nonetheless I still thought I had cracked the code (why are cases reversed
and remanded) so I looked a little deeper into the decisions of the Illinois, Indiana
and Wisconsin District Courts. There I found:

In the Illinois U.S.D.C. there were 30 MS cases. 22 denials were reversed
and 8 were affirmed.

In the Indiana U.S.D.C. there 46 MS denials of which 25 denials were
reversed: some for payment of benefits and some for further consideration
of the record, and, 21 denials were upheld.

In the Wisconsin U.S.D.C. Westlaw turned up 12 denials of which 9 were
reversed and remanded, and 3 denials were upheld.

By this time I was thinking that I was right in finding the key to the
reversals and I decided to cross-check my theory against the 10th Circuit.

At the 10th Circuit there were 14 denials of which 12 denials were upheld
and 2 were reversed. My theory was not looking good. So, I went to the U.S.D.C.s
in the 10th Circuit and found as follows:

Colorado: 10 MS denials; 8 reversals and 2 affirmances. Things are looking
up.

Kansas: 11 MS denials; 5 reversals and 6 affirmances.

Oklahoma: 10 MS denials; 8 reversals and 2 affirmances.

Utah: 4 MS denials; 2 reversals and 2 affirmances.

New Mexico & Wyoming: -0- MS cases on appeal. Maybe the SS
practitioners in those states know something about their FDCs that I don’t.

Nonetheless, the trend in Colorado, Kansas, Oklahoma, Illinois, Indiana,
Wisconsin and the Middle District of Florida is fairly clear. Those district court
judges are not reluctant to call an ALJ’s work product to task. (Let me note for the record that some of my best friends are ALJs.------ Some aren’t.)

What the 7th and the 10th Circuits have in common are three cases. In the 10th Circuit there is the case of Allen v. Barnhart (copy in its entirety in your handout) and in the 7th Circuit, the case of Spiva v. Astrue and Golembieski v. Barnhart.

In Allen, the 10th circuit case, turned on whether 100 jobs constituted a “significant number” of jobs for purposes of denying benefits.

We recognize that ... as a court acting within the confines of its administrative review authority, we are empowered only to “review the ALJ's decision for substantial evidence” and, accordingly, “we are not in a position to draw factual conclusions on behalf of the ALJ.” Drapeau v. Massanari, 255 F.3d 1211, 1214 (10th Cir.2001) ...This brings us to the Appellee's final line of defense—the principle of harmless error...Any attempt to save the decision, by finding that the one job Allen concededly can do constitutes significant work, usurps the ALJ’s primary responsibility to determine that question in light of the various case-specific considerations....Case remanded to ALJ to do his job.

Then in Spiva v. Astrue, 628 F.3d 346, Judge Posner unloaded on the Commissioner and the U.S. Attorney’s argument saying that “The district court defended the ALJ's decision as a determination based not on the grids but on the VE's identification of specific jobs in response to the ALJ's inquiries incorporating
Allen's RFC and associated limitations. This facially more creditable rationale for the decision risks obscuring the important institutional boundary preserved by the admonition that courts avoid usurping the administrative tribunal's responsibility to find the facts. And, to the extent a harmless-error determination rests on legal or evidentiary matters not considered by the ALJ, it risks violating the general rule against post hoc justification of administrative action recognized in *SEC v. Chenery Corp.*, 318 U.S. 80, 63 S.Ct. 454, 87 L.Ed. 626 (1943) and its progeny.

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The Commissioner's response is problematic because the general principles of administrative law preclude the Commissioner's lawyers from advancing grounds in support of the agency's decision that were not given by the ALJ. See SEC v. Chenery Corp., 318 U.S. 80, 93–95, 63, Steele, 290 F.3d at 941; Pinto v. Massanari, 249 F.3d 840, 847–48 (9th Cir.2001); Fargnoli v. Massanari, 247 F.3d 34, 44 n. 7 (3d Cir.2001). So the Commissioner's effort to pinpoint parts of the ALJ's decision that support the credibility finding is unhelpful.

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I know that not getting an RFC from your TP is heresy, but in our Circuit and in our District Courts I don’t think it will get the job done. Symptoms have to be quantified otherwise we will continue to lose cases for our clients. We are hoping that this effort discuss symptoms in a quantifiable way will help us down the line when we find ourselves at the AC or in FDC.

**Decisions in the 11th Circuit**

*Forsyth v. Commissioner of Soc. Sec.,* 503 Fed.Appx. 892 (11th Cir. 2013)

Holdings: The Court of Appeals held that:
1 substantial evidence supported administrative law judge's (ALJ) conclusion that there was good cause to afford more weight to opinion of non-examining doctor than to claimant's treating physicians, and
2 ALJ did not err by rejecting opinion of examining doctor that claimant would be unable to work up to 30 percent of the time when her multiple sclerosis (MS) was relapsing.

A treating physician's opinion must be given substantial or considerable weight unless “good cause” is shown to the contrary. Id.; see also 20 C.F.R. § 404.1527(c)(2) (“generally, we give more weight to opinions from your treating sources ...”). The ALJ does not have to defer to the opinion of a physician who conducted a single examination, and who was not a treating physician. See McSwain v. Bowen, 814 F.2d 617, 619 (11th Cir.1987). In the end, the ALJ may reject the opinion of any physician if the evidence supports a contrary conclusion. Sryock v. Heckler, 764 F.2d 834, 835 (11th Cir.1985). When, however, an incorrect application of the regulations results in harmless error because the correct application would not contradict the ALJ's ultimate findings, the ALJ's decision will stand. See Diorio v. Heckler, 721 F.2d 726, 728 (11th Cir.1983). The ALJ also considered the medical evidence in the record in formulating Denomme's RFC. See Sryock, 764 F.2d at 835. Specifically, the ALJ highlighted *879 that Denomme's own hearing testimony indicated that she left her last job due to her need for surgery to treat a jaw infection, as opposed to any symptoms from her multiple sclerosis (“MS”) or her alleged depression. Concerning Denomme's mental RFC, the ALJ accepted Denomme's claim that she was scared to be around people, even though she testified that her depression symptoms improved with medications, and the record illustrated that Denomme had been prescribed multiple antidepressant medications over the years to successfully manage her depression. As a result, even if the ALJ erred by failing to specify the weight he gave to Dr. Vrochopoulos's and Dr. Payne–Gair's opinions, any error was harmless. Denial affirmed.


Treating neurologist's multiple sclerosis diagnosis, along with results of nerve conduction studies and other objective testing, and neurologist's opinion that social security disability claimant met the medical listing for multiple sclerosis was not sufficient to establish that the claimant was “disabled” under the Social Security Act; although the testing showed abnormal results, and confirmed the multiple sclerosis diagnosis, there was no evidence of acute or chronic denervation, and the neurologist's opinion with respect to the medical listing went to an issue reserved to the ALJ. Social Security Act, § 205(g), 42 U.S.C.A. § 405(g)... The Court of Appeals held that: (1) substantial evidence supported ALJ's
decision not to give significant weight to treating physician's opinion that claimant was unable to perform any kind of gainful employment and should be considered permanently disabled, and (2) neurologist's multiple sclerosis diagnosis, along with results of objective testing, and neurologist's opinion that claimant met the medical listing for multiple sclerosis did not establish that the claimant was “disabled.” Commissioner’s denial is affirmed.

Brooks v. Astrue, 2016 WL 5436820, (11th Cir. 2016)

Substantial evidence supported ALJ's determination that claimant seeking disability insurance benefits retained residual functional capacity (RFC) to perform sedentary work, and thus was not disabled under Social Security Act; determination was based on wide range of evidence, including claimant's testimony, examination notes of treating physician, and examination and opinions of multiple non-treating consulting internists and psychiatrists. 20 C.F.R. § 404.1520(a).

On appeal, Brooks argues that the Commissioner's decision is not supported by substantial evidence because (1) the ALJ failed to properly weigh a disability finding of the VA; (2) the ALJ mis-characterized or misstated the record evidence; (3) the ALJ impermissibly acted as his own expert; and (4) the ALJ impermissibly “picks and chooses” through the evidence. Brooks also argues that the ALJ failed to give appropriate weight to the opinion of Brooks' treating physician. In sum, Brooks argues that the decision of the Commissioner must be vacated because the ALJ failed to give adequate weight to the evidence indicating that Brooks was disabled.

We disagree. As we have explained, “[t]he scheme of the Act places a very heavy initial burden on the claimant to establish existence of a disability.” Bloodworth v. Heckler, 703 F.2d 1233, 1240 (11th Cir. 1983). Our case law provides that even if a preponderance of the evidence weighs against the Commissioner's decision, we must affirm if substantial evidence supports the decision. Dyer v. Barnhart, 395 F.3d 1206, 1210 (11th Cir. 2005). Brooks offers no argument that the evidence relied upon by the ALJ—namely, Brooks' own testimony, examination notes submitted by Brooks' treating physician, and examinations and the opinions of multiple non-treating consulting internists and psychiatrists—was in any way not substantial. At this stage, we cannot reweigh the evidence, find facts anew, or substitute our judgment for the ALJ's
conclusions. Denial affirmed.

*Miller v. Commissioner of Soc. Sec.*, 246 Fed.Appx. 660 (11th Cir. 2007.)

Miller applied for disability insurance benefits in 2003 and alleged she became disabled on January 13, 2002, as a result of multiple sclerosis, lower back pain, numbness and tingling in her left side, depression, anxiety, asthma, chronic obstructive pulmonary disease, and hearing difficulty. An ALJ may rely solely on the testimony of a vocational expert in determining whether work is available in significant numbers in the national economy that a claimant is able to perform. See Jones, 190 F.3d at 1230. For the testimony of a vocational expert to constitute substantial evidence, “the ALJ must pose a hypothetical question which comprises all of the claimant's impairments.” Id. at 1229. If there is a conflict between the DOT and the jobs identified by a vocational expert in response to the hypothetical question, the testimony of the vocational expert “trumps” the DOT. Id. at 1229–30.

** Miller argues that, after our decision in Jones, the Commissioner published a ruling explaining that where a conflict exists between the DOT and the testimony of a vocational expert, neither automatically trumps the other.

The Commissioner correctly responds that agency rulings “do[ ] not bind this [C]ourt.” See *B.B. v. Schweiker*, 643 F.2d 1069, 1071 (5th Cir. Unit B Apr. 1981). “ ‘Rulings do not have the force and effect of the law or regulations but are to be relied upon as precedents in determining other cases where the facts are basically the same. A ruling may be superceded, modified, or revoked by later legislation, regulations, court decisions or rulings.’ ” *Heckler v. Edwards*, 465 U.S. 870, 874 n. 3, 104 S.Ct. 1532, 1535 n. 3, 79 L.Ed.2d 878 (1984) MS not established. Decision denying benefits affirmed.

**Decisions from the FDC Georgia**


Plaintiff Collins filed applications for disability insurance benefits and supplemental security income benefits on December 29, 2004, alleging disability since March 1, 2004, due to lumbar scoliosis, multiple sclerosis, and borderline intellectual functioning. The record does not reveal or confirm a definite diagnosis of multiple sclerosis, only that such a diagnosis is or has been “possible.” Plaintiff's treating physician, Dr. Jaquez, seems to rely on past medical records in issuing a December, 2006
opinion of disability, citing plaintiff's disabling diagnosis as “Multiple Sclerosis—possible primary progressive MS”. Prior treatment records from the Shepherd Center reference a diagnosis of “spastic paraparesis,” and “possible primary progressive multiple sclerosis,” although other notes indicate that there is “[n]o definite evidence of primary, progressive multiple sclerosis, but not completely ruled out,” as well as revealing that “[t]he workup for MS has been negative.” Dr. Jaquez does not point to any new or intervening diagnosis of multiple sclerosis or to any treatment notes that reveal such a definitive diagnosis. Accordingly, the ALJ's finding that the plaintiff's condition did not meet or equal Listing 11.09 was proper and is supported by substantial evidence. Denial affirmed.

Thompson v. Colvin, WL 1038743 (N.D. Georgia, Atlanta Division, 2015)

The evidence shows that the claimant has a history of onset diagnosis of multiple sclerosis after experiencing grand mal seizures. She is treated by neurologist Joseph Hormes, M.D., for multiple sclerosis as well as her seizure disorder. The claimant has the following severe impairments: major depressive disorder, multiple sclerosis, mild ataxia, and decreased vision. (20 C.F.R. § 404.1520(c)).

As for multiple sclerosis, the evidence shows that the claimant reports being diagnosed with the condition in 1999, following an onset initially marked by grand mal seizures. A December 2008 MRI of the claimant's brain shows multiple lesions consistent with a diagnosis of multiple sclerosis. Progress notes from Dr. Hormes in September 2009 show that he assesses the claimant with a neurogenic bladder secondary to multiple sclerosis, and he notes that she successfully manages use of an intermittent self-catheter. In progress notes from March 2010, Dr. Hormes assesses her with multiple sclerosis that is relapsing and remitting and a neurogenic bladder in remission. Dr. Hormes notes that the claimant has a Rubral tremor in the right upper extremity and prescribes treatment of Avonex intramuscularly once a week. General examination notes from Primary Care Partners in March 2011 show that the claimant is diagnosed with multiple sclerosis and that her reflexes are normal, with treatment deferred to neurology. Dr. Hormes opines that the claimant is unable to perform any job that requires physical activity.

“[T]he ALJ must state with particularity the weight given to different medical opinions and the reasons therefor.” Winschel, 631 F.3d at 1179 (citing Sharfarz v. Bowen, 825 F.2d 278, 279 (11th Cir.1987) (per curiam)); accord 20 C.F.R. §§
In the absence of such a statement, it is impossible for a reviewing court to determine whether the ultimate decision on the merits of the claim is rational and supported by substantial evidence.” Cowart v. Schweiker, 662 F.2d 731, 735 (11th Cir.1981). The ALJ did not address statements made by Dr. Berger which reflect his judgment about Plaintiff's hand tremors and poor motor skills and the impact these would have on her ability to maintain pace and complete tasks in a timely manner while working on a regular and continuing basis. Although the ALJ stated that she gave substantial weight to Dr. Berger's opinion, she rejected many of his opinions without explanation and found that Plaintiff had no limitations in her ability to complete tasks and maintain a consistent and competitive pace. [R. at 16]. The ALJ may have considered and implicitly rejected Dr. Berger's opinions, but the court is unable to determine if the rejection was supported by substantial evidence because the ALJ did not offer any supporting reasons. See Cowart, 662 F.2d at 735.

In summary, the ALJ did not properly evaluate the opinion of examining psychologist Dr. Berger who found that Plaintiff's physiological complications caused by her multiple sclerosis would likely interfere with her ability to maintain pace and complete tasks in a timely manner and that she would likely experience difficulties when attempting to work on a regular and continuing basis. (Reversed. Chuck Martin)

Foster v. Richardson, 335 F.Supp. 30 (N. D. Georgia, Atlanta Division 1971)

In 1960, plaintiff was diagnosed as having multiple sclerosis, a disease from which she now suffers and which now, without question, constitutes a disability impairment within the meaning of the Social Security Act. The difficult question in this case is not whether she is now disabled, but rather was she so disabled on September 30, 1956, the date all agree she last was eligible for benefits under the Act.

Plaintiff was seen by Donald W. Paty, M. D., at the request of her counsel in February, 1970. After a thorough neurological evaluation, he found that her disease of multiple sclerosis definitely started in 1957, and that the symptoms she had such as weakness of ankles, unsteadiness with eyes closed and occasional falling were probably due to this disease. He stated in a subsequent letter that “because of the extreme variability in symptoms in multiple sclerosis, we would find it hard, if not impossible, to assign a value to the disabling effects of symptoms without having observed or examined the patient during the period in question.” The use of the medical advisor in the instant case is not as critical as in the case
above cited because he is not forced to choose between conflicting medical opinions. If Dr. Brandt's evidence is disregarded, we are still left with the statement of her own expert, “In our experience these vague symptoms may proceed the time of diagnosis of multiple sclerosis for years. ... We cannot make any statement as to the degree of disability due to these symptoms. ... Because of the extreme variability in symptoms in multiple sclerosis, we find it hard, if not impossible, to assign a value to the disability effect of symptoms without having observed or examined the patient during the period in question.”

It was well said in *Patrick v. Finch* (D.C.Ky., 1970) 312 F.Supp. 121: “The award of [social security disability] benefits cannot rest upon imagination, speculation, conjecture, or sympathy-only credible proof in some form will suffice.” Denial affirmed.

*Ellison v. Colvin*, 2015 WL 1419595 (Southern District Court, Savannah Division. 2015)

Dr. Lafranchise noted that plaintiff had no new symptoms, but she stated that she was unable to continue working as a housekeeper “because of her neurologic deficits.” Dr. Lafranchise noted that he did “not think she will be able to return to work and she should be considered completely disabled.” (Id.) She still suffered from right hemisensory deficits and had leg clumsiness and gain instability. An MRI in 2011 showed that little had changed. Her lesion profusion remained mild. Several follow-up appointments consistently showed that her MS-related symptoms had not changed or progressed, though the doctor changed his headache diagnosis from tension headaches to migraines.

The ALJ found that Ellison had two step-two severe impairments: multiple sclerosis and degenerative disc disease of the cervical spine. Neither met a listing at step three. (Id.) At step four, the ALJ discounted the treating physician statements and found that plaintiff has the residual functional capacity to perform light work as defined in 20 CFR 404.1567(b) and 416.967(b) except...(multiple restrictions noted)

After consulting with a vocational expert (“VE”), the ALJ found that although Ellison is unable to perform any past work, she could return to work as a “furniture rental consultant,” a “sales attendant,” and a “ticket taker.” (Tr. 23.) She was thus not disabled at step five.

Dr. Sesay's implied finding that Ellison is perpetually suffering from MS-related “flares” at best exaggerated the situation, since Ellison reported that they occur “[m]aybe once every two weeks. Denial affirmed.
Physician's diagnosis of Social Security disability claimant as suffering from multiple sclerosis (MS), and accompanying evaluation of symptoms, was not material new evidence warranting remand to administrative law judge (ALJ) of benefits denial, where diagnosis of MS had been established at time of ALJ's hearing, and new evaluation was not qualitatively different from earlier physicians' examinations.

Substantial evidence supported administrative law judge's (ALJ) finding of non-disability as to claimant suffering from multiple sclerosis, including physicians' characterization of speech difficulties as minimal, claimant's questionable credibility, and claimant's engaging in physical activities at least as strenuous as most recent, sedentary, occupation.

Plaintiff first began having symptoms diagnosed as multiple sclerosis (“MS”) in 1958. MS is a progressive disease of the central nervous system that destroys the protective covering of nerve fibers in both the brain and the spinal cord. The disease is characterized by episodic symptoms that include numbness, weakness, incontinence, slurred speech, fatigue, clumsiness and unsteady gait, blurred or double vision, and mood changes.

While Plaintiff did exhibit an array of symptoms that suggested MS, these symptoms did not seem “profoundly complicating.” Based on this evidence, the ALJ made findings of fact that while Plaintiff suffers from severe impairments that limit him to sedentary work, Plaintiff's limitations nevertheless do not preclude him from performing his past relevant work as the manager of a travel agency. Denial Affirmed.


The ALJ found that Plaintiff has the following impairments which are considered “severe” impairments within the meaning of the Social Security Regulations: chronic multiple sclerosis pain, fibromyalgia, cervical spine pain, chronic opioid usage and obesity.
The Eleventh Circuit has consistently held that the opinions of treating physicians must be accorded substantial or considerable weight by the Commissioner unless good cause exists to discredit these opinions. See Lewis, 125 F.3d at 1440; Lamb v. Bowen, 847 F.2d 698, 703 (11th Cir.1988); Walker v. Bowen, 826 F.2d 996, 1000 (11th Cir.1987); MacGregor v. Bowen, 786 F.2d 1050, 1053 (11th Cir.1986); Broughton v. Heckler, 776 F.2d 960, 961 (11th Cir.1985). “Good cause exists ‘when the: (1) treating physician's opinion was not bolstered by the evidence; (2) evidence supported a contrary finding; or (3) treating physician's opinion was conclusory or inconsistent with the doctor's own medical records.’ ” Winschel v. Comm'r of Social Sec., 631 F.3d 1176, 1179 (11th Cir.2011) (quoting Phillips, 357 F.3d at 1241).

The agency medical consultant who completed a Physical RFC Assessment in November 2010 and opined that Plaintiff could frequently lift and/or carry 25 pounds and occasionally lift 50 pounds as well as sit, stand and walk for 6 hours out of an 8–hour workdayIn support of that opinion, Dr. Callins found “inconsistent phys. findings widespread in [the medical record evidence]” on Plaintiff's alleged chronic MS pain and that Dr. Walker, the consultative examiner, had noted that Plaintiff's complaints of chronic MS pain were exaggerated as were Plaintiff's alleged cervical spine limitations which were mild not severe. [R. at 551]. Dr. Callins also found that “No MDI was established for fibromyalgia” and that “Inconsistencies between claimant's allegations and [medical record evidence (‘MER’)] continue to be significant, despite addition of new MER for the purpose of clarification. Denial of benefits affirmed.


Through the date last insured, the claimant had the following severe impairment: multiple sclerosis Through the date last insured, the claimant had the residual functional capacity (“RFC”) to perform the full range of light work as defined in 20 C.F.R. 404.1567(b).2 Thus, through the date last insured, the claimant was capable of performing past relevant work as a sales associate and realtor.3

The notes suggested that although Plaintiff no doubt suffers symptoms of multiple sclerosis, she was responding to medication that allowed a level of functioning that would not warrant a finding of disabled even as of the date of the exam, which was just two months shy of two years past her last insured date.
In sum, the ALJ repeatedly acknowledged the progressive nature of multiple sclerosis but noted in the summation of his review of the medical evidence that Plaintiff's treatment for the disease was “rather conservative.” Denial affirmed.


The mere existence of impairments does not establish disability; instead, the ALJ must determine how a claimant's impairments limit her ability to work. *Moore v. Barnhart*, 405 F.3d 1208, 1213 n. 6 (11th Cir.2005).

Here, the ALJ specifically stated that he reviewed the entire record, ultimately concluding that Claimant's statements concerning the intensity, persistence and limiting effects of these symptoms were not entirely credible. The ALJ found that Claimant's allegations of disabling pain were not consistent with either treatment notes in the record or her statements regarding her functional abilities. (Id.) The ALJ based these findings on the accounts of daily living as testified to by Claimant at the hearing where she was represented by an attorney, as well as the absence of medical findings that would corroborate her allegations regarding the intensity, duration, and limiting effects of her impairments. (Id.)

Specifically, while the ALJ did accept Claimant's diagnosis of multiple sclerosis, he noted the lack of medical evidence to support the functional limitations or the level of pain alleged by Claimant. Denial affirmed.


Plaintiff mentioned she had been diagnosed with MS. Case, however, case hinged on Listings 12.04 & 12.06. MS was not a serious issue. Denial affirmed on grounds other than MS.


MS noted to be a non severe impairment. Not otherwise developed.

Cases from F. D. C. Alabama
Ms. Cagle was forty-four years old at the time of the alleged disability onset date, and she has a high school education. (Tr. at 26). Her past work experience includes employment as an appointment clerk, medical assistant, and nurse assistant. (Id.) Ms. Cagle amended her alleged disability onset date to May 4, 2011. (Tr. at 19). She alleges that she became disabled due to multiple sclerosis, high blood pressure, and anxiety. (Tr. at 168).

According to the ALJ, the plaintiff's degenerative disc disease of the cervical spine, mild to moderate multiple sclerosis (“MS”), hypertension, anxiety, depression, and borderline intellectual functioning are considered “severe” based on the requirements set forth in the regulations.

On July 25, 2012, the plaintiff's treating physician, Dr. LaGanke, completed a Patient Functional Questionnaire. Dr. LaGanke stated he had seen the plaintiff fourteen times since December of 2008. (Id.) He noted that the plaintiff had the diagnoses of multiple sclerosis, hypertension, and leg cramps. (Id.) He opined that, during an eight-hour workday, the plaintiff could sit for one hour at a time with a fifteen-minute break, stand for one hour at a time with a fifteen-minute break, and can walk between zero and one hours at a time with a fifteen-minute break. (Id.) He further claimed that, during an eight-hour workday, the plaintiff can sit for a total of two to three hours, stand for a total of one to two hours, walk for a total of two to three hours, and must lie down for two to three hours during the day to alleviate pain. (Tr. at 334). According to Dr. LaGanke, even under the best circumstances, the plaintiff would miss a total of fifty full or partial days of work over the course of a year.

[L]imitations noted by Dr. LaGanke, that pertain to her MS are minimal and consist only of an ataxic gait and an abnormal tandem walk,... Otherwise, she was neurologically intact and had no visual disturbance associated with MS. The claimant also complained of fatigue, but none of Dr. LaGanke's findings in the treatment records is sufficient to support the medical source statement that is alleged to have been completed by him in July 2012. That assessment showed the claimant's impairments would result in significant limitations in her ability to sustain work activity for an eight-hour workday While Dr. LaGanke has been a treating source for a significant period of time, the medical source statement he provided cannot be given significant weight. In fact, the statement is rejected as the conclusions are in the form of a checklist and the treating notes do not provide objective evidence of the limitations asserted. Hence, it is determined to be more of an aide to the claimant's quest for disability benefits rather than an actual assessment based on the
Finally, the ALJ stated that the “[r]ecords show a long history of treatment for MS, but only minimal resulting limitations, with an ataxic gait and abnormal tandem walking noted.” Denial of benefits affirmed.


Gaylord completed her high school education. (Tr. 213). Her past relevant work includes waitressing and bartending. (Tr. 213). Ms. Gaylord claims she became disabled on February 15, 2008, due to multiple sclerosis (“MS”), migraines, and anxiety.

The ALJ concluded that Ms. Gaylord's impairments do not prevent her from performing her past relevant work. (Tr. 19). The ALJ determined Ms. Gaylord retains a residual functioning capacity (“RFC”) to perform a full range of light work with the exception that she is never to climb ladders, ropes, or scaffolds and she must avoid exposure to extreme cold, extreme heat, wetness, and humidity.

Dr. Eslami continued his treatment of the claimant into February of 2009, where again he reported that Ms. Gaylord's strength, coordination, gait, and cerebellar function were normal. Similarly, Dr. Eslami examined Ms. Gaylord twice in 2010 and noted that Ms. Gaylord's strength was fair, gait was broad based, and her cranial nerves were “unremarkable.” Dr. Eslami maintained his opinion that Ms. Gaylord's MS was in remission through his last visit with Ms. Gaylord in November of 2012. Despite his remission opinion, Dr. Eslami did note that Ms. Gaylord was suffering back spasms, leg craps, and headaches. Nevertheless, Dr. Eslami never withdrew his remission diagnosis.

The ALJ discredited Dr. Riser's opinion testimony because the doctor's own report and the record as a whole do not support the doctor's findings. Denial affirmed.


Introduction. Neal was born on November 15, 1963. (R. 118). Neal alleges she is unable to work due to multiple sclerosis (“MS”), degenerative disk disease of the cervical spine, restless leg syndrome, and depression. Her past work experience consists of work as an elementary school teacher.

Following the hearing, the ALJ concluded that Neal had the following severe
impairments: multiple sclerosis and degenerative disc disease of the cervical spine

The ALJ determined that Neal had the residual functional capacity to perform sedentary work as defined in 20 CFR 404.1567(a) except the claimant may alternate between sitting or standing at 30–60 minute intervals while remaining at her work place.

Dr. Bryan, Neal's treating neurologist, on March 14, 2011 indicated that, in his opinion, since 2007 Neal had been suffering from “significant and persistent disorganization of motor function in two extremities, resulting in sustained disturbance of gross and dextrous movements, or gait and station;” “a visual impairment mal with loss of visual acuity, contraction of the visual field in the better eye, and/or loss of visual efficiency” (which Dr. Bryan explained consisted of “persistent blurred vision”); and “significant, reproducible fatigue of motor function with substantial muscle weakness on repetitive activity, demonstrated on physical examination, resulting from neurological dysfunction in areas of the central nervous system known to be pathologically involved by the multiple sclerosis process.” Accordingly, the court finds that the opinion of Neal's treating neurologist was material because it is “relevant and probative so that there is a reasonable possibility that it would change the administrative outcome.” *Caulder* 791 F.2d at 877

This case presents a peculiar situation. New and material evidence was properly submitted to the Appeals Council; however, because the new evidence was never placed in Neal's file, the Appeals Council was completely unaware of the new evidence at the time of its decision to deny review. Therefore, the Appeals Council did not consider the new evidence at all. Neal argues that the case must be reversed and remanded because the Appeals Council failed to consider the new evidence at all before denying review.

Where a claimant seeks review by the Appeals Council of an adverse ruling by an ALJ, the Appeals Council has discretion not to review the ALJ's denial of benefits. See 20 CFR § 404.981. However, “[w]hen the Appeals Council refuses to consider new evidence submitted to it and denies review, that decision is ... subject to judicial review because it amounts to an error of law.” *Keeton v. Dep't of Health & Human Servs.*, 21 F.3d 1064, 1066 (11th Cir.1994).

“When a claimant properly presents new evidence, and the Appeals Council denies review, the Appeals Council must show in its written denial that it has adequately evaluated the new evidence.” *Flowers v. Comm'r of Soc. Sec.*, 441 Fed. Appx. 735, 745, 2011 WL 4509878, 8 (11th Cir.2011) (panel decision) (citing *Epps v. Harris*, 624 F.2d 1267, 1273 (5th Cir.1980)). The Appeals Council's written denial does not
refer to the new evidence (R. 2), and the Commissioner admits that the Appeals Council was unaware of the evidence at the time of the decision. Although Neal does not argue that this case should be remanded under Flowers and Epps for the Appeals Council's failure to show in its written denial that it adequately evaluated the new evidence before denying review, this failure alone would constitute grounds for reversal. See Epps, 624 F.2d at 1273 (“Although the Appeals Council acknowledged that [the claimant] had submitted new evidence, it did not adequately evaluate it. Rather, it perfunctorily adhered to the decision of the hearing examiner. This failure alone makes us unable to hold that the [Commissioner]'s findings are supported by substantial evidence and requires us to remand this case for a determination of [the claimant's] disability eligibility reached on the total record.”); see also Cornelius, 936 F.2d at 1145–46 (holding that the Commissioner's “failure ... to provide the reviewing court with sufficient reasoning for determining that the proper legal analysis has been conducted mandates reversal.”).

The new evidence was relevant to the time period before the date of the ALJ's hearing decision. See 20 CFR § 404.970 (providing that, in determining whether to review a case, the Appeals Council must consider “additional evidence only where it relates to the period on or before the date of the administrative law judge hearing decision”). The new evidence is material because it consists of a medical opinion by a treating physician regarding the presence of medical signs and symptoms of a listed impairment during the relevant time period. See 20 CFR Pt. 404, Subpt. P, App. 1, § 11.09 (listing for multiple sclerosis); 20 CFR § 404.970 (providing that, in determining whether to review a case, “[i]f new and material evidence is submitted, the Appeals Council shall consider” the evidence). “A treating physician's opinion ‘must be given substantial or considerable weight unless ‘good cause’ is shown to the contrary.’ “Crawford v. Comm'r of Soc. Sec., 363 F.3d 1155, 1159 (11th Cir.2004) (quotation marks omitted); see also 20 C.F.R. §§ 404.1527(d)(2), 416.927(d)(2).

Even if the new evidence is not a “medical opinion” by a treating physician, it was still due to be included in the administrative record and considered by the Appeals Council, at the very least, under 20 C.F.R. § 404.1527(d)(2)-(3), which provides that, while not dispositive, the Commissioner will consider medical source opinions on whether an impairment meets or medically equals one of the listed impairments. Cf. Caulder v. Bowen, 791 F.2d 872, 877–78 (11th Cir.1986) (holding that a physician's “medical opinion on the presence of the impairment during the time period for which benefits are sought” was new and material evidence that should be considered by the Appeals Council, and explaining that, while the court “agree[d] with the [Commissioner's] assertion that a physician's statement that a claimant is disabled is not dispositive of the issue of disability[,] the statement,
however, must be considered in the [Commissioner]'s examination of the totality of the evidence.

Accordingly, the court finds that the opinion of Neal's treating neurologist was material because it is “relevant and probative so that there is a reasonable possibility that it would change the administrative outcome.” Caulder 791 F.2d at 877.10 The Appeals Council erred as a matter of law in not considering the evidence at all when determining whether to review the decision of the ALJ. See 20 CFR § 404.970(b); Epps, 624 F.2d at 1273 (holding that, in light of the Appeals Council's failure to show that it had adequately considered new evidence that had been properly submitted to it, the court was unable to determine whether the Appeals Council's decision to deny review was supported by substantial evidence).

Therefore, the court will not consider the letter from the Administrative Appeals Judge, and the letter does not change the court's conclusion that the opinion of Neal's treating neurologist is “relevant and probative so that there is a reasonable possibility that it would change the administrative outcome.” Caulder, 791 F.2d at 877. Case remanded for further consideration.


Ms. Holmes testified that she had difficulty maintaining her balance and that her legs felt uncoordinated. She stated further that she was constantly in pain and fatigued. The ALJ accepted Mrs. Holmes' allegations and testimony that she suffers from multiple sclerosis and found that she was unable to perform her past job as a cashier.

Under Paragraph 11.09(A), plaintiff must show that she suffers multiple sclerosis with [“significant and persistent disorganization of motor function in two extremities, resulting in sustained disturbance of gross and dexterous movements, or gait and station.”] Defendant [Commissioner of Social Security] argues that plaintiff's condition did not reach the level of significance required. Under Paragraph 11.09(C), plaintiff must show [“significant, reproducible fatigue of motor function with substantial muscle weakness on repetitive activity demonstrated on physical examination resulting from neurological dysfunction in areas of the central nervous system known to be pathologically involved by the multiple sclerosis process.”] Defendant contends that the record contains no evidence of reproducible fatigue. Defendant further argues that there is no evidence of abnormal
menta conditions or cranial nerve problems. Although plaintiff in her memorandum makes the statement that plaintiff's testimony regarding fatigue is consistent with the diagnosis of multiple sclerosis, plaintiff fails to point to any objective medical evidence of record of the required significant reproducible fatigue of motor function with muscle weakness on repetitive activity.

Thus, the ALJ's conclusion that plaintiff’s multiple sclerosis does not meet the requirements of the listings at 20 C.F.R. § 404.1525, App. 1, Paragraphs 11.09(A) or 11.09(C), is supported by substantial evidence. Denial affirmed.


At the time of the administrative hearing, Daniels was twenty-eight years old, had completed two years of vocational education at a community college (Tr. 78), and had previous work experience as a janitor, retail salesclerk, and cashier/stocker/storekeeper. Plaintiff alleges disability due to Multiple Sclerosis (hereinafter MS), neuropathy, hypertension, obesity, and cognitive loss.

On June 3, 2013, Dr. Khurram Bashir, at the UAB MS Clinic, examined Daniels, noting that he had examined him more than six years earlier for MS-related problems though Plaintiff never started disease-modifying therapy. Plaintiff rated his pain at seven. The Doctor noted that a recent brain MRI, when compared to one from 2007, showed worsening demyelinating disease, with new right temporal, and several left parietal, lobe deep white matter lesions, suggesting MS. Bashir found full motor strength throughout and normal independent gait and coordination. The Doctor's impression was that Daniels had relapsing remitting MS and acute MS relapse, presenting as partial cervical transverse myelitis, mild to moderate in severity, affecting his gait. Appropriate medications were prescribed and a regular exercise regimen was encouraged.

As for the opinion evidence, little weight is accorded Dr. Goff's opinions as reflected in his report of evaluation and accompanying mental medical source opinion form given their inconsistency internally and with the other evidence of record (Exhibit 9F). Dr. Goff's mental status examination and test results provide no basis for his opinion that the claimant has a marked degree of limitation in his ability to respond to customary work pressures. The claimant stopped working long before he was diagnosed with MS and before the condition became symptomatic. Denial affirmed.

At Step Two, the ALJ found Bethune has the following severe impairments: multiple sclerosis ("MS") and dysthymic disorder.

Dr. Zaremba opined, generally, that Bethune's diagnoses of MS, migraine headaches, Gastric GIST tumors, and GI bleeding caused pain and fatigue such that he could not work. The ALJ gave Dr. Zaremba's opinion little weight because it was inconsistent with other record evidence, including examination findings from Bethune's treating physicians and another physical consultative examination. The ALJ provided a detailed explanation of his findings, pointing to specific inconsistencies between Dr. Zaremba's examination and opinion and the other evidence of record. The ALJ stated that Dr. Zaremba diagnosed Bethune's MS as relapsing-unremitting; however, Dr. Bashir, a specialist in that field, diagnosed MS relapsing-remitting, consistent with evidence of no acute exacerbation since October 2011. Additionally, Dr. Zaremba characterizes Bethune as having chronic neck and back pain due to MS-related spinal cord lesions in direct contradiction to Dr. Bashir's findings that Bethune's back complaints are unrelated to MS. Dr. Zaremba's characterization of Bethune's migraines as moderately severe is consistent with the other evidence of record; however, as noted, those headaches do not occur as frequently or last as long as Bethune has alleged.

An ALJ is free to reject the opinion of any physician when evidence supports a contrary conclusion. Ellison v. Barnhart, 355 F.3d 1272, 1276 (11th Cir. 2003). That is precisely what the ALJ did here.... Denial affirmed.


Although Plaintiff alleges that her disability began in October 2007, the ALJ properly recognized that there is no medical evidence of record prior to April 2010. Additionally, Plaintiff's eventual treating physician, Dr. Hogan, reported in December 2010 that extensive evaluation had revealed a normal Lumbar Puncture (LP) and Multiple Sclerosis (MS) profile as well as a normal Visual Evoked Potential (VEP), revealing that it was very possible that changes in Plaintiff's brain MRI were vascular. Dr. Hogan has not diagnosed Plaintiff with MS and, while he has provided a limited supply of pain medications, has never reported that Plaintiff had disabling pain or limitations from any of her impairments or combinations of impairments.

The objective medical and other evidence supports the ALJ's conclusion that
Plaintiff's condition did not cause disabling limitations and instead shows that she could perform a reduced range of light work. The ALJ's determination that Plaintiff's testimony of her disabling pain was not credible is supported by substantial evidence. This Court will not substitute its judgment for that of the ALJ's when, as here, it is supported by substantial evidence. Denial affirmed.


Plaintiff files this appeal from the Commissioner's denial of her claim for a period of disability and disability insurance benefits. The parties have consented (doc. 18) to the exercise of jurisdiction by the Magistrate Judge and this case has been referred (doc. 19) to the undersigned to conduct all proceedings and order the entry of judgment....

...Plaintiff also had been diagnosed with possible multiple sclerosis, but her neurologist ruled out that condition in January 2009.... Denial affirmed.


At Step One, the ALJ found Cagle has not engaged in substantial gainful activity since the application date. (Tr. 26). At Step Two, the ALJ found Cagle had the following severe impairments: vasovagal syndrome, seizure disorder, multiple sclerosis (relapsing-remitting), headaches, an adjustment disorder with anxiety and depressed mood, and polysubstance abuse.

No discussion of MS in the record. Denial otherwise affirmed.


Dr. Barr order another brain scan because of the abnormal brain MRI and possible multiple sclerosis. (R. 305). The March 3, 2008 brain scan produced no evidence of abnormality. Id. Denial affirmed.

**Cases in FDC Florida**


She filed claims for Social Security disability benefits and supplemental security income payments (SSI), alleging that she became disabled due to multiple sclerosis.

The law judge found that the plaintiff has severe neurological symptoms of
uncertain etiology. He concluded that the medical evidence was conflicting and did not sufficiently confirm her claim of having multiple sclerosis.

Significant disagreement exists among the doctors as to the plaintiff's diagnosis. Since her alleged onset of disability in 1999, one doctor ruled out multiple sclerosis; two doctors were unclear as to the etiology of the symptoms, some doctors reported multiple sclerosis to be a possibility, one said it was likely, and others positively diagnosed her with multiple sclerosis.

Dr. Gerling testified, based upon his review of the medical records, that the plaintiff did not meet the threshold showing that supports a diagnosis of multiple sclerosis. In this respect, he testified that the MRI of the plaintiff's brain did not show typical lesions of multiple sclerosis. He explained that 92% of the time people who have multiple sclerosis have some typical lesions (id.). In addition, Dr. Gerling testified that tests of the plaintiff's spinal fluid did not demonstrate the typical abnormalities of multiple sclerosis. He said that over 90% of people with multiple sclerosis will have typical abnormalities in the spinal fluid. He concluded, based on these two circumstances, that the chance that the plaintiff has multiple sclerosis is in the range of 17% (id.). He said that, because the plaintiff does not meet the threshold showing for multiple sclerosis, he would not treat her for that condition. Moreover, the Commissioner suggests that, even if the law judge erred by failing to find that the plaintiff suffered from multiple sclerosis, the error was harmless. In this respect, what matters is not the disorder the plaintiff is diagnosed to have, but the functional limitations resulting from the disorder. *Davis v. Barnhart*, 2005 WL 2510227, (11th Cir.2005) (unpub. dec.) (“Disability is determined by the effect an impairment has on the claimant's ability to work, rather than the diagnosis of an impairment itself.”). The evidence does not compel a finding that, even if the plaintiff suffers from multiple sclerosis, her functional limitations are greater than those found by the law judge.

In any event, the law judge's failure to find that the plaintiff was suffering from multiple sclerosis would not constitute reversible error because such a finding would not change the determination of the plaintiff's residual functional capacity. Denial affirmed.


On May 12, 2011, Plaintiff filed an application for a period of disability and disability insurance benefits alleging she became unable to work on December 1, 2010 due to multiple sclerosis, anxiety, depression, double vision, weakness and numbness in her arms and legs, neck and back pain and daily headaches and migraines.
Accordingly, the ALJ ruled that Plaintiff has not been disabled through the date of the decision. Tr. 29-30. Two months after the hearing, Plaintiff submitted to the Appeals Council additional medical records dated May 2013. On July 15, 2014, the Appeals Council denied Plaintiff's request for review. Accordingly, the ALJ's April 9, 2013 decision is the final decision of the Commissioner. Plaintiff filed an appeal in this Court on November 12, 2014.

Plaintiff first asserts the ALJ failed to properly consider the combined effects of her multiple sclerosis with her other alleged impairments – degenerative disc disease; migraines and chronic headaches; neck and back pain; double vision, leg and arm weakness and numbness; and anxiety and depression – despite that these other impairments are the most common symptoms of multiple sclerosis, and they are well documented in the medical records. Plaintiff argues that the ALJ should have considered these impairments severe at step two and in combination with her multiple sclerosis in his RFC analysis at steps four and five of the sequential evaluation process. The Commissioner asserts that other than her multiple sclerosis, Plaintiff failed to show any of these other impairments significantly affected her ability to perform work-related activities and thus are severe. Moreover, the Commissioner argues, any error in the ALJ's finding that these other impairments are not severe is harmless because he found in Plaintiff's favor at step two and continued his analysis in the remaining steps in the sequential evaluation process. Id.

In this case, nowhere in the ALJ's opinion did he discuss, no less refer to, Dr. Drucker's examinations, his diagnosis and treatment of Plaintiff's diplopia nor his referral of Plaintiff to another physician for an opinion on whether surgery on her right eye was advisable. Nor did the ALJ discuss the orbital MRI done on Plaintiff. Furthermore, he did not discuss Dr. Hasan's records with regard to this diagnosis or treatment nor his opinion that Plaintiff needed surgery in her right eye. Without specifically addressing the objective medical evidence of Plaintiff's diplopia, the Court's review on appeal is frustrated. The undersigned cannot determine whether substantial evidence supports the ALJ decision at step two that Plaintiff's diplopia was not severe or whether the ALJ properly considered the medical evidence concerning this alleged impairment in combination with Plaintiff's other impairments at subsequent steps of the sequential evaluation process. Upon review of the record, the undersigned concludes that the ALJ failed to apply the proper legal standards, and thus his determination that the Plaintiff is not disabled is not supported by substantial evidence. Denial reversed & case remanded.

After reviewing Plaintiff's medical records and Plaintiff's testimony, the ALJ found that Plaintiff suffered from mild degenerative disc disease, diabetes mellitus neuropathy with pain, inactive multiple sclerosis, gall bladder disease, hypertension, and obesity, which were “severe” medically determinable impairments. Plaintiff now asserts three main points of error. First, she argues that the ALJ erred by failing to fully consider the opinions of her treating physician, Dr. Mickey and an examining psychiatrist, Dr. Raimondo. Second, she claims the ALJ erred by failing to properly incorporate all of the findings or state the weight given to the opinions of the state agency non-examining consultants. Third, Plaintiff contends the ALJ erred by failing to properly account for her functional limitations from peripheral neuropathy and obesity.

Plaintiff argues that the ALJ erred in determining her RFC because he failed to consider the full opinion of Plaintiff's treating physician, Dr. Mickey and made no reference at all to the opinion from the examining psychiatrist, Dr. Raimondo, in his decision, and such omission was error in light of the Eleventh Circuit's decision in Winschel v. Commissioner of Social Security, 631 F.3d 1176, 1179 (11th Cir.2011). In Winschel, the Eleventh Circuit held that whenever a physician offers a statement reflecting judgments about the nature and severity of a claimant's impairments, including symptoms, diagnosis, and prognosis, what the claimant can still do despite his or her impairments, and the claimant's physical and mental restrictions, the statement is an opinion requiring the ALJ to state with particularity the weight given to it and the reasons therefor. Id. (citing 20 CRF §§ 404.1527(a)(2), 416.927(a)(2); Sharfarz v. Bowen, supra). The Eleventh Circuit stated that “ '[i]n the absence of such a statement, it is impossible for a reviewing court to determine whether the ultimate decision on the merits of the claim is rational and supported by substantial evidence.' ” Winschel, 631 F.3d at 1178–79 (quoting Cowart v. Schwieker, 662 F.2d 731, 735 (11th Cir.1981)).

On June 8, 2010, Dr. Mickey completed a Medical Verification Form for Plaintiff indicating that Plaintiff had been diagnosed with multiple sclerosis and peripheral neuropathy. Dr. Mickey opined Plaintiff could not work (sitting down or standing up), could not volunteer, and could not go to school. R. 831. Dr. Mickey also opined that Plaintiff's ability to concentrate was limited due to pain. R. 831. Dr. Mickey opined Plaintiff's condition was permanent.

"If an action is to be upheld, it must be upheld on the same bases articulated in the agency's order.” Baker v. Comm'r of Soc. Sec., 384 Fed. Appx. 893, 896 (11th Cir. June 23, 2010)

Plaintiff began treatment with Dr. McDonald for multiple sclerosis in December 2009; he saw her in a follow up visit on March 22, 2010. R. 784–85. She reported that in December 2009 she had vision changes, had begun experiencing
numbness from the waist down, incontinence, and uncontrollable jerks of her body at times. She also reported that she was experiencing daily headaches. R. 784. On physical examination, Dr. McDonald noted Plaintiff had pin loss about halfway up her shin bilaterally. Dr. McDonald thought Plaintiff looked fairly well but did have some problems with the multiple sclerosis, and after neurological consultation with the neurologist, Dr. McDonald, Dr. Mickey recognized on two separate occasions that Plaintiff had been “newly diagnosed with multiple sclerosis,” as well as diabetic peripheral neuropathy, and opined that Plaintiff could not work. Dr. Mickey also opined that Plaintiff's ability to concentrate was limited due to pain and her condition was permanent.

Dr. Sklaroff noted that Plaintiff's compliance was a problem, but he was not “hard-nosed” about that because “long-term diabetes management is difficult,” and he confirmed there was evidence in the record of Plaintiff's neuropathy. He further opined that Plaintiff could be showing active peripheral neuropathy and possibly an “asymmetric component” ascribable to a prior multiple sclerosis event, which would preclude Plaintiff from lifting, bending, stooping, walking, sitting, standing and so forth.

Pursuant to Winschel, whenever a physician offers a statement reflecting judgments about the nature and severity of a claimant's impairments, including symptoms, diagnosis, and prognosis, what the claimant can still do despite his or her impairments, and the claimant's physical and mental restrictions, the statement is an opinion requiring the ALJ to state with particularity the weight given to it and the reasons therefore. 631 F.3d at 1179. Even treatment notes may constitute an opinion, as noted in Winschel....

For the reasons set forth above, the ALJ's decision is not consistent with the requirements of law and is not supported by substantial evidence. Accordingly, the Court REVERSES and REMANDS the Commissioner's decision pursuant to sentence four of 42 U.S.C. § 405(g). The Clerk of the Court is directed to enter judgment consistent with this opinion and, thereafter, to close the file. Denial reversed.


The ALJ found that Reilly has the following severe impairments: multiple sclerosis; obesity; a cognitive disorder; and an adjustment disorder; He is able to weed the yard, golf, watch television and go to the beach. He was able to go on a cruise and goes to his children's sporting events. He tolerates his medication well. In fact, his multiple sclerosis is in stable condition. Activities and
reports such as these are inconsistent with his allegations of incapacitating limitations or pain.

The claimant even stated that his symptoms have not worsened. In fact, when he stopped taking his Warfarin, his diffuse pain had resolved. Moreover, Dr. Gold's impression is that his multiple sclerosis is “stable.” The only finding on physical examination is some diminished sensation in his limbs. Otherwise, the claimant's motor examination is normal as well as his gait. Neurologically, progress notes show he is intact. Dr. Rivera's examination showed the claimant's hand-grip and his coordination were normal. There were no abnormalities in his cervical, thoracic, and lumbar spine. This further does not support Dr. Gold's opinion that the claimant has any deficits with feeling, pushing, or pulling. Dr. Rivera opined that based on the claimant's ability to perform work-related activities such as sitting, standing, walking, or lifting were not affected. Therefore, based upon the overall objective medical evidence and the minimal findings on physical examinations, I agree with the State Agency [consultants] that the claimant would be limited to light exertion. I do agree with Dr. Gold and the State Agency [consultants] that the claimant does have postural and environmental limitations.

When both exertional and nonexertional limitations affect a claimant's ability to work, the ALJ should make a specific finding as to whether the nonexertional limitations are severe enough to preclude a wide range of employment at the given work capacity level indicated by the exertional limitations. Courts will review this determination only to determine whether it is supported by substantial evidence. See Murray, 737 F.2d at 935; Allen v. Secretary of Health and Human Services, 726 F.2d 1470, 1473 (9th Cir.1984); Dellolio v. Heckler, 705 F.2d 123, 127-28 (5th Cir.1983); Hernandez v. Heckler, 704 F.2d 857, 862 (5th Cir.1983); Kirk, 667 F.2d at 537.

In the present case, the ALJ specifically found that Reilly could perform full range of light work and his additional limitations had little or no effect on his ability to perform work related activities. Denial affirmed.


The plaintiff, who was forty-nine years old at the time her insured status expired and who has the equivalent of a high school education, has worked as a medical assistant and secretary. She filed a claim for Social Security disability benefits, alleging that she became disabled due to multiple sclerosis, excess fluid around the brain, diabetes and arthritis
The law judge found that the plaintiff has severe impairments consisting of a history of multiple sclerosis, history of pseudotumor cerebri with irregular residual headache complaints, obesity, gastroesophageal reflux, diabetes mellitus, arthritis, hypertension and hyperlipidemia.

Based on the medical documentation, the law judge could determine that the plaintiff's impairments were not disabling. In this respect, the law judge stated that, during the pertinent time period, comprehensive physical examinations performed at hospitals were essentially normal. Specifically, a computerized tomography of the plaintiff's head was negative, and the plaintiff's neurological and musculoskeletal functioning were repeatedly found to be normal. Additionally, the law judge noted that the plaintiff's treating physician's progress notes during the insured period reflected “ailments that would not likely cause ... limitations for a 12–month period. Denial affirmed.


The undisputed evidence indicates that Mrs. Simms is now permanently disabled with multiple sclerosis. However, the plaintiff cannot recover disability insurance benefits unless she can demonstrate that this progressively degenerative disorder was sufficiently severe so as to render her ‘disabled’ within the meaning of Section 223(d)(1)(A) of the Act, 42 U.S.C. § 423(d)(1)(A), prior to expiration of her insured status on September 30, 1968.

The documentary medical evidence fully corroborated the live testimony and was quite extensive. The final diagnosis upon her discharge from St. Vincent's Hospital on May 20, 1969, was that she had multiple sclerosis, characterized by remissions and exacerbations. Reference was made therein to an episode of diplopia in June 1968 when the plaintiff became unable to turn her left eye to the side. This was followed by a remission of these symptoms, which, in turn, was followed by a recurrence which persisted approximately six weeks, only to subside once again.

Doctor Charles O. Joest, an obstetrician and gynecologist who has treated her from November 30, 1965, until the present on a continuous basis, concluded that the symptoms of multiple sclerosis became manifest on or about April 13, 1966, and have progressively increased in severity since that time. Doctor Joest felt ‘certain’ that she became unable, both mentally and physically, to work prior to September 30, 1968.

First of all, the administrative law judge's denial of the plaintiff's claim for disability benefits can be supported only by the conclusory opinion of the non-examining disability review physician that the claimant was not ‘disabled’
within the meaning of the Act on or before September 30, 1968. When viewed in the light of the medical opinions of three examining experts to the contrary, together with the uncontroverted testimony of Mrs. Mohr, Mrs. Simms and Mr. Simms that the plaintiff was unable to engage in normal housework activities much less ‘substantial gainful activity’, it cannot be said that the administrative law judge's opinion was bottomed on substantial evidence.

Alternatively, the administrative law judge appears to have misapplied his own regulation. As pointed out above, one of the two indices in the HEW regulations of sufficient severity of multiple sclerosis so as to constitute disabling impairment is ‘moderate motor deficits in two extremities'. It will be recalled that the evidence showed that, at that time, Mrs. Simms' right leg could not move at all and that she was forced to drag it. In addition, the movement of her hands was so restricted that she could not sew, hold pans, cook or perform other forms of housework. Furthermore, when Doctor Chandler examined her on September 12, 1967, her left arm and her left leg were numb and thus incapable of movement or feeling.

Denial reversed and case remanded.


Plaintiff alleges disability beginning on August 1, 2002 (the amended onset date), due to multiple sclerosis (“MS”) and a hearing loss. By way of summary, the ALJ determined that Plaintiff had the severe impairments of multiple sclerosis, relapsing-remitting type, and bilateral hearing loss, moderate to severe in left ear and mild to moderate in right ear.

Here, Plaintiff objects that the ALJ did not give controlling weight to the June 2007 opinion of Plaintiff's treating neurologist, as set forth in a Multiple Sclerosis Residual Functional Capacity questionnaire. In that document, Dr. Benezette opined that Plaintiff experienced significant and persistent disorganization of motor function in two extremities, specifically the left more than the right upper and lower extremities, resulting in sustained disturbance in gait and station.

Plaintiff presented to neurologist Dr. Jeffrey J. Ahmed. Plaintiff reported that she had not had a major flare-up of her multiple sclerosis in two years. Examination revealed that Plaintiff had some giveaway weakness at the hips on hip flexion during motor examination, but she had full power throughout.

Where a treating physician has merely made conclusory statements, the ALJ may afford them such weight as is supported by clinical or laboratory findings and other consistent evidence of a claimant's impairments. See *Wheeler v. Heckler*, 784
F.2d 1073, 1075 (11th Cir.1986); see also Schnor v. Bowen, 816 F.2d 578, 582
(11th Cir.1987). When a treating physician's opinion does not warrant controlling
weight, the ALJ must nevertheless weigh the medical opinion based on the 1) length
of the treatment relationship and the frequency of examination; 2) the nature and
extent of the treatment relationship; 3) the medical evidence supporting the opinion;
4) consistency with the record as a whole; 5) specialization in the medical issues at
issue; 6) other factors which tend to support or contradict the opinion. 20 C.F.R. §
404.1527(d). However, a treating physician's opinion is generally entitled to more
weight than a consulting physician's opinion. See Wilson v. Heckler, 734 F.2d 513,
518 (11th Cir.1984); see also 20 C.F.R. § 404.1527(d)(2).

Here, the ALJ did not find Plaintiff's statements concerning the intensity,
persistence and limiting effects of her symptoms to be entirely credible, noting, in
detail, that the medical evidence did not support her allegations. The ALJ also
detailed the absence of any hospitalizations, Plaintiff's statements that she has not
had a major flare up of her MS since 2002, the conservative and limited treatment
Plaintiff has undergone, and her refusal to undergo additional testing, medications
or use of an assistive device. Id. All of these findings have ample support in the
record. Although Plaintiff points out in her brief that no treating physician indicated
that she was exaggerating her symptoms and that Although “it is apparent that
[Plaintiff] suffered from chronic limitations resulting from her Multiple Sclerosis,”
the issue is not whether there is other evidence that supports Plaintiff, but whether
there is substantial evidence that supports the ALJ's determination. Here, that test is
met. A reviewing court will not disturb a clearly articulated credibility finding with
substantial supporting evidence in the record.

Denial Affirmed.

Garon v. Commissioner of Soc. Sec. , 2015 WL 1124708, U.S. D. C., M.D. Florida,
Fort Myers Division, (2015).

The ALJ noted that “[n]o additional objective medical testing confirmed this
condition. Physicians did not prescribe medications for multiple sclerosis. In
addition, no objective medical imaging confirmed the cause of the claimant's neck
pain. Moreover, a medically determinable impairment may not be established solely
on the basis of a claimant's allegations regarding symptoms [citations omitted].”
The ALJ found that Plaintiff’s allegations of multiple sclerosis was not a medically
determinable impairment, and was not a severe impairment.

Given the new evidence submitted to the Appeals Council confirming the
diagnosis of multiple sclerosis (“MS”), this Court should remand this case with
instructions to obtain a medical opinion regarding whether Ms. Garon's MS meets or equals the requirements of Listing 11.09.

The ALJ noted that “[n]o additional objective medical testing confirmed this condition. Physicians did not prescribe medications for multiple sclerosis. In addition, no objective medical imaging confirmed the cause of the claimant's neck pain. Moreover, a medically determinable impairment may not be established solely on the basis of a claimant's allegations regarding symptoms [citations omitted].” The ALJ found that Plaintiff's allegations of multiple sclerosis was not a medically determinable impairment, and was not a severe impairment.

Less than a month after this Decision, Plaintiff obtained an MRI on March 30, 2012, which showed “[m]ultiple periventricular and deep white matter foci of signal change. The findings would be compatible with demyelination/MS.” Less than two months after the MRI, Plaintiff saw Dr. DiTrapani–Stephenson who compared the past MRIs with the most recent MRI and noted a progression of lesions and diagnosed Plaintiff with relapsing remitting MS. Dr. DiTrapani–Stephenson attributed some of Plaintiff's complaints to MS. Dr. DiTrapani prescribed medication for Plaintiff and was in the process of determining the best MS medication for Plaintiff to take.

The new objective medical evidence of the MRI of March 30, 2012 and the report of Dr. DiTrapani–Stephenson relate to the possible diagnosis of MS in 2009. Plaintiff's disease had clearly progressed since 2009, and the progression did not simply occur from March 2, 2012, the date of the ALJ's decision until March 30, 2012, the date of the MRI. Therefore, the medical evidence of the MRI dated March 30, 2012 and Dr. DiTrapani–Stephenson's records relate to the period of time on or before the ALJ's decision.

Denial reversed and remanded for additional evaluation of new evidence.


Dr. Siano concluded plaintiff had no functional limitations from the headaches, gout, angina, enlarged heart, hypertension, neuropathy, GERD, and anxiety and only mild functional limitations from her uncontrolled diabetes, multiple sclerosis, back and hip pain, and obesity. T. 639–40. Dr. Siano also noted plaintiff's history of noncompliance.
Absent good cause, the opinion of a claimant's treating physician must be accorded considerable or substantial weight by the Commissioner. *Phillips v. Barnhart*, 357 F.3d 1232, 1240–41 (11th Cir.2004); *Lewis v. Callahan*, 125 F.3d 1436, 1440 (11th Cir.1997); *Broughton v. Heckler*, 776 F.2d 960, 960–61 (11th Cir.1985); *Jones v. Bowen*, 810 F.2d 1001, 1005 (11th Cir.1986). “Good cause” exists when: (1) the treating physician's opinion was not bolstered by the evidence; (2) the evidence supported a contrary finding; or (3) the treating physician's opinion was conclusory or inconsistent with the doctor's own medical records. *Phillips*, 357 F.3d at 1241; see also *Lewis*, 125 F.3d at 1440 (citing cases).

Review of the record does indeed confirm that Dr. Siano's opinions contain significant inconsistencies and lack support in the medical records; thus, the ALJ reasonably declined to rely on them.

In support of her second assignment of error—that the ALJ erred by failing to give sufficient weight to the opinions of advanced registered nurse practitioner Crystal Breland—plaintiff makes the same argument she made regarding the opinions of Dr. Harmon–Sheffield. The ALJ gave “little weight” to the opinions of Ms. Breland because he found them “inconsistent with the other evidence in the record.” The ALJ also found that the “treatment notes from Ms. Breland's clinic, the Washington County Health Department, fail[ed] to reveal the type of significant clinical and laboratory abnormalities one would expect if the claimant in fact were disabled.” The undersigned agrees that Ms. Breland's opinions were entitled to little weight. Not only are they inconsistent with and unsupported by other evidence in the record, but like Dr. Harmon–Sheffield's opinions, they also were conclusory in nature and expressed on pre-printed check-off forms. Moreover, as a nurse practitioner, Ms. Breland is not an “acceptable medical source” under the applicable regulations and her opinions “would only be afforded weight to the extent [they were] supported by the factors listed in 20 C.F.R. §§ 404.1527(c), and [were] consistent with the evidence of record.” *Busby v. Colvin*, No. 1:13cv215/MP/GRJ, 2015 WL 333068, at *7 (N.D.Fla. Jan.23, 2015); see also 20 C.F.R. §§ 404.1502, 404.1513(a), (d) (1); 416.902, 416.913(a)(d)(1); SSR 06–03p. The ALJ thus did not err in assigning little weight to Ms. Breland's opinions.

Turning to plaintiff's third assignment of error—that the ALJ erred by failing to give sufficient weight to the opinions of Dr. Joseph Siano—plaintiff argues that the ALJ should have given great weight to those opinions of Dr. Siano favored by plaintiff and failed to sufficiently explain his rationale for not doing so. The ALJ gave “no weight” to Dr. Siano's opinions, finding his examination “internally inconsistent to a high degree” and noting the “narrative indicates the claimant has little limitation related to her physical impairments, while the accompanying
checklist contains completely inconsistent limitations.” Review of the record does indeed confirm that Dr. Siano's opinions contain significant inconsistencies and lack support in the medical records; thus, the ALJ reasonably declined to rely on them. ALJ decision denying benefits is affirmed.


The ALJ concluded that the medical evidence showed that Yonce had multiple sclerosis, which was a severe impairment. This impairment did not meet or equal any of the impairments listed in the applicable social security regulations (the Listings) The ALJ did not doubt that Yonce was disabled as of the date of the decision. He found, however, that “the medical evidence simply does not support significant physical limitations from her alleged onset date to June 2001.”

John R. McCormick, M.D., and Hendrik Dinkla, M.D., treated Yonce since at least 1988. They determined that she had multiple sclerosis and optic neuritis (INO). “Multiple Sclerosis is a progressive central nervous system disorder that results in multiple neurological problems including trouble walking, fatigue and sensory loss.” Optic neuritis is often due to multiple sclerosis (MS), and results in rapid loss of vision and pain on moving the eye. It is subject to spontaneous remission and relapse, each relapse increasing the residual damage. (citing The Merck Manual 739 (17th ed.1999)). She also had degenerative lumbar spine disease.

After further testing, Dr. Shuster determined that Yonce had both MS and an inherited muscle disease, vacuolar myopathy,3 “that results in weakness and atrophy of the muscles and ... is also progressive.” Dr. Shuster (Mayo Clinic) opined that with “these two significant neurologic disorders, it is unlikely that Mrs. Yonce will be able to obtain gainful employment, as she would not likely be able to meet the physical demands of full-time employment.”

On February 6, 2004, Dr. Dinkla wrote as follows: “Mary Yonce has a long history of multiple sclerosis with severe fatigue, moderate spasticity. She also had an inflammatory myopathy. She has been disabled since June 2001.” The ALJ placed great reliance on the opinions of the reviewing physicians to determine that Yonce was not disabled before June 30, 2001. However, as noted above, these reviewing physicians did not have the benefit of Dr. Shuster's records, which showed that Yonce had an inherited neurological condition, vacuolar myopathy, that had not been diagnosed by Drs. McCormick and Dinkla. This additional neurological condition provided further support for Yonce's complaints of leg weakness and related problems within the insured period.

ORDERED that the decision of the Commissioner is REVERSED and that
the case is REMANDED for further proceedings.


At step two, the law judge found that Plaintiff had severe impairments of multiple sclerosis and obesity.

Plaintiff submitted documents dated September 13, 2013, nearly four months after the ALJ's decision, from Lane Carlin, M.D., Florida Neurology Group, in one of which Dr. Carlin opined in a two-line letter:

“Mr. McPherson is totally and permanently disabled due to multiple sclerosis. He has disabling fatigue, right body paresthesia and clumsiness requiring the use of a cane and severe hot flashes.”

“[W]hen a claimant properly presents new evidence to the Appeals Council, a reviewing court must consider whether that new evidence renders the denial of benefits erroneous.” Ingram, 496 F.3d at 1262

Here, clearly Plaintiff's MS existed prior to the ALJ's decision. Thus, any evidence showing an exacerbation of his condition is not probative to the disability decision at issue. Moreover, as noted by the Commissioner, the hospital notes show that Plaintiff's condition improved significantly during his stay. Tr. 367. A similar analysis applies to the September 2013 report from Dr. Carlin, concluding that Plaintiff was “totally and permanently disabled.” First, as with the Lee Memorial records, the documents from Plaintiff's neurosurgeon nearly three months after the ALJ's decision are neither new nor noncumulative. They did not reveal an undiscovered, preexisting condition, but rather, revealed that Plaintiff's MS had deteriorated to the extent described in Dr. Lane's report: “disabling fatigue, right body paresthesia and clumsiness requiring the use of a cane and severe hot flashes,” in which the physician concluded that Plaintiff was “totally and permanently disabled due to multiple sclerosis.” Tr. 372. Furthermore, the decision whether an individual is disabled and unable to work under the Social Security regulations is reserved to the Commissioner. Lanier v. Comm'r of Soc. Sec., 252 Fed. App'x 311, 314 (11th Cir.2007); see also 20 C.F.R. § 404.1527(e) (explaining that a physician's opinion that a claimant is “disabled” or “unable to work” is not a medical opinion and that this opinion is reserved exclusively to the Commissioner). In addition, Dr. Lane's September 2013 opinion was conclusory; he neither specifically explained how Plaintiff's impairments impacted his ability to work nor provided objective medical evidence to support his findings. See Edwards v. Sullivan, 937 F.2d 580, 583 (11th Cir.1991) (“The treating physician's report may be discounted when it is
not accompanied by objective medical evidence or is wholly conclusory.”).

The ALJ limited his RFC to two hours of walking in an eight-hour day, substantial evidence does not support the ALJ's decision in that regard. Id. The Commissioner responds that while the ALJ's determination regarding Plaintiff's past work as a security guard appears to be inaccurate and at odds with Plaintiff's testimony (compare Tr. 233—Plaintiff's testimony, with Tr. 107—the ALJ's finding), the error is harmless; because substantial evidence supports the ALJ's determination that Plaintiff could perform other work in the national economy. Doc. 25 at 11. The Court agrees. The VE testified that a hypothetical individual of Plaintiff’s background (age, education, work experience and RFC), could also work as an addresser, document preparer and call-out operator, each of which can be performed at the sedentary level. This supports the ALJ's ultimate determination that Plaintiff was not disabled but could perform a significant number of jobs in the national economy. Tr. 50–54, 111–12. Accordingly, any alleged error with respect to the security guard position is harmless, and substantial evidence supports the ALJ's determination that there are other jobs in the national economy that Plaintiff can perform with his RFC. Denial affirmed.


Plaintiff claims to be disabled due to “Multiple Sclerosis, optic problems, fatigues, arthritis, spinal disc damage,” as well as urinary and fecal incontinence, migraine headaches, pain, and balance problems.

A remand is required where the record contains a diagnosis of a severe condition that the ALJ failed to consider properly. Vega v. Comm'r of Social Security, 265 F.3d 1214, 1219 (11th Cir.2001). A mere diagnosis, however, is insufficient to establish that an impairment is severe. See Sellers v. Barnhart, 246 F.Supp.2d 1201, 1211 (M.D.Ala.2002). “The severity of a medically ascertained impairment must be measured in terms of its effect upon [a claimant's] ability to work and not simply in terms of deviation from purely medical standards of bodily perfection or normality.” Id., citing McCruter v. Bowen, 791 F.2d 1544, 1547 (11th Cir.1986)

As noted, the ALJ developed an RFC that does not include any limitation arising from Plaintiff's incontinence. “The claimant testified that she must take frequent restroom breaks; however, she was able to sit through the nearly hour-long hearing without a restroom break. Dr. Sanchez's physical examination revealed a mild loss of range of motion in Plaintiff's lumbar spine and left ankle, crepitus in both knees, and multiple
parathesias of both her arms and legs. His final impression was multiple sclerosis, optic neuritis and generalized weakness. Dr. Sanchez opined: “It is going to be impossible for the patient to maintain a full-time job in her current state of health which I do not see improving.”

She has a new job work at Jo–Ann Fabrics but at best she can only work about three to four hours a day and is essentially physically exhausted secondary to her MS and muscle pain and symptoms and she cannot work beyond that the Court finds that certain of the conclusions of the ALJ were not made in accordance with proper legal standards and are not supported by substantial evidence. The Court does not find that only one conclusion can be drawn from the evidence; but that the conclusion that was drawn did not meet the standard of review.

Denial reversed and remanded for further consideration.


Brandy Forsyth (“Plaintiff”) is appealing the Commissioner of the Social Security Administration's final decision denying her claim for disability insurance benefits and supplemental security income. Her alleged inability to work is based on the physical impairments of multiple sclerosis (“MS”), back pain, and headaches.

At step two, the ALJ found Plaintiff suffers from the following severe impairments: “multiple sclerosis, back pain and headaches.

Dr. Vernacchio evidently believed that his treatment of Plaintiff provided him with a base of knowledge sufficient for him to give a medical opinion as to the severity of Plaintiff's MS because on November 9, 2005, Dr. Vernacchio completed a disability form regarding Plaintiff's MS. In the disability form, Dr. Vernacchio stated that Plaintiff had been diagnosed with MS. Dr. Vernacchio opined that this condition did not permit work with restrictions, at least “not until managed by neurology.” Vernacchio indicated Plaintiff was unable to work and stated, “Extreme Fatigue—pain—possible improvement after managed by neurology,” although this depended on whether the “disease goes into remission.” Dr. Vernacchio found that Plaintiff's condition was permanent, and that she “needs evaluation—treatment by Neuro[logist].” Dr. Vernacchio stated that Plaintiff would be seen by a neurologist for a plan of care.

The Regulations instruct ALJs how to weigh the medical opinions of treating physicians properly. See 20 C.F.R. § 404.1527(d). Because treating physicians “are likely to be the medical professionals most able to provide a
detailed, longitudinal picture of [a claimant's] medical impairment(s),” a treating physician's medical opinion is to be afforded controlling weight if it is “well-supported by medically acceptable clinical and laboratory diagnostic techniques and is not inconsistent with the other substantial evidence” in the record. 20 C.F.R. § 404.1527(d) (2). When a treating physician's medical opinion is not due controlling weight, the ALJ must determine the appropriate weight it should be given by considering factors such as the length of treatment, the frequency of examination, the nature and extent of the treatment relationship, as well as the supportability of the opinion, its consistency with the other evidence, and the specialization of the physician. Id.

If an ALJ concludes the medical opinion of a treating physician should be given less than substantial or considerable weight, he or she must clearly articulate reasons showing “good cause” for discounting it. Lewis v. Callahan, 125 F.3d 1436, 1440 (11th Cir.1997). Good cause exists when (1) the opinion is not bolstered by the evidence, (2) the evidence supports a contrary finding, or (3) the opinion is conclusory or inconsistent with the treating physician's own medical records. Phillips v. Barnhart, 357 F.3d 1232, 1240–41 (11th Cir.2004); see also Edwards v. Sullivan, 937 F.2d 580, 583–84 (11th Cir.1991); Schnorr v. Bowen, 816 F.2d 578, 582 (11th Cir.1987) (stating that a treating physician's medical opinion may be discounted when it is not accompanied by objective medical evidence). The ALJ must “state with particularity the weight he [or she] gave the different medical opinions and the reasons therefor.” Sharfarz v. Bowen, 825 F.2d 278, 279–80 (11th Cir.1987); see also MacGregor v. Bowen, 786 F.2d 1050, 1053 (11th Cir.1986).

*4 The ALJ did not address Dr. Vernacchio's medical opinion or the records from Family Medical and Dental Centers.7 Therefore, it is not possible to determine what weight was given to Dr. Vernacchio's medical opinion, if any. Because Dr. Vernacchio's medical opinion is not discussed at all, there is a possibility it was overlooked. If it was not overlooked, it apparently was given no weight, and the ALJ failed to articulate any reasons for discounting it.

The ALJ failed to address the opinion of Dr. Vernacchio. Without an explanation, it is impossible to determine what weight Dr. Vernacchio's opinion was given, if any. In addition, because the Appeals Council considered the evidence from Dr. Kantor, this Court is required to consider it as well.

The Clerk of Court is directed to enter judgment pursuant to sentence four of 42 U.S.C. §§ 405(g), as incorporated by 42 U.S.C. § 1383(c)(3), REVERSING the Commissioner's decision and REMANDING this matter with the following instructions: Reevaluate the evidence with respect to the opinions of and records from Dr. Vernacchio and Dr. Kantor, explicitly stating what weight their respective opinions are given. If the ALJ decides to discount either or both of their opinions,
Adequate reasons supported by substantial evidence should be clearly articulated. Denial reversed.


Plaintiff alleges disability commencing January 1, 2008, due to multiple sclerosis (MS), Graves disease, hypertension, thyroid nodules, and vasovagal response. (R. 118) After a hearing, the ALJ found Plaintiff has the severe impairments of “multiple sclerosis (MS); right knee meniscus tear, status post arthroscopy and injections; hypertension; and anxiety.” Aided by the testimony of a VE, the ALJ determined that Plaintiff is not disabled and has the residual functional capacity (RFC) to perform a limited range of light work.

So, while MS is not per se disabling, the ALJ in evaluating a claimant with MS, must consider “the frequency and duration of the exacerbations, the length of remissions, and the evidence of any permanent disabilities.” _Wilcox v. Sullivan_, 917 F.2d 272, 277 (6th Cir. 1990). The Social Security regulations emphasize that “[i]n conditions which are episodic in character, such as multiple sclerosis ... consideration should be given to frequency and duration of exacerbations, length of remissions, and permanent residuals.” 20 C.F.R. Subpart P, App. 1, Section 11.00D. Consequently, “[w]hen a claimant with multiple sclerosis applies for social security benefits, it is error to focus on periods of remission from the disease to determine whether the claimant has the ability to engage in substantial gainful employment.” _Jones v. Sec’y of Health and Human Servs._, 35 F.3d 566 (6th Cir. 1994).

Here a claimant has alleged several impairments, the Commissioner has a duty to consider the impairments in combination and to determine whether the combined impairments render the claimant disabled. See _Jones v. Dep’t of Health and Human Servs._, 941 F.2d 1529, 1533 (11th Cir. 1991). Indeed, the Eleventh Circuit has repeatedly stated that an ALJ has the duty to consider the Plaintiff’s physical and mental impairments in combination. _Swindle v. Sullivan_, 914 F.2d 222, 226 (11th Cir. 1990); _Gibson v. Heckler_, 779 F.2d 619, 623 (11th Cir. 1986); _Hudson v. Heckler_, 755 F.2d 781, 785 (11th Cir. 1985). The ALJ must make specific and well-articulated findings to determine whether the claimant's particular combination of impairments are disabling. _Walker v. Bowen_, 826 F.2d 996, 1001(11th Cir. 1987).

Dr. Franklin treated Plaintiff and recorded that “for the most part, [Plaintiff] has not had any serious problems since a minor exacerbation in early May of 2012.... MS has been relatively well controlled.” Plaintiff reported increased fatigue during her
August 2013 appointment. The ALJ discussed this evidence of Plaintiff's fatigue and took it into account when assessing her RFC.

Plaintiff contends the ALJ erred in discounting treating neurologist Dr. Franklin's August 2013 RFC questionnaire in which he stated Plaintiff could not work. Specifically, Dr. Franklin opined that Plaintiff was unable to sustain even a low stress job and that she would miss work more than four days per month due to her MS. He indicated Plaintiff could sit for one hour at a time (and for a total of four hours per day), stand for 20 minutes (two hours total per day), and walk one to two blocks. The ALJ assigned little weight to this assessment, characterizing it as “overly sympathetic” to Plaintiff and inconsistent with Dr. Franklin's treatment notes.

After reviewing the medical evidence, I agree that Dr. Franklin's restrictive RFC evaluation is a surprise considering the overall positive tone of his treatment notes as well as those of other treating sources. Despite Plaintiff's contrary suggestion, the ALJ did not parse together positive comments from Dr. Franklin or consider his statements about Plaintiff's limitations out of context. The ALJ had good cause to reject Dr. Franklin's RFC assessment.

Of course, Plaintiff's treatment providers' observations that she is doing well in general does not automatically suggest she is capable of working. Compare Gonzalez v. Colvin, No. 1:10-cv-138-RJS, 2013 WL 5783741, at * 6-7 (D. Utah Oct. 28, 2013)

If a claimant submits new noncumulative and material evidence to the AC after the ALJ's decision, the AC shall consider such evidence, but only where it relates to the period on or before the date of the ALJ's hearing decision. 20 C.F.R. § 404.970(b). “Material” evidence is evidence that is “relevant and probative so that there is a reasonable possibility that it would change the administrative result.” Milano v. Bowen, 809 F.2d 763 (11th Cir. 1987). When evidence is submitted for the first time to the AC, that new evidence becomes part of the administrative record. Keeton v. Dep't of Health and Human Servs., 21 F.3d 1064, 1067 (11th Cir. 1994). The AC considers the entire evidence, including the new, material, and chronologically relevant evidence, and will review the ALJ's decision if the ALJ's “action, findings, or conclusion is contrary to the weight of the evidence currently of record.” 20 C.F.R. § 404.970(b). We review whether the new evidence renders the denial of benefits erroneous.” Ingram v. Comm. of Social Sec. Admin, 496 F.3d 1253, 1262 (11th Cir. 2007). “When the Appeals Council refuses to consider new evidence submitted to it and denies review, that decision is also subject to judicial review because it amounts to an error or law.” Keeton, 21 F.3d at 1066.. Here, as in Smith, the AC considered Plaintiff's newly submitted evidence, but found the information did not provide a basis for changing the ALJ's decision. Denial
affirmed.


The record reflects that the plaintiff, in 2005 and 2006, sought the medical assistance of Dr. Ismail. She was then examined by Dr. Ismail, a board certified neurologist, who determined that she was suffering from multiple sclerosis, based upon his finding of lesions in her brain and neck and the result of a spinal tap. On June 20, 2007, Dr. Azaret, also a board certified neurologist associated with Dr. Ismail, examined the plaintiff and noted that she still experienced numbness as well as diminished fine-finger movement and weakness in her grip. Dr. Azaret attended to the plaintiff on six separate occasions, not twice as noted by the ALJ. Dr. Azaret found the plaintiff to be in declining health and experiencing panic attacks. Notwithstanding such findings and the ALJ's determination that plaintiff's multiple sclerosis was a severe impairment, the ALJ, in his ruling, stated:

The undersigned notes that he has considered and given little weight to the opinion at Exhibit 17F as it is not well supported by the medical acceptable clinical findings and laboratory diagnostic techs, is conclusory and inconsistent with contemporaneous treatment notes of source, is inconsistent with other substantial medical evidence of record, inconsistent with the activities of daily living, is based heavily upon self reports of the claimant and is based upon subjective allegations of pain. As noted, this doctor only saw the claimant two times once in June 2007 and again in January 2008.

The ALJ should have, but did not, consider plaintiff's combination of impairments, both severe and non-severe, as mandated by SSR 96-8p on her residual functional capacity. “In assessing RFC, the adjudicator must consider limitations and restrictions imposed by all of an individual's impairments, even those that are not 'severe.' ”

Plaintiff was evaluated by psychiatrist Dr. Patel on referral from the Florida Department of Health, who diagnosed her with a depressive disorder. Dr. Patel found plaintiff's prognosis to be poor because of the neurological complications of MS and her depressive symptoms. Notwithstanding such professional findings, the ALJ found plaintiff's allegation of depression to be a non-severe impairment. In so finding, the ALJ failed to consider the effect of that impairment on claimant's ability to work, and gave such impairment no weight or consideration in his determination of plaintiff's residual functional capacity

Plaintiff's Motion for an Order Reversing the Decision of the Commissioner is GRANTED and said Decision is hereby reversed.

Charles Lee Martin, Martin & Jones PA, Decatur, GA, for Plaintiff.

She reported that she had had intermittent leg pain for two years, but it had become worse the night before, and she was using a wheelchair. Id. She said she used her wheelchair about once a month. Id. Plaintiff denied suffering depressed mood on most days, and denied sleep or appetite disturbance. Reviewing x-rays, Dr. Agens found no major problems with Plaintiff's cervical spine. Id. Dr. Agens said: Because of the patient's weakness in the legs I ordered an MRI of the cervical spine as well, but the intermittent nature of the weakness, the optic atrophy, the white matter lesions on the MRI all suggest that this may be multiple sclerosis. Although in the appropriate clinical setting this could reflect demyelinating damage the appearances certainly could be associated with other entities such as chronic [illegible] vessel disease, particularly if the patient has a history of diabetes, [illegible] hypertension or even migrainous cephalalgia.

She said that physicians thought that she had multiple sclerosis, but do not think that now, but that she has “bouts of weakness, periods where I can't walk and intense pain.

Dr. Kubiak's diagnosis on Axis I was Post Traumatic Stress Disorder, Rule Out Obsessive Compulsive Disorder, Major Depression, and Dysthymia. On Axis II he determined that she had a depressive personality disorder with avoidant features, a dependent personality disorder, and a self defeating personality disorder with borderline features. Id. On Axis V he assigned a GAF score of 40.

Plaintiff contends that the ALJ's finding at step 2, that Plaintiff's depression and panic disorders are not “severe” impairments, is error.

The ALJ also did not consider a statement by Joann Burgess, Plaintiff's neighbor. That statement, dated December 17, 2002, said that Plaintiff's husband took care of the housework, grocery shopping, cooking, and finances, and that on a good day, Plaintiff could cook a meal and run a vacuum, but the good days were “few and far between now.”

Thereafter, the only mental health impairments discussed are those from Plaintiff's testimony, that she said that she has an inability to concentrate and has memory deficits. The ALJ discounted this testimony because Dr. Hume had noted that Plaintiff “was in full control of her hygiene, cooking, cleaning, laundry tasks, and organizing her residence. Id. This particular reason for discounting Plaintiff's testimony is not supported by substantial evidence in the record, discussed above. The mental health evidence uniformly indicates that Plaintiff's ability to perform activities of daily living is impaired, at least to the extent of a “severe” impairment as intended at step 2.
Likewise, Dr. Kubiak found that Plaintiff suffered from a significant mental impairment. Dr. Kubiak determined that the MMPI II produced “a valid profile” that suggested: a high level of somatic complaints, anxiety, subjective depression, psychomotor retardation, physical malfunctioning, mental dullness, lassitude malaise, familial discord, social, self, and emotional alienation, difficulty controlling her thoughts and emotions, defective inhibitions, bizarre sensory experiences, and ego inflation.

Plaintiff tested high on the “anxiety, obsessions, health concerns, low self-esteem, social discomfort, work interference and negative treatment indicators.” Id. On another scale, it was suggested that Plaintiff was “not well put together psychologically and tends to be extremely passive.” Id. He assigned a GAF score of 40, which is on the borderline between major and severe impairment in several areas, such as work or school, family relations, judgment, thinking, or mood.

Of course, Dr. Christner, who the ALJ directly discounted, had the most to say about Plaintiff’s mental impairment, and especially her ability to remember and concentrate. Dr. Christner concluded that Plaintiff’s prognosis was guarded to poor. Additionally, poverty excuses noncompliance. Dawkins, 848 F.2d at 1213. There is a lot of evidence in this record that Plaintiff was unable to take medications due to inability to pay.

Accordingly, it is RECOMMENDED that the decision of the Commissioner to deny Plaintiff’s application for Social Security benefits be REVERSED and the case be REMANDED to directly consider the mental health evidence, Kennedy v. Astrue, 2009 WL 3336077, U.S.D.C. , N.D. Florida, Panama City Division, (2009).

Plaintiff said that her neurologist said her MRI suggested she had multiple sclerosis and “in two years they’ll most definitely tell me I have MS.” Id. She said that he told her that the MRI of the right side of her brain was “definitely different from the left side.” Id. She said she had pain on one side. Id.

Dr. Jacob found that Plaintiff’s acuity and field of vision were normal. He found distal sensory loss in the hands and feet bilaterally. Id. His impression was “severe protracted headache with blurred vision and vertigo.” Id. He said that the MRI findings were “suggestive of MS.

There was no evidence of a brain impairment causing the headaches. The ALJ noted that a CT scan of Plaintiff’s head on January 5, 2005, was normal. Id. An MRI of the head on February 25, 2005, suggested a demyelinating process, but nothing definite. Id. Multiple sclerosis was ruled out. Denial affirmed.

The Plaintiff's challenge to the Commissioner's decision focuses upon ALJ Stacy's determination that Plaintiff's medical condition had improved as of October 1, 2006. Based upon that improvement, ALJ Stacy concluded that Plaintiff retained the residual functional capacity ("RFC") to perform her past relevant work as a medical clerk and, accordingly, that Plaintiff was no longer disabled. Therefore, the Court will focus its discussion of the record on that issue.

ALJ Haack concluded in the CPD in this case that Plaintiff had the following severe impairments: adenocarcinoma of the colon status post surgical resection with resulting residual conditions, a depressive disorder and multiple sclerosis ("MS""). ALJ Stacy noted that ALJ Haack had concluded that Plaintiff, at the time of the CPD, had the medically determinable impairments of significant anemia, malignant neoplasm of her colon, and multiple sclerosis. ALJ Stacy noted that ALJ Haack had determined that Plaintiff's impairments resulted in the determination that Plaintiff had the RFC to perform less than the full range of sedentary work due to the extreme weakness and fatigue that Plaintiff suffered from her chemotherapy and interferon treatments.

The record also supports ALJ Stacy's determination that Plaintiff experienced medical improvement in both her multiple sclerosis and depressive disorder. Medical improvement in the severity of Plaintiff's impairments were also supported by Plaintiff's self-reported activities of daily living, which ALJ Stacy cited in support of his conclusion that there had been a decrease in the medical severity of Plaintiff's impairments. ALJ Stacy noted that Plaintiff self-reported that she was able to perform light household chores, take care of her 7 year old and get him ready for school in the mornings, drive and run small errands, walk in the neighborhood, perform light household chores, and go to church with a neighbor. (R. 19.) These activities evidence a marked improvement over the "extreme" fatigue that Plaintiff reported to ALJ Haack and which her oncologist had called "significant" and "debilitating." Denial affirmed.


Plaintiff has the following severe impairments: multiple sclerosis, asthma, and sleep apnea. Dr. Jeffery English, a neurologist with the MS Center of Atlanta
has treated Mr. Brooks for Multiple Sclerosis (“MS”) since the early 2000's. Over the course of this extensive treating relationship, Dr. English has made voluminous notes regarding the cognitive decline he has observed in his patient. A December 10, 2004 MRI report showed “Abnormal Brain MRI study showing moderate lesion load demyelinating disease without active enhancement.”

Dr. English felt that Mr. Brooks suffered from advancing cognitive decline: “He has been clinically and radiographically stable over the last year. He has some subtle changes which are progressing with his memory.” Mr. Brooks' struggled with the symptoms of MS. He was repeating conversations, merging conversation, and having trouble multitasking. Later in 2007, Dr. English continued to note that “Mr. Brooks appears stable with the exception of noted memory decline by his family. He is repeating himself more.”

Miles Davis, U.S. Magistrate Judge

FINDINGS OF THE ALJ

On April 11, 2014, (date of ALJ decision), the ALJ made several findings relative to the issues raised in this appeal...

3) Plaintiff has the following severe impairments: multiple sclerosis, asthma, and sleep apnea;...

5) After careful consideration of the entire record, the ALJ finds that Plaintiff has the residual functional capacity to perform sedentary work as defined in 20 CFR 404.1567(a). He is limited to the simple routine tasks of unskilled work involving no more than simple, short instructions and simple work-related decisions with few workplace changes. He is to avoid concentrated exposure to dust, fumes, and gases; Plaintiff is unable to perform any past relevant work; and Plaintiff has not been under a disability, as defined in the Act, from March 2, 2012, through the date of this decision.

III. STANDARD OF REVIEW

Review of the Commissioner's final decision is limited to determining whether the decision is supported by substantial evidence from the record and was a result of the application of proper legal standards. *Carnes v. Sullivan*, 936 F.2d 1215, 1218 (11th Cir.1991) (“[T]his Court may reverse the decision of the [Commissioner] only when convinced that it is not supported by substantial evidence or that proper legal standards were not applied.”); see also *Lewis v. Callahan*, 125 F.3d 1436, 1439 (11th Cir.1997); *Walker v. Bowen*, 826 F.2d 996, 999 (11th Cir.1987). “A determination that is supported by substantial evidence may be meaningless ... if it
is coupled with or derived from faulty legal principles.” *Boyd v. Heckler*, 704 F.2d 1207, 1209 (11th Cir.1983), superseded by statute on other grounds as stated in *Elam v. R.R. Ret. Bd.*, 921 F.2d 1210, 1214 (11th Cir.1991). As long as proper legal standards were applied, the Commissioner's decision will not be disturbed if in light of the record as a whole the decision appears to be supported by substantial evidence. 42 U.S.C. § 405(g); *Falge v. Apfel*, 150 F.3d 1320, 1322 (11th Cir.1998); *Lewis*, 125 F.3d at 1439; *Foote v. Chater*, 67 F.3d 1553, 1560 (11th Cir.1995). Substantial evidence is more than a scintilla, but not a preponderance; it is “such relevant evidence as a reasonable person would accept as adequate to support a conclusion.” *Richardson v. Perales*, 402 U.S. 389, 401, 91 S.Ct. 1420, 1427, 28 L.Ed.2d 842 (1971) (quoting *Consolidated Edison Co. v. NLRB*, 305 U.S. 197, 59 S.Ct. 206, 217, 83 L.Ed. 126 (1938)); *Lewis*, 125 F.3d at 1439. The court may not decide the facts anew, reweigh the evidence, or substitute its judgment for that of the Commissioner. *Martin v. Sullivan*, 894 F.2d 1520, 1529 (11th Cir.1990) (citations omitted). Even if the evidence preponderates against the Commissioner's decision, the decision must be affirmed if supported by substantial evidence. *Sewell v. Bowen*, 792 F.2d 1065, 1067 (11th Cir.1986).

**PLAINTIFF'S MEDICAL HISTORY**

Dr. Jeffery English, a neurologist with the MS Center of Atlanta (Tr. 275), has treated Mr. Brooks for Multiple Sclerosis (“MS”) since the early 2000's. Over the course of this extensive treating relationship, Dr. English has made voluminous notes regarding the cognitive decline he has observed in his patient. A December 10, 2004 MRI report showed “Abnormal Brain MRI study showing moderate lesion load demyelinating disease without active enchancement.” Mr. Brooks reported cognitive decline in April of 2005, stating that he was experiencing short term memory problems that had caused him to struggle in his classes. At that point, his wife had already taken over all the important household duties and he needed help at work. Dr. English noted “Memory is the biggest disabling factor.” (Tr. 308). Over the ensuing years Dr. English repeatedly noted cognitive decline, inadvisability to drive and subtle evidence of progression. His wife reported “some increase in agitation and some decrease in memory.” (Tr. 306.) Dr. English felt that Mr. Brooks suffered from advancing cognitive decline: “He has been clinically and radiographically stable over the last year. He has some subtle changes which are progressing with his memory.” Mr. Brooks' struggled with the symptoms of MS. He was repeating conversations, merging conversation, and having trouble multitasking. Later in 2007, Dr. English continued to note that “Mr. Brooks appears stable with the exception of noted memory decline by his family. He
is repeating himself more.” On February 13, 2009, Dr. English noted that “Mr. Brooks actually looked better than I've seen him in quite some time.” However, the treatment records for Mr. Brooks continue to relate the progressive decline of Mr. Brooks due to his MS: “Overall, he appears to be doing about the same. Besides the fatigue, his cognitive dysfunction is the biggest problem.” Dr. English noted again 2010 that Mr. Brooks “continues to have memory decline according to his wife. Otherwise stable think he has been doing very well.”

On April 12, 2012, Dr. English opined that Mr. Brooks suffered from MS and exhibited severe fatigue as a result of the illness. He also found that Mr. Brooks was capable of 5/5 grip strength and had 5/5 strength in his lower extremity. (Tr. 501). On August 15, 2013, Dr. English filled out a questionnaire in which he opined that Mr. Brooks suffered from MS, which caused, “persistent disorganization of motor function in two extremities.” He further felt Mr. Brooks suffered from a loss of cognitive abilities or affective changes that included short or long-term memory impairment, perceptual or thinking disturbances, and personality changes, and that those symptoms were accompanied by marked restriction of activities of daily living, marked difficulties in maintaining social functioning, marked difficulties in maintaining concentration, persistence, or pace, and repeated episodes of decompensation, each of extended duration. He indicated that Mr Brooks suffered from a medically documented history of an ongoing organic mental disorder that had lasted at least two years and had caused more than minimal limitation on Mr. Brooks' ability to do basic work activities, along with a current history of one or more years of being unable to function outside a highly supportive living arrangement, with an indication that Mr. Brooks was in continued need of the living arrangement. Mr. Brooks also suffered from significant, reproducible fatigue of motor function with substantial muscle weakness on repetitive activity, shown on physical examination, that resulted from neurological dysfunction in areas of the central nervous system known to be pathologically involved by the MS process.

The Department of Veterans Affairs (“VA”) reviewed Mr. Brooks' medical issues and assigned a permanent 100% disability evaluation for [his] service connected disability.

Mr. Brooks was also examined by Michael Kasabian, D.O., at the request of the Commissioner, on May 3, 2012. Mr. Brooks reported that his speech was sometimes bad, his balance was off and his memory was poor, he had a history of asthma and sleep apnea, and that when he stood for more than five minutes his ankles started to hurt. On examination his speech and hearing were normal, there was no edema in his extremities and peripheral pulses were intact and equal x 4, deep tendon reflexes were 2/4 and muscle strength was 5/5 in all four extremities. He could stand on his heels and toes, grip strength was 5/5 bilaterally, he could
handle fine objects without difficulty and could tie his shoes without assistance. He
did not need a cane or other assistive device, and he had no limp. Dr. Kasabian's
impression was history of MS, history of ankle pain, asthma, and sleep apnea.

Dr. Kasabian examined Mr. Brooks again on September 25, 2012. Mr. Brooks
reported that his only MS symptom was left knee pain. His examination was again
completely normal as to strength, gait, speech, dexterity and hearing, although the
left knee was a little tender with range of motion testing.

Mr. Brooks is a veteran, and as such is entitled to medical care by the VA.
Based on his physical condition and inability to work, the VA rated him 100%
disabled as of March 24, 2012. The bases of his disability included weakness in all
four extremities associated with MS, with sleep apnea and asthma. (Id.).
It is clear in the Eleventh Circuit that a disability rating by the Department of
Veterans Affairs or Florida's Division of Workers Compensation is not binding on
the Commissioner, but is entitled to great weight, and that it is error for the
Commissioner to ignore it. Falcon v. Heckler, 732 F.2d 827 (11th Cir.1984)
(holding that because Florida workers compensation disability law and Social
Security disability law operate similarly, the ALJ must give great weight to a
workers compensation decision); Bloodsworth v. Heckler, 703 F.2d 1233, 1241
(11th Cir.1983) (holding that “findings of disability by another agency, although not
binding on the [Commissioner], are entitled to great weight.”); Rodriguez v.
Schweiker, 640 F.2d 682, 686 (5th Cir. Unit A, March 25, 1981)3 (holding that “a
V[eterans] A[dministration] rating is certainly not binding on the [Commissioner],
but it is evidence that should be considered and is entitled to great weight ... and [in
this case] should have been more closely scrutinized.”); DePaepe v. Richardson,
Finally, Mr. Brooks contends that the ALJ erred in rejecting Dr. English's opinion.
Absent good cause, the opinion of a claimant's treating physician must be accorded
considerable or substantial weight by the Commissioner. Phillips v. Barnhart, 357
F.3d 1232, 1240–1241 (11th Cir.2004); Lewis v. Callahan, 125 F.3d 1436, 1440
(11th Cir.1997); Broughton v. Heckler, 776 F.2d 960, 960–961 (11th Cir.1985);
Jones v. Bowen, 810 F.2d 1001, 1005 (11th Cir.1986).

“Good cause” for discounting the opinion of a treating physician exists
when: (1) the treating physician's opinion was not bolstered by the evidence; (2) the
evidence supported a contrary finding; or (3) the treating physician's opinion was
conclusory or inconsistent with the doctor's own medical records. Phillips, 357 F.3d
at 1241; see also Lewis, 125 F.3d at 1440 (citing cases).
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“Good cause” for discounting the opinion of a treating physician exists when: (1) the treating physician's opinion was not bolstered by the evidence; (2) the evidence supported a contrary finding; or (3) the treating physician's opinion was conclusory or inconsistent with the doctor's own medical records. *Phillips*, 357 F.3d at 1241; see also *Lewis*, 125 F.3d at 1440 (citing cases).

If a treating physician's opinion on the nature and severity of a claimant's impairments is well-supported by medically acceptable clinical and laboratory diagnostic techniques, and is not inconsistent with other substantial evidence in the record, the ALJ must give it controlling weight. 20 C.F.R. § 404.1527(d)(2). Where a treating physician has merely made conclusory statements, the ALJ may afford them such weight as is supported by clinical or laboratory findings and other consistent evidence of a claimant's impairments. See *Wheeler v. Heckler*, 784 F.2d 1073, 1075 (11th Cir.1986); see also *Schnor v. Bowen*, 816 F.2d 578, 582 (11th Cir.1987). When a treating physician's opinion does not warrant controlling weight, the ALJ must nevertheless weigh the medical opinion based on (1) the length of the treatment relationship and the frequency of examination; (2) the nature and extent of the treatment relationship; (3) medical evidence supporting the opinion; (4) consistency with the record as a whole; (5) specialization in the medical impairments at issue; and (6) other factors which tend to support or contradict the opinion. 20 C.F.R. 404.1527(d).

The opinion of a non-examining physician is entitled to little weight, and, if contrary to the opinion of a treating physician, is not good cause for disregarding the opinion of the treating physician, whose opinion generally carries greater weight. See 20 CFR § 404.1527(d)(1); *Broughton v. Heckler*, 776 F.2d 960, 962 (11th Cir.1985); *Wilson v. Heckler*, 734 F.2d 513, 518 (11th Cir.1984); *Hurley v. Barnhart*, 385 F.Supp.2d 1245, 1255 (M.D.Fla.2005). However, a brief and conclusory statement that is not supported by medical findings, even if made by a treating physician, is not persuasive evidence of disability. *Johns v. Bowen*, 821 F.2d 551, 555 (11th Cir.1987); *Warncke v. Harris*, 619 F.2d 412, 417 (5th Cir.1980).

“When electing to disregard the opinion of a treating physician, the ALJ must clearly articulate its reasons.” *Phillips*, 352 F.3d at 1241. Failure to do so is reversible error. *Lewis*, 125 F.3d at 1440 (citing *MacGregor v. Bowen*, 786 F.2d 1050, 1053 (11th Cir.1986)); see also *Nyberg v. Comm'r of Soc. Sec.*, 179 Fed.Appx. 589, 591 (11th Cir.2006) (Table, text in WESTLAW)(also citing *MacGregor*).
The ALJ examined and considered the entire medical evidence. His comment on “progression” was ambiguous at worst, and was only the smallest part of his overall discussion of Mr. Brooks' condition. He specifically relied on the reports of Dr. Kasabian and Dr. Dol. He gave supported reasons for rejecting Dr. English's opinion. He noted Dr. Kasabian's finding that Mr. Brooks had full range of motion and normal muscle strength in his arms and legs, and complained only of left knee pain. He also noted Dr. Doll's findings of good recent and remote memory, providing a good personal history, good and coherent language and the ability to perform two-step commands. He further noted that in March 2012, Dr. English filled out a form that identified severe fatigue (but not sensory loss or motor loss) as Mr. Brooks' only symptom while finding full grip and leg strength.

“In determining whether substantial evidence supports a decision, we give great deference to the ALJ's fact findings.” Hunter v. Social Security Administration, Commissioner, 808 F.3d 818, 822 (11th Cir.2015) citing Black Diamond Coal Min. Co., 95 F.3d 1079, 1082 (11th Cir.1996). The ALJ found that Mr. Brooks was able to perform sedentary work, and his finding was supported by substantial record evidence. Mr. Brooks has failed to show that the ALJ applied improper legal standards, erred in making his findings, or that any other ground for reversal exists. For the foregoing reasons, the Commissioner's decision should not be disturbed. 42 U.S.C. § 405(g); Lewis, 125 F.3d at 1439; Foote, 67 F.3d at 1560. Denial Affirmed


Plaintiff initially alleged disability beginning on March 8, 2003, but later amended her onset date to January 1, 2005, asserting disabling symptoms related to multiple sclerosis (herein “MS”). Plaintiff was 50 years old at the time of the ALJ's decision, with a high school education and past relevant work experience as an administrative clerk, receptionist, order clerk, store manager, office manager, and sales person...

Based on his review of the evidence, the ALJ found that Plaintiff had the following severe impairments: Multiple Sclerosis (“MS”), memory problems and fatigue (R. 17, Finding 3). The ALJ concluded that Plaintiff could perform a full range of light work with seizure precautions. Where a treating physician has merely made conclusory statements, the ALJ may afford them such weight as is supported by clinical or laboratory findings and
other consistent evidence of a claimant's impairments. See Wheeler v. Heckler, 784 F.2d 1073, 1075 (11th Cir.1986); see also Schnor v. Bowen, 816 F.2d 578, 582 (11th Cir.1987). When a treating physician's opinion does not warrant controlling weight, the ALJ must nevertheless weigh the medical opinion based on the 1) length of the treatment relationship and the frequency of examination; 2) the nature and extent of the treatment relationship; 3) the medical evidence supporting the opinion; 4) consistency with the record as a whole; 5) specialization in the medical issues at issue; 6) other factors which tend to support or contradict the opinion. 20 C.F.R. § 404.1527(d). However, a treating physician's opinion is generally entitled to more weight than a consulting physician's opinion. See Wilson v. Heckler, 734 F.2d 513, 518 (11th Cir.1984); see also 20 C.F.R. § 404.1527(d)(2).

Furthermore, Dr. Ortolani found Plaintiff's experience of pain, fatigue or other symptoms severe enough to “constantly” interfere with her concentration and attention, and concluded that Plaintiff was incapable of even a “low stress” job. Id. These severe limitations, according to Dr. Ortolani, have been in effect, with “constant” exacerbations since 2002

The ALJ “considered but rejected” this opinion, finding it to be “contrary to [the doctor's] own internal notes”; “contradicted by his own objective findings and notes of improvement”; “not well supported by medically acceptable clinical and laboratory diagnostic techniques”; and “inconsistent with other substantial medical evidence and nonmedical evidence of record.” Plaintiff contends that this determination is neither accurate nor sufficient to discount the opinion of the treating physician.

Although Plaintiff was reported to be doing “about the same at this time,” Dr. Ortolani pronounced her “incapable of working at this stage,” due to “a moderate amount of problems with memory, thinking and concentration.”

Dr. Kolluri began treating Plaintiff in August 2006, and he assessed no restrictions or limitations. Contrary to Dr. Ortolani's opinion, Plaintiff did not appear to have significant memory or concentration problems on her August 2006 examination. Although she reported “on and off” trouble with her memory, it was noted that she was alert and oriented and a good historian and cognitive therapy and rehabilitation was recommended. Moreover, her gait was “unremarkable.” On October 2006, a new MRI was interpreted to show no new enhancing lesions, but did show two new lesions. Examination was unremarkable, and Dr. Kolluri noted that she was “pretty stable” except for “some fatigue” (R. 213).

The ALJ's determination to discount the opinion of Dr. Ortolani was made in accordance with proper standards and is supported by substantial evidence. Denial Affirmed.

MS mentioned but ruled out medically.


Neurological examination revealed mild spasticity and mild left hemiparesis and bilateral Babinski's sign. The Plaintiff had fairly impressive nystagmus and her eye movements were somewhat choppy. Dr. Lifton was concerned about the possibility of a primary demyelinating illness such as multiple sclerosis or an autoimmune process. On May 22, 2000, Dr. Lifton advised the Plaintiff that he did not see evidence of multiple sclerosis or a specific autoimmune disorder but that she should be seen by a rheumatologist. Denial Affirmed.


James Sheppard, M.D., a DOC physician, diagnosed Plaintiff with a history of cervical myelitis, etiology unclear. Because of the unclear etiology, Dr. Sheppard was unable to completely exclude positive multiple sclerosis, although it seemed unlikely and no specific treatment was recommended. Dr. Valenstein opined that multiple sclerosis was "in the differential," but spinal fluid examination did not support the diagnosis, and Plaintiff had a normal brain scan (id.). He also noted that numerous conditions were within the "differential of myelopathy," so further studies would be helpful (id.).

Lastly, the ALJ stated that Plaintiff "acted out" his pain symptoms to garner methadone, and that alone negates his credibility. The ALJ, however, has not clearly articulated his basis for this finding. To the extent the finding is based on the earlier reasons stated by the ALJ, such as a lack of objective medical evidence, it is only partially supported by the record (as previously discussed). Denial affirmed.


The ALJ found that the MRI "suggests" a possible demyelinating medical condition, however, no medically determinable impairment that could cause claimant's alleged disabling limitations was established.

Plaintiff, Jamie Lavender on behalf of Charles Lavender seeks judicial review of the final decision of the Commissioner of the Social Security ("Commissioner")
denying her father's claim for Social Security Disability Insurance (“SSDI”) benefits from his alleged onset date of March 20, 2002 through June 29, 2004. The Commissioner determined that Mr. Lavender was disabled from June 30, 2004 through the date of his death on October 31, 2005, however found no evidence to support the claim that Mr. Lavender was disabled prior to that time. On February 3, 2005, on initial determination, the claimant was found to be disabled as of June 30, 2004. (Id.). On April 8, 2005, the claimant filed a Request for Reconsideration agreeing with the decision that he was totally disabled, however contending that he was totally and permanently disabled from March 20, 2002, and that his onset date should be March 20, 2002.

Diffuse hyperintensities within the periventricular and subcortical white matter are non-specific and may represent small vessel ischemic changes. However, given the linear appearance and pericallosal and callosal location, primary demyelinating process suggest as multiple sclerosis may give rise to this imaging appearance.

In some cases, it may be possible, based on the medical evidence to reasonably infer that the onset of a disabling impairment(s) occurred some time prior to the date of the first recorded medical examination, e.g., the date the claimant stopped working. How long the disease may be determined to have existed at a disabling level of severity depends on an informed judgment of the facts in the particular case. This judgment, however, must have a legitimate medical basis. At the hearing, the administrative law judge (ALJ) should call on the services of a medical advisor when onset must be inferred. If there is information in the file indicating that additional medical evidence concerning onset is available, such evidence should be secured before inferences are made.

The ALJ found it “reasonable to conclude that the condition was disabling one week earlier on June 30, 2004, the claimant's initial alleged onset date.” (Tr. p. 19). The ALJ failed to cite to any medical evidence showing that the onset date of the claimant's disability was June 30, 2004.

To determine the onset date, the ALJ also appears to have relied on the claimant's self-reporting at the hospital as to his ability to function independently. However, the hospital staff noted in the medical records that the claimant's statements were confusing. Further, the Plaintiff testified at the hearing that the claimant drastically changed in 2002 and was unable to perform his daily functioning.

The ALJ considered the Plaintiff's testimony at the hearing noting that the
Plaintiff testified that, the claimant was becoming sick around 2000, which was the same time claimant and his spouse were divorcing. He became more and more disoriented and was unable to take care of himself or his business. She testified that before claimant was placed in a nursing home, he was declining and just sat around and cried. He was weak and felt dizzy. He fell frequently and was extremely bruised. He had progressively worsening anger with outbursts of rage. He had loss of bladder control and was eventually unable to perform even basic grooming and hygiene.

SSR 83–20 provides that if reasonable inferences about the progression of the impairment are unable to be made based upon the evidence in the record and additional medical evidence is not available, then other information may be obtained from family members to furnish additional information as to the course of the claimant's condition.

The decision of the Commissioner is REVERSED and this case is REMANDED for further administrative proceedings. The ALJ shall appoint a medical advisor to provide an opinion as to the claimant's onset date. Denial reversed.


Plaintiff's counsel contended that the SSA had made a typographical error, and the Notice of Award should have indicated $33,216.50. Doc. 14. Counsel “contacted the Social Security Administration, and was informed that a corrected version of the award letter would be prepared and forwarded to her.” Doc. 14 at 2 n. 1. Although counsel's mathematical calculation of her fee appeared to be correct, as of January 20, 2015, no other award letter had been received from the SSA and counsel filed the fee petition without the revised award letter so as to be in accordance with the 30 day filing deadline required by Court rules. Doc. 14. The Court denied without prejudice the Motion, granting Plaintiff leave to file the fee petition within 30 days of receipt of the revised Notice of Award with the correct calculation of attorney's fees. Doc. 15.

In this renewed unopposed Motion for Fees, Plaintiff's attorney, Shea Fugate, petitions this Court pursuant to 42 U.S.C. § 406(b) for authorization to charge her client a fee for federal court representation in the amount of $27,962.81 ($33,216.50–$5,253.69). Doc. 16. However, counsel does not address any potential award of § 406(a) fees by the Social Security, which also must be deducted from the cap of the 25% past due benefits. This fee is based on a contingency fee agreement.
between counsel and Plaintiff and counsel's calculations regarding past due benefits received by Plaintiff. Upon review and noting no objection, it is respectfully RECOMMENDED that the Motion be GRANTED with a proviso that counsel not seek any additional fee for administrative work from the SSA pursuant to § 406(a). According to Federal Rule of Civil Procedure 54(d)(2)(B) and Local Rule 4.18(a), all claims for attorney's fees preserved by appropriate pleadings shall be asserted by separate motion filed not later than 14 days following the entry of judgment. The difficulty, of course, is that a judgment remanding the case for additional proceedings rarely (if ever) results in agency action immediate enough to give rise to a claim for attorney's fees in a timely manner.


The also determined that she was totally and permanently disabled owing to multiple sclerosis. Her claim was denied, however, owing to an absence of the requisite quarters of coverage. What this means to the claimant, is that she may only reopen the earnings record to have quarters of coverage posted for 3 years, 3 months, and 15 days prior to her application date. She applied for benefits on September 22, 1982. Therefore the time limitation would allow her to have quarters of coverage posted back to June 7, 1979. This would allow her a total of 4 quarters for 1982, 1981, 1980 and 2 quarters of coverage for 1979, the third and fourth quarters of that year. This is a total of 14 quarters of coverage. She needs 20 quarters of coverage out of the last 40 in order to be found eligible.

SSA may also revise its records after the time limitation to transfer incorrect entries of SEI to the proper individual or the proper period if the total amount entered in its records is not changed. Where an individual is incorrectly credited with an item of SEI, all or part of which belongs to some other individual, the other individual may be credited with that part of the SEI entry which is determined to be his, even though he had not filed an SEI tax return.

The plaintiff also relied upon *Bocian v. Mathews,* 411 F.Supp. 1200 (N.D.Iowa 1976) to support her interpretation. In the district court the plaintiff argued that the Secretary was barred by the time limitations on opening and revising determinations—four years. See, 20 C.F.R. § 404.957 (1976). The district court affirmed the Administrative Law Judge's decision by applying the same exception which the plaintiff argues in the instant case, 42 U.S.C. § 405(c)(5)(G). The court held: Thus self-employment income which is reflected on the records of some individual's income account maintained by the Secretary pursuant to [statute] may be reallocated to some other individual's account at any time to correct errors in the
allocation. The case at bar appears to fall squarely within that category. Bocian v. Mathews, supra at 1203.

The instant case is very similar to the facts in Bocian. Husband and wife were self-employed together; earnings were attributed to only one spouse an alternation of the records was sought well after the time limitation. The court found that Subsection (G) applied to permit reopening and reallocation of the self-employment earnings. Thus, Bocian is persuasive authority in the plaintiff's favor. Denial reversed.


At step two, the ALJ found that the plaintiff suffered from the following severe impairments: “multiple sclerosis (MS), diabetes mellitus, major depression, a history of alcohol abuse, and hypertension.”

Plaintiff testified that he left his employment with Hillsborough County Car Auction upon being diagnosed with MS. On March 16, 2004, Plaintiff was admitted to the University Community Hospital of Tampa, Florida, complaining of numbness of the right arm and neck pain. The admitting physician, Dr. Humayun Mian, assessed that the Plaintiff was experiencing probable demyelinating disease in the form of MS, right motor sensory paresis secondary to the MS, and right carotid bruit. Dr. Mian thereafter referred Plaintiff to Dr. Shrinath Kamat.

Prior to being diagnosed with MS, Plaintiff was employed as a painter of an apartment complex; a dishwasher at a TGIF restaurant; a fry cook at a Popeye's fast food restaurant; and, according to his testimony at the hearing, as a cabinet assembler at Bay City Plywood. Plaintiff then worked at the Hillsborough County Car Auction where his responsibilities included “writing up cars, parking cars.” Plaintiff testified that he left his employment with Hillsborough County Car Auction upon being diagnosed with MS.

In the hearing before the ALJ, Plaintiff testified that, after he was diagnosed with MS and his other ailments in 2004, he was incarcerated for five-and-one-half years for “unlawful sex with a minor.” Plaintiff further testified that, during his incarceration, he was given a shot of Benadryl every day to treat his multiple sclerosis.

On February 11, 2009, while incarcerated, Plaintiff was transferred from the Pinellas County Jail to the Bureau of Prisons. In the transfer report, the prison Health Services noted Copaxone and Glatiramer Acetate as Plaintiff's active medications. On February 18, 2009, Plaintiff reported joint pain, low back pain, shoulder pain, numbness, constipation and anxiety to the prison Health Services.
On June 18, 2010, Plaintiff presented himself to neurologist Dr. Anoop K. Reddy for an evaluation of his MS. (Tr. 381). Plaintiff reported his symptoms as numbness in his hands, poor balance, and slurred speech. (Tr. 381). Plaintiff further reported that he had been taking Copaxone for his MS, had stopped taking the medication for a short time after being released from jail, but had begun taking it again. Finally, Plaintiff stated that he drank four beers a day.

Denial Affirmed.


At step two, the ALJ found that Plaintiff has the following severe impairments: multiple sclerosis (“MS”), bursitis of the left knee, impingement syndrome of the left elbow, neuropathy, degenerative disc disease, osteoarthritis, and obesity.

Plaintiff has failed to show that there is a reasonable possibility that the treatment notes from January 4, 2015, would have changed the administrative outcome. According to Plaintiff, these records document similar symptoms and complaints as Plaintiff related when hospitalized in August 2014. Again, Plaintiff failed to show in any way how these records would reasonably alter the administrative outcome. Denial affirmed.


Ruth Henchey, M.D., referred Plaintiff to the West Florida Regional Medical Center on June 14, 2005, for a diagnostic work-up related to possible multiple sclerosis (“MS”).

Dr. Bashir noted that Plaintiff “had[d] been evaluated by multiple physicians, but no definite diagnoses had been made” and that various treatments had not provided relief. Denial Affirmed.


Seizures. MS not a significant factor.


Plaintiff takes about ten medications, including ones for pain and suspected
multiple sclerosis. By her testimony, the medications cause hair loss, blurred vision, exposure to heat, drowsiness, dizziness, memory problems, hallucinations, hearing impairment and dry mouth.

No specific dx of MS


The Claimant maintains she became disabled on December 25, 2004, due to hypertension, degenerative disc disease, gastroesophageal reflux disease (“GERD”) and multiple sclerosis.

The ALJ found that through the date last insured, the Claimant had the following severe impairments: MS, and degenerative disc disease with secondary pain symptoms.

Absent good cause, the opinions of treating physicians must be accorded substantial or considerable weight. *Lamb*, 847 F.2d at 703.

Good cause exists when the: “(1) treating physician's opinion was not bolstered by the evidence; (2) evidence supported a contrary finding; or (3) treating physician's opinion was conclusory or inconsistent with the doctor's own medical records.” *Phillips v. Barnhart*, 357 F.3d at 1232, 1240–41 (11th Cir.2004) (citations omitted); see also *Edwards v. Sullivan*, 937 F.2d 580, 583 (11th Cir.1991); *MacGregor v. Bowen*, 786 F.2d 1050, 1053 (11th Cir.1986). *Johnson v. Barnhart*, 138 Fed.Appx. 266, 269 (11th Cir.2005). “The opinion of a non-examining physician does not establish the good cause necessary to reject the opinion of a treating physician.” *Johnson*, 138 Fed.Appx. at 269.

It is well established in the Eleventh Circuit that the opinions of a non-examining physician do not constitute substantial evidence on which to base a decision. *Spencer ex rel. Spencer v. Heckler*, 765 F.2d 1090, 1094 (11th Cir.1985). In his decision, ALJ Murray relies on the testimony and opinions of Dr. Goren and rejects those of Claimant's treating neurologist, Dr. Rosenthal, and a one-time consultative examiner, Dr. Hoffen. Dr. Goren was a non-examining physician who testified based on a records review. Therefore, his opinion does not constitute substantial evidence on which ALJ Murray may base his decision. *Spencer ex rel. Spencer*, 765 F.2d at 1094; *Johnson*, 138 Fed.Appx. at 269.8

Although ALJ Russell gave great weight to the opinions of Dr. Hoffen, ALJ Murray concluded that his opinion could not be accepted. ALJ Murray stated in conclusory fashion that Dr. Hoffen's opinion was not supported by the objective evidence, including that of Dr. Mamsa. R. 19. He did not explain why Dr. Hoffen's opinion was not supported by the objective evidence or how it was inconsistent with
Dr. Mamsa’s opinion. Id.

In this case, the Court is unable to conclude that the Claimant is disabled without any doubt. Accordingly, it is recommended that the Commissioner’s decision be reversed and remanded pursuant to sentence four of 42 U.S.C. § 405(g) for further proceedings. Denial Reversed and remanded.


Dr. Blackburn’s impression was chronic pain syndrome with multifocal pain, which “certainly fits with fibromyalgia.” His only recommendation was to get an MRI of the brain to rule out multiple sclerosis or “any type of structural problem at the cranial cervical junction.” Id. He prescribed Neurontin. He concluded: “Obvious this is going to be a longstanding problem.

No clear findings of MS. Reversed for payment of benefits on other grounds.

The ALJ wrote that he gave little weight to the opinion of Dr. Zislis because Plaintiff had not been hospitalized since March, 2003, for mental health treatment, and Dr. Zislis's notes “reveal overall stability of the claimant's condition.” He found that Plaintiff “tolerates all of her medications well,” and “[a]lthough she alleges depression and that she spends most of her time at home, she admitted she goes out occasionally with friends to dinner or the movies and is sociable.” The ALJ rejected the opinion of Dr. Gwock because, although Dr. Gwock said he had treated Plaintiff for 20 years, “the evidence includes minimal records from Dr. Gwock.”

These reasons are insufficient to refuse to give substantial weight to the opinions of these two treating physicians. The initial error was in failing to discuss the records that predated the alleged onset date, on March 16, 2003. Those records were highly relevant to the issue of whether to give substantial weight to the opinions of Dr. Zislis and Dr. Gwock. Plaintiff had been under the care of Dr. Zislis and Dr. Gwock for years, and they knew the correlation between her fibromyalgia pain, depression, headaches, and the stress of a full time job. Most of these records were sent to Dr. Gwock as Plaintiff’s primary physician, and Dr. Gwock was responsible for all of the referrals to specialists. Both Dr. Gwock and Dr. Zislis also had Dr. Szczesny’s opinions to consider, which were fully consistent with their own. The conclusion that Plaintiff’s mental condition is “stable” is supported by the later records from Dr. Zislis, but fails to consider the fact that Plaintiff at that time was under no stress at all. She not working, and spent her days trying to cope with her fibromyalgia. She continued to take strong medications to manage her depression, migraine headaches, and fibromyalgia pain, and arranged her life to avoid all stress so as to avoid fibromyalgia flare ups. Finally, getting out of the house a few times a month does not show an ability to work 40 hours a week. Since the reasons
provided for failing to give substantial weight to the opinions of two treating physicians are insufficient, this court must now accept those opinions as true. Denial reversed and remanded for further consideration.

Seventh Circuit
Illinois


At step one, the ALJ found that Claimant had not engaged in substantial gainful activity (“SGA”) since December 28, 2010, the protective application date. (R. 14.) At step two, the ALJ found that Claimant had the severe impairments of lumbar degenerative disease, multiple sclerosis with myelopathy and obesity. At step three, the ALJ found that Claimant did not have an impairment or combination of impairments that met or medically equaled the severity of one of the listed impairments...At step four, the ALJ found that Claimant was unable to perform any of his past relevant work. At step five, however, the ALJ found that there were jobs that existed in significant numbers in the national economy that Claimant could perform.

On May 3, 2011, Claimant was examined by state agency consultant physician, Dr. Anand Lal, M.D. Claimant complained of pain and burning sensation in his right hand, right chest, and lower extremities – the right side more than the left, and also reported issues with his vision. Dr. Lal indicated that, at the time, Claimant had no neurological deficits and was alert and oriented, but had an antalgic gate that required the use of a cane to help ambulate. Dr. Lal's impression was that Claimant suffered from demyelinating disease affecting the cervical and thoracic spine as evidenced by the MRI performed in January of 2011, generalized weakness on his right side, and pins, needles, paresthesia,8 and tingling feeling in both lower extremities, right chest, abdominal wall and right arm probably secondary to demyelinating disease. Id. On May 13, 2011, an Illinois Request for Medical Advice (“IRMA”) was completed by state agency consultant physician, Dr. Lenore Gonzalez, M.D. Dr. Gonzalez indicated that as of February 24, 2011, Claimant met Listing 11.09A, see 20 C.F.R. Part 404, Subpart P, Appendix 1 § 11.09, for multiple sclerosis.

On June 10, 2011, however, non-examining state agency consultant physician, Dr. Linda B. Caldwell, M.D., completed a Physical Residual Functional Capacity Assessment. Dr. Caldwell reviewed the medical evidence from January 24, 2011 through May 3, 2011 and found that it of record failed to support that
Claimant met Listing 11.09A because there was no convincing evidence that the intensity, persistence, and limiting effects of Claimant's symptoms affected his ability to do basic work activities as severely as reported.

Subsequently, on June 23, 2011, Dr. Gonzalez completed another RFC assessment and adopted the findings of Dr. Caldwell. An additional review of the medical evidence was completed by Dr. Charles Wabner, M.D. on September 30, 2011. Based on the June 23, 2011 RFC Assessment, Dr. Wabner revised Dr. Gonzalez's prior decision and found that Claimant failed to meet listing 11.09A. A September 2012 brain MRI revealed several areas of increased T2/Flair signal in the periventricular region, juxtacortical, and that the thoracic spine MRI demonstrated several discrete lesions throughout the cord. The small foci were of abnormal T2 location scattered throughout the brain, some of which were new, while others were stable, compatible with multiple sclerosis.

With respect to the evidence submitted after Dr. Caldwell rendered her opinion, the ALJ found it consistent with that opinion because, at a June 2011 examination, Dr. Cohen had recorded “5/5 strength bilaterally, and Claimant's gait and station were normal despite somewhat decreased sensation in his lower extremities and right upper extremity.” The ALJ found that “[t]he record would tend to correlate to a gradual, if progressive, process that remits in response to therapy.” He noted that Claimant's 2011 MRI “documented multiple lesions and hyperintense foci consistent with demyelinating disease,” but concluded that “there were no new MRIs showing disease advance, although the most recent September 2012 MRIs showed several areas of increased T2/Flair signal in the periventricular region and one juxtacortical with several discrete lesions throughout the thoracic spine.”

Though the standard of review is deferential, a reviewing court must “conduct a critical review of the evidence” before affirming the Commissioner's decision. *Eichstadt v. Astrue*, 534 F.3d 663, 665 (7th Cir. 2008). It may not, however, “displace the ALJ's judgment by reconsidering facts or evidence, or by making independent credibility determinations.” *Elder v. Astrue*, 529 F.3d 408, 413 (7th Cir. 2008). Even when there is adequate evidence in the record to support the decision, however, the findings will not be upheld if the ALJ does not “build an accurate and logical bridge from the evidence to the conclusion.” *Berger v. Astrue*, 516 F.3d 539, 544 (7th Cir. 2008).

Dr. Caldwell's assessment formed the basis of the Commissioner's decision to find that Listing 11.09 was not met and that Plaintiff was capable of lifting and carrying 20 pounds occasionally and 10 pounds frequently, standing and walking for two to three hours and sitting for six hours, and could perform “no more than frequent fingering with the upper right extremity.” Dr. Caldwell rendered her opinion in June 2011. In her narrative explanation for her conclusion, Dr. Caldwell
noted that one consulting examiner had noted that, “at this time, [Plaintiff] has no neurological deficits,” and that the CE had recorded “no sensory deficits.” While the ALJ “has the authority to assess the medical evidence and give more weight to evidence he finds more credible,” Stuckey v. Sullivan, 881 F.2d 506, 509 (7th Cir. 1989), the Seventh Circuit has “recognized that an ALJ cannot play the role of doctor and interpret medical evidence when he or she is not qualified to do so.” Murphy v. Astrue, 496 F.3d 630, 634 (7th Cir. 2007). When the ALJ “rel[ies] on conjecture and [his] own assessment of the medical evidence to reach conclusions unsupported by the record,” the decision is not supported by substantial evidence. See Blakes ex rel. Wolfe v. Barnhart, 331 F.3d 565, 569 (7th Cir. 2003). Furthermore, an ALJ “must obtain an updated medical opinion from a medical expert...[w]hen additional medical evidence is received that in the opinion of the administrative law judge...may change the State agency medical or psychological consultant's finding” regarding the Listings. SSR 96-6p, 1996 WL 374180, at *4.

In this case, when the ALJ concluded that the medical evidence submitted after Dr. Caldwell's opinion was rendered was consistent with her opinion, he inappropriately “played doctor” and ascribed medical significance to those records which he was not required to do. Although the ALJ's determination as to Listing 11.09 and claimant's RFC rested his conclusion that the evidence submitted after Dr. Caldwell's assessment was consistent with that assessment, the evidence in fact contradicted that assessment in significant ways. First, with respect to the 2012 MRI, the ALJ found that MRI did not indicate advance of Claimant's MS; however, the MRI in fact revealed the presence of new lesions that were not present in the earlier MRI (on which Dr. Caldwell's opinion relied). But whether or not these results were consistent with advance of the disease and Claimant's alleged symptoms was a medical decision that the ALJ was not qualified to make. See Goins v. Colvin, 764 F.3d 677, 680 (7th Cir. 2014) (holding ALJ's interpretation of MRI evidence error); see also Moon v. Colvin, 763 F.3d 718, 722 (7th Cir. 2014) (“ALJs are required to rely on expert opinions instead of determining the significance of particular medical findings themselves.”).

But one of Czarnecki's physicians, after more than a year of treating her, had prescribed a cane, and the ALJ impermissibly ‘played doctor’ by substituting her own opinion that a cane really wasn't necessary.” For the foregoing reasons, Claimant Rios' motion for summary judgment is granted and the Commissioner's cross-motion for summary judgment is denied. The Court finds that this matter should be remanded to the Commissioner for further proceedings consistent with this Order. Denial reversed.

Dr. Bortoli also indicated that Plaintiff is supposed to be taking Avonex but Plaintiff cannot afford the medication and therefore she is applying for disability. Dr. Bortoli had a hard time ascertaining the frequency of Plaintiff's seizures and apparently found her not credible.

Dr. Hoffman's diagnostic impression was that Plaintiff may suffer from a Conversion Disorder whereby she mimics her mother's symptoms following being told that there is a “possibility” that she has multiple sclerosis. In terms of Axis III, Dr. Hoffman's diagnostic impression was that Plaintiff has a seizure disorder secondary to a brain lesion of unknown origin thought to be a sign of multiple sclerosis at this time although doctors are noncommittal.


The Seventh Circuit demands even greater deference to the ALJ's evidentiary determinations. So long as the ALJ “minimally articulate[s] his reasons for crediting or rejecting evidence of disability,” the determination must stand on review. Scivally v. Sullivan, 966 F.2d 1070, 1076 (7th Cir.1992). Minimal articulation means that an ALJ must provide an opinion that enables a reviewing court to trace the path of his reasoning. Walker v. Bowen, 834 F.2d 635, 643 (7th Cir.1987), Stephens v. Heckler, 766 F.2d 284, 287 (7th Cir.1985).

Any analysis should begin with Listing 11.00(A) and (E). Although Plaintiff's medical records plainly document her history of seizures and the possibility of having multiple sclerosis, the ALJ altogether failed to discuss, or even cite, Listing 11.00. Depending on the circuit, this omission alone would dictate remand. Compare Burnett v. Commissioner, 220 F.3d 112, 119-20 (3d Cir.2000)(remanding where the ALJ “‘merely stated a summary conclusion that appellant's impairments did not meet or equal any Listed Impairments,’ without identifying the relevant listed impairments, discussing the evidence, or explaining his reasoning.”)(citing Clifton v. Chater, 79 F.3d 1007, 1009) (10th Cir.1996)), with Senne v. Apfel, 198 F.3d 1065, 1067 (8th Cir.1999)(holding that the conclusory form of the ALJ's decision alone does not justify remand). However, the Seventh Circuit has not directly ruled whether failing to discuss or even cite a Listing at step three justifies remand. See Steele v. Barnhart, 290 F.3d 936, 940 (7th Cir.2002)(stating the Seventh Circuit
need not address the tension between the circuits as to whether a conclusory statement at Step Three is fatal because the ALJ's decision could not stand even if she cited the correct rule. But the Magistrate Judge is hard pressed to proceed without a complete analysis at Step Three. Principles of administrative law require the ALJ to rationally articulate the grounds for her decisions thereby building “an accurate and logical bridge from the evidence to her conclusion.” *Dixon v. Massanari*, 270 F.3d 1171, 1176 (7th Cir.2001). This then allows the Magistrate Judge to confine his review to the reasons supplied by the ALJ. See *Johnson v. Apfel*, 189 F.3d 561, 564 (7th Cir.1999); *Sarchet v. Chater*, 78 F.3d 305, 307 (7th Cir.1996). This has not been done and the Magistrate Judge cannot proceed. Before the ALJ can proceed onto Step Four and Five of the disability determination, the ALJ must at the very least discuss Listing 11.00 since it applies to Plaintiff's history of seizures and possibility of multiple sclerosis. The Magistrate Judge is not suggesting that once evaluated the ALJ should determine that Plaintiff satisfies either Listing 11.00(A) or (E), but only that some elaboration is necessary. or the above stated reasons, Plaintiff's Motion for Summary Judgment is granted. The case is remanded for determination of Plaintiff’s seizure disorder and possible multiple sclerosis under Listing 11.00. It is further ordered that Defendant's Motion for Summary Judgment is denied. Denial reversed.


The parties agree that plaintiff suffers from multiple sclerosis.

However, the ALJ also made several factual errors. His opinion stated that Dr. Sostrin determined that plaintiff has no visual abnormalities. Dr. Sostrin's history and physical of plaintiff, dated September 26, 1983, stated however that plaintiff suffers from “audiovisual deficits.” The ALJ also found that Dr. Sostrin's finding that plaintiff could not control her bowels was contradicted by the hospital records. The ALJ misinterpreted plaintiff's medical records. Doctor Sostrin's report, confirmed by plaintiff's testimony, stated that plaintiff suffered from rectal sphincter incontinence. The hospital report, also confirmed by plaintiff's testimony, stated that plaintiff has control of her urinary sphincter muscle.

The ALJ's opinion also stated that he found plaintiff's complaint of pain not credible. The degree of plaintiff's pain is well-documented in the medical records. (“intractable, constant, right abdominal pain radiating into the inguinal area” in February, 1982); (“constant pain in the right and lower and mid portion of the abdomen” in February 1982); (“suprapubic and right and left lower quadrant tenderness); (plaintiff has had severe headaches for several years); (“shooting pain
down legs, arms and abdomen”); (prescription for codeine). The ALJ based his finding that plaintiff's claim of pain was not credible on her demeanor at the hearing. The Court believes that the ALJ improperly engaged in what the United States Court of Appeals for the Eleventh Circuit has termed “sit and squirm” jurisprudence.” As that Court explained: In this approach, an ALJ who is not a medical expert will subjectively arrive at an index of traits which he expects the claimant to manifest at the hearing. If the claimant falls short of the index, the claim is denied. *Wilson v. Heckler*, 734 F.2d 513, 517 (11th Cir.1984), quoting from *Freeman v. Schweiker*, 681 F.2d 727, 731 (11th Cir.1982).

The Court's review of the hearing transcript in this case convinces it that the ALJ simply did not evaluate plaintiff's claim of disability objectively. And in response to plaintiff's statement “I think I could—right now I think I could go to sleep...” regarding the degree of her fatigue, the ALJ cavalierly retorted: “I feel the same way, I've been listening to cases like this for 20 years, but I'm not going to go to sleep.” The Court believes that these comments reflect the mindset of an ALJ who was indifferent to the evidence being presented to him and who had made up his mind that plaintiff's claim was hardly worthy of consideration. At the very least, the ALJ ignored the progressive nature of plaintiff's disease. The only question remaining is whether this case should be remanded for further evidence or whether the Court should decide on the record before it that plaintiff is entitled to social security benefits. The Court believes that the latter course is dictated in this case. Reversed for payment of benefits.


Thus, after cursorily reviewing the medical evidence, the ALJ summarily concluded that the medical records would not have precluded the sedentary work. Significantly, the ALJ cites no medical evidence for the proposition that the plaintiff's condition would not have precluded sedentary work. ALJ's finding is suspect because it contradicts evidence on the “cold record.” *Herron v. Shalala*, 19 F.3d 329, 335 (7th Cir.1994). For example, although the ALJ concludes that the “medical records revealed only complaints of left leg weakness,” the record specifically indicates that the plaintiff suffered general weakness in the lower extremities, including problems with his right leg. In addition, the ALJ indicates that there was no showing of physical therapy, or that he was taking medication for his condition, despite the fact that the record clearly indicates that the plaintiff was taking prescribed medication beginning in 1984, and as recently as April, 1987 was given physical therapy and antibiotics. The ALJ also makes no
mention whatsoever in his opinion of the extensive medical records provided from
the hospital in Greece or of the records indicating that the plaintiff received sickness
benefits and certifications of an inability to work in Greece for significant periods of
time during the two years prior to his last date insured.

This court finds that the ALJ's decision is not supported by substantial
evidence because it failed to consider the evidence presented on the record. In
particular, the ALJ's disregard for the clear evidence that the plaintiff was unable to
sit for more than a few minutes at a time necessitates a finding that the plaintiff was
not able to perform the full range of sedentary jobs, and therefore, is disabled under
the act. This court therefore GRANTS the plaintiff's motion for summary judgment
and DENIES the Commissioner's motion for summary judgment. The finding of the
ALJ that the plaintiff is not disabled is REVERSED.

U.S.D.C. Indiana

The claimant, Barbara M. Ellis, applied for Supplemental Security Income on July
19, 2007, alleging a disability onset date of June 28, 2007. Her claim initially was
denied on September 26, 2007, and again upon reconsideration on November 27,
2007. Ellis requested a hearing before an Administrative Law Judge (“ALJ”). A
hearing before ALJ Sherry Thompson was held on November 4, 2009, at which Ellis
and vocational expert Richard T. Fisher testified.

Ellis first challenges the ALJ's RFC finding on three grounds. First, Ellis
argues that the ALJ failed to consider the entire record because she did not mention
several of Ellis' diagnosed impairments. Second, Ellis argues that the ALJ failed to
assign the appropriate weight to an examining physician's opinion and, therefore, did
not properly assess her limitations in stooping, squatting, and balancing. Third, Ellis
complains that the ALJ did not account for the lapse of time and additional medical
evidence that arose after the state medical examiners rendered their opinions and the
ALJ conducted the hearing.

Thus, as explained in this section of the Ruling (SSR 96–8p), there is a
difference between what the ALJ must contemplate and what she must articulate in
her written decision. See Morphew v. Apfel, 2000 WL 682661,(S.D.Ind. Feb.15,
2000) (“There is a distinction here [in SSR 96–8p] between what the ALJ must
consider and what the ALJ must articulate in the written opinion.”); Lawson v. Apfel,
medium work satisfied the requirements of SSR 96–8p) (“[SSR 96–8p] does not
require an ALJ to discuss all of a claimant's abilities on a function-by-function basis. Rather, an ALJ must explain how the evidence supports his or her conclusions about the claimant's limitations and must discuss the claimant's ability to perform sustained work activities.

An ALJ need only “minimally articulate his or her justification for rejecting or accepting specific evidence of a disability” and is not required to provide a written statement about every piece of evidence in the record. *Rice*, 384 F.3d at 371 (internal citations omitted). The ALJ only needs to “make a bridge between the evidence and the outcome as to his ... determination.” *Rice*, 384 F.3d at 372. See also *Haynes v. Barnhart*, 416 F.3d 621, 626 (7th Cir.2005) (stating that the ALJ must build a logical bridge between the evidence and conclusion); *Zurawski v. Halter*, 245 F.3d 881, 889 (7th Cir.2001) (same); *Clifford v. Apfel*, 227 F.3d 863, 872 (7th Cir.2000) (same). The law does not require the ALJ to discuss every detail of the record, as long as she considered evidence in the record that was favorable to the claimant. *Golembiewski v. Barnhart*, 322 F.3d 912, 917 (7th Cir.2003). The ALJ may not ignore an entire line of evidence that was favorable to the claimant. See, e.g., *Zurawski*, 245 F.3d at 887; *Henderson v. Apfel*, 179 F.3d 507, 514 (7th Cir.1999); *Zblewski v. Schweiker*, 732 F.2d 75, 78–79 (7th Cir.1983). Otherwise it is impossible for a reviewing court to tell whether the ALJ's decision rests upon substantial evidence. *Golembiewski*, 322 F.3d at 917.

Although Ellis did not show how consideration of these diagnoses would further limit her abilities and affect the final disposition of her claim, Ellis' shortcomings are outweighed by the ALJ's failure to fulfill her duty and create a logical bridge between the evidence and her conclusion. The court cannot accept an opinion that omits mention of eleven diagnosed impairments and ignores three years of medical history. Although the ALJ stated that she considered all the evidence of record, if this boilerplate statement was all the ALJ was required to provide, the court would be forced to speculate whether diagnoses were in fact considered, and the claimant would be denied meaningful review. The ALJ, while not required to engage in a meaningful discussion of every piece of evidence, cannot ignore a substantial amount of medical history, particularly that which may be favorable for the claimant, without providing some explanation. At minimum, the ALJ should have explained why she disregarded the three year lapse between the reviewing physicians rendering their opinions and her decision and why the additional impairments would not affect Ellis' RFC. Despite the Commissioner pointing to medical evidence substantiating the ALJ's decision, he was unable to point to any recent evidence showing that the ALJ's RFC finding would stand irrespective of the three years of treatment Ellis sought after the reviewing physician gave the opinion the ALJ adopted. The court cannot speculate whether these diagnoses and the lapse
of time, if considered, would have affected the ALJ's opinion. Therefore, Ellis' claim is REMANDED


Background: Claimant suffering from multiple sclerosis (MS), degenerative disc disease, and neurogenic bladder sought judicial review of denial by Commissioner of Social Security of her application for disability insurance benefits (DIB).

ALJ improperly evaluated credibility of claimant's testimony, in determining her eligibility for Social Security disability insurance benefits (DIB), based on her multiple sclerosis (MS), degenerative disc disease, and neurogenic bladder, where he determined that claimant's statements concerning intensity, persistence, and limiting effects of her symptoms were unsupported by medical evidence within the record, but this determination was based on a medical record that was incomplete; fair comparison could not be made between claimant's reported symptoms and the medical record since claimant's physician's letter explaining her disability had not specified what time period it concerned. 20 C.F.R. § 404.1529c

Despite opining that Thompson's impairments could reasonably produce the alleged symptoms, the ALJ concluded that Thompson's description of “the intensity, persistence and limiting effects of these symptoms prior to the date last insured” was “not persuasive to the extent the statements are not supported by the medical and other evidence of record.” In short, the medical record did not support Thompson's allegations that her impairments were disabling before March 31, 2006

Finally, in forming Thompson's RFC, the ALJ evaluated the report of the Agency's consultative examiner, Dr. Inabnit. Dr. Inabnit indicated that Thompson was in physical therapy twice a week following her February 2006 MS exacerbation. He also attested that Thompson had no limitations in her range of motion, her gross motor skills were intact, she could ambulate without her cane with a slow and purposeful gait, and she had a grip strength that was normal at a 4/5

For the step five analysis, the ALJ posited a hypothetical question to the VE to determine if there were any unskilled entry-level jobs for a person with Thompson's restrictions. The VE responded that this hypothetical person could work as a cashier, an appointment clerk, or an office helper. (Id.) The VE opined that the use of a cane to ambulate would not interfere with the hypothetical individual's ability to do any of the previous jobs.

SSR–96–5p (“For treating sources, the rules also require that we make every reasonable effort to recontact such sources for clarification when they provide
opinions on issues reserved to the Commissioner and the bases for such opinions are not clear to us.”). Dr. Toth–Russell's letter indicated that Claimant's ailments cause her pain and paresthesias in her limbs, limit her ability to walk, occasionally cause her to fall, and fatigue her. Dr. Toth–Russell further noted that these symptoms were limiting to the point where Claimant cannot sustain an eight-hour work day and cannot perform tasks that require any degree of standing or repetitive motion.

The ALJ concluded that Dr. Toth–Russell's opinion was not entitled to controlling weight for several reasons; however, these reasons are deficient. Last, the ALJ attempted to accommodate Dr. Toth–Russell's opinion “that the claimant could not retain a position that required standing ... by reducing the claimant's exertional level from the light exertional level determined by the state agency physicians (Exhibit 13F) to the sedentary exertional level.” However, after examining Exhibit 13F, the Court notes that the state physicians did not find that the Claimant was capable of working in a light exertional category; rather, more akin to Dr. Toth–Russell, the state report concludes that Claimant can only work at a sedentary level. The state doctor indicated Claimant may only stand two hours in an eight hour workday and may only sit for six hours in an eight hour workday. (Id.) As discussed in SSR 83–10, these restrictions on the Claimant qualify her for only sedentary work. See SSR 83–10. Thus, the ALJ's failure to develop the treating physician's opinion, coupled with the ALJ's improper evaluation of the state physician's assessment, demonstrate that the ALJ's RFC analysis is not supported by substantial evidence.

Again, the ALJ found Claimant's impairments could “reasonably be expected to cause the alleged symptoms.” However, the ALJ further noted that the Claimant's statements “concerning the intensity, persistence and limiting effects of theses symptoms prior to the date last insured are not persuasive” because they were not supported by the medical or other evidence within the record. (Id.) In support of this conclusion, the ALJ evaluated: (a) Claimant's need for help around the household with chores and her ability to drive; (b) the exacerbations of Claimant's MS symptoms and how long they last; (c) Claimant's medication and medical treatment, including the fact the record failed to support the Claimant's testimony she received annual infusion treatments for her MS from 1999 to 2007; (d) Claimant's need to lay down, walk with a cane, her ability to deal with her blurred vision, and her ability to self-catheterize; and (e) other factors such as how frequently Claimant visited her doctors and those physicians' notes documenting Claimant's various conditions.

However, as discussed above, the ALJ failed to resolve crucial ambiguities—ambiguities closely linked to the intensity, persistence, and limiting effects of Claimant's symptoms—in the letter from Claimant's treating physician. The Court concludes that this error affected the entire credibility analysis. On
remand, the ALJ shall conduct a new credibility determination for the Claimant after clarifying Dr. Toth–Russell's opinion. See Washington v. Astrue, No. 09–CV–4484, 2010 WL 3516114, at *16 (N.D.Ill. Sept. 1, 2010) (ordering a new credibility analysis after concluding that the ALJ improperly assessed the plaintiff's testimony about his symptoms).

Similarly, the Court notes that its reasoning applies to the ALJ's flawed step four hypothetical questions and the VE's opinion that Claimant could still perform her past relevant work. On remand, the ALJ should revisit his reliance on the VE's testimony based on any changes to Claimant's RFC and, if necessary, obtain updated VE testimony. See Young, 362 F.3d at 1004–05 (noting that when an RFC is deficient, the hypothetical questions an ALJ poses to a VE are generally deficient as well; accordingly, the ALJ's conclusion that a claimant can adjust to other work in the national or regional economy is likewise invalid); *747 Martinez v. Astrue, No. 2:09–CV62–PRC, 2009 WL 4611415, at *16 (N.D.Ind. Nov. 30, 2009) Denial reversed and remanded.

U.S.D.C. Wisconsin

Holdings: The District Court, C.N. Clevert, Jr., Chief Judge, held that:
1 ALJ provided insufficient analysis of decision to give little weight to opinion of claimant's treating physician;
2 ALJ provided insufficient analysis of decision to give significant weight to opinion of examining doctor;
3 ALJ provided insufficient explanation of his finding that claimant's impairments did not meet the regulatory listings regarding neurological disorders and multiple sclerosis;
4 ALJ did not provide the necessary discussion to support his rejection of the credibility of claimant's subjective complaints of pain; and
5 substantial evidence did not support ALJ's determination that claimant did not have a cognitive disorder prior to July 7, 2008.

In proceedings on claim for Social Security disability insurance benefits based on multiple sclerosis, ALJ provided insufficient explanation of his finding that claimant's impairments did not meet the regulatory listings regarding neurological disorders and multiple sclerosis; the ALJ's only statement regarding the listings was that the medical evidence in the file was not consistent with the claimant's multiple sclerosis meeting or equaling one of the neurological listings. 20 C.F.R. §§
The ALJ convened a third hearing on October 28, 2008, at which Emanuele appeared with counsel and testimony was given by medical expert Dr. Larry Larrabee, and VE Albers. (Tr. 516–75.) Dr. Elmudesi's report was also provided to the ALJ. On November 24, 2008, the ALJ issued his decision finding Emanuele disabled, but only as of July 7, 2008, the date on which she saw Dr. Elmudesi. The ALJ found Emanuele not disabled from her alleged onset date of June 4, 2004, to July 7, 2008. Review was denied by the Appeals Council on March 9, 2009, making the ALJ's determination the final decision of the Commissioner. In this appeal from the Commissioner's decision Emanuele seeks judicial review on the denial of benefits for the period June 4, 2004, to July 7, 2008.

An ALJ must “‘minimally articulate his reasons for crediting or rejecting evidence of disability,’ ” Clifford v. Apfel, 227 F.3d 863, 870 (7th Cir.2000) (quoting Scivally v. Sullivan, 966 F.2d 1070, 1076 (7th Cir.1992)), “build[ing] an accurate and logical bridge from the evidence to his conclusion,” id. at 872.

Although the ALJ need not discuss every piece of evidence, he or she cannot select and discuss only the evidence supporting the decision. Herron v. Shalala, 19 F.3d 329, 333 (7th Cir.1994). Evidence favoring as well as disfavoring the claimant must be examined by the ALJ, and the ALJ's decision should reflect that examination. Zurawski v. Halter, 245 F.3d 881, 888 (7th Cir.2001). If the ALJ's decision lacks evidentiary support or is “so poorly articulated as to prevent meaningful review,” the district court should remand the case. Brindisi ex rel. Brindisi v. Barnhart, 315 F.3d 783, 785 (7th Cir.2003) (internal quotation marks omitted). However, a “sketchy opinion” may be sufficient if it is clear the ALJ considered the important evidence and the ALJ's reasoning can be traced. Id. at 787.

With this RFC determination, the ALJ then found that prior to July 7, 2008, Emanuele could have performed her past relevant work as a waitress and that there were a significant number of jobs in the national economy that she could have performed, such as food preparation worker (12,000 jobs), small products assembly (12,500 jobs), and janitor (5,000 jobs). Therefore, Emanuele lost at step four and step five.

According to the ALJ, beginning on July 7, 2008, there were no jobs in the national economy that Emanuele could perform. Therefore, he found her disabled as of that date.

Although Emanuele does not explicitly label her argument as one aimed at the ALJ's step three determination, the court reads her brief liberally. See Haines, 404 U.S. at 520, 92 S.Ct. 594.

Although the ALJ wrote several paragraphs about listing 12.02, regarding organic
mental disorders, and Emanuele's psychological testing with Dr. Elmudesi, his complete discussion of the listings regarding neurological disorders and multiple sclerosis is as follows: “The medical evidence in the file was not consistent with the claimant's multiple sclerosis meeting or equaling one of the neurological listings.” This one-sentence conclusion does not meet the minimally articulated standard for reasoning; the ALJ has failed to build a logical bridge between the evidence and his conclusion. As Emanuele points out, listing 11.00 applies to neurological conditions and listing 11.09 applies to multiple sclerosis specifically. However, the ALJ did not mention these listings or the requirements set forth in them. Therefore, the case will be remanded for reconsideration of the neurological listings again at step three.

[i]t is not sufficient to make a conclusory statement that “the individual's allegations have been considered” or that “the allegations are (or are not) credible.” ... The determination or decision must contain specific reasons for the finding on credibility, supported by the evidence in the case record, and must be sufficiently specific to make clear to the individual and to any subsequent reviewers the weight the adjudicator gave to the individual's statements and the reasons for that weight. SSR 96–7p, quoted in *Brindisi*, 315 F.3d at 787.

Although Dr. Carlson's report does support the ALJ's rejection of Emanuele's claims of pain and limitations, the ALJ failed to address adequately the significant evidence that was contrary to his conclusion, or at least not as strong as Dr. Carlson's report. For instance, Dr. Michael Connor on July 7, 2008, stated that Emanuele's “hypesthesias and dysesthesias are possibly secondary to multiple sclerosis versus fibromyalgia versus idiopathic.

Second, the ALJ wrote that “[o]verall, the claimant's multiple sclerosis was stable, until she experienced a deterioration of her health and was diagnosed with cognitive disorder on July 7, 2008, the established date of disability,” citing Exhibits 1 F, 3F, 4F, 5F, 13F, and 14F. (Tr. 21.) Yet the ALJ later wrote that MRI results in Exhibit 5F caused Dr. Khatri to observe a worsening of Emanuele's condition. (Tr. 23.) As Emanuele argues, the same Exhibit is being used to show stability and worsening. The ALJ needed to discuss more which records showed stability and how, rather than referencing sixty-eight pages of records, some of which contradict a finding of stability.

The ALJ fails to cite any evidence in the record regarding use of waitressing as past relevant work. It may be in the record, but this court should not have to scour the record to find it. Because the ALJ has not cited to the evidence supporting a finding that waitressing is past relevant work, his decision is not sufficiently supported on this point as well. Denial reversed and remanded.
Tom Bush for claimant

The court reviews an ALJ's decision to ensure that it is supported by “substantial evidence” and consistent with applicable law. Nelms v. Astrue, 553 F.3d 1093, 1097 (7th Cir.2009); Scheck v. Barnhart, 357 F.3d 697, 699 (7th Cir.2004). Substantial evidence is such relevant evidence as a reasonable person could accept as adequate to support a conclusion. Terry v. Astrue, No. 09–1045, 2009 WL 2634418, at *4 (7th Cir. Aug.28, 2009). Thus, where conflicting evidence would allow reasonable people to differ as to whether the claimant is disabled, the responsibility for that decision falls on the ALJ. Binion v. Chater, 108 F.3d 780, 782 (7th Cir.1997). A reviewing federal court may not decide the facts anew, re-weigh the evidence or substitute its judgment for that of the ALJ. Id.

However, this does not mean that the court acts as an “uncritical rubberstamp.” Garfield v. Schweiker, 732 F.2d 605, 610 (7th Cir.1983). In determining whether substantial evidence exists, the court reviews the entire record, taking into account both the evidence in support of the ALJ's conclusion and anything that fairly detracts from its weight. Young v. Sec'y of Health and Human Services, 957 F.2d 386, 388–89 (7th Cir.1992). The court cannot uphold a decision that lacks evidentiary support, ignores important evidence, or fails to build an accurate and logical bridge from the evidence to the result. See, e.g., Hopgood ex rel. L.G. v. Astrue, No. 08–2491, 2009 WL 2591354, at *2 (7th Cir. Aug.25, 2009); Villano v. Astrue, 556 F.3d 558, 562 (7th Cir.2009); Lopez v. Barnhart, 336 F.3d 535, 539 (7th Cir.2003); Rohan v. Chater, 98 F.3d 966, 971 (7th Cir.1996); Sarchet v. Chater, 78 F.3d 305, 307 (7th Cir.1996). Further, if the ALJ commits an error of law, such as violating agency rules for evaluating disability claims, see Prince v. Sullivan, 933 F.2d 598, 602 (7th Cir.1991), the court “may reverse without regard to the volume of evidence in support of the factual findings.” White v. Apfel, 167 F.3d 369, 373 (7th Cir.1999).

In September 1996, plaintiff saw neurologist L. Cass Terry, complaining of dizziness, blurred vision, and a period of numbness and tingling along the left side of the body and in both feet, along with severe fatigue. Dr. Terry suspected demyelinative disease, i.e. multiple sclerosis. (Tr. at 448.) Subsequent testing and examination in 1998 confirmed the diagnosis. (Tr. at 449; 452; 619–20) On October 20, 1998, Dr. Terry wrote that “it is clear now that the diagnosis is multiple sclerosis.”

On April 27, 1999, following plaintiff's cervical fusion, Dr. Novom provided another report, opining that plaintiff was temporarily totally disabled from work following her surgery. He suggested possible permanent restrictions but stated that plaintiff “may require even greater ... restrictions at work depending on the status of
On November 22, 1999, plaintiff underwent a 2½ hour functional capacity evaluation (“FCE”) on referral from her primary care physician, Dr. Joan Milott. The evaluation, conducted by an occupational therapist, generally reflected an ability for light work, i.e. lifting 15–20 pounds occasionally, 5–8 pounds frequently, with regular postural changes and only occasional crouching/kneeling. (Tr. at 747–57.)

It is my medical opinion Ms. Sucharski is more disabled/impaired than which she is presently willing to admit. Though Ms. Sucharski in most commendable fashion expresses great interest in returning to some variety of work estimating being able to lift or carry as much as 25 lb. I find such projection unrealistic. I remain skeptical Ms. Sucharski will be able to return to any variety of gainful employ without frequent interruption due to exacerbation or worsening of demyelinative disease. Having said as much, I find no objection to this woman attempting return to work not exceeding four hours per day abiding by certain restrictions including confinement to mostly sedentary work.[.]

Although she did not directly link it to her rejection of Dr. Kori–Graf's report, the ALJ also noted, earlier in her decision, that the RFC she adopted was more generous than the findings of several physicians who examined plaintiff, including the results of the November 1999 FCE and the opinion of Dr. Braza, plaintiff's rehabilitation specialist, as well as the reports of the state agency consultants.

These reasons do not withstand scrutiny. While an ALJ may reject an opinion lacking objective medical support in the record, she may not consider the record in a cramped fashion, citing only evidence in support of her conclusion and ignoring evidence to the contrary. See Golembiewski v. Barnhart, 322 F.3d 912, 917 (7th Cir.2003). In the present case, the record contains significant evidence supporting Dr. Kori–Graf's report, which the ALJ failed to consider. Most importantly, in April 2004, Dr. Terry, plaintiff's longtime treating physician, wrote:

Ever since the MS exacerbation in 1998, Ms. Sucharski has had moderate to severe fatigue with brief episodes of mild to moderate fatigue. To my knowledge she has never been free of fatigue from this disease. I have tried to ease her back into a part-time working condition where she would be sitting most of the time. She was never able to tolerate a full 40 hour per week position at any form of employment. It is true, as the ALJ noted, that Dr. Kori–Graf checked “no” when asked about “significant reproducible fatigue of motor function with substantial muscle weakness on repetitive activity involved by the multiple sclerosis process” and “significant and persistent disorganization of motor function in two extremities resulting in sustained disturbance of gross motor and dexterous movement or gait and station.” But these questions pertained to whether plaintiff met the MS Listing, see 20 C.F.R. Part 404, Subpart P, Appendix 1, § 11.09, a claim she does not make. The ALJ failed to
explain why the absence of these symptoms cast doubt on Dr. Kori–Graf's opinion as to plaintiff's functional limitations.

As noted above, in his June 6, 2001 report Dr. Novom opined, inter alia, that plaintiff was limited to part-time, sedentary work. In her 2004 decision, the ALJ rejected this report because Dr. Novom was hired by plaintiff's former employer to conduct an independent medical evaluation and based his opinion on just one exam, and the report was contrary to Dr. Terry's findings just one month earlier when plaintiff's neurological results were “normal.” As the court found during the first round of judicial review, these reasons were flawed. T

Nor can Dr. Novom's report legitimately be questioned based on Dr. Swanson's test results. Dr. Swanson found plaintiff to be functioning well cognitively in March 1999 (Tr. at 410), with relatively little cognitive change on repeat testing in December 2001 (Tr. at 721–22). But Dr. Swanson offered no opinion on whether plaintiff possessed the physical stamina for work. Indeed, she specifically noted that “pain and fatigue may be disabling irrespective of the results of cognitive testing. The degree to which [plaintiff] is disabled due to physical problems, fatigue, and pain would need to be documented by her neurologist, Dr. L. Cass Terry, MD, PhD.” Dr. Terry authorized part-time work only.

This application has been pending for eight years, the evidence in the case is not likely to change, and remand for further proceedings would serve no useful purpose. The matter has been remanded once under sentence four already, and the ALJ has yet to produce a reasoned decision. See Wilder, 153 F.3d at 804. The evidence of record, properly evaluated, supports but one reasonable conclusion. Therefore, I will remand the matter with instructions that the application be granted. See Elder v. Astrue, 529 F.3d 408, 414 (7th Cir.2008) (citing Bladow v. Apfel, 205 F.3d 356, 359 (8th Cir.2000) (explaining that, under SSR 96–8p, ability to work only part-time mandates disability finding); Kelley v. Apfel, 185 F.3d 1211, 1214–15 (11th Cir.1999) (same)).

Golembiewski v. Barnhart, 322 F.3d 912, (CA 7th Cir., 2002)

Claimant sought review of final determination of the Commissioner of the Social Security Administration denying his claim for disability benefits. The Court of Appeals held that: (1) ALJ erred discrediting claimant's testimony about pain without explaining reasons for rejecting testimony; (2) ALJ mischaracterized evidence; and (3) ALJ was required to consider entire constellation of ailments affecting claimant once ALJ found one or more of impairments was severe. Vacated and remanded.

*913 Before BAUER, CUDAHY, and COFFEY, Circuit Judges.
Opinion
PER CURIAM.

Michael Golembiewski, a former automobile radiator repairman, applied for disability insurance benefits at the age of 39 asserting that he could not work because of back problems and epileptic seizures. An administrative law judge denied benefits after finding that Golembiewski was not disabled when his eligibility for insurance expired, and the Social Security Administration's appellate council declined review. Golembiewski then brought this action in the district court, which upheld the agency's decision, and Golembiewski appeals. Because the ALJ insufficiently explained why he discredited Golembiewski's testimony, mischaracterized the medical evidence, and ignored evidence of Golembiewski's disability, we remand the case to the agency for further proceedings.

Golembiewski's medical records document a history of ailments stretching back to his childhood. As a child, Golembiewski had to have his right leg partially amputated because of a birth defect, and during early adulthood he began to have epileptic seizures on account of head injuries sustained during an accident. Because of his seizures, Golembiewski in 1992 was referred to the Mayo Clinic, where Dr. Elson So, a neurologist, prescribed the anticonvulsant Tegretol. The medication successfully controlled Golembiewski's epilepsy until 1994, when he returned to the clinic suffering frequent spells. In response, Dr. So instructed Golembiewski to increase his Tegretol dosage (and to abstain from alcohol), and by the end of 1994, Dr. So later reported, the seizures again were under control.

The event that led to Golembiewski's alleged disability occurred in November 1995. Golembiewski crashed his pickup truck into another truck, hit his head, injured his back, and again began having daily seizures. Upon examination at the Mayo Clinic, Dr. So suggested that Golembiewski's new seizures were related to the trauma (though he did not identify a precise cause). Dr. So also reported that following the accident Golembiewski complained of bowel and bladder urgency. And an MRI taken at the clinic revealed additional problems with Golembiewski's back, including a small area of myelomlaclia (softening of the spinal cord) in his middle back, degenerative disk disease in his lower back, and two disk extrusions—one between two cervical vertebrae and the other between two thoracic vertebrae. Although the thoracic extrusion did not affect the spinal cord, the cervical extrusion did, and Dr. So thought that this deformity could explain the neck discomfort felt by Golembiewski after his car accident.

To combat the new seizures, Dr. So prescribed another anticonvulsant, Depakote, and within a few weeks the spells had stopped. With respect to the bowel and bladder problems, urologists at the clinic did not identify a neurological
cause—though after finding two kidney stones, they instructed Golembiewski to drink more water. Golembiewski's back and neck pain, however, persisted for the next two years, and in August 1997 he went to Parkview Memorial Hospital in Fort Wayne, Indiana, complaining of "severe pain." There an emergency care center physician delivered Demoral intramuscularly, prescribed other painkillers, and scheduled Golembiewski to see Dr. Stephen Schroeder, a neurosurgeon. Dr. Schroeder found that Golembiewski had crepitance (crinkling) in his neck, limited flexion when performing low back motions, pain when performing straight leg raises from a supine position, and patchy hypesthesia (diminished sensitivity) on his left arm and chest. Reviewing an MRI taken earlier in February 1996, Dr. Schroeder also observed significant spondylosis (stiffening of the vertebrae) and a potential disk rupture between Golembiewski's diseased cervical vertebrae. After looking at another MRI from March 1996, Dr. Schroeder further saw disk degeneration in the lower back with probable "lumbosacral herniation."

In light of Golembiewski's significant soft tissue pain, Dr. Schroeder approved a course of physical therapy at Adams County Memorial Hospital in Decatur, Indiana. Unfortunately, physical therapy provided no relief, and in both February and April 1998, Golembiewski returned to Adams County reporting back strain. That May Golembiewski also had another car accident after suffering a seizure. During this period Golembiewski reported that he was having seizures daily, and an electroencephalogram (EEG) performed in October 1998 showed abnormal electrical activity in Golembiewski's brain that was consistent with partial seizure disorder.

In January 1999 Golembiewski reported additional problems to his family practitioner, Dr. Michael Person. Golembiewski complained that he had developed numbness, weakness, and tingling in his upper extremities, making him unable to use his hands to hold onto objects. In addition, the following month Dr. Person noted that Golembiewski's right leg was draining fluid from a red lesion above his prosthesis. And in April 1999 Dr. Person again reported that Golembiewski was suffering from severe neck pain. That month Golembiewski also had another accident; he burned his left foot with a high-power pressure washer at his radiator shop, and his left leg became infected.

After burning his foot, Golembiewski applied for disability benefits. Dr. Sam Davis, a physician employed by the State of Indiana, then assessed Golembiewski's functional capacity to work and concluded that Golembiewski could perform several work-related tasks. Specifically, Dr. Davis determined that Golembiewski occasionally could lift up to twenty pounds, that he could stand and walk for two hours and sit for six hours (with breaks) during an eight-hour workday, and that he could use hand and foot controls without limitation. Dr. Davis also found that Golembiewski occasionally could balance, stoop, and crouch, but could never kneel,
crawl, or climb stairs or ladders. According to Dr. Davis, Golembiewski needed to avoid machinery, heights, and slick or uneven surfaces because of his seizures.

The ALJ held a hearing in June 2000 at which Golembiewski testified and presented his medical records (many of which we have not discussed because they are redundant or irrelevant). At the hearing Golembiewski explained that he had problems walking because his prosthesis fit poorly, that he suffered a seizure once or twice a week lasting between four and five minutes, and that until as recently as December 1998 he had suffered seizures every four days. Golembiewski also testified that he had pain in his middle and lower back, that he could sit comfortably only for five minutes at a time, and that he periodically dropped items from his right hand.

The ALJ also solicited testimony from a vocational expert. The vocational expert explained that someone of Golembiewski's age, education, and work experience—who could not work around machinery because of seizures—would be able to work as an assembler, inspector, packager, or cashier. But when asked about the number of jobs for someone with Golembiewski's impairments, who could not sit or stand for more than five minutes, the vocational expert did not suggest any available jobs. He *915 instead responded that a “selective job placement” would be required.

The ALJ denied Golembiewski's application for benefits. In his decision the ALJ first noted that Golembiewski was insured for disability benefits only through December 31, 1998, and that he needed to demonstrate a disability while he remained insured. During that time period, the ALJ concluded, Golembiewski's seizures were controlled by medication, he suffered neck and back pain, and his MRIs showed some disk degeneration and mild bulging, but no herniations. The ALJ also determined that despite Golembiewski's seizures, disk degeneration, and chronic pain, he retained the capacity for light work. After finding Golembiewski's own testimony not credible “for the reasons set forth in the body of the decision,” the ALJ determined from the vocational expert's testimony that Golembiewski could hold jobs as an assembler, packager, inspector, and cashier. Engaging in the familiar five-step analysis used to evaluate disability claims, 20 C.F.R. § 404.1572, the ALJ concluded that Golembiewski (1) did not have a job, (2) had a severe impairment, (3) did not have an impairment or combination of impairments listed in the agency's regulations, (4) could not return to his job repairing radiators, (5) but could work a significant number of jobs in the national economy. Golembiewski then appealed to the agency's appeals council, but his request for review was denied, making the ALJ's decision the final decision of the Commissioner. 20 C.F.R. § 404.981.

We will uphold the Commissioner's decision if it is supported by substantial evidence and is free of legal error. 42 U.S.C. § 405(g). This is a deferential but not
entirely uncritical standard, Scott v. Barnhart, 297 F.3d 589, 593 (7th Cir.2002), for
the Commissioner's decision cannot stand if it lacks evidentiary support or an
adequate discussion of the issues, Brindisi v. Barnhart, 315 F.3d 783, 785 (7th
Cir.2003). On appeal Golembiewski argues that the decision lacks the detail needed
to permit meaningful review for three independent reasons: (1) the ALJ insufficiently
explained why he discredited Golembiewski's testimony; (2) the ALJ
mischaracterized the medical evidence discussed in his decision; and (3) the ALJ
ignored significant other evidence that supported Golembiewski's claim. We
consider these arguments in turn.

Golembiewski's first contention relies on the principle that ALJs must explain
why they find an applicant's testimony unbelievable. Social Security Ruling 96–7p
provides that ALJs must supply “specific reasons” for a credibility finding; the ALJ
cannot state simply that “the individual's allegations have been considered” or that
“the allegations are (or are not) credible.” SSR 96–7p. Here the ALJ found
Golembiewski's testimony—including his complaint that in 1998 he suffered weekly
seizures and pain so severe that he could not sit or stand comfortably for more than
five minutes—less than credible “for the reasons set forth in the body of the decision.”
Yet the body of the decision contains no reasons why the ALJ found Golembiewski's
testimony unbelievable. The ALJ also failed to apply the factors for evaluating
symptoms set forth in Social Security Ruling 96–7p, such as the degree to which
Golembiewski's asserted limitations were consistent with the medical evidence or the
ALJ's own observations. See Steele v. Barnhart, 290 F.3d 936, 942 (7th Cir.2002);
Zurawski v. Halter, 245 F.3d 881, 887–88 (7th Cir.2001); Schaudeck v.
Commissioner, 181 F.3d 429, 433 (3d Cir.1999).

The ALJ's inadequate credibility determination matters here because crediting
*916 Golembiewski's testimony would establish that he was disabled before
December 31, 1998—the date on which his eligibility for benefits expired. With
respect to his epilepsy, for example, Golembiewski testified that in December 1998
he suffered seizures every four days, and an EEG taken just two months earlier
showed abnormal electrical activity in Golembiewski's brain consistent with partial
seizure disorder. If the ALJ had credited Golembiewski's testimony about the
frequency of his spells, then that evidence—in conjunction with the contemporaneous
EEG—would suggest that Golembiewski was disabled under Social Security Listing
11.03. The listing provides for an automatic disability finding upon a showing of
documented seizures “occurring more frequently than once weekly in spite of at least
3 months of prescribed treatment.” 20 C.F.R. Pt. 404, Subpt. P, App. 1, § 11.03; see
Steele, 290 F.3d at 940 (collecting cases).

Similarly, Golembiewski testified that when his insurance expired he could
not comfortably sit or stand for more than five minutes. According to the vocational
expert, inability to sit or stand for such a short period—coupled with Golembiewski's partially amputated leg, chronic back pain, and inability to drive or operate machinery because of seizures—would have required a “selective job placement.” The vocational expert neither explained what he meant by a “selective job placement,” nor identified any jobs that Golembiewski could work if his testimony were fully believed. To establish that Golembiewski was not disabled, the Commissioner needed to offer evidence of jobs that he could work. See 20 C.F.R. § 404.1520(f). The Commissioner defends the ALJ's credibility determination on the theory that the body of the ALJ's decision implicitly supplies reasons for rejecting the testimony. With respect to the frequency of Golembiewski's seizures, the Commissioner says that the ALJ “clearly rejected” any suggestion that the seizures occurred every four days in 1998 because he found Golembiewski's seizures to be “well controlled.” The Commissioner also speculates that even if Golembiewski had suffered seizures every four days in 1998, the spells occurred because he refused to follow prescribed treatment. Similarly, with respect to Golembiewski's testimony about his ability to sit and stand comfortably, the Commissioner says that the ALJ found that evidence to be incredible because he observed Golembiewski sitting for 40 minutes at the hearing.

The Commissioner's response is problematic for two reasons. First, nothing in Social Security Ruling 96–7p suggests that the reasons for a credibility finding may be implied. Indeed, the cases make clear that the ALJ must specify the reasons for his finding so that the applicant and subsequent reviewers will have a fair sense of the weight given to the applicant's testimony. Steele, 290 F.3d at 942; Briggs v. Massanari, 248 F.3d 1235, 1239 (10th Cir.2001); Schaudeck, 181 F.3d at 433–34. Second, regardless of the requirements of Social Security Ruling 96–7p, general principles of administrative law preclude the Commissioner's lawyers from advancing grounds in support of the agency's decision that were not given by the ALJ. See SEC v. Chenery Corp., 318 U.S. 80, 93–95, 63 S.Ct. 454, 87 L.Ed. 626 (1943); Steele, 290 F.3d at 941; Pinto v. Massanari, 249 F.3d 840, 847–48 (9th Cir.2001); Fargnoli v. Massanari, 247 F.3d 34, 44 n. 7 (3d Cir.2001). So the Commissioner's effort to pinpoint parts of the ALJ's decision that support the credibility finding is unhelpful.

In addition to containing an insufficient credibility determination, the ALJ's decision is further compromised by a mischaracterization of the medical evidence. Specifically, the ALJ discounted the significance of Golembiewski's MRIs taken before 1999 by remarking that they showed only “some disc degenerations” with “no herniations.” But as Golembiewski correctly notes, the ALJ cited no evidence for his view that the MRIs showed no herniations. And according to Dr. Schroeder, an MRI from March 1996 actually showed disk degeneration with
probable “lumbosacral herniation.” The Commissioner does not explain how Dr. Schroeder's diagnosis of probable herniation can be squared with a finding of “no herniations,” so we see no basis to sustain the ALJ's assessment of Golembiewski's MRIs.

What is more (not that more is needed), we also agree with Golembiewski that the ALJ ignored significant evidence supporting his claim. The ALJ must evaluate the record fairly. Thus, although the ALJ need not discuss every piece of evidence in the record, Dixon v. Massanari, 270 F.3d 1171, 1176 (7th Cir.2001), the ALJ may not ignore an entire line of evidence that is contrary to the ruling, Zurawski, 245 F.3d at 888. Otherwise it is impossible for a reviewing court to tell whether the ALJ's decision rests upon substantial evidence. Smith v. Apfel, 231 F.3d 433, 438 (7th Cir.2000). A remand is required here because the ALJ improperly ignored three lines of evidence.

First, the ALJ entirely failed to discuss Golembiewski's bowel and bladder dysfunction. After his car accident in 1995, Golembiewski reported bowel and bladder urgency to Dr. So, who described the problem as “quite disabling.” And in January 2000 Golembiewski told Dr. So that since 1997 he had suffered urinary incontinence two to three times a month—a problem that one doctor at the Mayo Clinic thought was possibly consistent with a “neurogenic bladder” (bladder dysfunction caused by malfunctioning nerves). The Commissioner says that discussion of this line of evidence was not required because Golembiewski was still working in 1997 and, in any event, his incontinence was too infrequent to significantly impact his ability to work. But that argument misunderstands the issue. Incontinence constitutes an impairment under the Social Security Act that must be considered to determine whether an applicant is disabled. See Crowley v. Apfel, 197 F.3d 194, 198–99 & n. 17 (5th Cir.1999) (collecting cases). Evidence that Golembiewski's bladder impairment did not interfere with his work therefore would be a reason for the ALJ to discount the disabling nature of the problem, but it would not justify ignoring the problem entirely as the ALJ did here.

Second, the ALJ's decision contains no discussion of Golembiewski's limited ability to bend on account of his bad back. After an examination in August 1997, Dr. Schroeder reported that Golembiewski could rotate his neck only 60 degrees and that motion in his lower back was reduced to 40 degrees of flexion, 15 degrees of extension, and 10 degrees of tilting. In contrast, Dr. Davis opined in his July 1999 report for the State of Indiana that Golembiewski could “stoop occasionally,” meaning that he could bend at the waist for up to a third of an eight-hour day. See SSR 83–14. The reports of Dr. Schroeder and Dr. Davis thus establish potentially conflicting assessments of Golembiewski's bending ability. Yet despite his obligation to resolve such conflicts, e.g., Scott, 297 F.3d at 596; see also Godbey v.
Apfel, 238 F.3d 803, 808 (7th Cir.2000), the ALJ did not address either doctor's assessment—a significant omission since Golembiewski would have to bend at the waist occasionally in order to perform light work, SSR 83–10; see Lauer v. Apfel, 169 F.3d 489, 492 (7th Cir.1999).

*918 The third line of evidence ignored by the ALJ concerns Golembiewski's propensity to drop objects because of tingling in his hands. Problems manipulating objects by hand reduces the number of jobs available to a disability applicant. Sanders v. Sullivan, 983 F.2d 822, 824 (8th Cir.1992). The ALJ therefore needed to discuss Golembiewski's grasping impairment. True, the record contains no evidence of the impairment before December 31, 1998, when his eligibility for benefits expired, and Golembiewski needed to show that he was disabled before that date. Callaghan v. Shalala, 992 F.2d 822, 824 (7th Cir.1998); Armstrong v. Commissioner, 160 F.3d 587, 589 (9th Cir.1998). But Dr. Person reported that Golembiewski had begun to drop objects in January 1999—just two weeks after his insurance expired. Although Dr. Person's report does not specify whether the condition developed days or months earlier, the ALJ needed to develop a full and fair record. Smith, 231 F.3d at 437; Thompson v. Sullivan, 933 F.2d 581, 585 (7th Cir.1991). So instead of ignoring the issue, the ALJ should have elicited more information to determine when Golembiewski began to have grasping problems.

We close with an additional observation. Golembiewski has a host of significant medical conditions, including the partially amputated leg, epilepsy, back pain, bowel and bladder dysfunction, and grasping problems that we have discussed. Having found that one or more of Golembiewski's impairments was “severe,” the ALJ needed to consider the aggregate effect of this entire constellation of ailments—including those impairments that in isolation are not severe. 20 C.F.R. § 404.1520; see also Sims v. Barnhart, 309 F.3d 424, 432 (7th Cir.2002); Green v. Apfel, 204 F.3d 780, 782 (7th Cir.2000); Cunningham v. Apfel, 222 F.3d 496, 501 (8th Cir.2000). On remand the agency must remember that a competent evaluation of Golembiewski's application depends on the total effect of all his medical problems. The judgment of the district court is vacated, and the case is remanded with instructions to remand the case to the agency. We urge the Commissioner, when taking a fresh look at the matter, to assign a new ALJ to handle any additional proceedings deemed necessary. See Sarchet v. Chater, 78 F.3d 305, 309 (7th Cir.1996).

VACATED and REMANDED.

Spiva v. Astrue, 628 F.3d 346 (C.A. 7th 2010)

Synopsis

Background: Claimant sought review of a decision of the Commissioner of
Social Security denying his application for disability insurance benefits (DIB) and supplemental security income (SSI) benefits. The United States District Court for the Eastern District of Wisconsin, J.P. Stadtmueller, J., 2010 WL 771551, affirmed Commissioner's decision. Claimant appealed.

Holdings: The Court of Appeals, Posner, Circuit Judge, held that:
1 determination that claimant was not totally disabled was not supported by substantial evidence;
2 adverse credibility finding was not supported by substantial evidence; and
3 ALJ failed to develop facts and record at hearing for pro se claimant who suffered from mental disorders, since questioning of claimant was perfunctory. Reversed and remanded.

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Before POSNER, TINDER, and HAMILTON, Circuit Judges.

Opinion
POSNER, Circuit Judge.

In Parker v. Astrue, 597 F.3d 920 (7th Cir.2010), we criticized the handling of social security disability claims in the following respects: (1) opinions of administrative law judges denying benefits routinely state (with some variations in wording) that although “the claimant's medically determinable impairments could reasonably be expected to produce the alleged symptoms, ... the claimant's statements concerning the intensity, persistence and limiting effects of these symptoms are not entirely credible,” yet fail to indicate which statements are not credible and what exactly “not entirely” is meant to signify; (2) many of the Social Security Administration's administrative law judges seem poorly informed about mental illness; and (3) in defiance of the principle of SEC v. Chenery Corp., 318 U.S. 80, 87–88, 63 S.Ct. 454, 87 L.Ed. 626 (1943), the government's lawyers who defend denials of disability benefits often rely heavily on evidence not (so far as appears) relied on by the administrative law judge, and defend the tactic by invoking an overbroad conception of harmless error. See also, e.g., Larson v. Astrue, 615 F.3d 744, 749, 751 (7th Cir.2010) (misunderstanding of mental illness; Chenery violation); McClesky v. Astrue, 606 F.3d 351, 352, 354 (7th Cir.2010) (credibility boilerplate; Chenery violation); Kangail v. Barnhart, 454 F.3d 627, 629 (7th Cir.2006) (misunderstanding of mental illness); Mendez v. Barnhart, 439 F.3d 360, 362 (7th Cir.2006) (Chenery violation); Ryan v. Commissioner of Social Security, 528 F.3d 1194, 1199–1201 (9th Cir.2008) (misunderstanding of mental illness); Kohler v. Astrue, 546 F.3d 260, 268–69 (2d Cir.2008) (same); Haga v. Astrue, 482
F.3d 1205, 1207–08 (10th Cir.2007) (Chenery violation); Robbins v. Social Security Administration, 466 F.3d 880, 883–85 and n. 2 (9th Cir.2006) (credibility boilerplate).

The administrative law judge found that the applicant in this case, David Spiva, “has the following severe combination of impairments [she probably meant to write ‘combination of severe impairments’]: mood disorder, schizophrenia, dysthymia [a form of depression with milder symptoms than major depressive disorder], psychosis, depression, alcohol and cannabis abuse, and attention deficit disorder.” Schizophrenia is a psychosis, and dysthymia a form of depression, and depression a mood disorder, so what the administrative law judge intended by adding depression, psychosis, and mood disorder to the list of Spiva's impairments is, like much else in her opinion, unclear.

She concluded that Spiva was not totally disabled, because he could perform the last job he had held, which had been at Walmart, and lots of other jobs (unspecified) as well. She said “there was reference to malingering as an issue”; Spiva had been found to be “evasive during his consultative evaluation”; there were references to his “not taking medication as prescribed”; he had admitted being “able to do simple household chores and interact[] with family members,” including “babysitting for his child while the mother worked”; and he had “moved to Milwaukee in July 2006 because the child's mother needed help.” That's it—and is a remarkably sparse summary of a rich record.

*349 Spiva was working at a Walmart store in Mississippi when in 2004, at the age of 28, he checked himself into a psychiatric clinic. He told William Turner, his attending physician, that he had suffered from “horrible thoughts” since childhood and had attempted suicide with rat poison in his teens. When he was a child his father had died from a gunshot wound to the head and his mother had beaten him. He had served time in prison on drug charges. He had left his home in Milwaukee (where people told him he was “crazy”), hoping to “get a fresh start” in the South. But although he had found work shelving goods and loading trucks at Walmart, “thoughts of harming himself and thoughts of harming other people” continued to haunt him. He reported “having spirits within him from other people that are evil spirits.” He said “he had been very depressed and anxious. He had decreased appetite, decreased sleep and decreased energy. He had had auditory hallucinations, hearing ‘spirits.’ [He] stated that his thoughts were not his, that his thoughts were being controlled by other people's spirits. He stated that he always had thoughts of wanting to hurt people.” Dr. Turner tentatively diagnosed Spiva as having a psychotic disorder, a mood disorder, and a personality disorder. After a few days on Geodon, a drug for treating schizophrenia, and Lexapro, a drug for the treatment of major depressive disorder, Spiva was discharged with a
prescription for another antidepressant drug, Zoloft.

Five months later he checked himself back into the facility. He had stopped taking Zoloft because it wasn't working. His condition had worsened. He reported that “evil spirits” were “after him,” that sometimes he could control the spirits and at other times they controlled him, and that he often thought about hurting his family. He denied having visual hallucinations—he would admit only to auditory ones—yet also said that he was seeing the spirits, though not with his “physical eye.” He was prescribed both antipsychotic and antidepressant drugs (Abilify, Effexor, Cymbalta, Trazodone, and again Geodon). After a week in the facility Spiva was discharged, but he didn't return to work because he “wasn't functioning right.”

Dr. Shannon Johnson of the clinic opined that as long as Spiva stayed on the drugs prescribed for his mental illnesses and kept his appointments with mental-health professionals, he would be able to maintain “steady, gainful employment.” The two mental-health professionals whom the Mississippi Disability Determination Services (a state agency that works with the Social Security Administration) asked to evaluate Spiva's mental condition agreed that he was capable of working full time. One of them, William Osborn, a psychologist, could not decide whether Spiva was psychotic, in part it seems because he was uncommunicative, refusing for example to discuss his previous diagnoses of and treatments for mental illness. Osborn concluded that probably Spiva could “perform routine repetitive tasks, interact with coworkers, receive supervision, and maintain concentration and attention.” The other consultant, however, Janise Hinson, while she agreed that Spiva could return to work, thought his vocational options might be limited by his difficulties in concentrating and in interacting with people (maintaining “socially appropriate behavior”), including both members of the general public and supervisors and coworkers, and in adhering to basic standards of cleanliness and neatness.

In 2006, no longer working, Spiva returned to Milwaukee to help a woman with whom he had had a child. He has had no fixed residence after returning from the *350 South, but has moved from relative to relative, each of whom would eventually “put him out” because “I [Spiva] ended up losing control of my thoughts.” (An aunt with whom he had lived in Mississippi had said: “He is lovable one day, but displays a lot of anger and hate the next day.... He doesn't talk like himself.... He has a lot of hate and anger in him, and it's hard to get to his head.”) He laughs at inappropriate times, and at times exhibits uncontrollable rage. At the time of the disability hearing he was living with a cousin who wanted him to leave; he may be running out of relatives to live with.

He was admitted to a psychiatric clinic in Milwaukee in 2006, where he “talked a lot about spirits” (in typical schizophrenic fashion he believes that people, as well as spirits, insert unwanted thoughts into his brain telepathically) and told a
doctor that he didn't want to live any more. He returned to the clinic the following year and this time was referred to a hospital for treatment. He told hospital personnel that there was “evil in me” and “around me” and made “vague” threats that he would harm himself and others. He said that he and his daughter (a child of nine) share the same spirit; since the spirit tells him to do evil things, it may tell the daughter to do evil things to him. He had what one medical examiner called delusions of persecution and of “alien control.” When his “walls are not up,” spirits invade his body. He is “willing to cooperate [with mental health professionals] but is fearful of groups of people confronting him.” His thinking is “nihilistic and grandiose.” In a 2007 hospitalization he “came in with vague complaints. ‘Burning inside that feels like anger that needs to explode.’ ” He was discharged two weeks after being admitted, with a diagnosis of an unspecified mood disorder. At the time he was taking several medications, including the mood-stabilizer Depakote and the antidepressant Trazodone.

Spiva was the only person to testify at his disability hearing. He testified that he was unable to work because he was afraid he might have to be “around somebody negative” and would “have an evil thought of hurting them”; “all I think about is bad stuff and doing bad.” He added that because of his medications he had trouble sleeping and as a result spent most of the day groggy and irritable. But he had babysat for his daughter and sometimes he would help out at a friend's day-care facility, and in the past month he had attended two parties hosted by a cousin with whom he was then living.

1 Without some analysis, nowhere to be found in the administrative law judge's opinion, it is difficult to understand her determination that Spiva can do the kind of work he did at Walmart. An employee who stocks shelves at a Walmart or a Walgreens or a Costco or a Treasure Island—large stores with limited sales personnel—has to be able to interact with customers; the employees who stock the store's shelves are often the only employees whom a customer can find to ask about the location of specific items. A psychotic person busy trying to cope with evil spirits and evil thoughts is not likely to be employable as a shelf stocker in such a store. Maybe he can do other jobs but the administrative law judge didn't discuss any other jobs that Spiva might be able to do. She seems to have thought that because his job with Walmart involved unloading trucks as well as stocking shelves it was a simple, unskilled, routine job that anyone could do.

That may be an accurate description of unloading trucks at a loading dock (though there would still be a question whether Spiva can work under supervision), but that was only part of his job. He did testify that his job at Walmart “started off like stocking foods and stuff and I guess like loading trucks.... I was working at the store, like the stocking stuff and then it changed like to stocking the trucks.” So
maybe loading trucks at a Walmart or similar store can be a full-time job, but this possibility was not explored at the hearing and the administrative law judge described Spiva's job simply as “stocker work.”

An administrative law judge is required to determine (at what is called “stage four” of the Social Security Administration's disability algorithm) whether, despite his limitations, the applicant for benefits can do his previous work. 20 C.F.R. § 404.1520(a)(4)(iv), (f); Castile v. Astrue, 617 F.3d 923, 925 (7th Cir.2010). If so, that's the end of the case. And that's the point at which the administrative law judge stopped in this case. She made no finding concerning what jobs Spiva might be capable of doing besides his previous one (which was never precisely defined) and how many such jobs might be available in the Milwaukee area.

The grounds, which we summarized earlier, on which the administrative law judge based her determination that Spiva's testimony was “not entirely credible” are inconsistent with the record. Her remark about malingering was based on a statement by a doctor who at first thought Spiva might be malingering but later decided that he was not. The government's brief cites what it describes as additional evidence of malingering, but as nearly as we can determine the evidence is a statement by a doctor who expressed regret that Spiva wasn't willing to share with him the details of the family feud that had driven him to seek treatment.

The references in the treatment notes to Spiva's being vague or evasive when questioned about his illness could be evidence of malingering, but equally could reflect the effects of his psychotic mentation. Nothing in the treatment notes suggests that Spiva was being deliberately or strategically vague or evasive. “Burning inside that feels like anger that needs to explode” may be vague, but it is consistent with Spiva's other psychiatric symptoms. His refusal at the time of his 2007 hospitalization to allow the hospital “to contact anyone about him,” is “evasive” in a literal sense but also consistent with paranoia.

The administrative law judge's reference to Spiva's failing to take his medications ignores one of the most serious problems in the treatment of mental illness—the difficulty of keeping patients on their medications. The drugs used to treat schizophrenia, for example, can make a patient feel drowsy and stunned. See, e.g., National Institute of Mental Health, Schizophrenia 9 (2009), www.nimh.nih.gov/health/publications/schizophrenia/schizophrenia–booket–2009.pdf (visited Nov. 14, 2010); John M. Grohol & National Institute of Mental Health, “Schizophrenia and Psychosis Treatment: Part 2, Length of Treatment and Side Effects,” Psych Central (Nov. 12, 2006), http://psychcentral.com/disorders/schizophrenia/schizo_treatment2.htm (visited Nov. 14, 2010). As a result he may be unwilling to keep taking them. The administrative law judge also ignored Spiva's testimony that he can't afford all the medications...
prescribed for him because he has no health insurance. And she ignored the finding that Spiva had scored only 20 on the “Global Functioning Assessment” scale (which runs from 0 to 100), a score that indicates (so far as bears on this case) “some danger of hurting himself or others.”

The government's brief points out that all the medical professionals who have dealt with Spiva believe that he's capable of working full time. Yet the administrative law judge mentioned none of this evidence. The brief argues that if she had, her finding that Spiva is not totally disabled would be solidly grounded. This ignores the fact that she made an explicit finding that Spiva's “mental impairments moderately limit his social functioning and concentration/persistence/pace.” She added, it is true, that his impairments “only mildly limit his activities of daily living,” and this is relevant because the mental and physical capabilities that a person employs in his nonworking hours are relevant to his ability to work. But an ability to engage in “activities of daily living” (with only mild limitations) need not translate into an ability to work full time. In this case it may mean nothing more than that Spiva can survive outside a mental institution or halfway house. Whether he can work full time as a “stocker”—the only type of job that the administrative law judge mentioned—is the question, and she offered no basis for her answer. No vocational expert, who might have been able to infer from Spiva's limitations what jobs he could do, testified. And the only activity of daily living to which the administrative law judge referred was babysitting, from which an ability to work full time could not be inferred, as we held in Gentle v. Barnhart, 430 F.3d 865, 867–68 (7th Cir.2005). She didn't mention the evidence that Spiva's performance of household chores was incompetent; as the aunt with whom he had lived for a time stated, he needed help with everything because “his mind runs a lot.”

The basis for the administrative law judge's finding that Spiva's mental impairments limit his social functioning must have been (though she didn't say so) Janise Hinson's determination that Spiva is capable of interacting with coworkers and supervisors on “a limited basis.” The question is whether that “limited basis” is nevertheless consistent with his being able to work full time. The administrative law judge did not address that question, for when she expressed concern with Spiva's credibility and concluded that he could do his old job at Walmart she made no mention of his mental impairments. She may have forgotten her earlier finding or changed her mind; who knows?

34 It is not obvious that a person who hears evil spirits can respond to customers' requests for help in finding particular items that they want to buy, which is a component of the job of stocking shelves in a retail store. Hinson opined that Spiva can maintain his concentration for two hours at a time; whether, given his psychoses and his attention deficit disorder, he could maintain concentration for an
entire workday is unknown. Because he was unrepresented by counsel—and mentally impaired to boot—the administrative law judge was supposed to try by questioning him to obtain all information relevant to his claim, Nelms v. Astrue, 553 F.3d 1093, 1098 (7th Cir.2009); Thompson v. Sullivan, 933 F.2d 581, 585–86 (7th Cir.1991); Moran v. Astrue, 569 F.3d 108, 112–13 (2d Cir.2009), much like an investigating magistrate in a Continental legal system, rather than assume, as in an adversarial setting in which the plaintiff is pro se, that he is capable of providing the information that his lawyer, if he had had one, would have elicited on direct examination. Her questioning of Spiva was perfunctory; she seems not to have read his medical records.

The government's brief refers to contradictions in Spiva's testimony; the administrative law judge did not mention these. Some of them may not be contradictions: he testified that he did not drive, yet he had told one of his doctors that he did—but that was years earlier. Since he is psychotic, his inability to maintain consistency in responding to different medical personnel cannot automatically be ascribed to an intention to deceive. The government's brief intimates that the administrative law judge found that Spiva's credibility was impaired by substance abuse. She did not; her opinion mentions substance abuse but does not relate it to the issue of Spiva's credibility.

5 The administrative law judge's opinion is unsatisfactory, and likewise the government's brief and oral argument, which misstate the record in several places and, worse, seem determined to dissolve the Chenery doctrine in an acid of harmless error. The doctrine of harmless error indeed is applicable to judicial review of administrative decisions. E.g., Borovsky v. Holder, 612 F.3d 917, 920–21 (7th Cir.2010); Parker v. Astrue, supra, 597 F.3d at 924; Mengistu v. Ashcroft, 355 F.3d 1044, 1047 (7th Cir.2004); see also 5 U.S.C. § 706; National Ass'n of Home Builders v. Defenders of Wildlife, 551 U.S. 644, 659–60, 127 S.Ct. 2518, 168 L.Ed.2d 467 (2007). If it is predictable with great confidence that the agency will reinstate its decision on remand because the decision is overwhelmingly supported by the record though the agency's original opinion failed to marshal that support, then remanding is a waste of time. But that is not the government's understanding of the doctrine of harmless error, if we may judge from its brief and oral argument in this case (and not only this case—see, e.g., Terry v. Astrue, 580 F.3d 471, 475–77 (7th Cir.2009) (per curiam); Villano v. Astrue, 556 F.3d 558, 562–63 (7th Cir.2009) (per curiam); Craft v. Astrue, 539 F.3d 668, 675, 678–79 (7th Cir.2008); Stout v. Commissioner, Social Security Administration, 454 F.3d 1050, 1054–56 (9th Cir.2006); Allen v. Barnhart, 357 F.3d 1140, 1145 (10th Cir.2004)). The government seems to think that if it can find enough evidence in the record to establish that the administrative law judge might have reached the same result had she considered all
the evidence and evaluated it as the government's brief does, it is a case of harmless error. But the fact that the administrative law judge, had she considered the entire record, might have reached the same result does not prove that her failure to consider the evidence was harmless. Had she considered it carefully, she might well have reached a different conclusion.

The government implies that if the administrative law judge's opinion consisted of two words—“benefits denied”—a persuasive brief could substitute for the missing opinion. That is incorrect. It would displace the responsibility that Congress has delegated to the Social Security Administration—the responsibility not merely to gesture thumbs up or thumbs down but to articulate reasoned grounds of decision based on legislative policy and administrative regulation—into the Justice Department, which represents the agency in the courts. The Chenery doctrine “provides an assurance that the object of the court's review is the product of a body or official to whom Congress delegated authority. That constraint in turn polices the conditions for judicial deference to agency action.” Kevin M. Stack, “The Constitutional Foundations of Chenery,” 116 Yale L.J. 952, 1021 (2007). The Justice Department has overstepped its proper bounds. The district court's denial of relief is reversed and the case remanded with instructions to return the matter to the Social Security Administration for further proceedings consistent with this opinion.

**Allen v. Barnhart**, 57 F.3d 1140 United States Court of Appeals, Tenth Circuit.

Holdings: The Court of Appeals, Lucero, Circuit Judge, held that:
1 ALJ erred in using Medical-Vocational grids;
2 ALJ erred in specifying jobs that were not available under limitations on claimant's residual functional capacity (RFC); and
3 determining of whether remaining one job that claimant concededly could do constituted significant work was for ALJ, not reviewing court. Reversed and remanded.

Opinion
LUCERO, Circuit Judge.

Plaintiff Thomas Joel Allen appeals from a district court order affirming the denial *1142 of his application for disability benefits. The district court (adopting the magistrate judge's findings and recommendations) effectively conceded that the administrative law judge (ALJ) erred in his analysis, but upheld the denial of benefits nonetheless by relying upon certain analytical revisions offered on judicial review.
Affirming this post hoc effort to salvage the ALJ's decision would require us to overstep our institutional role and usurp essential functions committed in the first instance to the administrative process. Because the ALJ's decision cannot stand on its own erroneous rationale, we reverse and remand the case for further proceedings before the agency.\footnote{1}

Upon receiving an application for disability benefits, an ALJ is required to assess whether or not the claimant is disabled in a five-step, sequential analysis. This analysis evaluates whether (1) the claimant is presently engaged in substantial gainful activity, (2) the claimant has a medically severe impairment or impairments, (3) the impairment is equivalent to one of the impairments listed in the appendix of the relevant disability regulation,\footnote{2} (4) the impairment prevents the claimant from performing his or her past work, and (5) the claimant possesses a residual functional capability (RFC) to perform other work in the national economy, considering his or her age, education, and work experience. 20 C.F.R. § 404.1520(a)(4) (2003); see also, \textit{Trimiar v. Sullivan}, 966 F.2d 1326, 1329 (10th Cir.1992); \textit{Williams v. Bowen}, 844 F.2d 748, 750–52 (10th Cir.1988).

\footnote{1 In order to help evaluate the step five requirement, whether or not there are sufficient jobs in the economy that the claimant can perform given his or her age, education, and work experience, the Social Security Administration has created Medical–Vocational Guidelines, also known as “the grids.” See 20 C.F.R. § 404.1567; id. pt. 404, subpt. P, app. 2; \textit{Trimiar}, 966 F.2d at 1332. Five degrees of residual functional capacity are outlined in the grids by general exertional level—sedentary, light, medium, heavy, and very heavy exertion. 20 C.F.R. § 404.1569a; \textit{Trimiar}, 966 F.2d at 1332 n. 22. Residual functional capacity reflects “the maximum degree to which the individual retains the capacity for sustained performance of the physical-mental requirements of jobs.” 20 C.F.R. pt. 404, subpt. P, app. 2, § 200.00(c). If the ALJ finds that a claimant's exertional capacity, education, age, and skills fit precisely within the criteria of a particular grid level, the ALJ may conclude the claimant is not disabled. Haddock v. Apfel, 196 F.3d 1084, 1088 (10th Cir.1999).

Based on medical records indicating a history of chronic back problems, the ALJ determined that Allen's severe spinal impairment precluded his return to past relevant work. Finding that his impairment did not foreclose all significant opportunities for gainful employment, however, the ALJ denied disability benefits at step five of the controlling analytical sequence, erroneously concluding that Allen was not disabled because he retained the capacity to perform light work. The difficulty with the ALJ's decision stems from his failure to link his findings regarding Allen's RFC to his conclusion regarding Allen's vocational opportunities, resulting in a flawed assessment of Allen's disability status.
While the ALJ found Allen capable of light work, this finding was qualified by many additional physical restrictions including: limits on climbing stairs, ramps, ladders, scaffolds or ropes; on bending, stooping, crawling or crouching; on operating controls either overhead or with foot pedals; and on working in unprotected heights or near dangerous moving machinery. Further qualifying Allen's RFC with significant nonexertional restrictions, the ALJ included limits on more than simple or moderately detailed work instructions; on more than superficial interaction with co-workers and supervisors; and on more than occasional interaction, in person or by phone, with the public. After acknowledging that this restrictive RFC precluded Allen's return to his past work, the ALJ's decision splintered into two distinct rationales—one relying upon an erroneous application of the Medical–Vocational Guidelines and the other relying upon a flawed specification of jobs available—both of which are plainly at odds with the RFC findings. During Allen's disability hearing, the ALJ questioned a vocational expert (VE) fairly extensively regarding other jobs Allen could perform, yet his findings do not comport with these inquiries. Specifically, the ALJ asked the VE to list jobs that a hypothetical individual with Allen's RFC could perform. In response, the VE suggested surveillance systems monitor. Then the ALJ proposed another hypothetical matching Allen's RFC, but without the public contact restrictions. To this latter question, the VE replied by listing jobs such as toll booth operator and self-service cafeteria worker.

2 “[B]ased upon the claimant's age, education, work experience, and the RFC described ...,” the ALJ found that “the ‘Medical–Vocational Guidelines' (commonly know as the ‘Grids') ... would apply and direct a conclusion that the claimant is ‘not disabled.’ ” Aplt.App., Vol. II at 22–23. To reach this conclusion, the ALJ ignored the many additional physical and mental restrictions that he found qualified Allen's RFC and simply applied the grids for light work—contrary to the pertinent regulations and a large body of circuit precedent precluding use of the grids unless the claimant's RFC precisely matches the RFC specified for the grid relied upon. See 20 C.F.R. §§ 404.1569, 404.1569a; id. pt. 404, subpt. P, app. 2, § 200.00(e); Haddock, 196 F.3d at 1088 (“When a claimant's exertional level, age, education, and skill level (i.e., work experience) fit precisely within the criteria of a grid rule, an ALJ may base a determination of nondisability conclusively on the grids.”); Channel v. Heckler, 747 F.2d 577, 581–82 (10th Cir.1984) (citing case law recognizing that an ALJ's conclusive reliance on grids is erroneous when the ALJ fails to make findings regarding non-exertional impairments). This error is so plain that the grid rationale set out in the ALJ's dispositional findings is not even a subject of discussion in the Appellee's briefs.

3 The district court defended the ALJ's decision as a determination based not
on the grids but on the VE's identification of specific jobs in response to the ALJ's inquiries incorporating Allen's RFC and associated limitations. This facially more creditable rationale for the decision is based on statements made in the body of the ALJ's decision, yet this rationale was not carried forward into the final dispositional section. In any event, this reconstructed version of the ALJ's decision ultimately founders on the same RFC *1144 complications that undercut the grid rationale. The ALJ recited that the VE had "identified jobs in significant numbers ... within the limits set by [Allen's] RFC," and then named "surveillance monitor," "toll booth operator," and "self-service (cafeteria) cashier." Aplt.App., Vol. II at 21. Again, the problem is that the VE had specifically omitted the latter two obviously public occupations when the ALJ limited his query to Allen's precise RFC, which included limitations on public interaction. See id. at 19–20, 379–80.

4 Painted into a corner by these undeniable errors in the ALJ's decision, the Appellee makes the only argument left: that the denial of benefits is supportable on the basis that the remaining (one hundred statewide) surveillance-monitor jobs identified by the VE constitute "work which exists in significant numbers" under 42 U.S.C. § 423(d)(2)(A). See Trimiar, 966 F.2d at 1330. Attempting to bolster this position, the Appellee cites a few cases in which courts affirmed an ALJ's judgment that a small number of statewide jobs satisfied the "significant numbers" condition set out in the statute. None of these cases involved a number as low as one hundred. Overriding the bare numbers is the procedural fact that these cases involved court review of a finding of numerical significance made by the ALJ; they were not deciding in the first instance that a particular number was significant under the circumstances. This court has made it clear that judicial line-drawing in this context is inappropriate, that the issue of numerical significance entails many fact-specific considerations requiring individualized evaluation, and, most importantly, that the evaluation "should ultimately be left to the ALJ's common sense in weighing the statutory language as applied to a particular claimant's factual situation." Trimiar, 966 F.2d at 1330 (quotation omitted). Such a determination is precisely what is presently lacking.

Because the ALJ erroneously relied upon 800 publicly interactive jobs, despite the direct conflict with his RFC findings, he never had occasion to decide if the one hundred surveillance jobs alone constituted a significant number under the statute. Thus, he did not give explicit consideration to the factors this court has recognized should guide the ALJ's commonsense judgment, such as "the level of [Allen's] disability; the reliability of the [VE's] testimony; the distance [Allen] is capable of travelling to engage in the assigned work; the isolated nature of the jobs; [and] the types and availability of such work." Trimiar, 966 F.2d at 1330 (quotation omitted). Faced with this problem, the Appellee punts, saying that "[e]ven without these two
[public] jobs, the ALJ found that Claimant was not disabled because a significant number of jobs existed.” Aplee. Br. at 8. To the extent the Appellee is asserting that the ALJ alternatively found the one hundred surveillance jobs alone sufficient to satisfy the numerical-significance requirement, the statement is wrong; to the extent the Appellee is not making that assertion, the statement is meaningless.

We should emphasize that Trimiar's insistence on an antecedent exercise of judgment by the ALJ is not novel. On the contrary, it is consistent with, if not compelled by, our broader recognition that as a court acting within the confines of its administrative review authority, we are empowered only to “review the ALJ's decision for substantial evidence” and, accordingly, “we are not in a position to draw factual conclusions on behalf of the ALJ.” Drapeau v. Massanari, 255 F.3d 1211, 1214 (10th Cir.2001) (quotation omitted). Unless we could hold as a matter of law—and thus not fact, which is beyond our purview—that one hundred is so large a number as to conclusively establish the requisite numerical significance, Drapeau *1145 precludes affirmance here just as Trimiar does.

5 This brings us to the Appellee's final line of defense—the principle of harmless error. We have generally recognized the applicability of this principle in the administrative review setting. See St. Anthony Hosp. v. United States Dep't of Health & Human Servs., 309 F.3d 680, 691 (10th Cir.2002) (following All Indian Pueblo Council v. United States, 975 F.2d 1437, 1443 (10th Cir.1992)). Further, we have specifically applied it in social security disability cases, though not always by name and without settling on a definitive characterization of its precise contours and range of application in this somewhat unique, nonadversarial setting. For example, this court has held that certain technical errors were “minor enough not to undermine confidence in the determination of th[e] case,” Gay v. Sullivan, 986 F.2d 1336, 1341 n. 3 (10th Cir.1993); Diaz v. Secretary of Health & Human Servs., 898 F.2d 774, 777 (10th Cir.1990), and that an “ALJ's conduct, although improper, d[id] not require reversal” because the procedural impropriety involved had not “altered the evidence before the ALJ,” Glass v. Shalala, 43 F.3d 1392, 1396–97 (10th Cir.1994). For present purposes, one significant thing this heterogeneous group of cases has in common is that in none of them did this court hold an ALJ's failure to make a dispositive finding of fact harmless on the basis that the missing fact was clearly established in the record, which is the only possible basis for invoking the principle in this case.

Two considerations counsel a cautious, if not skeptical, reception to this idea. First, if too liberally embraced, it could obscure the important institutional boundary preserved by Drapeau's admonition that courts avoid usurping the administrative tribunal's responsibility to find the facts. Second, to the extent a harmless-error determination rests on legal or evidentiary matters not considered by the ALJ, it risks
violating the general rule against post hoc justification of administrative action recognized in SEC v. Chenery Corp., 318 U.S. 80, 63 S.Ct. 454, 87 L.Ed. 626 (1943) and its progeny.

With these caveats, it nevertheless may be appropriate to supply a missing dispositive finding under the rubric of harmless error in the right exceptional circumstance, i.e., where, based on material the ALJ did at least consider (just not properly), we could confidently say that no reasonable administrative factfinder, following the correct analysis, could have resolved the factual matter in any other way. Such an approach might have been open to us here had the number of available jobs identified by the VE not been one hundred but considerably greater. In Trimiar, we explicitly addressed an ALJ's finding of numerical significance with respect to an occupation reflecting 650–900 statewide jobs, indicating that such a number was small enough to put the issue in a gray area requiring the ALJ to address it and us to review what he or she decided. See Trimiar, 966 F.2d at 1330. As the number in this case is even lower, excusing the ALJ's failure to assess it in connection with the Trimiar factors would be an improper exercise in judicial factfinding rather than a proper application of harmless-error principles.

In sum, the ALJ's decision contains two critical errors: use of the grids contrary to RFC findings, and specification of available jobs contrary to VE testimony based on the same RFC findings. Any attempt to save the decision, by finding that the one job Allen concededly can do constitutes significant work, usurps the ALJ's primary responsibility to determine that question in light of the various case-specific considerations outlined in Trimiar.

*1146 The judgment of the district court is REVERSED and the cause is REMANDED with instructions to remand, in turn, to the Commissioner for further proceedings consistent with this opinion.

Post Hoc Rationalizations in the 11th Circuit


Background: Claimant applied for disability insurance and supplemental social security income benefits. Commissioner of Social Security denied claim. Claimant petitioned for judicial review. The United States District Court for the Middle District of Florida affirmed. Claimant appealed. Holdings: The Court of Appeals held that:
1 substantial evidence supported determination by administrative law judge (ALJ)
that claimant had residual functional capacity (RFC) to perform full range of sedentary work and
2 ALJ could rely on Medical Vocational Guidelines (Grids), rather than vocational expert's testimony, to determine that claimant was not disabled.

Before HULL, WILSON and MARTIN, Circuit Judges.
Opinion

PER CURIAM:

John L. Baker appeals the magistrate judge's order affirming the Administrative Law Judge's ("ALJ") denial of disability insurance and supplemental social security income benefits, 42 U.S.C. § 405(g), on behalf of the Commissioner of Social Security. On appeal, Baker argues that his use of a cane renders him unable to perform the full range of work at the "sedentary" exertional level. He also argues that the ALJ inappropriately relied on the Medical Vocational Guidelines at 20 C.F.R. pt. 404, subpt. P, app. 2 ("Grids"), rather than a vocational expert's testimony, to determine whether he was disabled.

When an ALJ denies benefits and the Appeals Council "denies review, we review the ALJ's decision as the Commissioner's final decision." Doughty v. Apfel, 245 F.3d 1274, 1278 (11th Cir.2001). We review the ALJ's decision "to determine whether it is supported by substantial evidence." Moore v. Barnhart, 405 F.3d 1208, 1211 (11th Cir.2005) (per curiam) (citation omitted). We do not reweigh the evidence, decide the facts anew, or make credibility determinations. Id. (citation omitted). We review de novo the legal principles on which the ALJ's decision is based. Id. (citation omitted).

An individual claiming disability benefits carries the burden of demonstrating that he is disabled. Id. (citation omitted). The social security regulations outline a five-step, sequential evaluation process to determine whether a claimant is disabled. Id. (citation omitted); 20 C.F.R. § 404.1520(a)(4)(i)-(v). It is undisputed that Baker meets steps one through three.

At step four, the ALJ must evaluate the claimant's residual functional capacity ("RFC") and the claimant's ability to return to his past relevant work. Phillips v. Barnhart, 357 F.3d 1232, 1238 (11th Cir.2004) (citation omitted). RFC is that which an individual is still able to do despite the limitations caused by his impairments. Id.; 20 C.F.R. § 404.1545(a). There are 3 types of limitations: (1) exertional limitations affect an individual's ability to meet the seven strength demands of the job; (2) non-exertional limitations affect an individual's ability to meet the non-strength
demands of the job; and (3) limitations that are both exertional and non-exertional. 20 C.F.R. § 404.1569a(b)–(d). The ALJ must use “all the relevant medical and other evidence” to determine if the claimant can return to his past relevant work. Phillips, 357 F.3d at 1238 (citation omitted).

If the ALJ assesses the claimant's RFC and determines that the claimant cannot return to his past relevant work, then the ALJ moves on to step five. Id. at 1238–39. At step five, the ALJ must determine if there are other jobs in the national economy to which a claimant could adjust, considering the claimant's RFC, age, education, *895 and work experience. 20 C.F.R. § 404.1520(a)(4)(v); Phillips, 357 F.3d at 1239. The ALJ considers the physical requirements of a job, as divided into five exertional levels: sedentary, light, medium, heavy, and very heavy. 20 C.F.R. § 404.1567(a)–(e). “[I]n order for an individual to do a full range of work at a given exertional level, such as sedentary, the individual must be able to perform substantially all of the exertional and nonexertional functions required to work at that level.” Soc. Sec. Ruling (“SSR”) 96–8p, 61 Fed.Reg. 34474–01 (July 2, 1996). According to the regulations:

Sedentary work involves lifting no more than 10 pounds at a time and occasionally lifting or carrying articles like docket files, ledgers, and small tools. Although a sedentary job is defined as one which involves sitting, a certain amount of walking and standing is often necessary in carrying out job duties. Jobs are sedentary if walking and standing are required occasionally and other sedentary criteria are met. 20 C.F.R. § 404.1567(a).

The ALJ may approach step five in one of two ways. Phillips, 357 F.3d at 1239. First, an ALJ may apply the Grids, 20 C.F.R. pt. 404, subpt. P, app. 2, which provide adjudicators with a guideline for jobs available in the national economy for someone of the claimant's characteristics. Id. at 1239–40. Second, the ALJ may consult a vocational expert. Id. at 1240. A vocational expert is an expert on the kinds of jobs an individual can perform based on his capacity and impairments. Id. Generally, after determining the claimant's RFC and ability to return to past relevant work, the ALJ can use the Grids to determine if other jobs exist in the national economy that a claimant is able to perform and, consequently, whether the claimant is disabled. Id. at 1242. However, an ALJ must consult a vocational expert upon finding either (1) that the claimant is not able to perform a full range of work at a given residual functional level or (2) that the “claimant has nonexertional impairments that significantly limit basic work skills.” Id. (citation and quotation omitted). If the ALJ concludes that the claimant can perform a full range of work at a given level, and also that the claimant has no non-exertional limitations that significantly limit basic work skills, the ALJ may rely exclusively on the Grids to determine if the claimant is disabled. Id. at 1242–43.
Baker argues that the ALJ erred in finding that he had the RFC to perform the full range of sedentary work. The parties dispute whether the ALJ determined if Baker's cane was “medically necessary,” but this issue is not dispositive. Even an individual using a medically required hand-held assistive device can perform sedentary work, depending on the facts and circumstances of the case. See SSR 96–9p, 61 Fed.Reg. 34478–01 (July 2, 1996). The ALJ determined that Baker “requires a cane for ambulation but is able to walk effectively with it.” However, Baker argues, the ALJ did not perform a function-by-function analysis of the effects of Baker's cane on specific basic sedentary work skills. Baker argues that the ALJ made no finding about the effects of Baker's cane on balancing, prolonged versus brief ambulation, standing, lifting and carrying with one hand, balancing on level terrain, and stooping.

The ALJ found that Baker's cane was needed for ambulation, but that Baker was able to walk effectively with its assistance. Although some of the reporting physicians noted that Baker requires a cane to walk, no physician of record rendered an opinion that suggests that the cane limits his ability *896 to comply with the exertional requirements of sedentary work. Rather, the ALJ found that there was no loss of motion or deformity of major joints, that Baker only had “mild” lumbar paravertebral muscle spasms, and had no sensory or reflex deficits. The only restrictions placed on Baker by his physician were no repetitive motions and no heavy lifting. Further, the ALJ discredited Baker's testimony concerning the limits on his physical capacity. Moore, 405 F.3d at 1212 (“We recognize that credibility determinations are the province of the ALJ.”) (citation omitted). Substantial evidence supports the ALJ's determination that Baker has the RFC to perform the full range of sedentary work.

Baker also argues that the ALJ erred by relying solely on Grids and by failing to consult a vocational expert regarding whether Baker's cane use erodes the sedentary occupational base. He argues that because the ALJ determined that Baker's cane is “medically required,” he was obligated to determine whether use of a cane constitutes a non-exertional impairment that significantly limits Baker's ability to perform all the basic exertional and non-exertional sedentary tasks. See Phillips, 357 F.3d at 1242.

The ALJ permissibly relied on the Grids to determine that Baker is not disabled. The ALJ discounted Baker's testimony concerning the incapacitating effects of his impairment. Ultimately, the ALJ considered the medical and other evidence of record and concluded that Baker “has the residual functional capacity to perform the full range of sedentary work.” Baker required the cane for walking—an exertional function and one of the “strength requirements” of a job. Other than his
own discredited testimony, the record contains no evidence to suggest that Baker's use of a cane is a non-exertional limitation that significantly impaired the basic work skills required to perform at a sedentary level. See 20 C.F.R. § 404.1569a(c). Because the ALJ concluded that Baker had the RFC to perform the full range of sedentary work that was unimpaired by his use of a cane, the ALJ did not err by relying on the Grids to determine that Baker was not disabled. See Phillips, 357 F.3d at 1240–42.

Baker also complains that the government improperly advanced an argument for the first time on appeal—namely, that Baker's cane was not medically required—and that the magistrate judge improperly adopted this argument. The Supreme Court has held that a court may not accept appellate counsel's post hoc rationalizations for agency actions. See FPC v. Texaco Inc., 417 U.S. 380, 397, 94 S.Ct. 2315, 2326, 41 L.Ed.2d 141 (1974) (citation omitted). If an action is to be upheld, it must be upheld on the same bases articulated in the agency's order. Id. (citation omitted). In this case, however, the agency's action may be upheld based on the ALJ's opinion, without relying on a post hoc rationalization. We do not address the magistrate's reasoning, as our review is limited to the agency decision. See, e.g., Crawford v. Comm'r of Soc. Sec., 363 F.3d 1155, 1158 (11th Cir.2004) (per curiam) (“We review the Commissioner's decision to determine if it is supported by substantial evidence and based on proper legal standards.”) (quotation and citation omitted).

Accordingly, we affirm the magistrate judge's order upholding the Commissioner's denial of benefits.
Straddling the Invisible Line of Ethics and Professionalism When Trying a Social Security Case

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*Amy Uren appears in her own personal capacity and not as a representative of the Social Security Administration. The views expressed are solely her own and are not those of the Administration.
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Straddling the Invisible Line of Ethics and Professionalism When Trying a Social Security Case

Stop and look around you at the other attendees in the room. You see faces that are familiar over the years and also some new ones that we hope are here to take up the mantle as we older more experienced Social Security practitioners begin to slow down and retire. No neither of us are announcing our retirement, but many in this room may not be here next year for one reason or another. You are all probably thinking why in the world are we talking about this at an ethics and professionalism presentation. Well we are going to tell you. Stop and think about how many attorneys, paralegals, judges, staff attorneys, and other SSA/ ODAR employees are no longer with us through retirement, disability, and yes even death. The reason I mention this is because regardless of which side of the “aisle” we sit, Claimant’s rep or Agency, we all try to serve a special group of individuals who rely upon not only our expertise in the subject matter but also our ethical and professional self. This presentation will deal with subject matter that is important to those who have spent a good portion of our careers working with this vulnerable population--disabled individuals. We will also deal with possible ways to interpret and handle life under the new 5 day Rule. Although it has gone into effect, it will not be enforced until May of this year and as of the preparation of this paper, there is no additional guidance from the Agency on how it is to be handled.

As members of the Bar, we must not only zealously represent our clients, but we must also adhere to personal and professional standards. Likewise, the members of the Bench must also strive to achieve similar goals. The purpose of this presentation is to have both sides look at problems that exist so that we as professionals may work toward improving the workplace for both Judges and representatives alike.

No one likes an environment rife with hostility, so regardless of where we sit in the hearing room or how long we have been admitted to practice, as members of the State Bar of Georgia or wherever we have been admitted, we are all obligated to uphold the established standards of professional conduct. As a reminder, let us look at some of the pertinent portions of the Georgia Rules of Professional Conduct.
RULE 1.1 COMPETENCE

A lawyer shall provide competent representation to a client. Competent representation as used in this Rule means that a lawyer shall not handle a matter, which the lawyer knows or should know to be beyond the lawyer's level of competence without associating another lawyer who the original lawyer reasonably believes to be competent to handle the matter in question. Competence requires the legal knowledge, skill, thoroughness and preparation reasonably necessary for the representation.

The maximum penalty for a violation of this Rule is disbarment.

RULE 1.3 DILIGENCE

A lawyer shall act with reasonable diligence and promptness in representing a client. Reasonable diligence as used in this Rule means that a lawyer shall not without just cause to the detriment of the client in effect willfully abandon or willfully disregard a legal matter entrusted to the lawyer.

The maximum penalty for a violation of this Rule is disbarment.

RULE 1.4 COMMUNICATION

A lawyer shall explain a matter to the extent reasonably necessary to permit the client to make informed decisions regarding the representation, shall keep the client reasonably informed about the status of matters and shall promptly comply with reasonable requests for information.

The maximum penalty for a violation of this Rule is a public reprimand.

RULE 1.14 CLIENT UNDER A DISABILITY

(a) When a client's ability to make adequately considered decisions in connection with the representation is impaired, whether because of age, mental or medical disability or for some other reason, the lawyer shall, as far as reasonably possible, maintain a normal client-lawyer relationship with the client.

(b) A lawyer may seek the appointment of a guardian or take other protective action with respect to a client when the lawyer reasonably believes that the client cannot adequately act in the client's own interest.

The maximum penalty for a violation of this Rule is a public reprimand.

And in addition, the 5 day rule. It is included in its entirety straight from the Federal Register in the appendix to this presentation. The only changes made were enlarging the print and were done to aide in being able to read the small print.
As you can see, failure to follow these ethical rules carries very stiff penalties. While most of the attorneys and Judges involved in Social Security Disability cases are hardworking, honest, ethical and trustworthy, there are some unfortunate exceptions. Our goal today is to examine some of the most glaring examples of unprofessional conduct from the Bench and Bar perspective, encourage discussion and hopefully, come to a renewed resolve and commitment to be the very best examples of professionalism and competency possible.

I am sure you have had situations where it did not matter how professional or thoughtful an Administrative Law Judge can be, he/she may still be on good grounds in denying a case. However, if a Judge’s tone and approach are inappropriate, then he or she will subject themselves to scrutiny that may result in a bias and misconduct complaint at best and perhaps, at worst, removal from position secondary to contractual, policy and/or Standards of Conduct violations, including conduct unbecoming an Administrative Law Judge.

It is the opinion of both authors that there is no room for browbeating a claimant or reducing them to tears. This sometimes happens despite one’s best tone, approach and intentions, as the hearing process for a claimant can be overwhelming and fraught with anxiety. During those times, it is very important for the Administrative Law Judge and the representative to assist in restoring a claimant’s composure so that they can have their day in court and articulate their position in an effective manner.

Bias is an inherent part of our humanity. Whether it is politics, sports, religion, cultural or social preferences, there is no escaping the strong feelings that result from the formulation of our personal opinions. This brief list of examples just scratches the surface! These personal opinions are based on our exposure, what we have been taught and what we have experienced, both positively and negatively. How does one successfully resist the urge to act upon their bias (es), especially when a claimant’s presentation during a hearing triggers it? At best, as Administrative Law Judges, we must strive to resist the urge to give into the bias and resolve to remain fair and impartial. Likewise, representatives need to make sure that under no circumstances should their claimant appear coached. It is frustrating for Judges to hear the same
answer from every one of a particular attorney’s claimants even when the particular impairment claimed would not affect the claimant in that particular way. Both Judges and representatives should avoid categorizing certain impairments in terms of how a claimant needs to act. For example, decisions for a claimant with a back problem often-illicit comments in a decision like “the claimant did not appear to exhibit any indication that his back was hurting during the forty-five minute hearing”. This is also a form of bias that borders on “sit and squirm” jurisprudence and is just as much an inappropriate thought process as making a decision based on race, nationality or sexual orientation.

In preparation for this presentation, we both informally polled attorneys after our hearings to hear their views about Administrative Law Judges and their conduct during hearings. Some of the examples that they shared with us involving inappropriate Administrative Law Judge conduct are as follows:

- ALJs interrogate claimants versus questioning them, asking the same question over and over again in a slightly different tone or manner to see if they can obtain a different response from the claimant;
- ALJs belittle claimants and attorneys;
- ALJs are ill prepared—their questions reflect that they have not read the file at all;
- ALJs are wedded to their hearing script to the detriment of real fact finding;
- ALJs go out of their way to discredit the claimant in a manner that goes above and beyond the expected questioning pursuant to Social Security Ruling 96-7p;
- ALJs do not trust the attorneys to have screened the cases for merit before bringing it forward to hearing;
- ALJs are adversarial versus serving as fact finders;
- ALJs misunderstand the purpose of hearing testimony and feel that it should be taken as fact unless contradicted in the record;
- Some ALJs are all about getting a win at any cost, even if it means violating the ethical standards that govern all members of the Bar;
- ALJs are not approachable;
- ALJs do not employ good people skills;
• ALJs will overly focus on a claimant’s appearance or criminal history in the credibility portion of the decision;
• ALJs devotes pages in the decision for enduring blistering cross examination—appears to be biased towards the expert;
• ALJs limit the extent of cross examination conducted by the attorney;
• ALJs make promises on the record that are not reflected in the final decision---Example: VEs testimony was deemed to be less than significant in terms of numbers and they later affirmed the case, using that specific job;
• ALJs do not appear to be paying attention during the hearing process---repeating questions that have already been asked and answered;
• ALJs can be very provocative when it comes to questions about the claimant’s sexual history;
• ALJs postpone the hearing because they have not had an opportunity to review the entire record, when medical evidence is submitted either the day of or the day before the hearing.

Similarly, we polled both Administrative Law Judges and representatives about some negative examples of attorney/representative conduct as it pertains to representation of Social Security claimants.

• Some representatives are poorly prepared; and do not know the record or their claimant;
• While distance and travel issues can make it hard to have multiple or even one face to face meeting with claimants, representatives should at least take the time to get to know their claimant by multiple phone calls and not rely on office staff to prepare the claimant for the hearing;
• Some representatives submit multiple copies of the same medical records even after the case has been pulled or wait to submit a large amount right before the hearing. Granted, it may be difficult to get a single RFC or one short medical report right before the hearing, but 50+ pages the day before or the day of the hearing should not be a regular practice. In fact this behavior was one of the reasons the 5 day rule was promulgated. Similarly, an ALJ should not always postpone a hearing just because the records were
submitted late. A conscientious representative would offer or would have a brief synopsis or brief on the medicals and any issue it raises or settles;

- Always know the pertinent Listings and Regulations as they apply to your claimant’s case. Do not cite inappropriate regulations when they clearly do not apply. For example, the 35 year arduous work rule cannot apply to a 40 year old. Stop and think before you speak!

- Zealously representing your claimant is always a good thing. Just remember, don’t beat a dead horse. Your credibility on really farfetched cases will cause you to take a hit on other cases that would be close ones when your arguments and preparation of the case are such that they can be the deciding factor;

- Attorneys from certain firms have not met or spoken with their clients. Attorneys fly in, the claimant fails to appear and no 1696 or fee agreement has been signed by the claimant and the attorney who appears at the hearing. As a result, the Administrative Law Judge has no choice but to postpone the hearing. If these documents were in place, the attorney would still have been able to make an opening statement and establish their point of view on the record. This wastes time and resources for all concerned;

- Attorneys are wedded to their examination script and do not know the central issues of their case. When asked to get to the heart of the case, they falter before regaining their composure and proceeding with the hearing;

- While there are no rules of evidence at issue in a disability hearing, leading questions can be perceived by Administrative Law Judges as being disingenuous.

These examples just begin to touch on issues that exist on both sides. We welcome you to come forward to discuss “pet peeves” from both sides. Please refrain from naming names or pointing fingers, as this would also be inappropriate from both a manners and ethical standpoint. Remember the old adage, “If you can’t say something nice about someone, do not say anything at all.”

In addition to the examples already mentioned are the day to day issues that arise. Many practitioners deal with issues on a daily basis that straddle the fence between what is an ethical
issue and what is a professional issue. My portion of this presentation deals with the submission of evidence that is adverse to the claimant either prior to an ALJ hearing or at the hearing level.

The rules regarding appropriate behavior for representatives have been taken from what should be appropriate behavior to what is expected to be appropriate behavior. What do I mean? Well, to put it simply, things have changed a lot since I first began practicing Social Security law more than twenty-five years ago. When I first began practicing, there were no written rules of conduct before the Social Security Administration. Attorneys were governed by their own rules in the state in which they practiced. While many of the states adopted the model rules of professionalism verbatim, some states did not and made their own criteria specific to their own personal choices.

In 1998, Social Security issued final rules governing the conduct of all claimant’s representatives both attorneys and non-attorneys who appear before the agency. See, 63 Fed.Reg.41404 (Aug. 4, 1998). This was codified at 20 CFR §§ 404.1740 and 416.1540. As I previously stated, each State Bar is responsible for promulgating their rules of conduct and code of professional responsibility with extensive commentaries in detailed analysis. Social Security was criticized for placing attorneys in potential conflict with state bar codes of conduct. The conflict often included a difference of opinion with regard to the submission of adverse evidence. The proposed rules required notification to Social Security that claimant did not consent to the release of evidence. This placed many attorneys in conflict with state bar rules. The final revised rule conformed to the representative’s duty to submit evidence and conformity with the requirements placed on claimants. 20 CFR §§ 404.1740(b)(1) and 416.1540(b)(1).

It is important to understand what the term adverse evidence means. Adverse evidence is information or evidence that does not prove or that may raise a doubt about whether the claimant is disabled. There has always been a difference in position on the issue of this evidence between the agency, adjudicators, and those who represent claimants that evidence that is not favorable to the claimant or that is in fact damaging to the claimant should not be required to be submitted to Social Security. The agency’s conduct rules address a representative’s affirmative duty to
comply with the agency request for all information. “A representative shall assist the claimant in complying as soon as practicable with request for information or evidence at any stage of the administrative decision making process and shall act with reasonable diligence and promptness in representing a claimant. This includes providing prompt and responsive answers to request from the agency for information pertinent to processing the claim.” There have been assertions made in the past that the Social Security Administration interpreted these obligations to require the submission of such evidence within the context of the agency’s expectations in relation to claimants. The Social Security Act and its regulations only require a claimant to prove his or her disability not his or her ability. Social Security therefore expects claimants to bring to the agency’s attention anything that shows they are disabled including medical evidence that can be used to reach a conclusion about the impairment. Because claimant’s representatives stand in the same position as the claimant and have the same rights and responsibilities with respect to submitting evidence as the claimants they represent, it is imperative that they too provide that same information. Neither the Act nor the regulations place an absolute or clear obligation on the claimants to submit all evidence they have or to disclose all sources of available information even when asked to do so by an ALJ. Social Security has interpreted the law to require only the submission of evidence that supports the disability claim.

The question then becomes one that turns on the facts of a particular case. For example, does this position change if the ALJ has requested a specific piece of information? A case in point may occur when an ALJ learns there are two different reports by two different specialists who treated the claimant. The representative submitted only one report. If the ALJ specifically asked for the second report, does this create a duty to turn it over even if it does not support the disability claim or in fact even harms the claim? In this particular situation, it is less about disclosing adverse evidence than about being honest with the agency because the rules promulgated by Social Security expects claimant’s representatives to answer truthfully and avoid committing a fraud on the tribunal. It is imperative that the representative avoid a violation of the rules of conduct by making any false or misleading statements. For example, they need to make sure they do not say that that report was never written or there was not a second cardiac examination. While the agency is not specifically saying that you have to dig up all the
information from every source if your claimant did not tell you about it or the record did not indicate the existence of additional information, it does have a serious problem with wrong information or an out and out falsehood.

This representation could result in a violation of the prohibition against making false or misleading statements about a material fact concerning a matter within Social Security's jurisdiction. By doing so, a representative could be disqualified or suspended from representing claimants before the Social Security Administration. There are also administrative and civil penalties applicable to both claimants and representatives for knowingly making statements or representations that are incorrect, incomplete, false or misleading or that omit material facts or conceal material information that are made in knowing disregard for the truth. These civil monetary penalties were included in the Social Security Independence and Program Improvements Act of 1994. This particular act gave Social Security the authority to impose civil monetary penalties against any person, organization, agency or other entity who makes or causes to be made a statement of representation of a material fact for use in determining an initial or continuing light to or the amount of benefits under Title II and Title XVI that the person knows or should know is false or misleading or omits a material fact. Social Security could also impose civil monetary penalties for statements or representations made in knowing disregard for the truth. Therefore I suggest that you do not misrepresent the availability of medical evidence or what has been done to obtain that evidence. Always be up front with your ALJ when asked specifically about evidence and if you do not know the answer tell them that you will get back to them with the correct information.

What should we do when we have medical evidence that may not favorable to our client? Well, I will always submit evidence that an ALJ has specifically asked for or that I told an ALJ to leave the record open for. Saying this does not mean I roll over and play dead as if there was nothing else I can do. I recontact that physician to see if additional information could be gleaned that would be more favorable to the claimant or to get that physician to explain why he wrote what he did in the treatment notes to lessen the effect that this unfavorable report makes toward my claimant. For example, the record was left open in a case where an individual had an
orthopedic problem due to a bad back and a bad knee. This particular orthopedist was only treating the claimant for the situation with his knee and had no ability to comment on the back because he did not know anything about the claimant’s problems with his back because a different person not in his practice was treating the claimant for this problem. The report came from the orthopedist that the claimant could stand two hours out of an eight hour day but would be able to do a sedentary job with no problem. All of this is good if your claimant is over fifty but in my case, the claimant was thirty-nine years old and because of his back problems that had already required two surgeries and the fact that the claimant was looking at a third surgery, he was not able to do the prolong sitting that was required for the sedentary job. I contacted this orthopedist to get him to clarify that his statement that the claimant could do a sedentary job just fine was with regard to his treatment of the knee only and that he was not commenting on any limitations as a result of the back. That way I was able to submit all of the information that the ALJ had asked for and was able to provide a report that did not damage my client’s case that relied on multiple conditions.

Another example is when a RFC is prepared. You need to make sure that the treating source actually did prepare the RFC and not someone in his office that did not understand all of the person’s problems. Often times somebody at the front desk will hurriedly fill out something and it may not adequately reflect all of the claimant’s problems. If a RFC is sent to you that does not seem correct, do not just assume that the doctor prepared this RFC and that everything on there comports with a finding of non-disability. The doctors need to help explain anything in the RFC form that would be detrimental to the claimant’s case.

With regard to the 5 day rule, while the rule has already gone into effect, actual enforcement is not until May of this year. Of course the Agency is made of many different personalities and thinking, so how the rule is applied may differ from office to office and ALJ to ALJ. The fine points and possible exceptions will be discussed in detail during the presentation.
While this is not all the answers for all aspects of the many different issues that arise in any case before SSA/ODAR, please feel free during the presentation when the floor is open for questions to ask about specific areas that might be of interest to you.
APPENDIX:

SSA 20 CFR
Parts 404, 405, 406
Operations, Social Security Administration, 5107 Leesburg Pike, Falls Church, VA 22041, (703) 6057100. For information on eligibility or filing for benefits, call our national toll-free number, 1-800-772-1213 or TTY 1-800-325-0778, or visit our Internet site, Social Security Online, at http://www.socialsecurity.gov.

SUPPLEMENTARY INFORMATION

Background

We are revising and making final the rules for creating nationally uniform hearing and Appeals Council procedures, which we proposed in a notice of proposed rulemaking (NPRM) published in the Federal Register on July 12, 2016 (81 FR 45079). In the preamble to the NPRM, we discussed the changes we proposed from our current rules and our reasons for proposing those changes. In the NPRM, we proposed revisions to: (1) The time frame for notifying claimants of a hearing date; (2) the information in our hearing notices; (3) the period when we require claimants to inform us about or submit written evidence, written statements, objections to the issues, and subpoena requests; (4) what constitutes the official record; and (5) the manner in which the Appeals Council would consider additional evidence.

As we explained in the preamble to our NPRM, we proposed these changes to ensure national consistency in our policy and procedures and improve accuracy and efficiency in our administrative review process. We expect this final rule will positively affect our ability to manage our workloads and lead to better public service. Interested readers may refer to the preamble to the NPRM, available at http://msw.regulations.gov under docket number SSA-2014-0052.

What changes are we making from the NPRM?

We are making several changes in this final rule from the NPRM based on some of the public comments we received. We briefly outline those changes here and provide additional detail on the changes in the comment and response section that follows. We are also making minor editorial changes throughout this final rule. For the reader’s ease of review, we refer to the general requirement that all evidence, objections, or written statements be submitted at least 5 business days before the date of the hearing as the “5-day requirement.”

We adopted the following changes from our NPRM in this final rule:

• We lengthened the time frame for notifying claimants of a hearing date in 20 CFR 404.938 and 416.1438 from at least 60 days to at least 75 days;

• In 20 CFR 404.935(b)(3)(iv) and 416.1435(b)(3)(v), we removed the phrase “through no fault of your own” to reduce the evidentiary burden on claimants who are unable to provide evidence; We added the same exceptions to the 5-day requirement that we proposed for the submission of evidence in 20 CFR 404.935 and 416.1435 to the deadlines related to objecting to the issues (2.0 CFR 404.939 and 411.1435), presenting written statements (20 CFR 404.949 and 416.1449), and submitting subpoenas (20 CFR 404.950(d)(2) and 416.1450(d)(2)).

• We added language to 20 CFR 404.949 and 416.1449 to clarify that the 5-day requirement applies only to pre-hearing written statements, not to post-hearing written statements;

• We added an example of an exception for submitting additional evidence to the Appeals Council in 20 CFR 404.970(b)(3)(v) and 416.1470(b)(3)(v);
• We reorganized paragraphs (a)(5) and (b) of 20 CFR 404.970 and 416.1470;
• We revised the proposed subsection 20 CFR 404.970(d) and 416.1470(d);
• We added clarifying cross-references to 20 CFR 404.900 and 416.1400 and 20 CFR 404.929 and 416.1429 to place the 5-day requirement in 20 CFR 404.935 and 416.1435 in context; and,
• We broadened the existing cross-reference in 20 CFR 404.968 and 416.1468 and 20 CFR 404.979 and 416.1479 to reference the entire section of 20 CFR 404.970 and 416.1470, and we removed the cross-reference to 20 CFR 404.976 and 416.1476 in 20 CFR 404.979 and 415.1479.

Public Comments

We initially provided a 30-day comment period that would have ended on August 11, 2016. We subsequently extended the comment period for an additional 15 days, until August 26, 2016 (81 FR 51412). We received 154 comments on our proposed rule from the public, interested advocacy groups, and several members of Congress. We did not consider six comments because they either came from employees who commented in their official employment capacity, which is a violation of our policy, or they were outside the scope of the rulemaking. We published, and carefully considered the remaining 148 comments and, where appropriate, made changes in response to these comments.

Below, we summarize and respond to the comments submitted on the proposed rule, and respond to the significant issues relevant to this rulemaking. We do not respond to comments that are outside the scope of this rulemaking proceeding.

Hearing Notice Requirement

Comment: Several commenters supported our proposal to provide more advance notice of a hearing, but asked that we adopt the 75-day advance notice requirement currently in place in the Boston region, rather than the 60-day advance notice we proposed in the NPRM. Several of the commenters stated that earlier notice would allow claimants to: (1) Obtain and submit the information and evidence, especially when a medical provider is uncooperative; (2) make arrangements for transportation to the hearing; (3) take into account time frames under the regulations implementing the Health Insurance Portability and Accountability Act (HIPAA) that provide an entity up to 60 days before it must produce records (45 CFR 164.524(b)); and (4) avoid a postponement of hearing due to non-receipt of medical records.

Several other commenters said that even a 75-day notice requirement is insufficient, and that we should provide notice 90 to 120 days in advance of a hearing.

Response: We recognize that claimants and representatives may, sometimes face challenges in acquiring medical records. In response to multiple advocate comments indicating a preference for 75 days' advance notice of a hearing instead of 60 days, we are revising the final rule to provide 75 days' advance notice. Since we already have approximately a decade of experience in using the 75-day advance notice period for the Boston Region, we believe its expansion nationwide is justified.

We proposed a 60-day period in our NPRM because we believed it would promote the efficiency of our hearing process (81 FR at 45081). However, we recognize the concerns that that commenters raised, including stated concerns about the adequacy of a 60-day advance notice requirement in light of the timeframe an entity has to provide evidence to an individual under the HIPAA regulations. In order to minimize the burden on claimants, we are inclined to adopt the commenters' suggestion that we continue to provide at least 75-days advance notice of a hearing, as we have done under the rules we have been applying in the Boston region since 2006. Some commenters requested that we extend the advance notice period to 90 or 120 days instead of the proposed 60-days advance notice. We have decided not to extend the advance notice period to 90 or 120 days, because providing a hearing date this far in advance would increase the likelihood that an adjudicator's schedule will change by the scheduled hearing date. Moreover, in contrast to the current model to support the use of a longer time period.

Exceptions to the 5-Day Requirement

Comment: Several commenters asked that we retain the exception in 20 CFR 404.935(b)(3)(iv) in the final rule because it recognized the difficulties of obtaining medical evidence, while another commenter suggested we eliminate this exception because it was vague and contrary to the intent and purpose of the proposed rule. Several commenters expressed concerns about our exceptions to the 5-day requirement in case the claim was too narrowly defined, too subjective, and would increase our workloads. Other commenters suggested that we add additional exceptions, such as when the claimant is homeless or lacks representation. Two commenters requested that the Appeals Council also find good cause for submitting evidence after the 5-day requirement if the claimant was unrepresented or homeless at the hearing level.

Response: We provide examples of exceptions to the 5-day requirement in final 20 CFR 404.935(b)(3) and 416.1435(b)(3) and have clarified that we did not intend for them to be all-inclusive or to exclude other extenuating circumstances that may result in a claimant being unable to meet the 5-day requirement. To clarify this point, we changed the regulatory text to state that "examples include, but are not limited to" the outlined exceptions. Because circumstances vary, we determine whether a claimant qualifies for an exception on a case-by-case basis.

We do not anticipate that evaluating requests for exceptions to the 5-day requirement will increase our workloads. We recognize that compliance with the 5-day requirement will not be possible in all situations; however, based on our experience in the Boston region, we expect that providing at least 75 days' advance notice of a hearing will significantly increase the number of times evidence is obtained and submitted at least 5 business days before the hearing. We also note that in our experience the need to evaluate requests to submit evidence pursuant to one of the exceptions has not caused workload spikes in our Boston region, where a 5-day requirement has been in place for more than a decade. When a claimant or appointed representative is aware that he or she will need more time to submit evidence in accordance with one of the exceptions, we expect that he or she will provide us with the necessary information in advance. To do so, the claimant or representative should notify the administrative law judge (ALJ) of what the evidence generally consists of and the expected volume of evidence (e.g., one visit to a treating physician or a one-week hospital stay). When the claimant or his or her representative timely provides this information to the ALJ, we expect that evaluating the request for an exception will likely be very simple.

The fact that a claimant is homeless or lacks representation does not automatically excuse him or her from complying with our rules. However, situations such as these may result in circumstances that warrant
an exception to the 5-day requirement. We will evaluate these circumstances carefully on a case-by-case basis under the exceptions described in the final rule.

Comment: Commenters who represented advocacy groups noted that our proposed rule did not include exceptions to deadline requirements for objections to the issues (20 CFR 404.939 and 416.1439), presenting written statements (20 CFR 404.949 and 416.1449), and submitting subpoenas (20 CFR 404.950(4)(2) and 416.950(d)(2)). Some commenters had concerns that the 5-day requirement, as applied to objections to the issues, could force representatives to develop boilerplate notices that list all possible objections in every case.

Response: We agree with the commenters’ concerns, and we have added exceptions for the deadlines related to objecting to the issues (20 CFR 404.939 and 416.1439), presenting written statements (20 CFR 404.949 and 416.1449), and submitting subpoenas (20 CFR 404.950(d)(2)) in appeals. The exceptions in 20 CFR 404.939 and 416.1439 should eliminate the need for representatives to develop boilerplate notices.

Appeals Council Authority

Comment: While one commenter supported the proposed in subsections 20 CFR 404.970(d) and 416.1470(d) that the Appeals Council conduct hearings to develop evidence, other commenters expressed concern about the proposal. A few of these commenters stated it was an expansion of the Appeals Council’s authority and was inconsistent with the Administrative Procedure Act. Other commenters stated that we did not provide an adequate explanation of the authority for such hearings.

Response: Since the beginning of our hearing process in 1940, our regulations (currently found in sections 20 CFR 404.970(d) and 416.1470(d)) authorized the Appeals Council to conduct hearings to develop evidence. We proposed to revise sections 20 CFR 404.970(d) and 416.1470(d) to clarify the Appeals Council’s authority in this area. Although we disagree with some of the comments, including concerns that the proposal lacked legal support, we understand the concerns the commenters raised regarding this proposal. As a result, we have decided to remove the rule we proposed in subsections 404.970(d) and 416.1470(d). The Appeals Council will continue to exercise its authority to develop evidence in accordance with 20 CFR 404.976(b) and 416.1446(b).

"Inform" Option

Comment: Several commenters stated the proposed rule may have unintended consequences because appointed representatives may rely on the "Inform" option in 20 CFR 404.935 and 416.1435 and in 20 CFR 404.1512 and 416.912 to avoid developing evidence. A few commenters stated if we retain the "Inform" option, we should require the claimant to inform the hearing office earlier so there would be time to develop the evidence and avoid unnecessary supplemental hearings.

Response: On April 20, 2015, we implemented a final rule that requires a claimant to "inform us about or submit all evidence known to you that relates to whether you are blind or disabled," 81 FR 14838. As we stated in the preamble to that proposed rule, we specifically added this option because we did not intend to shift our burden to develop the record to claimants. In the proposed rule, as in this final rule, we recognize that some individuals, many of whom do not have appointed representatives, require our assistance in obtaining medical evidence needed to adjudicate their claims. Claimants who are unable to obtain evidence necessary to adjudicate their claims may inform us of this difficulty and we will continue to seek out evidence on their behalf to develop the record for their hearing. By adopting this final rule, we have not changed our longstanding policy of assisting claimants in developing the record. At the hearing level, this policy has been explicitly set forth in our sub-regulatory instructions.

Because most claimants are represented at the hearing level, and because we are providing more advance notice of a hearing than we have in the past, we expect to significantly reduce the number of postponed hearings or supplemental hearings needed based on evidence that was available at least 5 business days before the hearing.

In our experience, the vast majority of representatives act ethically in regard to evidence development and make good faith efforts to assist claimants in obtaining and submitting the required evidence before a hearing, as required under 20 CFR 404.1470(b)(2) and 416.1540(b)(2). Therefore, we do not expect the "Inform" option to significantly affect our administrative processes.

In those circumstances in which hearing officers assist unrepresented claimants in developing evidence, our sub-regulatory instructions will clarify that employees in our hearing offices should undertake development as early as possible to reduce the number of continuances or postponed hearings.

5-Day Requirement

Comment: Some commenters thought the 5-day requirement in the proposed rules was inconsistent with our duty to make eligibility decisions based on the evidence presented at the hearing.

Response: In developing these rules, we were guided by the two principles that we have always applied when we make decisions regarding our programs: As the Supreme Court has observed, the Social Security system "must be fair—and it must work." These final rules appropriately balance these two guiding principles. These rules are fair because they provide the claimant with more advance notice of his or her hearing, and they provide appropriate exceptions to the 5-day requirement. At the same time, the 5-day requirement promotes the efficiency of our hearings process and allows it to work more effectively by ensuring that ALJs have a more complete evidentiary record when they hold hearings. Striking such a balance in our rules is of paramount importance to us, and the option would not be present if, as some commenters suggested, we merely gave claimants more advance notice of a hearing, without the 5-day requirement. Conversely, that balance would not be present if we simply imposed a 5-day requirement, without giving a claimant more advance notice of a hearing. Given the size of our hearing workloads, where the need for efficiency is "self-evident," these final rules appropriately balance the twin concerns of fairness and efficiency that always guide us.

In publishing this final rule, we do not intend to change the purpose of a hearing, which under our ALJ looks fundamentally into the issues and obtains oral testimony from the claimant and witnesses, if any. Additionally, our final rule contemplates that some circumstances may warrant the introduction of new evidence at of after the hearing, and includes appropriate exceptions to accommodate those circumstances. Under our final rule, adjudicators will continue to make decisions based on the evidence of record, including the evidence adduced at the hearing. However, we expect that our final rule will help to ensure that evidentiary records are more...
Comment: Some commenters stated that the philosophical underpinnings of the rule in 20 CFR 404.1512 is that ALJs must have all evidence that is available at the time of the hearing so they can reach the correct decision. The commenters thought that the proposed rule conflicted with our rule requiring claimants to submit all evidence. The commenters noted that it would not make sense to place a duty on the claimant to submit evidence when at the same time, rules are created that would allow an ALJ not to consider that evidence.

Response: Our approach with this rule is tied to the "philosophical underpinnings" of 20 CFR 404.1512 and 416.912, which describe a claimant's ongoing duty to "inform us about or submit all evidence known to you that relates to whether or not you are blind or disabled." This rule will ensure claimants have the benefit of a fully developed record at the time our ALJs conduct their hearings. We recognize that there will be circumstances in which claimants cannot produce evidence at least business days before the hearing. As stated above, we have included appropriate exceptions to the 5-day requirement to ensure fairness when a claimant or his or her representative actively and diligently seeks evidence but is unable to obtain it. To bolster this point, in 20 CFR 404.935(b)(3)(iv) and 416.1435(b)(3)(iv), we removed the phrase "through no fault of your own" to ensure that our adjudicators interpret this exception consistent with our intent. We intend the words "actively" and "diligently" to be interpreted using their ordinary English usage. When a claimant or representative shows that he or she made a good faith effort to timely request, obtain, and submit evidence, but he or she did not receive the evidence in time to submit it at least 5 business days before the hearing because of circumstances outside his or her control, we expect that our adjudicators would find that this standard is met.

Some commenters perceived this rule as an exclusionary procedure designed to prevent the introduction of medical records at the expense of the claimant's case. Our experience is more consistent with one of the commenters from the Boston region who noted that most ALJs "effectively draw the line between evidence which had been available but was not submitted and previously unavailable evidence" and "do not use the 5-day rule as a punitive device against claimants or their representatives." Further, in those situations in which an ALJ in the Boston region did not correctly find reason to accept evidence outside the 5-day time frame, the Appeals Council granted review in order to consider the information on appeal where the evidence raised a reasonable probability of changing the outcome of the case. This important practice will continue in our final rule.

1 Richardson v. Paredes, 402 U.S. 389, 399 (1971)

2 See Annual Statistical Supplement to the Social Security Bulletin, Apr./May 2014, Table 2.9, at page 281 (2014).

3 See Bambuti v. Thomas, 540 F.3d 38, 24-29 (2d Cir. 2008) ("As we have observed, the Social Security hearing system is 'probably the largest adjudicative agency in the western world.'... The need for efficiency is self-evident."); (quoting Heckler v. Campbell, 461 U.S. 456, 461 n.2 (1983)).

Comment: Some commenters pointed out that the 5-day requirement would preclude a claimant from submitting evidence at the hearing or Appeals Council level of the administrative process, particularly if a claimant is illiterate or does not speak English, or is without an appointed representative or obtained a representative shortly before the hearing date, and this exclusion was an undue burden, fundamentally unfair, and disadvantaged claimants in favor of adjudicators.

Response: We expect that this final rule will enhance our decision-making process and allow us to provide more timely decisions to claimants. We do not intend to unduly burden claimants with this rule. By asking claimants to inform us about or submit evidence at least 5 business days before the hearing, we expect that evidentiary records will be more complete and comprehensive at the time of the scheduled hearing. In turn, this should facilitate the ALJ's ability to look fully into the issues at the hearing and produce a timely, accurate decision. As stated above, we will continue our longstanding practice of assisting those individuals who, for various reasons, are unable to develop the record themselves. This rule also incorporates appropriate exceptions to take into account for the needs of individuals who, due to unique circumstances, do not fully understand or are not capable of adhering to our requirements or requirements of the hearing or Appeals Council.

Comment: Some commenters said that the proposed rule makes the administrative review process more formal and adversarial. Commenters also asked the agency to clarify that if a claimant informs an ALJ about evidence at least 5 business days before the hearing, the ALJ must consider the evidence regardless of whether an exception exists. Commenters said that the proposed rule overlooked that an ALJ adjudicates a case through the date of his or her decision, and that he or she needs evidence of ongoing treatment to adjudicate the case. Commenters also said that the proposed rule did not provide the claimant with an opportunity to submit evidence to rebut other evidence produced at or after the hearing or permit an ALJ to hold the record open when a new issue arises during the hearing.

Response: From our experience, similar rules that applied in the Boston region for approximately a decade have not resulted in a more adversarial process or misunderstandings from the public. Moreover, many of our other rules that apply nationwide impose deadlines or other requirements on the public, such as the deadline to appeal a determination or decision. While processing a case, we frequently request that individuals submit a response or provide us with information within certain timeframes. We have not found that these provisions make our process more adversarial. Rather, like this final rule, they are necessary for efficient administration of our programs.

If a claimant informs an ALJ about evidence 5 or more days before the hearing, there would be no need for the ALJ to find that an exception applies, because the claimant notified us prior to the deadline.

While it is true that, in many cases, an ALJ adjudicates the case through the date of the hearing decision, our rule is not intended to prevent a claimant from submitting evidence related to ongoing treatment. Rather, we expect that evidence of ongoing treatment, which was unavailable at least 5 business days before the hearing, would qualify under the exception in 20 CFR 404.935(b)(3) and 416.1435(b)(3) to submit rebuttal evidence. The claimant could also rebut evidence introduced at or after the hearing by submitting a written statement to the ALJ. As previously mentioned, we added language to 20 CFR
404.949 and 416.1449 to clarify that the 5-day requirement applies only to pre-hearing written statements, not to post-hearing statements. Comments: Some commenters stated that the 5-day requirement could affect a representative's ability to prepare useful and persuasive pre-hearing statements, given that the Office of Disability Adjudication and Review (ODAR) frequently exhibits files very close to the hearing date.

Response: For the same reasons we are adopting a 5-day requirement for available evidence, we are adopting this requirement for pre-hearing written statements to ensure that an ALJ has the benefit of reviewing arguments before the hearing. This will allow the ALJ to be fully aware of any unresolved issue(s) that a claimant is raising and which the ALJ may need to address at the hearing. While we are sympathetic to the commenters who noted exhibit numbers were unlikely to be available at least 5 business days before the hearing, we note that this issue existed under our prior rules as well and therefore, this convenience does not outweigh our need for a complete case file before the hearing.

Comment: Some commenters stated that the 5-day requirement, could disadvantage claimants who hire representatives shortly before the hearing date.

Response: We reiterate that we expect all appointed representatives to make good faith efforts to assist claimants in obtaining and submitting the required evidence before a hearing, as required under 20 CFR 404.1740(b)(2) and 416.1540(b)(2). However, we have included appropriate exceptions to the 5-day requirement to ensure fairness when a claimant or his or her representative actively and diligently seeks evidence but is unable to obtain it. The appointment of a representative shortly before a hearing may be such an exception, depending on the circumstances surrounding the late appointment. In addition, we note that if a claimant informs an ALJ about evidence 5 or more days before the hearing, there would be no need for the ALJ to find that an exception applies, because the claimant notified us prior to the deadline.

Representation

Comment: A few commenters argued that when taking a new case, representatives often find that prior counsel was incompetent in obtaining evidence, and this rule, as applied at both the hearing and Appeals Council levels, unjustly harms claimants represented by such individuals.

Response: We reiterate that we expect all appointed representatives to make good faith efforts to assist claimants in obtaining and submitting the required evidence before a hearing, as required under 20 CFR 404.1740(b)(2) and 416.1540(b)(2). Additionally, if a new representative can show that a prior representative did not adequately uphold his or her duty to the claimant, we expect that our adjudicators would find that this would warrant an exception to the 5-day requirement.

Other

Comment: Several commenters stated the new standard at the Appeals Council level would force claimants to choose between filing a new claim and appealing an ALJ's decision to the Appeals Council, which could result in the loss of significant benefits. Another commenter stated it would result in filing more new applications overall or the reopening of prior applications so that a claimant could submit previously excluded evidence.

Response: It bears reiterating that we expect the final rule will help to ensure that evidentiary records are more complete at the time of the scheduled hearing. However, our final rule contemplates that some circumstances may justify a new statement of evidence as evidence at or after the hearing, and includes an "inform" option and broad exceptions to accommodate these circumstances. With the "inform" option and the broad exceptions to the 5-day requirement, we do not expect to see a spike in new applications or reopenings.

Moreover, it is already our policy that if a claimant wants to file a new disability application under the same title and for the same benefit type as a disability claim pending at the Appeals Council level, and the claimant does not have evidence of a new critical or disabling condition, the claimant must choose to continue the appeal of the prior claim or file a new application. Nothing in the proposed or final rule substantively changes this policy.

Under our current rules in 20 CFR 404.970 and 416.1470, the Appeals Council considers additional evidence only if it is new, material, and related to the period on or before the date of the ALJ's decision. This does not mean that the Appeals Council grants a claimant's request for review of an ALJ's decision whenever additional evidence meets this criteria. In many cases, the Appeals Council adds evidence that meets the criteria to the record, but denies the request for review of the case. Under our current rule, the Appeals Council will review a case in this situation only if it finds that the ALJ's action, findings, or conclusion is contrary to the weight of the evidence currently on record. This final rule provides more clarity to this procedure. Under this final rule, the Appeals Council will grant review of a case based on the receipt of additional evidence if the evidence is new, material, and related to the period on or before the date of the hearing decision and if there is a reasonable probability that the additional evidence would change the outcome of the decision.

If a claimant submits evidence that the Appeals Council does not consider, the Appeals Council will notify the claimant that if he or she files a new application for disability insurance benefits within 6 months or a new application for Supplemental Security Income within 60 days of the Appeals Council notice, the date of the request for review will constitute a protective filing for a new application.

Comment: One commenter expressed concerns about the proposed language in 20 CFR 404.951(b) and 416.1451(b) because adding the phrase "appropriate reference" was insufficient to describe what evidence an ALJ must include in the record.

Response: During the time that substantially the same rule was in place in the Boston region, we did not experience any confusion as to the meaning of the phrase "appropriate reference." Further, this language is consistent with our longstanding sub-regulatory policies and practices nationwide, and adoption of this language does not change our policies regarding what constitutes the official record.

Comment: Many commenters submitted a broad statement that there have been "serious problems" and inconsistencies with implementation of the 5-day requirement in the Boston region. The commenters generally presented two main points: (1) There was variance in applying the 5-day requirement between ALJs; and (2) ALJs who did apply the rule varied in when the 5-day requirement ended and in evaluating whether an exception to the 5-day requirement applied.

Response: We also agree that in a report issued by the Administrative Conference of the United States (ACUS) on December 13, 2013, ACUS noted several variances in applying similar rules in the Boston region. However, in response to the ACUS report, we provided additional training to adjudicators and staff regarding
application of our Part 405 rules. We also incorporated our instructions for processing cases originating in the Boston region into our training materials for all staff, including addressing Part 405 issues in several of our quarterly Videos-On-Demand series that focus on new or problematic areas of adjudication. We updated our sub-regulatory guidance to include references and instructions on how to process cases under Part 405. We will provide the tra...,ii nr.; instruction necessary to ensure consistent application of our rules nationwide.

Comment: One commenter asked if we retain the 5-d-ay requirement, we amend the language to require that each party make every reasonable effort to ensure the A.L.J. receives all the evidence. The commenter noted that proposed 20 CFR 404.935(a) acid 416.1435(a) require “every effort,” which the commenter believed is an impossible standard to meet.

Response: While our final rule requires a claimant—"make every effort to ensure that the administrative law judge receives all of the evidence," we do not believe the rule creates an “impossible, standard” because it also includes appropriate exceptions to accommodate circumstances when, despite good faith efforts, the claimant cannot satisfy the 5-day requirement.

Comment: Some commenters stated that 20 CFR 404.944(a)(1) and 416.1444(a)(1) conflict with 20 CFR 404.1512 and 416.912 because one regulation requires an ALJ to “accept[] as evidence—i... documents that are material to the issues” while the other regulation requires a claimant to submit evidence that “relates to whether or not you are blind or disabled.”

Response: A claimant continues to have a duty to submit all evidence that relates to whether or not he or she is, blind or disabled, subject to our other requirements, at the hearing and Appeals Council levels of the administrative process. Whereas 20 CFR 404.1512 and 416.912 explain a claimant’s responsibility, 20 CFR 404.944(a)(1) and 416.1444(a)(1) address actions an administrative law judge will take. We expect claimants to submit evidence that relates to whether they are blind or disabled, but our administrative law judges are responsible for making the legal determination whether evidence is “material to the issues.”

Regulatory Procedures

Executive Order 12866, as Supplemented by Executive Order 13563

We consulted with the Office of Management and Budget (OMB) and determined that this final rule meets the criteria for a significant regulatory action under Executive Order 12866, as supplemented by Executive Order 13563. Therefore, OMB reviewed it.

Regulatory Flexibility Act

We certify that this final rule would not have a significant economic impact on a substantial number of small entities because it affects individuals only. Therefore, a regulatory flexibility analysis is not required under the Regulatory Flexibility Act, as amended.

Paperwork Reduction Act

These final rules contain reporting requirements in regulation sections §§ 404.968, 404.976, 416.1468, and 416.1476 that require OMB clearance under the Paperwork Reduction Act of 1995 (PRA). SSA will submit separate information collection requests to OMB in the future for these regulations sections. We will not collect the information referenced in these burden sections until we receive OMB approval.

(Catalog of Federal Domestic Assistance Program Nos. 96.001, Social Security-Disability Insurance; 96.002, Social Security-Retirement Insurance; 96.004, Social Security-Survivors Insurance; and 96.006, Supplemental Security Income)

List of Subjects

20 CFR Part 404

Administrative practice and procedure; Blind; Disability benefits; Old-Age, Survivors, and Disability Insurance; Reporting and recordkeeping requirements; Social Security.

20 CFR Part 405

Administrative practice and procedure; Blind; Disability benefits; Old-Age, Survivors, and Disability Insurance; Public assistance programs; Reporting and recordkeeping requirements; Social Security; Supplemental Security Income (SSI).

20 CFR Part 416

Administrative practice and procedure; Aged, Blind, Disability benefits, Public assistance programs; Reporting and recordkeeping requirements; Supplemental Security Income (SSI).

Carolyn W. Colvin,

Acting Commissioner of Social Security.

For the reasons set out in the preamble, we amend 20 CFR chapter III, parts 404, 405, and 416 as set forth below:

PART 404-FEDERAL OLD-AGE, SURVIVORS AND DISABILITY INSURANCE (1950-

Subpart J-[Amended]

a 1. The authority citation for subpart J of part 404 continues to read as follows:

Authority: Secs. 201(j), 204(f), 205(a)-(b), (d)-(l), 1221, 223(i), 225, and 702(a)(5) of the Social Security Act (42 U.S.C. 401, 404(f), 405(a)-(l), (d)-(l), and 702); 1221, 423(i), 425, and 902(g)(5) (§ 201(j)); see 5, Pub. L. 97-45; 96 Stat. 2500 (42 U.S.C. 405 note); see 5, 1988.405(c)); see 5, Pub. L. 98-460; 98 Stat. 1307 (42 U.S.C. 421 note); see 292, Pub. L. 108-203, 118 Stat. 509 (42 U.S.C. 902 note).
any new evidence that may have been submitted for consideration.

§404.935 Submitting written evidence to an administrative law judge.

(a) When you submit your request for hearing, you should also submit information or evidence as required by § 404.1512 or any summary of the evidence to the administrative law judge. Each party must make every effort to ensure that the administrative law judge receives all of the evidence and must inform the other party or witness of the contents of any written evidence, as required in § 404.1512, no later than 5 business days before the date of the scheduled hearing. If you do not comply with this requirement, the administrative law judge may decline to consider or obtain the evidence, unless the circumstances described in paragraph (b) of this section apply.

(L) If you have o,v,d.enca required under § 404.1512 but you have missed the deadline described in paragraph (a) of this section, the administrative law judge will accept the evidence if he or she has not yet issued a decision and you did not inform us about or submit the evidence before the deadline because:

(1) Our action misled you;
(2) You had a physical, mental, educational, or linguistic limitation(s) that prevented you from informing us about or submitting the evidence earlier;

(3) Some other unusual, unexpected, or unavoidable circumstance beyond your control prevented you from informing us about or submitting the evidence earlier. Examples include, but are not limited to:

(i) You were seriously ill, and your illness prevented you from contacting us in person, in writing, or through a friend, relative, or other person;
(ii) There was a death or serious illness in your immediate family;
(iii) Important records were destroyed or damaged by fire or other accidental cause; or
(iv) You actively and diligently sought evidence from a source and the evidence was not received or was received less than 5 business days prior to the hearing.

(b) In § 404.938, revise paragraphs (a) and (b) to read as follows:

§404.938 Notice of a hearing before an administrative law judge.

(a) Issuing the notice. After we set the time, and place of the hearing, we will mail notice of the hearing to you at your last known address, or give the notice to you by personal service, unless you have indicated in writing that you do not wish to receive this notice. We will mail or serve the notice at least 75 days before the date of the hearing.

(b) Notice information. The notice of hearing will tell you:

(1) The specific issues to be decided in our case;
(2) That you may designate a person to represent you during the proceedings;
(3) How to request that we change the time or place of your hearing;
(4) That your hearing may be dismissed if neither you nor the person you designate to act as your representative appears at your scheduled hearing without good reason under § 404.957;
(5) Whether your appearance or that of any other party or witness is scheduled to be made in person, by video teleconferencing, or by telephone. If we have scheduled you to appear at the hearing by video teleconferencing, the notice of hearing will tell you that, the scheduled place for the hearing is a video teleconferencing site and explain what it means to appear at your hearing by video teleconferencing;
(6) That you must make every effort to inform us about or submit all written evidence that is not already in the record no later than 5 business days before the date of the scheduled hearing, unless you show that your circumstances meet the conditions described in § 404.935(b); and
(7) Any other information about the scheduling and conduct of your hearing.

6. Revise § 404.939 to read as follows:

§404.939 Objections to the issues.

If you object to the issues to be decided at the hearing, you must notify the administrative law judge in writing at the earliest possible opportunity, but no later than 5 business days before the date set for the hearing, unless you show that your circumstances meet the conditions described in § 404.935(b). You must state the reason(s) for your objection(s). The administrative law judge will make a decision on your objection(s) either at the hearing or in writing before the hearing.

7. Revise § 404.944 to read as follows:

§404.944 Administrative law judge hearing procedures—general.

A hearing is open to the parties and to other persons the administrative law judge considers necessary and proper. At the hearing, the administrative law judge looks fully into the issues, questions you and the other witnesses, and, subject to the provisions of § 404.935: Accepts as evidence any documents that are material to the issues; may stop the hearing temporarily and continue it at a later date if he or she finds that there is material evidence missing at the hearing; and may reopen the hearing at any time before he or she mails a notice of the decision in order to receive new and material evidence. The administrative law judge may decide when the evidence will be presented and when the issues will be discussed.

8. Revise § 404.949 to read as follows:

§404.949 Presenting written statements and oral arguments.

You or a person you designate to act as your representative may appear before the administrative law judge to state your case, present a written summary of your case, or enter written statements about the facts and law material to your case in the record. If presenting written statements prior to hearing, you must provide a copy of your written statements for each party no later than 5 business days before the date set for the hearing, unless you show that your circumstances meet the conditions described in § 404.935(b).

In § 404.950, revise paragraphs (c) and (d) to read as follows:

§404.950 Presenting evidence at a hearing before an administrative law judge.

(c) Admissible evidence. Subject to the provisions of § 404.935, the administrative law judge may receive any evidence at the hearing that he or she believes is material to the issues, even though the evidence would not be admissible in court under the rules of evidence used by the court.

(d) Subpoenas. (1) When it is reasonably necessary for the full presentation of a case, an administrative law judge or a member of the Appeals Council may, on his or her own initiative or at the request of a party, issue
subpoenas for the appearance and testimony of witnesses and for the production of books, records, correspondence, papers, or other documents that are material to an issue at the hearing.

(2) Parties to a hearing who wish to subpoena documents or witnesses must file a written request for the issuance of a subpoena with the administrative law judge or at one of our offices at least 10 business days before the hearing date, unless you show that your circumstances meet the conditions described in § 404.935(b). The written request must give the names of the witnesses or documents to be produced; describe the address or location of the witnesses or documents with sufficient detail to find them; state the important facts that the witness or document is expected to prove; and indicate why these facts could not be proven without issuing a subpoena.

(3) We will pay the cost of issuing the subpoena.

(4) We will pay subpoened witnesses the same fees and mileage they would receive if they had been subpoenaed by a Federal district court.

10. Revise § 404.951 to read as follows:

§404.951 Official record.

(a) Hearing recording. All hearings will be recorded. The hearing recording will be prepared as a typed copy of the proceedings if—

(1) The case is sent to the Appeals Council without a decision or with a recommended decision by the administrative law judge;

(2) You seek judicial review of your case by filing an action in a Federal district court within the stated time period, unless we request the court to remand the case; or

(3) An administrative law judge or the Appeals Council asks for a written record of the proceedings.

(b) Contents of the official record. All evidence upon which the administrative law judge relies for the decision must be contained in the record, either directly or by appropriate reference. The official record will include the applications, written statements, certificates, reports, affidavits, medical records, and other documents that were used in making the decision under review and any additional evidence or written statements that the administrative law judge admits into the record under §§ 404.929 and 404.935. All exhibits introduced as evidence must be marked for identification and incorporated into the record. The official record of your claim will contain all of the marked exhibits and a verbatim recording of all testimony offered at the hearing. It also will include any prior initial determinations or decisions on your claim.

11. In § 404.968, revise the second sentence of paragraph (a) introductory text to read as follows:

§404.968 How to request Appeals Council review.

(a) You should submit any evidence you wish to have considered by the Appeals Council with your request for review, and the Appeals Council will consider the evidence in accordance with § 404.970.

12. Revise § 404.970 to read as follows:

§404.970 Cases the Appeals Council will review.

(a) The Appeals Council will review a case if—

(1) There appears to be an abuse of discretion by the administrative law judge;

(2) There is an error of law;

(3) The action, findings or conclusions of the administrative law judge are not supported by substantial evidence;

(b) There is a broad policy or procedural issue that may affect the general public interest;

(c) Subject to paragraph (b) of this section, the Appeals Council receives additional evidence that is new, material, and relates to the period on or before the date of the hearing decision, and there is a reasonable probability that the additional evidence would change the outcome of the decision.

(d) The Appeals Council will only consider additional evidence under paragraph (a)(3) of this section if you show good cause for not informing us about or submitting the evidence as described in § 404.935 because:

(1) Our action misled you;

(2) You had a physical, mental, educational, or linguistic limitation(s) that prevented you from informing us about or submitting the evidence earlier; or

(3) Some other unusual, unexpected, or unavoidable circumstance beyond your control prevented you from informing us about or submitting the evidence earlier. Examples include, but are not limited to:

(i) You were seriously ill, and your illness prevented you from contacting us in person, in writing, or through a friend, relative, or other person;

(ii) There was a death or serious illness in your immediate family;

(iii) Important records were destroyed or damaged by fire or other accidental cause;

(iv) You actively and diligently sought evidence from a source and the evidence was not received or was received less than 5 business days prior to the hearing;

(v) You received a hearing level decision on the record and the Appeals Council reviewed your decision.

(e) If you submit additional evidence that does not relate to the period on or before the date of the administrative law judge hearing decision as required in paragraph (a)(3) of this section, or the Appeals Council does not find you had good cause for missing the deadline to submit the evidence in § 404.935, the Appeals Council will send you a notice that explains why it did not accept the additional evidence and advises you of your right to file a new application. The notice will also inform you that if you file a new application within 6 months after the date of the Appeals Council’s notice, your request for review will constitute a written statement indicating an intent to claim benefits under § 404.630. If you file a new application within 6 months of the Appeals Council’s notice, we will use the date you requested Appeals Council review as the filing date for your new application.

13. Revise § 404.976 to read as follows:

§404.976 Procedures before the Appeals Council on review.

(a) Limitation of issues. The Appeals Council may limit the issues it considers if it notifies you and the other parties of the issues it will review.

(b) Oral argument. You may request to appear before the Appeals Council to present oral argument. The Appeals Council will grant your request if it decides that your case raises an important question of law or policy or that oral argument would help to reach a proper decision.

If your request to appear is granted, the Appeals Council will tell you the time and place of the oral argument at least 10 business days before the scheduled date. The
Appeals Council will determine whether your appearance, or the appearance of any other person relevant to the proceeding, will be in person, by video teleconferencing, or by telephone.

§404.979 [Amended]

M 14 Revise the first sentence of § 404.979 to read as follows:

After it has reviewed all the evidence in the administrative law judge hearing record and any additional evidence received, subject to the limitations on Appeals Council consideration of additional evidence in § 404.970, the Appeals Council will make a decision or remand the case to an administrative law judge.* * *

PART 405—[REMOVED AND RESERVED]

M 15 Under the authority of sections 205(a), 702(a)(5), and 1631(d)(1) of the Social Security Act, part 405 is removed and reserved.

PART 416—SUPPLEMENTAL SECURITY INCOME FOR THE AGED, BLIND, AND DISABLED

Subpart N—Determination, Administrative Review Process, and Reopening of Determinations and Decisions

16. The authority citation for subpart N of part 416 continues to read as follows:


17. In § 416.1400, revise the second sentence of paragraph (b) to read as follows:

§416.1400 Introduction.

(b) * * * Subject to certain timeframes at the hearing level (see § 416.1435) and the limitations on Appeals Council consideration of additional evidence (see §416.1470), we will consider at each step of the review process any information you present as well as all the information in our records.* * *

18. Revise the fifth and eighth sentences of § 416.1429 to read as follows:

§416.1429 Hearing before an administrative law judge—general.

* * * You may submit new evidence (subject to the provisions of § 416.1435), examine the evidence used in making the determination or decision under review, and present and question witnesses. * * * If you waive your right to appear at the hearing, in person, by video teleconferencing, or by telephone, the administrative law judge will make a decision based on the preponderance of the evidence that is in the file and, subject to the provisions of § 416.1435, any new evidence that may have been submitted for consideration.* * *

19. Revise § 416.1435 to read as follows:

§416.1435 Submitting written evidence to an administrative law judge.

(a) When you submit your request for hearing, you should also submit information or evidence as required by § 416.912 or any summary of the evidence to the administrative law judge. Each party must make every effort to ensure that the administrative law judge receives all of the evidence and must inform us about or submit any written evidence, as required in § 416.912, no later than 5 business days before the date of the scheduled hearing. If you do not comply with this requirement, the administrative law judge may decline to consider or obtain the evidence unless the circumstances described in paragraph (b) of this section apply.

(b) If you have evidence required under § 416.912 but you have missed the deadline described in paragraph (a) of this section, the administrative law judge will accept the evidence if he or she has not yet issued a decision and you did not inform us about or submit the evidence before the deadline because:

(1) Our action misled you;

(2) You had a physical, mental, educational, or linguistic limitation(s) that prevented you from informing us about or submitting the evidence earlier; or

(3) Some other unusual, unexpected, or unavoidable circumstance beyond your control prevented you from informing us about or submitting the evidence earlier. Examples include, but are not limited to:

(i) You were seriously ill, and your illness prevented you from contacting his in person, in writing, or through a friend, relative, or other person;

(ii) There was a death or serious illness in your immediate family;

(iii) Important records were destroyed or damaged by fire or other accidental cause; or

(iv) You actively and diligently sought evidence from a source and the evidence was not received or was received less than 5 business days prior to the hearing.

(c) Claims Not Based on an Application For Benefits. Notwithstanding the requirements in paragraphs (a)—(b) of this section, for claims that are not based on an application for benefits, the evidentiary requirement to inform us about or submit evidence no later than 5 business days before the date of the scheduled hearing will not apply if our other regulations allow you to submit evidence after the date of an administrative law judge decision.

20. In § 416.1438, revise paragraphs (a) and (b) to read as follows:

§416.1438 Notice of a hearing before an administrative law judge.

(a) Issuing the notice. After we set the time and place of the hearing, we will mail notice of the hearing to you at your last known address, or give the notice to you by personal service, unless you have indicated in writing that you do not wish to receive this notice. We will mail or serve the notice at least 75 days before the date of the hearing.

(b) Notice information. The notice of hearing will tell you:

(1) The specific issues to be decided in your case;

(2) That you may designate a person to represent you during the proceedings;

(3) How to request that we change the time or place of your hearing;

(4) That your hearing may be dismissed if neither you nor the person you designate to act as your representative appears at your scheduled hearing without good reason under § 416.1457;

(5) Whether your appearance or that of any other party or witness is scheduled to be made in person, by video teleconferencing, or by telephone. If we have scheduled
you to appear at the hearing by video teleconferencing, the notice of hearing will tell you that the scheduled place for the hearing is a video teleconferencing site and explain what it means to appear at your hearing by video teleconferencing:

(6) That you must make every effort to inform us about or submit all written evidence that is not already in the record no later than 5 business days before the date of the scheduled hearing, unless you show that your circumstances meet the conditions described in § 416.1435(b); and.

(7) Any other information about the scheduling and conduct of your hearing.

§ 416.1439 Objections to the issues.

If you object to the issues to be decided at the hearing, you must notify the administrative law judge in writing at the earliest possible opportunity, but no later than 5 business days before the date set for the hearing, unless you do not show that your circumstances meet the conditions described in § 416.1435(b). You must state the reason(s) for your objection(s). The administrative law judge will make a decision on your objection(s) either at the hearing or in writing before the hearing.

§ 416.1444 Administrative law judge hearing procedures—general.

A hearing is open to the parties and to other persons the administrative law judge considers necessary and proper. At the hearing, the administrative law judge may ask questions of the parties or other witnesses and, subject to the provisions of §§ 416.1435: Accepts as evidence any documents that are material to the issues; may stop the hearing temporarily and continue it at a later date if he or she finds that there is material evidence missing at the hearing; and may reopen the hearing any time before he or she mails a notice of the decision in order to receive new and material evidence. The administrative law judge may decide when the evidence will be presented and when the issues will be discussed.

§ 416.1449 Presenting written statements and oral arguments.

You or a person you designate to act as your representative may appear before the administrative law judge to state your case, present a written summary of your case, or enter written statements about the facts and law material to your case in the record. If presenting written statements prior to hearing, you must provide a copy of your written statements for each party no later than 5 business days before the date set for the hearing, unless you show that your circumstances meet the conditions described in § 416.1435(b).

§ 416.1450 Presenting evidence at a hearing before an administrative law judge.

(c) Admissible evidence. Subject to the provisions of § 416.1435, the administrative law judge may receive any evidence at the hearing that he or she believes is material to the issues, even though the evidence would not be admissible in court under the rules of evidence used by the court.

(d) Subpoenas. (1) When it is reasonably necessary for the full presentation of a case, an administrative law judge or a member of the Appeals Council may, on his or her own initiative or at the request of a party, issue subpoenas for the appearance and testimony of witnesses and for the production of books, records, correspondence, papers, or other documents that are material to an issue at the hearing.

(2) Parties to a hearing who wish to subpoena documents or witnesses must file a written request for the issuance of a subpoena with the administrative law judge or at one of our offices at least 10 business days before the hearing date, unless you show that your circumstances meet the conditions described in § 416.1435(b). The written request must give the names of the witnesses or documents to be produced; describe the address or location of the witnesses or documents with sufficient detail to find them; state the important facts that the witness or document is expected to prove; and indicate why these facts could not be proven without issuing a subpoena.

(3) We will pay the cost of issuing the subpoena.

(4) We will pay subpoenas witnesses the same fees and mileage they would receive if they had been subpoenaed by a Federal district court.

§ 416.1451 Official record.

(a) Hearing recording. All hearings will be recorded. The hearing recording will be prepared as a typed copy of the proceedings if—

(1) The case is sent to the Appeals Council without a decision or with a recommended decision by the administrative law judge;

(2) You seek judicial review of your case by filing an action in a Federal district court within the stated time period, unless we request the court to remand the case; or

(3) An administrative law judge or the Appeals Council asks for a written record of the proceedings.

(b) Contents of the official record. All evidence upon which the administrative law judge relies for the decision must be contained in the record, either directly or by appropriate reference. The official record will include the applications, written statements, certificates, reports, affidavits, medical records, and other documents that were used in making the decision under review and any additional evidence or written statements that the administrative law judge admits into the record under §§ 416.1429 and 416.1435. All exhibits introduced as evidence must be marked for identification and incorporated into the record. The official record of your claim will contain all of the marked exhibits and a verbatim recording of all testimony offered at the hearing. It also will include any prior initial determinations or decisions on your claim.

§ 416.1468 How to request Appeals Council review.

(a) *** You should submit any evidence you wish to have considered by the Appeals Council with your request for review, and the Appeals Council will consider the evidence in accordance with § 416.1470, ***
§416.1470 Cases the Appeals Council will review.

(a) The Appeals Council will review a case if—

(1) There appears to be an abuse of discretion by the administrative law judge;
(2) There is an error of law;
(3) The action, findings or conclusions of the administrative law judge are not supported by substantial evidence;
(4) There is a broad policy or procedural issue that may affect the general public interest; or
(5) Subject to paragraph (b) of this section, the Appeals Council receives additional evidence that is new, relevant, and material to an issue being considered. However, in reviewing decisions based on an application for benefits, the Appeals Council will only consider additional evidence under paragraph (a)(5) of this section if you show good cause for not informing us about or submitting the evidence as described in § 416.1435 because:
   (1) Our action misled you;
   (2) You had a physical, mental, educational, or linguistic limitation(s) that prevented you from informing us about or submitting the evidence earlier; or
   (3) Some other unusual, unexpected, or unavoidable circumstance beyond your control prevented you from informing us about or submitting the evidence earlier. Examples include, but are not limited to:
   (i) You were seriously ill, and your illness prevented you from contacting us in person, in writing, or through a friend, relative, or other person;
   (ii) There was a death or serious illness in your immediate family;
   (iii) Important records were destroyed or damaged by fire or other accidental cause;
   (iv) You actively and diligently sought evidence from a source and the evidence was not received or was received less than 5 business days prior to the hearing; or
   (v) You received a hearing level decision on the record and the Appeals Council reviewed your decision.

(b) If you submit additional evidence that does not relate to the period on or before the date of the administrative law judge hearing decision as required in paragraph (a)(5) of this section, or the Appeals Council does not find you had good cause for missing the deadline to submit the evidence in § 416.1435, the Appeals Council will send you a notice that explains why it did not accept the additional evidence and advises you of your right to file a new application. The notice will also advise you that if you file a new application within 60 days after the date of the Appeals Council's notice, your request for review will constitute a written statement indicating an intent to claim benefits under § 416.340. If you file a new application within 60 days of the Appeals Council's notice, we will use the date you requested Appeals Council review as the filing date for your new application.

§416.1476. Procedures before the Appeals Council on review.

(a) Limitation of issues. The Appeals Council may limit the issues it considers if it notifies you and the other parties of the issues it will review.

(b) Oral argument. You may request to appear before the Appeals Council to present oral argument. The Appeals Council will grant your request if it decides that your case raises an important question of law or policy or that oral argument would help to reach a proper decision. If your request to appear is granted, the Appeals Council will tell you the time and place of the oral argument at least 10 business days before the scheduled date. The Appeals Council will determine whether your appearance, or the appearance of any other person relevant to the proceeding, will be in person, by video teleconferencing, or by telephone.

§416.1479 [Amended]

§ 416.1479 [Amended]

■29. Revise § 416.1476 to read as follows:

After it has reviewed all the evidence in the administrative law judge hearing record and any additional evidence received, subject to the limitations on Appeals Council consideration of additional evidence in § 416.1470, the Appeals Council will make a decision or remand the case to an administrative law judge.

* * *

[FPR 416.30103 Filed 1.2-15-16; 8:45 am]
BILLING CODE 4191-02-P
DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT

24 CFR Part 91
[Docket No. FR 5891—F-02]
RIN 2506—AC41

Modernizing HUD’s Consolidated Planning Process To Narrow the Digital Divide and Increase Resilience to Natural Hazards

AGENCY: Office of the Assistant Secretary for Community Planning and Development, HUD.

ACTION: Final rule.

SUMMARY: HUD’s Consolidated Plan is a planning mechanism designed to help States and local governments to assess their affordable housing and community development needs and to make data-driven, place-based investment decisions. The Consolidated Planning process serves as the framework for a community-wide dialogue to identify housing and community development priorities that align and focus funding from HUD’s formula block grant programs. This rule amends HUD’s Consolidated Plan regulations to require that jurisdictions consider two additional concepts in their planning efforts:

The first concept is how to address the need for broadband access for low- and moderate-income residents in the communities they serve. Broadband is the common term used to refer to a high-speed, always-on connection to the Internet. Such connection is also referred to as high-speed broadband or high-speed Internet. Specifically, the rule requires that States and localities that submit a Consolidated Plan document describe the broadband access in housing occupied by low- and moderate-income households. If low-income residents in the communities do not have such access, States and jurisdictions must consider providing broadband access to these residents in their decisions on how to invest HUD funds. The second concept added to the Consolidated Plan process requires jurisdictions to consider incorporating resilience to natural hazard risks, taking care to anticipate how risks will increase due to climate change, into the development of the plan in order to begin addressing impacts of climate change on low- and moderate-income residents.

DATES: Effective Date: January 17, 2017.

FURTHER INFORMATION CONTACT: Lora Routt, Senior Advisor, Office of Community Planning and Development, Department of Housing and Urban Development, Office of Community Planning and Development, 451 7th Street SW, Suite 7204, Washington, DC 20410 at 202-402-4492 (this is not a toll-free number). Individuals with speech or hearing impairments may access this number via TTY by calling the Federal Relay Service at 800-877-8339 (this is a toll-free number).

SUPPLEMENTARY INFORMATION:

I. Executive Summary

A. Purpose of This Rule

The purpose of this rule is to require States and local governments to evaluate the availability of broadband access and the vulnerability of housing occupied by low- and moderate-income households to natural hazard risks, many of which may be increasing due to climate change, in their Consolidated Planning efforts. These evaluations are to be conducted using readily available data sources developed by Federal government agencies, other available data and analyses (including State, Tribal, and local hazard mitigation plans that have been approved by the Federal Emergency Management Agency (FEMA)), and data that State and local government grantees may have available to them. Where access to broadband Internet service is not currently available or is minimally available (such as in certain rural areas), States and local governments must consider ways to bring broadband Internet access to low- and moderate-income residents, including how HUD funds could be used to narrow the digital divide for these residents. Further, where low- and moderate-income communities are at risk of natural hazards, including those that are expected to increase due to climate change, States and local governments must consider ways to incorporate appropriate hazard mitigation and resilience into their community planning and development goals, codes, and standards, including the use of HUD funds to accomplish these objectives. These two planning considerations reflect emerging needs of communities in this changing world. Broadband provides access to a wide range of resources, services, and products, which assist not only individuals and, but also communities, in their efforts to improve their economic outlooks. Analysis of natural hazards, including the anticipated effects of climate change on those hazards, is important to help ensure that jurisdictions are aware of existing and developing vulnerabilities in the geographic areas that they serve that can threaten the health and safety of the populations they serve.
Understanding the New Changes in the Mental Listings to Better Try Mental Impairments Effective January 17, 2017

Honorable Harry E. Siegrist, III
Honorable Suzanne A. Littlefield
Social Security Administration
Atlanta, Georgia
Understanding the New Changes in the Mental Listings
to Better Try Mental Impairments

Effective January 17, 2017

Presented by

Hon. Harry E. Siegrist III
and
Hon. Suzanne A. Littlefield
Administrative Law Judges
Social Security Administration
Office of Disability Adjudication and Review
Atlanta Downtown Office
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References:

Listing 12.00/112.00 20 CFR Parts 404 and 416 Final Rule Mental Listing

Introduction
-Changes became effective for all determinations and decisions issued after January 17, 2017.
-The proposed changes were first published in the Federal Register on August 19, 2010, some changes to that publication were made (see preamble to Final Rule).
-DSM-5 published in May 2013 was considered in making the Final Rule, including terminology changes, adding listing for trauma and stressor-related disorders and others, descriptions of disorders, diagnostic criteria.

New “B” Criteria
-Activities of daily living is now “understand, remember or apply information”, the claimant only needs to show limitations in one of the three items. Pertains to learning, recalling and using information. Evidence comes from medical evidence, background, 3rd parties, field reports, Teacher Questionnaires and performance during examinations.
-Social functioning is now “interact with others”; basically the same concept as before
-Concentration, persistence or pace is the same as before
-Episodes of decompensation is gone and replaced with “adapt or manage oneself”; evidence of ability to manage symptoms and control of moods and behavior, medical statements about person’s ability to adapt to changes.
-The greatest degree of limitation in any paragraph will be the degree of limitation for that whole paragraph. ADLs are now a source of information for all four paragraphs.

New Listing 12.05 and 112.05-Intellectual Disorders
-Still requires evidence that the disorder started before age 22
-Full Scale IQ of 70 or below or combination of FSIQ 71-75 and either verbal or performance IQ 70 or below. Now must first look to Full Scale-can no longer use the lowest. Must also show deficits in adaptive function manifested by an extreme limitation or two marked limitations.
-no longer covers BIF
Listing 12.09 and 112.09 Substance Addiction disorders were removed entirely.

New Listing 12.11 and 112.11-Neurodevelopmental disorders:
- covers specific learning disorder, borderline intellectual functioning and tic disorder

New Listing 12.13 and 112.13-Eating Disorders
- covers anorexia nervosa, bulimia nervosa, binge-eating disorder, avoidance/restrictive food disorder.

New Listing 112.14-Neurodevelopment Disorders in infants and toddlers
- only covers children from birth to age 3.

New Listing 12.15 and 112.15-Trauma and Stressor Related Disorders
- new listing to evaluate PTSD, adjustment disorders

Preparing for the Hearing
- Remember that Program Unification Rule regulation also went into effect on January 17, 2017 but will not be enforced until May 1, 2017. Requires all evidence to be submitted at least 5 days before the ALJ hearing (Ensuring Program Uniformity at the Hearing and Appeals Council Levels of Administrative Review Process, Final Rule published Federal Register 2016 Dec 16; 81(242) 90987-97)

- Get treating doctors to provide realistic limitations-not everything is extreme-they would have been paid below the ALJ level then.

- Review your case and file a brief-do not avoid problem areas like reports that the claimant can do more than the claimant alleges, substance abuse, earnings after the AOD.

Residual Functional Capacity Evaluation
- there is more to ask the Vocational Expert than “how many days missed per month” and “what percentage off task”.

- ask your own RFC of the VE

- add or subtract limitations to/from the RFC given by the ALJ
-do not ask using terms rare, mild, moderate, marked or extreme-these are not vocational terms and the VE cannot evaluate them

- Remember your limitations must have support in the medical record of evidence-they cannot come just from the claimant’s testimony
Changes to the Mental Disorders Listings  
Effective Date 1/17/2017

- **New listing titles to reflect current medical terminology used in the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (DSM–5):**
  - 12.02 and 112.02: Neurocognitive disorders (previously organic mental disorders)
  - 12.03 and 112.03: Schizophrenia spectrum and other psychotic disorders (previously Schizophrenic, paranoid and other psychotic disorders)
  - 12.04 and 112.04: Depressive, bipolar and related disorders (previously affective disorders)
  - 12.05 and 112.05: Intellectual disorder (previously intellectual disability)
  - 12.06 and 112.06: Anxiety and obsessive compulsive disorders (previously anxiety disorders)
  - 12.07 and 112.07: Somatic symptom and related disorders (previously somatoform disorders)
  - 12.08 and 112.08: Personality and impulse control disorders (previously personality disorders)
  - 12.10 and 112.10: Autism spectrum disorder (previously autism and other pervasive developmental disorders)
  - 12.11 and 112.11: Neurodevelopmental disorders (NEW LISTING)
  - 12.13 and 112.13: Eating disorders (NEW LISTING)
  - 12.14: Developmental disorders in infants and toddlers (NEW LISTING)
  - 12.15 and 112.15: Trauma and stressor-related disorders (NEW LISTING)

- **New “B criteria”:**
  - Change the fourth category in the “B criteria” to “adapt or manage oneself.” We will rate this category using the same five-point scale already used to rate the first three B criteria: none, mild, moderate, marked, and extreme. We will no longer evaluate “episodes of decompensation, each of extended duration” in the B criteria.
  - Clarification that a claimant has to demonstrate a limitation in only one part and not in each of the three parts of “understand, remember, or apply information” and “concentrate, persist, or maintain pace.” For example, a limitation in any one of these parts (understand or remember or apply; concentrate or persist or maintain pace; adapt or manage oneself) may prevent you from completing a work-related task.
  - Clarification that the greatest degree of limitation in any part of a paragraph B1, B3, or B4 will be the degree of limitation for that whole area of functioning.
  - ADLs are now a source of information about all four of the paragraph B areas of mental functioning.

<table>
<thead>
<tr>
<th>Prior Paragraph B Criteria</th>
<th>New Paragraph B Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>B1: activities of daily living</td>
<td>B1: understand, remember, or apply information¹</td>
</tr>
<tr>
<td>B2: social functioning</td>
<td>B2: interact with others</td>
</tr>
<tr>
<td>B3: concentration, persistence, or pace</td>
<td>B3: concentrate, persist, or maintain pace</td>
</tr>
<tr>
<td>B4: episodes of decompensation</td>
<td>B4: adapt or manage oneself²</td>
</tr>
</tbody>
</table>

¹ This area pertains to learning, recalling and using information. Examples include, understanding/following instructions, answering and asking questions, problem-solving and using reason/judgment.

² The area of “adapt and manage oneself” pertains primarily to regulating emotions, controlling behavior and maintaining well-being. Examples include, adapting to change, setting realistic goals, making independent plans, maintaining personal hygiene (previously discussed under ADLs) and being aware of hazards.
• **Definitions for B criteria:**
  - No limitation (or none). You are able to function in this area independently, appropriately, effectively, and on a sustained basis.
  - Mild limitation. Your functioning in this area independently, appropriately, effectively, and on a sustained basis is slightly limited.
  - Moderate limitation. Your functioning in this area independently, appropriately, effectively, and on a sustained basis is fair.
  - Marked limitation. Your functioning in this area independently, appropriately, effectively, and on a sustained basis is seriously limited.
  - Extreme limitation. You are not able to function in this area independently, appropriately, effectively, and on a sustained basis.

• **The “paragraph C” criteria:** revised to reference a “serious and persistent” disorder. We find a mental disorder to be “serious and persistent” when there is a medically documented history of the existence of the mental disorder in the listing category over a period of at least 2 years, and evidence shows that your disorder satisfies both C1 and C2.

• **Listings 12.05 and 112.05 concerning intellectual disorders.**
  - Parts A and B still require evidence about your current intellectual and adaptive functioning and about the history of your disorder to demonstrate or support the conclusion that the disorder began prior to your attainment of age 22.
  - The part A criteria provides that an individual must also satisfy:
    1. Significantly subaverage general intellectual functioning evident in your cognitive inability to function at a level required to participate in standardized testing of intellectual functioning; and
    2. Significant deficits in adaptive functioning currently manifested by your dependence upon others for personal needs (for example, toileting, eating, dressing, or bathing). The significant deficits in adaptive functioning must have evidence from another source aside from the claimant, i.e., cannot rely on claimant’s statement alone.
  - The part B criteria requires a full scale IQ score of 70 or below, or a combination of a full scale IQ score of 71-75, with either a verbal or performance IQ score of 70 or below, to determine if the claimant satisfies 12.05 or 112.05. You must also satisfy significant deficits in adaptive functioning currently manifested by extreme limitation of one, or marked limitation of two, of the new “B criteria.” In contrast to part A, significant deficits in adaptive functioning can come from any source.

• **Listings 12.09 and 112.09** (substance addiction disorders) are removed in their entireties. Please note that this does not affect our rules and regulations regarding DAA materiality.

• **New listings 12.11 and 112.11**, to evaluate neurodevelopmental disorders. Examples include specific learning disorder, borderline intellectual functioning and tic disorders, but does not include neurocognitive disorders (12.02), autism spectrum disorder (12.10) or personality and impulse-control disorder (12.08).

• **New listings 12.13 and 112.13**, to evaluate eating disorders. Examples of these disorders include anorexia nervosa, bulimia nervosa, binge-eating disorder and avoidant/restrictive food disorder.

• **New listing 112.14**, to evaluate neurodevelopmental disorders in infants and toddlers. Impairments related to children from birth to age 3 are evaluated under this new listing only, while impairments for
children ages 3 to attainment of age 18 are evaluated under the remaining listings in 112.00. For example, if a 2-year-old child has autism, you would evaluate it under this new listing. For a 6-year-old, use listing 112.10.

- **New listings 12.15 and 112.15**, which will be used to evaluate trauma- and stressor-related disorders, such as posttraumatic stress disorder. Under the current rules, we evaluate trauma- and stressor-related disorders under listings 12.06 and 112.06 (anxiety disorders). Examples include PTSD and other trauma- and stressor-related disorders (such as adjustment-like disorders with prolonged duration). This does not include anxiety and OCD (12.06) and cognitive impairments that result from neurological disorders (such as a TBI), that are evaluated under neurocognitive disorders (12.02).

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Extrapolating RFC 2017 Mental
Prepared by Atty. John Christopher Rabon, GS ATL ODAR

The paragraph “B” criteria must correspond to the claimant’s RFC. If there is a moderate (or greater) finding in any of the paragraph “B” criteria, then there must be a corresponding limitation in the RFC. Fortunately, the listings spell out which types of limitations correspond to findings in each of the paragraph “B” criteria.

| Understand, remember, and apply information | 1. understanding and learning terms, instructions, procedures |
|                                            | 2. following one- or two-step oral instructions to carry out a task |
|                                            | 3. describing work activity to someone else |
|                                            | 4. asking and answering questions and providing explanations |
|                                            | 5. recognizing a mistake and correcting it |
|                                            | 6. identifying and solving problems |
|                                            | 7. sequencing multi-step activities |
|                                            | 8. using reason and judgment to make work-related decisions |

| Interact with others | 1. cooperating with others |
|                     | 2. asking for help when needed |
|                     | 3. handling conflicts with others |
|                     | 4. stating own point of view |
|                     | 5. initiating or sustaining conversation |
|                     | 6. understanding and responding to social cues (physical, verbal, emotional) |
|                     | 7. responding to requests, suggestions, criticism, correction, and challenges |
|                     | 8. keeping social interactions free of excessive irritability, sensitivity, argumentativeness, or suspiciousness. |

| Concentrate, persist, or maintain pace | 1. initiating and performing a task that you understand and know how to do |
|                                       | 2. working at an appropriate and consistent pace |
|                                       | 3. completing tasks in a timely manner |
|                                       | 4. ignoring or avoiding distractions while working |
|                                       | 5. changing activities or work settings without being disruptive |
|                                       | 6. working close to or with others without interrupting or distracting them |
|                                       | 7. sustaining an ordinary routine and regular attendance at work |
|                                       | 8. working a full day without needing more than the allotted number or length of rest periods during the day. |

| Adapt and manage oneself | 1. responding to demands |
|                         | 2. adapting to changes |
|                         | 3. managing your psychologically based symptoms |
|                         | 4. distinguishing between acceptable and unacceptable work performance |
|                         | 5. setting realistic goals |
|                         | 6. making plans for yourself independently of others |
|                         | 7. maintaining personal hygiene and attire appropriate to a work setting |
|                         | 8. being aware of normal hazards and taking appropriate precautions |
If you see limitations in any of the areas mentioned on the right side of the chart, then you will need at least a moderate limitation in the corresponding “B” criteria.

**Example 1**, if the RFC included, “the claimant is limited to one or two step instructions”

*Then*, the claimant would have at least a moderate limitation in understanding, remembering, and applying information.

**Example 2**, if the RFC included, “the claimant would be off task for 5% of the workday”

*Then*, the claimant would have at least a moderate limitation in concentrate, persist, or maintain pace.

**Example 3**, if the RFC included, “the claimant is limited to a low stress environment defined as an environment that does not require production rate work”

*Then*, the claimant would have at least a moderate limitation in adapt and manage oneself.

**Example 4**, if the RFC included, “the claimant can have no interaction with the general public and only occasional interaction with coworkers and supervisors”

*Then*, the claimant would have at least a moderate limitation in interacting with others.

It is worth noting that a single provision in the RFC can trigger limitations in more than one area of the B criteria.

**Example 5**, if the RFC included, “the claimant is limited to understanding, remembering, and carrying out simple repetitive tasks for two-hour periods”

*Then*, the claimant would have at least a moderate limitation in understanding, remembering, and applying and in concentrate, persist, or maintain pace.
12.00 Mental Disorders - Adult

12.00 Mental Disorders

A. How are the listings for mental disorders arranged, and what do they require?

1. The listings for mental disorders are arranged in 11 categories: neurocognitive disorders (12.02); schizophrenia spectrum and other psychotic disorders (12.03); depressive, bipolar and related disorders (12.04); intellectual disorder (12.05); anxiety and obsessive-compulsive disorders (12.06); somatic symptom and related disorders (12.07); personality and impulse-control disorders (12.08); autism spectrum disorder (12.10); neurodevelopmental disorders (12.11); eating disorders (12.13); and trauma- and stressor-related disorders (12.15).

2. Listings 12.07, 12.08, 12.10, 12.11, and 12.13 have two paragraphs, designated A and B; your mental disorder must satisfy the requirements of both paragraphs A and B. Listings 12.02, 12.03, 12.04, 12.06, and 12.15 have three paragraphs, designated A, B, and C; your mental disorder must satisfy the requirements of both paragraphs A and B, or the requirements of both paragraphs A and C. Listing 12.05 has two paragraphs that are unique to that listing (see 12.00A3); your mental disorder must satisfy the requirements of either paragraph A or paragraph B.
   a. Paragraph A of each listing (except 12.05) includes the medical criteria that must be present in your medical evidence.
   b. Paragraph B of each listing (except 12.05) provides the functional criteria we assess, in conjunction with a rating scale (see 12.00E and 12.00F), to evaluate how your mental disorder limits your functioning. These criteria represent the areas of mental functioning a person uses in a work setting. They are: understand, remember, or apply information; interact with others; concentrate, persist, or maintain pace; and adapt or manage oneself. We will determine the degree to which your medically determinable mental impairment affects the four areas of mental functioning and your ability to function independently, appropriately, effectively, and on a sustained basis (see §§ 404.1520a(c)(2) and 416.920a(c)(2) of this chapter). To satisfy the paragraph B criteria, your mental disorder must result in “extreme” limitation of one, or “marked” limitation of two, of the four areas of mental functioning. (When we refer to “paragraph B criteria” or “area[s] of mental functioning” in the introductory text of this body system, we mean the criteria in paragraph B of every listing except 12.05.)
   c. Paragraph C of listings 12.02, 12.03, 12.04, 12.06, and 12.15 provides the criteria we use to evaluate “serious and persistent mental disorders.” To satisfy the paragraph C criteria, your mental disorder must be “serious and persistent”; that is, there must be a medically documented history of the existence of the
disorder over a period of at least 2 years, and evidence that satisfies the criteria in both C1 and C2 (see 12.00G). (When we refer to “paragraph C” or “the paragraph C criteria” in the introductory text of this body system, we mean the criteria in paragraph C of listings 12.02, 12.03, 12.04, 12.06, and 12.15.)

3. Listing 12.05 has two paragraphs, designated A and B, that apply to only intellectual disorder. Each paragraph requires that you have significantly subaverage general intellectual functioning; significant deficits in current adaptive functioning; and evidence that demonstrates or supports (is consistent with) the conclusion that your disorder began prior to age 22.

B. Which mental disorders do we evaluate under each listing category?

1. **Neurocognitive disorders (12.02).**
   
   a. These disorders are characterized by a clinically significant decline in cognitive functioning. Symptoms and signs may include, but are not limited to, disturbances in memory, executive functioning (that is, higher-level cognitive processes; for example, regulating attention, planning, inhibiting responses, decision-making), visual-spatial functioning, language and speech, perception, insight, judgment, and insensitivity to social standards.

   b. Examples of disorders that we evaluate in this category include major neurocognitive disorder; dementia of the Alzheimer type; vascular dementia; dementia due to a medical condition such as a metabolic disease (for example, late-onset Tay-Sachs disease), human immunodeficiency virus infection, vascular malformation, progressive brain tumor, neurological disease (for example, multiple sclerosis, Parkinsonian syndrome, Huntington disease), or traumatic brain injury; or substance-induced cognitive disorder associated with drugs of abuse, medications, or toxins. (We evaluate neurological disorders under that body system (see 11.00). We evaluate cognitive impairments that result from neurological disorders under 12.02 if they do not satisfy the requirements in 11.00 (see 11.00G).)

   c. This category does not include the mental disorders that we evaluate under intellectual disorder (12.05), autism spectrum disorder (12.10), and neurodevelopmental disorders (12.11).

2. **Schizophrenia spectrum and other psychotic disorders (12.03).**

   a. These disorders are characterized by delusions, hallucinations, disorganized speech, or grossly disorganized or catatonic behavior, causing a clinically significant decline in functioning. Symptoms and signs may include, but are not limited to, inability to initiate and persist in goal-directed activities, social withdrawal, flat or inappropriate affect, poverty of thought and speech, loss of interest or pleasure, disturbances of mood, odd beliefs and mannerisms, and paranoia.
b. Examples of disorders that we evaluate in this category include schizophrenia, schizoaffective disorder, delusional disorder, and psychotic disorder due to another medical condition.

3. **Depressive, bipolar and related disorders (12.04).**
   a. These disorders are characterized by an irritable, depressed, elevated, or expansive mood, or by a loss of interest or pleasure in all or almost all activities, causing a clinically significant decline in functioning. Symptoms and signs may include, but are not limited to, feelings of hopelessness or guilt, suicidal ideation, a clinically significant change in body weight or appetite, sleep disturbances, an increase or decrease in energy, psychomotor abnormalities, disturbed concentration, pressured speech, grandiosity, reduced impulse control, sadness, euphoria, and social withdrawal.
   b. Examples of disorders that we evaluate in this category include bipolar disorders (I or II), cyclothymic disorder, major depressive disorder, persistent depressive disorder (dysthymia), and bipolar or depressive disorder due to another medical condition.

4. **Intellectual disorder (12.05).**
   a. This disorder is characterized by significantly subaverage general intellectual functioning, significant deficits in current adaptive functioning, and manifestation of the disorder before age 22. Signs may include, but are not limited to, poor conceptual, social, or practical skills evident in your adaptive functioning.
   b. The disorder that we evaluate in this category may be described in the evidence as intellectual disability, intellectual developmental disorder, or historically used terms such as “mental retardation.”
   c. This category does not include the mental disorders that we evaluate under neurocognitive disorders (12.02), autism spectrum disorder (12.10), or neurodevelopmental disorders (12.11).

5. **Anxiety and obsessive-compulsive disorders (12.06).**
   a. These disorders are characterized by excessive anxiety, worry, apprehension, and fear, or by avoidance of feelings, thoughts, activities, objects, places, or people. Symptoms and signs may include, but are not limited to, restlessness, difficulty concentrating, hyper-vigilance, muscle tension, sleep disturbance, fatigue, panic attacks, obsessions and compulsions, constant thoughts and fears about safety, and frequent physical complaints.
   b. Examples of disorders that we evaluate in this category include social anxiety disorder, panic disorder, generalized anxiety disorder, agoraphobia, and obsessive-compulsive disorder.
   c. This category does not include the mental disorders that we evaluate under trauma- and stressor-related disorders (12.15).

6. **Somatic symptom and related disorders (12.07).**
   a. These disorders are characterized by physical symptoms or deficits that are not intentionally produced or feigned, and that, following clinical investigation, cannot be fully explained by a general medical condition, another mental disorder, the
direct effects of a substance, or a culturally sanctioned behavior or experience. These disorders may also be characterized by a preoccupation with having or acquiring a serious medical condition that has not been identified or diagnosed. Symptoms and signs may include, but are not limited to, pain and other abnormalities of sensation, gastrointestinal symptoms, fatigue, a high level of anxiety about personal health status, abnormal motor movement, pseudoseizures, and pseudoneurological symptoms, such as blindness or deafness.

b. Examples of disorders that we evaluate in this category include somatic symptom disorder, illness anxiety disorder, and conversion disorder.

7. **Personality and impulse-control disorders (12.08).**

a. These disorders are characterized by enduring, inflexible, maladaptive, and pervasive patterns of behavior. Onset typically occurs in adolescence or young adulthood. Symptoms and signs may include, but are not limited to, patterns of distrust, suspiciousness, and odd beliefs; social detachment, discomfort, or avoidance; hypersensitivity to negative evaluation; an excessive need to be taken care of; difficulty making independent decisions; a preoccupation with orderliness, perfectionism, and control; and inappropriate, intense, impulsive anger and behavioral expression grossly out of proportion to any external provocation or psychosocial stressors.

b. Examples of disorders that we evaluate in this category include paranoid, schizoid, schizotypal, borderline, avoidant, dependent, obsessive-compulsive personality disorders, and intermittent explosive disorder.

8. **Autism spectrum disorder (12.10).**

a. These disorders are characterized by qualitative deficits in the development of reciprocal social interaction, verbal and nonverbal communication skills, and symbolic or imaginative activity; restricted repetitive and stereotyped patterns of behavior, interests, and activities; and stagnation of development or loss of acquired skills early in life. Symptoms and signs may include, but are not limited to, abnormalities and unevenness in the development of cognitive skills; unusual responses to sensory stimuli; and behavioral difficulties, including hyperactivity, short attention span, impulsivity, aggressiveness, or self-injurious actions.

b. Examples of disorders that we evaluate in this category include autism spectrum disorder with or without accompanying intellectual impairment, and autism spectrum disorder with or without accompanying language impairment.

c. This category does not include the mental disorders that we evaluate under neurocognitive disorders (12.02), intellectual disorder (12.05), and neurodevelopmental disorders (12.11).

9. **Neurodevelopmental disorders (12.11).**

a. These disorders are characterized by onset during the developmental period, that is, during childhood or adolescence, although sometimes they are not diagnosed until adulthood. Symptoms and signs may include, but are not limited to, underlying abnormalities in cognitive processing (for example, deficits in
learning and applying verbal or nonverbal information, visual perception,
memory, or a combination of these); deficits in attention or impulse control; low
frustration tolerance; excessive or poorly planned motor activity; difficulty with
organizing (time, space, materials, or tasks); repeated accidental injury; and
deficits in social skills. Symptoms and signs specific to tic disorders include
sudden, rapid, recurrent, non-rhythmic, motor movement or vocalization.
b. Examples of disorders that we evaluate in this category include specific learning
disorder, borderline intellectual functioning, and tic disorders (such as Tourette
syndrome).
c. This category does not include the mental disorders that we evaluate under
neurocognitive disorders (12.02), autism spectrum disorder (12.10), or
personality and impulse-control disorders (12.08).

   a. These disorders are characterized by disturbances in eating behavior and
      preoccupation with, and excessive self-evaluation of, body weight and
      shape. Symptoms and signs may include, but are not limited to, restriction of
      energy consumption when compared with individual requirements; recurrent
      episodes of binge eating or behavior intended to prevent weight gain, such as
      self-induced vomiting, excessive exercise, or misuse of laxatives; mood
      disturbances, social withdrawal, or irritability; amenorrhea; dental problems;
      abnormal laboratory findings; and cardiac abnormalities.
   b. Examples of disorders that we evaluate in this category include anorexia nervosa,
      bulimia nervosa, binge-eating disorder, and avoidant/restrictive food disorder.

11. Trauma- and stressor-related disorders (12.15).
   a. These 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 close friend, and the psychological aftermath of clinically significant
      effects on functioning. Symptoms and signs may include, but are not limited to,
      distressing memories, dreams, and flashbacks related to the trauma or stressor;
      avoidant behavior; diminished interest or participation in significant activities;
      persistent negative emotional states (for example, fear, anger) or persistent
      inability to experience positive emotions (for example, satisfaction, affection);
      anxiety; irritability; aggression; exaggerated startle response; difficulty
      concentrating; and sleep disturbance.
   b. Examples of disorders that we evaluate in this category include posttraumatic
      stress disorder and other specified trauma- and stressor-related disorders (such
      as adjustment-like disorders with prolonged duration without prolonged
      duration of stressor).
   c. This category does not include the mental disorders that we evaluate under
      anxiety and obsessive-compulsive disorders (12.06), and cognitive impairments
      that result from neurological disorders, such as a traumatic brain injury, which
      we evaluate under neurocognitive disorders (12.02).
C. What evidence do we need to evaluate your mental disorder?

1. General. We need evidence from an acceptable medical source to establish that you have a medically determinable mental disorder. We also need evidence to assess the severity of your mental disorder and its effects on your ability to function in a work setting. We will determine the extent and kinds of evidence we need from medical and non-medical sources based on the individual facts about your disorder. For additional evidence requirements for intellectual disorder (12.05), see 12.00H. For our basic rules on evidence, see §§ 404.1512, 404.1513, 404.1520b, 416.912, 416.913, and 416.920b of this chapter. For our rules on evaluating opinion evidence, see §§ 404.1527 and 416.927 of this chapter. For our rules on evidence about your symptoms, see §§ 404.1529 and 416.929 of this chapter.

2. Evidence from medical sources. We will consider all relevant medical evidence about your disorder from your physician, psychologist, and other medical sources, which include health care providers such as physician assistants, psychiatric nurse practitioners, licensed clinical social workers, and clinical mental health counselors. Evidence from your medical sources may include:
   a. Your reported symptoms.
   b. Your medical, psychiatric, and psychological history.
   c. The results of physical or mental status examinations, structured clinical interviews, psychiatric or psychological rating scales, measures of adaptive functioning, or other clinical findings.
   d. Psychological testing, imaging results, or other laboratory findings.
   e. Your diagnosis.
   f. The type, dosage, and beneficial effects of medications you take.
   g. The type, frequency, duration, and beneficial effects of therapy you receive.
   h. Side effects of medication or other treatment that limit your ability to function.
   i. Your clinical course, including changes in your medication, therapy, or other treatment, and the time required for therapeutic effectiveness.
   j. Observations and descriptions of how you function during examinations or therapy.
   k. Information about sensory, motor, or speech abnormalities, or about your cultural background (for example, language or customs) that may affect an evaluation of your mental disorder.
   l. The expected duration of your symptoms and signs and their effects on your functioning, both currently and in the future.

3. Evidence from you and people who know you. We will consider all relevant evidence about your mental disorder and your daily functioning that we receive from you and from people who know you. We will ask about your symptoms, your daily functioning, and your medical treatment. We will ask for information from third parties who can tell us about your mental disorder, but you must give us permission to do so. This evidence may include information from your family, caregivers, friends, neighbors, clergy, case managers, social workers, shelter staff, or other community support and outreach
workers. We will consider whether your statements and the statements from third parties are consistent with the medical and other evidence we have.

4. Evidence from school, vocational training, work, and work-related programs.
   a. School. You may have recently attended or may still be attending school, and you may have received or may still be receiving special education services. If so, we will try to obtain information from your school sources when we need it to assess how your mental disorder affects your ability to function. Examples of this information include your Individualized Education Programs (IEPs), your Section 504 plans, comprehensive evaluation reports, school-related therapy progress notes, information from your teachers about how you function in a classroom setting, and information about any special services or accommodations you receive at school.
   b. Vocational training, work, and work-related programs. You may have recently participated in or may still be participating in vocational training, work-related programs, or work activity. If so, we will try to obtain information from your training program or your employer when we need it to assess how your mental disorder affects your ability to function. Examples of this information include training or work evaluations, modifications to your work duties or work schedule, and any special supports or accommodations you have required or now require in order to work. If you have worked or are working through a community mental health program, sheltered or supported work program, rehabilitation program, or transitional employment program, we will consider the type and degree of support you have received or are receiving in order to work (see 12.00D).

5. Need for longitudinal evidence.
   a. General. Longitudinal medical evidence can help us learn how you function over time, and help us evaluate any variations in the level of your functioning. We will request longitudinal evidence of your mental disorder when your medical providers have records concerning you and your mental disorder over a period of months or perhaps years (see §§ 404.1512(d) and 416.912(d) of this chapter).
   b. Non-medical sources of longitudinal evidence. Certain situations, such as chronic homelessness, may make it difficult for you to provide longitudinal medical evidence. If you have a severe mental disorder, you will probably have evidence of its effects on your functioning over time, even if you have not had an ongoing relationship with the medical community or are not currently receiving treatment. For example, family members, friends, neighbors, former employers, social workers, case managers, community support staff, outreach workers, or government agencies may be familiar with your mental health history. We will ask for information from third parties who can tell us about your mental disorder, but you must give us permission to do so.
   c. Absence of longitudinal evidence. In the absence of longitudinal evidence, we will use current objective medical evidence and all other relevant evidence available to us in your case record to evaluate your mental disorder. If we purchase a
consultative examination to document your disorder, the record will include the results of that examination (see §§ 404.1514 and 416.914 of this chapter). We will take into consideration your medical history, symptoms, clinical and laboratory findings, and medical source opinions. If you do not have longitudinal evidence, the current evidence alone may not be sufficient or appropriate to show that you have a disorder that meets the criteria of one of the mental disorders listings. In that case, we will follow the rules in 12.00).

6. **Evidence of functioning in unfamiliar situations or supportive situations.**
   a. **Unfamiliar situations.** We recognize that evidence about your functioning in unfamiliar situations does not necessarily show how you would function on a sustained basis in a work setting. In one-time, time-limited, or other unfamiliar situations, you may function differently than you do in familiar situations. In unfamiliar situations, you may appear more, or less, limited than you do on a daily basis and over time.
   b. **Supportive situations.** Your ability to complete tasks in settings that are highly structured, or that are less demanding or more supportive than typical work settings does not necessarily demonstrate your ability to complete tasks in the context of regular employment during a normal workday or work week.
   c. **Our assessment.** We must assess your ability to complete tasks by evaluating all the evidence, such as reports about your functioning from you and third parties who are familiar with you, with an emphasis on how independently, appropriately, and effectively you are able to complete tasks on a sustained basis.

D. **How do we consider psychosocial supports, structured settings, living arrangements, and treatment?**

1. **General.** Psychosocial supports, structured settings, and living arrangements, including assistance from your family or others, may help you by reducing the demands made on you. In addition, treatment you receive may reduce your symptoms and signs and possibly improve your functioning, or may have side effects that limit your functioning. Therefore, when we evaluate the effects of your mental disorder and rate the limitation of your areas of mental functioning, we will consider the kind and extent of supports you receive, the characteristics of any structured setting in which you spend your time, and the effects of any treatment. This evidence may come from reports about your functioning from you or third parties who are familiar with you, and other third-party statements or information. Following are some examples of the supports you may receive:
   a. You receive help from family members or other people who monitor your daily activities and help you to function. For example, family members administer your medications, remind you to eat, shop for you and pay your bills, or change their work hours so you are never home alone.
b. You participate in a special education or vocational training program, or a psychosocial rehabilitation day treatment or community support program, where you receive training in daily living and entry-level work skills.

c. You participate in a sheltered, supported, or transitional work program, or in a competitive employment setting with the help of a job coach or supervisor.

d. You receive comprehensive “24/7 wrap-around” mental health services while living in a group home or transitional housing, while participating in a semi-independent living program, or while living in individual housing (for example, your own home or apartment).

e. You live in a hospital or other institution with 24-hour care.

f. You receive assistance from a crisis response team, social workers, or community mental health workers who help you meet your physical needs, and who may also represent you in dealings with government or community social services.

g. You live alone and do not receive any psychosocial support(s); however, you have created a highly structured environment by eliminating all but minimally necessary contact with the world outside your living space.

2. **How we consider different levels of support and structure in psychosocial rehabilitation programs.**

   a. Psychosocial rehabilitation programs are based on your specific needs. Therefore, we cannot make any assumptions about your mental disorder based solely on the fact that you are associated with such a program. We must know the details of the program(s) in which you are involved and the pattern(s) of your involvement over time.

   b. The kinds and levels of supports and structures in psychosocial rehabilitation programs typically occur on a scale of “most restrictive” to “least restrictive.” Participation in a psychosocial rehabilitation program at the most restrictive level would suggest greater limitation of your areas of mental functioning than would participation at a less restrictive level. The length of time you spend at different levels in a program also provides information about your functioning. For example, you could begin participation at the most restrictive crisis intervention level but gradually improve to the point of readiness for a lesser level of support and structure and possibly some form of employment.

3. **How we consider the help or support you receive.**

   a. We will consider the complete picture of your daily functioning, including the kinds, extent, and frequency of help and support you receive, when we evaluate your mental disorder and determine whether you are able to use the four areas of mental functioning in a work setting. The fact that you have done, or currently do, some routine activities without help or support does not necessarily mean that you do not have a mental disorder or that you are not disabled. For example, you may be able to take care of your personal needs, cook, shop, pay your bills, live by yourself, and drive a car. You may demonstrate both strengths and deficits in your daily functioning.
b. You may receive various kinds of help and support from others that enable you to do many things that, because of your mental disorder, you might not be able to do independently. Your daily functioning may depend on the special contexts in which you function. For example, you may spend your time among only familiar people or surroundings, in a simple and steady routine or an unchanging environment, or in a highly structured setting. However, this does not necessarily show how you would function in a work setting on a sustained basis, throughout a normal workday and workweek. (See 12.00H for further discussion of these issues regarding significant deficits in adaptive functioning for the purpose of 12.05.)

4. How we consider treatment. We will consider the effect of any treatment on your functioning when we evaluate your mental disorder. Treatment may include medication(s), psychotherapy, or other forms of intervention, which you receive in a doctor’s office, during a hospitalization, or in a day program at a hospital or outpatient treatment program. With treatment, you may not only have your symptoms and signs reduced, but may also be able to function in a work setting. However, treatment may not resolve all of the limitations that result from your mental disorder, and the medications you take or other treatment you receive for your disorder may cause side effects that limit your mental or physical functioning. For example, you may experience drowsiness, blunted affect, memory loss, or abnormal involuntary movements.

E. What are the paragraph B criteria?

1. Understand, remember, or apply information (paragraph B1). This area of mental functioning refers to the abilities to learn, recall, and use information to perform work activities. Examples include: understanding and learning terms, instructions, procedures; following one- or two-step oral instructions to carry out a task; describing work activity to someone else; asking and answering questions and providing explanations; recognizing a mistake and correcting it; identifying and solving problems; sequencing multi-step activities; and using reason and judgment to make work-related decisions. These examples illustrate the nature of this area of mental functioning. We do not require documentation of all of the examples.

2. Interact with others (paragraph B2). This area of mental functioning refers to the abilities to relate to and work with supervisors, co-workers, and the public. Examples include: cooperating with others; asking for help when needed; handling conflicts with others; stating own point of view; initiating or sustaining conversation; understanding and responding to social cues (physical, verbal, emotional); responding to requests, suggestions, criticism, correction, and challenges; and keeping social interactions free of excessive irritability, sensitivity, argumentativeness, or suspiciousness. These examples illustrate the nature of this area of mental functioning. We do not require documentation of all of the examples.

3. Concentrate, persist, or maintain pace (paragraph B3). This area of mental functioning refers to the abilities to focus attention on work activities and stay on task at a
sustained rate. Examples include: initiating and performing a task that you understand and know how to do; working at an appropriate and consistent pace; completing tasks in a timely manner; ignoring or avoiding distractions while working; changing activities or work settings without being disruptive; working close to or with others without interrupting or distracting them; sustaining an ordinary routine and regular attendance at work; and working a full day without needing more than the allotted number or length of rest periods during the day. These examples illustrate the nature of this area of mental functioning. We do not require documentation of all of the examples.

4. Adapt or manage oneself (paragraph B4). This area of mental functioning refers to the abilities to regulate emotions, control behavior, and maintain well-being in a work setting. Examples include: responding to demands; adapting to changes; managing your psychologically based symptoms; distinguishing between acceptable and unacceptable work performance; setting realistic goals; making plans for yourself independently of others; maintaining personal hygiene and attire appropriate to a work setting; and being aware of normal hazards and taking appropriate precautions. These examples illustrate the nature of this area of mental functioning. We do not require documentation of all of the examples.

F. How do we use the paragraph B criteria to evaluate your mental disorder?

1. General. We use the paragraph B criteria, in conjunction with a rating scale (see 12.00F2), to rate the degree of your limitations. We consider only the limitations that result from your mental disorder(s). We will determine whether you are able to use each of the paragraph B areas of mental functioning in a work setting. We will consider, for example, the kind, degree, and frequency of difficulty you would have; whether you could function without extra help, structure, or supervision; and whether you would require special conditions with regard to activities or other people (see 12.00D).

2. The five-point rating scale. We evaluate the effects of your mental disorder on each of the four areas of mental functioning based on a five-point rating scale consisting of none, mild, moderate, marked, and extreme limitation. To satisfy the paragraph B criteria, your mental disorder must result in extreme limitation of one, or marked limitation of two, paragraph B areas of mental functioning. Under these listings, the five rating points are defined as follows:
   a. No limitation (or none). You are able to function in this area independently, appropriately, effectively, and on a sustained basis.
   b. Mild limitation. Your functioning in this area independently, appropriately, effectively, and on a sustained basis is slightly limited.
   c. Moderate limitation. Your functioning in this area independently, appropriately, effectively, and on a sustained basis is fair.
   d. Marked limitation. Your functioning in this area independently, appropriately, effectively, and on a sustained basis is seriously limited.
   e. Extreme limitation. You are not able to function in this area independently, appropriately, effectively, and on a sustained basis.
3. **Rating the limitations of your areas of mental functioning.**
   a. **General.** We use all of the relevant medical and non-medical evidence in your case record to evaluate your mental disorder: the symptoms and signs of your disorder, the reported limitations in your activities, and any help and support you receive that is necessary for you to function. The medical evidence may include descriptors regarding the diagnostic stage or level of your disorder, such as “mild” or “moderate.” Clinicians may use these terms to characterize your medical condition. However, these terms will not always be the same as the degree of your limitation in a paragraph B area of mental functioning.

   b. **Areas of mental functioning in daily activities.** You use the same four areas of mental functioning in daily activities at home and in the community that you would use to function at work. With respect to a particular task or activity, you may have trouble using one or more of the areas. For example, you may have difficulty understanding and remembering what to do; or concentrating and staying on task long enough to do it; or engaging in the task or activity with other people; or trying to do the task without becoming frustrated and losing self-control. Information about your daily functioning can help us understand whether your mental disorder limits one or more of these areas; and, if so, whether it also affects your ability to function in a work setting.

   c. **Areas of mental functioning in work settings.** If you have difficulty using an area of mental functioning from day-to-day at home or in your community, you may also have difficulty using that area to function in a work setting. On the other hand, if you are able to use an area of mental functioning at home or in your community, we will not necessarily assume that you would also be able to use that area to function in a work setting where the demands and stressors differ from those at home. We will consider all evidence about your mental disorder and daily functioning before we reach a conclusion about your ability to work.

   d. **Overall effect of limitations.** Limitation of an area of mental functioning reflects the overall degree to which your mental disorder interferes with that area. The degree of limitation is how we document our assessment of your limitation when using the area of mental functioning independently, appropriately, effectively, and on a sustained basis. It does not necessarily reflect a specific type or number of activities, including activities of daily living, that you have difficulty doing. In addition, no single piece of information (including test results) can establish the degree of limitation of an area of mental functioning.

   e. **Effects of support, supervision, structure on functioning.** The degree of limitation of an area of mental functioning also reflects the kind and extent of supports or supervision you receive and the characteristics of any structured setting where you spend your time, which enable you to function. The more extensive the support you need from others or the more structured the setting you need in order to function, the more limited we will find you to be (see 12.00D).
Specific instructions for paragraphs B1, B3, and B4. For paragraphs B1, B3, and B4, the greatest degree of limitation of any part of the area of mental functioning directs the rating of limitation of that whole area of mental functioning.

i. To do a work-related task, you must be able to understand and remember and apply information required by the task. Similarly, you must be able to concentrate and persist and maintain pace in order to complete the task, and adapt and manage yourself in the workplace. Limitation in any one of these parts (understand or remember or apply; concentrate or persist or maintain pace; adapt or manage oneself) may prevent you from completing a work-related task.

ii. We will document the rating of limitation of the whole area of mental functioning, not each individual part. We will not add ratings of the parts together. For example, with respect to paragraph B3, if you have marked limitation in maintaining pace, and mild or moderate limitations in concentrating and persisting, we will find that you have marked limitation in the whole paragraph B3 area of mental functioning.

iii. Marked limitation in more than one part of the same paragraph B area of mental functioning does not satisfy the requirement to have marked limitation in two paragraph B areas of mental functioning.

4. How we evaluate mental disorders involving exacerbations and remissions.

a. When we evaluate the effects of your mental disorder, we will consider how often you have exacerbations and remissions, how long they last, what causes your mental disorder to worsen or improve, and any other relevant information. We will assess any limitation of the affected paragraph B area(s) of mental functioning using the rating scale for the paragraph B criteria. We will consider whether you can use the area of mental functioning on a regular and continuing basis (8 hours a day, 5 days a week, or an equivalent work schedule). We will not find that you are able to work solely because you have a period(s) of improvement (remission), or that you are disabled solely because you have a period of worsening (exacerbation), of your mental disorder.

b. If you have a mental disorder involving exacerbations and remissions, you may be able to use the four areas of mental functioning to work for a few weeks or months. Recurrence or worsening of symptoms and signs, however, can interfere enough to render you unable to sustain the work.

G. What are the paragraph C criteria, and how do we use them to evaluate your mental disorder?

1. General. The paragraph C criteria are an alternative to the paragraph B criteria under listings 12.02, 12.03, 12.04, 12.06, and 12.15. We use the paragraph C criteria to evaluate mental disorders that are “serious and persistent.” In the paragraph C criteria, we recognize that mental health interventions may control the more obvious symptoms and signs of your mental disorder.
2. **Paragraph C criteria.**
   
   a. We find a mental disorder to be “serious and persistent” when there is a medically documented history of the existence of the mental disorder in the listing category over a period of at least 2 years, and evidence shows that your disorder satisfies both C1 and C2.
   
   b. The criterion in C1 is satisfied when the evidence shows that you rely, on an ongoing basis, upon medical treatment, mental health therapy, psychosocial support(s), or a highly structured setting(s), to diminish the symptoms and signs of your mental disorder (see 12.00D). We consider that you receive ongoing medical treatment when the medical evidence establishes that you obtain medical treatment with a frequency consistent with accepted medical practice for the type of treatment or evaluation required for your medical condition. We will consider periods of inconsistent treatment or lack of compliance with treatment that may result from your mental disorder. If the evidence indicates that the inconsistent treatment or lack of compliance is a feature of your mental disorder, and it has led to an exacerbation of your symptoms and signs, we will not use it as evidence to support a finding that you have not received ongoing medical treatment as required by this paragraph.
   
   c. The criterion in C2 is satisfied when the evidence shows that, despite your diminished symptoms and signs, you have achieved only marginal adjustment. "Marginal adjustment" means that your adaptation to the requirements of daily life is fragile; that is, you have minimal capacity to adapt to changes in your environment or to demands that are not already part of your daily life. We will consider that you have achieved only marginal adjustment when the evidence shows that changes or increased demands have led to exacerbation of your symptoms and signs and to deterioration in your functioning; for example, you have become unable to function outside of your home or a more restrictive setting, without substantial psychosocial supports (see 12.00D). Such deterioration may have necessitated a significant change in medication or other treatment. Similarly, because of the nature of your mental disorder, evidence may document episodes of deterioration that have required you to be hospitalized or absent from work, making it difficult for you to sustain work activity over time.

H. **How do we document and evaluate intellectual disorder under 12.05?**

   1. **General.** Listing 12.05 is based on the three elements that characterize intellectual disorder: significantly subaverage general intellectual functioning; significant deficits in current adaptive functioning; and the disorder manifested before age 22.

   2. **Establishing significantly subaverage general intellectual functioning.**
      
      a. **Definition.** Intellectual functioning refers to the general mental capacity to learn, reason, plan, solve problems, and perform other cognitive functions. Under 12.05A, we identify significantly subaverage general intellectual functioning by the
cognitive inability to function at a level required to participate in standardized intelligence testing. Our findings under 12.05A are based on evidence from an acceptable medical source. Under 12.05B, we identify significantly subaverage general intellectual functioning by an IQ score(s) on an individually administered standardized test of general intelligence that meets program requirements and has a mean of 100 and a standard deviation of 15. A qualified specialist (see 12.00H2c) must administer the standardized intelligence testing.

b. **Psychometric standards.** We will find standardized intelligence test results usable for the purposes of 12.05B1 when the measure employed meets contemporary psychometric standards for validity, reliability, normative data, and scope of measurement; and a qualified specialist has individually administered the test according to all pre-requisite testing conditions.

c. **Qualified specialist.** A “qualified specialist” is currently licensed or certified at the independent level of practice in the State where the test was performed, and has the training and experience to administer, score, and interpret intelligence tests. If a psychological assistant or paraprofessional administered the test, a supervisory qualified specialist must interpret the test findings and co-sign the examination report.

d. **Responsibility for conclusions based on testing.** We generally presume that your obtained IQ score(s) is an accurate reflection of your general intellectual functioning, unless evidence in the record suggests otherwise. Examples of this evidence include: a statement from the test administrator indicating that your obtained score is not an accurate reflection of your general intellectual functioning, prior or internally inconsistent IQ scores, or information about your daily functioning. Only qualified specialists, Federal and State agency medical and psychological consultants, and other contracted medical and psychological experts may conclude that your obtained IQ score(s) is not an accurate reflection of your general intellectual functioning. This conclusion must be well supported by appropriate clinical and laboratory diagnostic techniques and must be based on relevant evidence in the case record, such as:
   i. The data obtained in testing;
   ii. Your developmental history, including when your signs and symptoms began;
   iii. Information about how you function on a daily basis in a variety of settings; and
   iv. Clinical observations made during the testing period, such as your ability to sustain attention, concentration, and effort; to relate appropriately to the examiner; and to perform tasks independently without prompts or reminders.

3. **Establishing significant deficits in adaptive functioning.**
   a. **Definition.** Adaptive functioning refers to how you learn and use conceptual, social, and practical skills in dealing with common life demands. It is your typical functioning at home and in the community, alone or among others. Under
12.05A, we identify significant deficits in adaptive functioning based on your dependence on others to care for your personal needs, such as eating and bathing. We will base our conclusions about your adaptive functioning on evidence from a variety of sources (see 12.00H3b) and not on your statements alone. Under 12.05B2, we identify significant deficits in adaptive functioning based on whether there is extreme limitation of one, or marked limitation of two, of the paragraph B criteria (see 12.00E; 12.00F).

b. Evidence. Evidence about your adaptive functioning may come from:
   i. Medical sources, including their clinical observations;
   ii. Standardized tests of adaptive functioning (see 12.00H3c);
   iii. Third party information, such as a report of your functioning from a family member or friend;
   iv. School records, if you were in school recently;
   v. Reports from employers or supervisors; and
   vi. Your own statements about how you handle all of your daily activities.

c. Standardized tests of adaptive functioning. We do not require the results of an individually administered standardized test of adaptive functioning. If your case record includes these test results, we will consider the results along with all other relevant evidence; however, we will use the guidelines in 12.00E and F to evaluate and determine the degree of your deficits in adaptive functioning, as required under 12.05B2.

d. How we consider common everyday activities.
   i. The fact that you engage in common everyday activities, such as caring for your personal needs, preparing simple meals, or driving a car, will not always mean that you do not have deficits in adaptive functioning as required by 12.05B2. You may demonstrate both strengths and deficits in your adaptive functioning. However, a lack of deficits in one area does not negate the presence of deficits in another area. When we assess your adaptive functioning, we will consider all of your activities and your performance of them.
   ii. Our conclusions about your adaptive functioning rest on whether you do your daily activities independently, appropriately, effectively, and on a sustained basis. If you receive help in performing your activities, we need to know the kind, extent, and frequency of help you receive in order to perform them. We will not assume that your ability to do some common everyday activities, or to do some things without help or support, demonstrates that your mental disorder does not meet the requirements of 12.05B2. (See 12.00D regarding the factors we consider when we evaluate your functioning, including how we consider any help or support you receive.)

e. How we consider work activity. The fact that you have engaged in work activity, or that you work intermittently or steadily in a job commensurate with your abilities, will not always mean that you do not have deficits in adaptive
functioning as required by 12.05B2. When you have engaged in work activity, we need complete information about the work, and about your functioning in the work activity and work setting, before we reach any conclusions about your adaptive functioning. We will consider all factors involved in your work history before concluding whether your impairment satisfies the criteria for intellectual disorder under 12.05B. We will consider your prior and current work history, if any, and various other factors influencing how you function. For example, we consider whether the work was in a supported setting, whether you required more supervision than other employees, how your job duties compared to others in the same job, how much time it took you to learn the job duties, and the reason the work ended, if applicable.

4. Establishing that the disorder began before age 22. We require evidence that demonstrates or supports (is consistent with) the conclusion that your mental disorder began prior to age 22. We do not require evidence that your impairment met all of the requirements of 12.05A or 12.05B prior to age 22. Also, we do not require you to have met our statutory definition of disability prior to age 22. When we do not have evidence that was recorded before you attained age 22, we need evidence about your current intellectual and adaptive functioning and the history of your disorder that supports the conclusion that the disorder began before you attained age 22. Examples of evidence that can demonstrate or support this conclusion include:

a. Tests of intelligence or adaptive functioning;
b. School records indicating a history of special education services based on your intellectual functioning;
c. An Individualized Education Program (IEP), including your transition plan;
d. Reports of your academic performance and functioning at school;
e. Medical treatment records;
f. Interviews or reports from employers;
g. Statements from a supervisor in a group home or a sheltered workshop; and
h. Statements from people who have known you and can tell us about your functioning in the past and currently.

I. How do we evaluate substance use disorders? If we find that you are disabled and there is medical evidence in your case record establishing that you have a substance use disorder, we will determine whether your substance use disorder is a contributing factor material to the determination of disability (see §§ 404.1535 and 416.935 of this chapter).

J. How do we evaluate mental disorders that do not meet one of the mental disorders listings?

1. These listings include only examples of mental disorders that we consider serious enough to prevent you from doing any gainful activity. If your severe mental disorder does not meet the criteria of any of these listings, we will consider whether you have an impairment(s) that meets the criteria of a listing in another body system. You may have
another impairment(s) that is secondary to your mental disorder. For example, if you have an eating disorder and develop a cardiovascular impairment because of it, we will evaluate your cardiovascular impairment under the listings for the cardiovascular body system.

2. If you have a severe medically determinable impairment(s) that does not meet a listing, we will determine whether your impairment(s) medically equals a listing (see §§ 404.1526 and 416.926 of this chapter).

3. If your impairment(s) does not meet or medically equal a listing, we will assess your residual functional capacity for engaging in substantial gainful activity (see §§ 404.1520 and 416.920 of this chapter). When we assess your residual functional capacity, we consider all of your impairment-related mental and physical limitations. For example, the side effects of some medications may reduce your general alertness, concentration, or physical stamina, affecting your residual functional capacity for non-exertional or exertional work activities. Once we have determined your residual functional capacity, we proceed to the fourth, and if necessary, the fifth steps of the sequential evaluation process in §§ 404.1520 and 416.920 of this chapter. We use the rules in §§ 404.1594 and 416.994 of this chapter, as appropriate, when we decide whether you continue to be disabled.

12.01 Category of Impairments, Mental Disorders

12.02 Neurocognitive disorders (see 12.00B1), satisfied by A and B, or A and C:

A. Medical documentation of a significant cognitive decline from a prior level of functioning in one or more of the cognitive areas:
   1. Complex attention;
   2. Executive function;
   3. Learning and memory;
   4. Language;
   5. Perceptual-motor; or

AND

B. Extreme limitation of one, or marked limitation of two, of the following areas of mental functioning (see 12.00F):
   1. Understand, remember, or apply information (see 12.00E1).
   2. Interact with others (see 12.00E2).
   3. Concentrate, persist, or maintain pace (see 12.00E3).
   4. Adapt or manage oneself (see 12.00E4).

OR
C. Your mental disorder in this listing category is “serious and persistent;” that is, you have a medically documented history of the existence of the disorder over a period of at least 2 years, and there is evidence of both:
   1. Medical treatment, mental health therapy, psychosocial support(s), or a highly structured setting(s) that is ongoing and that diminishes the symptoms and signs of your mental disorder (see 12.00G2b); and
   2. Marginal adjustment, that is, you have minimal capacity to adapt to changes in your environment or to demands that are not already part of your daily life (see 12.00G2c).

12.03 Schizophrenia spectrum and other psychotic disorders (see 12.00B2), satisfied by A and B, or A and C:

A. Medical documentation of one or more of the following:
   1. Delusions or hallucinations;
   2. Disorganized thinking (speech); or
   3. Grossly disorganized behavior or catatonia.

AND

B. Extreme limitation of one, or marked limitation of two, of the following areas of mental functioning (see 12.00F):
   1. Understand, remember, or apply information (see 12.00E1).
   2. Interact with others (see 12.00E2).
   3. Concentrate, persist, or maintain pace (see 12.00E3).
   4. Adapt or manage oneself (see 12.00E4).

OR

C. Your mental disorder in this listing category is “serious and persistent;” that is, you have a medically documented history of the existence of the disorder over a period of at least 2 years, and there is evidence of both:
   1. Medical treatment, mental health therapy, psychosocial support(s), or a highly structured setting(s) that is ongoing and that diminishes the symptoms and signs of your mental disorder (see 12.00G2b); and
   2. Marginal adjustment, that is, you have minimal capacity to adapt to changes in your environment or to demands that are not already part of your daily life (see 12.00G2c).

12.04 Depressive, bipolar and related disorders (see 12.00B3), satisfied by A and B, or A and C:

A. Medical documentation of the requirements of paragraph 1 or 2:
1. Depressive disorder, characterized by five or more of the following:
   a. Depressed mood;
   b. Diminished interest in almost all activities;
   c. Appetite disturbance with change in weight;
   d. Sleep disturbance;
   e. Observable psychomotor agitation or retardation;
   f. Decreased energy;
   g. Feelings of guilt or worthlessness;
   h. Difficulty concentrating or thinking; or
   i. Thoughts of death or suicide.

2. Bipolar disorder, characterized by three or more of the following:
   a. Pressured speech;
   b. Flight of ideas;
   c. Inflated self-esteem;
   d. Decreased need for sleep;
   e. Distractibility;
   f. Involvement in activities that have a high probability of painful consequences that are not recognized; or
   g. Increase in goal-directed activity or psychomotor agitation.

AND

B. Extreme limitation of one, or marked limitation of two, of the following areas of mental functioning (see 12.00F):
   1. Understand, remember, or apply information (see 12.00E1).
   2. Interact with others (see 12.00E2).
   3. Concentrate, persist, or maintain pace (see 12.00E3).
   4. Adapt or manage oneself (see 12.00E4).

OR

C. Your mental disorder in this listing category is “serious and persistent;” that is, you have a medically documented history of the existence of the disorder over a period of at least 2 years, and there is evidence of both:
   1. Medical treatment, mental health therapy, psychosocial support(s), or a highly structured setting(s) that is ongoing and that diminishes the symptoms and signs of your mental disorder (see 12.00G2b); and
   2. Marginal adjustment, that is, you have minimal capacity to adapt to changes in your environment or to demands that are not already part of your daily life (see 12.00G2c).

12.05 Intellectual disorder (see 12.00B4), satisfied by A or B:
A. Satisfied by 1, 2, and 3 (see 12.00H):
   1. Significantly subaverage general intellectual functioning evident in your cognitive inability to function at a level required to participate in standardized testing of intellectual functioning; and
   2. Significant deficits in adaptive functioning currently manifested by your dependence upon others for personal needs (for example, toileting, eating, dressing, or bathing); and
   3. The evidence about your current intellectual and adaptive functioning and about the history of your disorder demonstrates or supports the conclusion that the disorder began prior to your attainment of age 22.

OR

B. Satisfied by 1, 2, and 3 (see 12.00H):
   1. Significantly subaverage general intellectual functioning evidenced by a or b:
      a. A full scale (or comparable) IQ score of 70 or below on an individually administered standardized test of general intelligence; or
      b. A full scale (or comparable) IQ score of 71-75 accompanied by a verbal or performance IQ score (or comparable part score) of 70 or below on an individually administered standardized test of general intelligence; and
   2. Significant deficits in adaptive functioning currently manifested by extreme limitation of one, or marked limitation of two, of the following areas of mental functioning:
      a. Understand, remember, or apply information (see 12.00E1); or
      b. Interact with others (see 12.00E2); or
      c. Concentrate, persist, or maintain pace (see 12.00E3); or
      d. Adapt or manage oneself (see 12.00E4); and
   3. The evidence about your current intellectual and adaptive functioning and about the history of your disorder demonstrates or supports the conclusion that the disorder began prior to your attainment of age 22.

12.06 Anxiety and obsessive-compulsive disorders (see 12.00B5), satisfied by A and B, or A and C:

A. Medical documentation of the requirements of paragraph 1, 2, or 3:
   1. Anxiety disorder, characterized by three or more of the following:
      a. Restlessness;
      b. Easily fatigued;
      c. Difficulty concentrating;
      d. Irritability;
      e. Muscle tension; or
      f. Sleep disturbance.
   2. Panic disorder or agoraphobia, characterized by one or both:
a. Panic attacks followed by a persistent concern or worry about additional panic attacks or their consequences; or
b. Disproportionate fear or anxiety about at least two different situations (for example, using public transportation, being in a crowd, being in a line, being outside of your home, being in open spaces).

3. Obsessive-compulsive disorder, characterized by one or both:
   a. Involuntary, time-consuming preoccupation with intrusive, unwanted thoughts; or
   b. Repetitive behaviors aimed at reducing anxiety.

AND

B. Extreme limitation of one, or marked limitation of two, of the following areas of mental functioning (see 12.00F):
   1. Understand, remember, or apply information (see 12.00E1).
   2. Interact with others (see 12.00E2).
   3. Concentrate, persist, or maintain pace (see 12.00E3).
   4. Adapt or manage oneself (see 12.00E4).

OR

C. Your mental disorder in this listing category is “serious and persistent;” that is, you have a medically documented history of the existence of the disorder over a period of at least 2 years, and there is evidence of both:
   1. Medical treatment, mental health therapy, psychosocial support(s), or a highly structured setting(s) that is ongoing and that diminishes the symptoms and signs of your mental disorder (see 12.00G2b); and
   2. Marginal adjustment, that is, you have minimal capacity to adapt to changes in your environment or to demands that are not already part of your daily life (see 12.00G2c).

12.07 Somatic symptom and related disorders (see 12.00B6), satisfied by A and B:

A. Medical documentation of one or more of the following:
   1. Symptoms of altered voluntary motor or sensory function that are not better explained by another medical or mental disorder;
   2. One or more somatic symptoms that are distressing, with excessive thoughts, feelings, or behaviors related to the symptoms; or
   3. Preoccupation with having or acquiring a serious illness without significant symptoms present.

AND
B. Extreme limitation of one, or marked limitation of two, of the following areas of mental functioning (see 12.00F):
   1. Understand, remember, or apply information (see 12.00E1).
   2. Interact with others (see 12.00E2).
   3. Concentrate, persist, or maintain pace (see 12.00E3).
   4. Adapt or manage oneself (see 12.00E4).

12.08 Personality and impulse-control disorders (see 12.00B7), satisfied by A and B:

   A. Medical documentation of a pervasive pattern of one or more of the following:
      1. Distrust and suspiciousness of others;
      2. Detachment from social relationships;
      3. Disregard for and violation of the rights of others;
      4. Instability of interpersonal relationships;
      5. Excessive emotionality and attention seeking;
      6. Feelings of inadequacy;
      7. Excessive need to be taken care of;
      8. Preoccupation with perfectionism and orderliness; or
      9. Recurrent, impulsive, aggressive behavioral outbursts.

   AND

   B. Extreme limitation of one, or marked limitation of two, of the following areas of mental functioning (see 12.00F):
      1. Understand, remember, or apply information (see 12.00E1).
      2. Interact with others (see 12.00E2).
      3. Concentrate, persist, or maintain pace (see 12.00E3).
      4. Adapt or manage oneself (see 12.00E4).

12.09 [Reserved]

12.10 Autism spectrum disorder (see 12.00B8), satisfied by A and B:

   A. Medical documentation of both of the following:
      1. Qualitative deficits in verbal communication, nonverbal communication, and social interaction; and
      2. Significantly restricted, repetitive patterns of behavior, interests, or activities.

   AND

   B. Extreme limitation of one, or marked limitation of two, of the following areas of mental functioning (see 12.00F):
1. Understand, remember, or apply information (see 12.00E1).
2. Interact with others (see 12.00E2).
3. Concentrate, persist, or maintain pace (see 12.00E3).
4. Adapt or manage oneself (see 12.00E4).

12.11 Neurodevelopmental disorders (see 12.00B9), satisfied by A and B:

A. Medical documentation of the requirements of paragraph 1, 2, or 3:
   1. One or both of the following:
      a. Frequent distractibility, difficulty sustaining attention, and difficulty organizing tasks; or
      b. Hyperactive and impulsive behavior (for example, difficulty remaining seated, talking excessively, difficulty waiting, appearing restless, or behaving as if being “driven by a motor”).
   2. Significant difficulties learning and using academic skills; or
   3. Recurrent motor movement or vocalization.

AND

B. Extreme limitation of one, or marked limitation of two, of the following areas of mental functioning (see 12.00F):
   1. Understand, remember, or apply information (see 12.00E1).
   2. Interact with others (see 12.00E2).
   3. Concentrate, persist, or maintain pace (see 12.00E3).
   4. Adapt or manage oneself (see 12.00E4).

12.12 [Reserved]

12.13 Eating disorders (see 12.00B10), satisfied by A and B:

A. Medical documentation of a persistent alteration in eating or eating-related behavior that results in a change in consumption or absorption of food and that significantly impairs physical or psychological health.

AND

B. Extreme limitation of one, or marked limitation of two, of the following areas of mental functioning (see 12.00F):
   1. Understand, remember, or apply information (see 12.00E1).
   2. Interact with others (see 12.00E2).
   3. Concentrate, persist, or maintain pace (see 12.00E3).
   4. Adapt or manage oneself (see 12.00E4).
12.15 Trauma- and stressor-related disorders (see 12.00B11), satisfied by A and B, or A and C:

A. Medical documentation of all of the following:
   1. Exposure to actual or threatened death, serious injury, or violence;
   2. Subsequent involuntary re-experiencing of the traumatic event (for example, intrusive memories, dreams, or flashbacks);
   3. Avoidance of external reminders of the event;
   4. Disturbance in mood and behavior; and
   5. Increases in arousal and reactivity (for example, exaggerated startle response, sleep disturbance).

AND

B. Extreme limitation of one, or marked limitation of two, of the following areas of mental functioning (see 12.00F):
   1. Understand, remember, or apply information (see 12.00E1).
   2. Interact with others (see 12.00E2).
   3. Concentrate, persist, or maintain pace (see 12.00E3).
   4. Adapt or manage oneself (see 12.00E4).

OR

C. Your mental disorder in this listing category is “serious and persistent;” that is, you have a medically documented history of the existence of the disorder over a period of at least 2 years, and there is evidence of both:
   1. Medical treatment, mental health therapy, psychosocial support(s), or a highly structured setting(s) that is ongoing and that diminishes the symptoms and signs of your mental disorder (see 12.00G2b); and
   2. Marginal adjustment, that is, you have minimal capacity to adapt to changes in your environment or to demands that are not already part of your daily life (see 12.00G2c).
A. How are the listings for mental disorders for children arranged, and what do they require?

1. The listings for mental disorders for children are arranged in 12 categories: neurocognitive disorders (112.02); schizophrenia spectrum and other psychotic disorders (112.03); depressive, bipolar and related disorders (112.04); intellectual disorder (112.05); anxiety and obsessive-compulsive disorders (112.06); somatic symptom and related disorders (112.07); personality and impulse-control disorders (112.08); autism spectrum disorder (112.10); neurodevelopmental disorders (112.11); eating disorders (112.13); developmental disorders in infants and toddlers (112.14); and trauma- and stressor-related disorders (112.15). All of these listings, with the exception of 112.14, apply to children from age three to attainment of age 18. Listing 112.14 is for children from birth to attainment of age 3.

2. Listings 112.07, 112.08, 112.10, 112.11, 112.13, and 112.14 have two paragraphs, designated A and B; your mental disorder must satisfy the requirements of both paragraphs A and B. Listings 112.02, 112.03, 112.04, 112.06, and 112.15 have three paragraphs, designated A, B, and C; your mental disorder must satisfy the requirements of both paragraphs A and B, or the requirements of both paragraphs A and C. Listing 112.05 has two paragraphs that are unique to that listing (see 112.00A3); your mental disorder must satisfy the requirements of either paragraph A or paragraph B.

   a. Paragraph A of each listing (except 112.05) includes the medical criteria that must be present in your medical evidence.

   b. Paragraph B of each listing (except 112.05) provides the functional criteria we assess to evaluate how your mental disorder limits your functioning. For children ages 3 to 18, these criteria represent the areas of mental functioning a child uses to perform age-appropriate activities. They are: understand, remember, or apply information; interact with others; concentrate, persist, or maintain pace; and adapt or manage oneself. (See 112.00I for a discussion of the criteria for children from birth to attainment of age 3 under 112.14.) We will determine the degree to which your medically determinable mental impairment affects the four areas of mental functioning and your ability to function age-appropriately in a manner comparable to that of other children your age who do not have impairments. (Hereinafter, the words “age-appropriately” incorporate the qualifying statement, “in a manner comparable to that of other children your age who do not have impairments.”) To satisfy the paragraph B criteria, your mental disorder must result in “extreme” limitation of one, or “marked” limitation of two, of the four areas of mental functioning. (When we refer to “paragraph B criteria” or “area[s] of mental functioning” in the introductory text of this body system, we mean the criteria in paragraph B of every listing except 112.05 and 112.14.)
c. Paragraph C of listings 112.02, 112.03, 112.04, 112.06, and 112.15 provides the criteria we use to evaluate “serious and persistent mental disorders.” To satisfy the paragraph C criteria, your mental disorder must be “serious and persistent”; that is, there must be a medically documented history of the existence of the disorder over a period of at least 2 years, and evidence that satisfies the criteria in both C1 and C2 (see 112.00G). (When we refer to “paragraph C” or “the paragraph C criteria” in the introductory text of this body system, we mean the criteria in paragraph C of listings 112.02, 112.03, 112.04, 112.06, and 112.15.)

3. Listing 112.05 has two paragraphs, designated A and B, that apply to only intellectual disorder. Each paragraph requires that you have significantly subaverage general intellectual functioning and significant deficits in current adaptive functioning.

B. Which mental disorders do we evaluate under each listing category for children?

1. Neurocognitive disorders (112.02).
   a. These disorders are characterized in children by a clinically significant deviation in normal cognitive development or by a decline in cognitive functioning. Symptoms and signs may include, but are not limited to, disturbances in memory, executive functioning (that is, higher-level cognitive processes; for example, regulating attention, planning, inhibiting responses, decision-making), visual-spatial functioning, language and speech, perception, insight, and judgment.
   b. Examples of disorders that we evaluate in this category include major neurocognitive disorder; mental impairments resulting from medical conditions such as a metabolic disease (for example, juvenile Tay-Sachs disease), human immunodeficiency virus infection, vascular malformation, progressive brain tumor, or traumatic brain injury; or substance-induced cognitive disorder associated with drugs of abuse, medications, or toxins. (We evaluate neurological disorders under that body system (see 111.00). We evaluate cognitive impairments that result from neurological disorders under 112.02 if they do not satisfy the requirements in 111.00. We evaluate catastrophic genetic disorders under listings in 110.00, 111.00, or 112.00, as appropriate. We evaluate genetic disorders that are not catastrophic under the affected body system(s).)
   c. This category does not include the mental disorders that we evaluate under intellectual disorder (112.05), autism spectrum disorder (112.10), and neurodevelopmental disorders (112.11).

2. Schizophrenia spectrum and other psychotic disorders (112.03).
   a. These disorders are characterized by delusions, hallucinations, disorganized speech, or grossly disorganized or catatonic behavior, causing a clinically significant decline in functioning. Symptoms and signs may include, but are not limited to, inability to initiate and persist in goal-directed activities, social
withdrawal, flat or inappropriate affect, poverty of thought and speech, loss of interest or pleasure, disturbances of mood, odd beliefs and mannerisms, and paranoia.

b. Examples of disorders that we evaluate in this category include schizophrenia, schizoaffective disorder, delusional disorder, and psychotic disorder due to another medical condition.

3. **Depressive, bipolar and related disorders (112.04).**
   a. These disorders are characterized by an irritable, depressed, elevated, or expansive mood, or by a loss of interest or pleasure in all or almost all activities, causing a clinically significant decline in functioning. Symptoms and signs may include, but are not limited to, feelings of hopelessness or guilt, suicidal ideation, a clinically significant change in body weight or appetite, sleep disturbances, an increase or decrease in energy, psychomotor abnormalities, disturbed concentration, pressured speech, grandiosity, reduced impulse control, sadness, euphoria, and social withdrawal. Depending on a child’s age and developmental stage, certain features, such as somatic complaints, irritability, anger, aggression, and social withdrawal may be more commonly present than other features.
   b. Examples of disorders that we evaluate in this category include bipolar disorders (I or II), cyclothymic disorder, disruptive mood dysregulation disorder, major depressive disorder, persistent depressive disorder (dysthymia), and bipolar or depressive disorder due to another medical condition.

4. **Intellectual disorder (112.05).**
   a. This disorder is characterized by significantly subaverage general intellectual functioning and significant deficits in current adaptive functioning. Signs may include, but are not limited to, poor conceptual, social, or practical skills evident in your adaptive functioning.
   b. The disorder that we evaluate in this category may be described in the evidence as intellectual disability, intellectual developmental disorder, or historically used terms such as “mental retardation.”
   c. This category does not include the mental disorders that we evaluate under neurocognitive disorders (112.02), autism spectrum disorder (112.10), or neurodevelopmental disorders (112.11).

5. **Anxiety and obsessive-compulsive disorders (112.06).**
   a. These disorders are characterized by excessive anxiety, worry, apprehension, and fear, or by avoidance of feelings, thoughts, activities, objects, places, or people. Symptoms and signs may include, but are not limited to, restlessness, difficulty concentrating, hyper-vigilance, muscle tension, sleep disturbance, fatigue, panic attacks, obsessions and compulsions, constant thoughts and fears about safety, and frequent physical complaints. Depending on a child’s age and developmental stage, other features may also include refusal to go to school, academic failure, frequent stomachaches and other physical complaints, extreme worries about sleeping away from home, being overly clinging, and exhibiting tantrums at times of separation from caregivers.
b. Examples of disorders that we evaluate in this category include separation anxiety disorder, social anxiety disorder, panic disorder, generalized anxiety disorder, agoraphobia, and obsessive-compulsive disorder.

c. This category does not include the mental disorders that we evaluate under trauma- and stressor-related disorders (112.15).

6. **Somatic symptom and related disorders (112.07).**
   a. These disorders are characterized by physical symptoms or deficits that are not intentionally produced or feigned, and that, following clinical investigation, cannot be fully explained by a general medical condition, another mental disorder, the direct effects of a substance, or a culturally sanctioned behavior or experience. Symptoms and signs may include, but are not limited to, pain and other abnormalities of sensation, gastrointestinal symptoms, fatigue, abnormal motor movement, pseudoseizures, and pseudoneurological symptoms, such as blindness or deafness.
   b. Examples of disorders that we evaluate in this category include somatic symptom disorder and conversion disorder.

7. **Personality and impulse-control disorders (112.08).**
   a. These disorders are characterized by enduring, inflexible, maladaptive, and pervasive patterns of behavior. Onset may occur in childhood but more typically occurs in adolescence or young adulthood. Symptoms and signs may include, but are not limited to, patterns of distrust, suspiciousness, and odd beliefs; social detachment, discomfort, or avoidance; hypersensitivity to negative evaluation; an excessive need to be taken care of; difficulty making independent decisions; a preoccupation with orderliness, perfectionism, and control; and inappropriate, intense, impulsive anger and behavioral expression grossly out of proportion to any external provocation or psychosocial stressors.
   b. Examples of disorders that we evaluate in this category include paranoid, schizoid, schizotypal, borderline, avoidant, dependent, obsessive-compulsive personality disorders, and intermittent explosive disorder.

8. **Autism spectrum disorder (112.10).**
   a. These disorders are characterized by qualitative deficits in the development of reciprocal social interaction, verbal and nonverbal communication skills, and symbolic or imaginative play; restricted repetitive and stereotyped patterns of behavior, interests, and activities; and stagnation of development or loss of acquired skills. Symptoms and signs may include, but are not limited to, abnormalities and unevenness in the development of cognitive skills; unusual responses to sensory stimuli; and behavioral difficulties, including hyperactivity, short attention span, impulsivity, aggressiveness, or self-injurious actions.
   b. Examples of disorders that we evaluate in this category include autism spectrum disorder with or without accompanying intellectual impairment, and autism spectrum disorder with or without accompanying language impairment.
c. This category does not include the mental disorders that we evaluate under neurocognitive disorders (112.02), intellectual disorder (112.05), and neurodevelopmental disorders (112.11).

9. **Neurodevelopmental disorders (112.11).**
   a. These disorders are characterized by onset during the developmental period, that is, during childhood or adolescence, although sometimes they are not diagnosed until adulthood. Symptoms and signs may include, but are not limited to, underlying abnormalities in cognitive processing (for example, deficits in learning and applying verbal or nonverbal information, visual perception, memory, or a combination of these); deficits in attention or impulse control; low frustration tolerance; excessive or poorly planned motor activity; difficulty with organizing (time, space, materials, or tasks); repeated accidental injury; and deficits in social skills. Symptoms and signs specific to tic disorders include sudden, rapid, recurrent, non-rhythmic, motor movement or vocalization.
   b. Examples of disorders that we evaluate in this category include specific learning disorder, borderline intellectual functioning, and tic disorders (such as Tourette syndrome).
   c. This category does not include the mental disorders that we evaluate under neurocognitive disorders (112.02), autism spectrum disorder (112.10), or personality and impulse-control disorders (112.08).

10. **Eating disorders (112.13).**
    a. These disorders are characterized in young children by persistent eating of nonnutritive substances or repeated episodes of regurgitation and re-chewing of food, or by persistent failure to consume adequate nutrition by mouth. In adolescence, these disorders are characterized by disturbances in eating behavior and preoccupation with, and excessive self-evaluation of, body weight and shape. Symptoms and signs may include, but are not limited to, failure to make expected weight gains; restriction of energy consumption when compared with individual requirements; recurrent episodes of binge eating or behavior intended to prevent weight gain, such as self-induced vomiting, excessive exercise, or misuse of laxatives; mood disturbances, social withdrawal, or irritability; amenorrhea; dental problems; abnormal laboratory findings; and cardiac abnormalities.
    b. Examples of disorders that we evaluate in this category include anorexia nervosa, bulimia nervosa, binge-eating disorder, and avoidant/restrictive food disorder.

11. **Developmental disorders in infants and toddlers (112.14).**
    a. Developmental disorders are characterized by a delay or deficit in the development of age-appropriate skills, or a loss of previously acquired skills, involving motor planning and control, learning, relating and communicating, and self-regulating.
    b. Examples of disorders that we evaluate in this category include developmental coordination disorder, separation anxiety disorder, autism spectrum disorder, and regulation disorders of sensory processing (difficulties in regulating...
emotions, behaviors, and motor abilities in response to sensory stimulation). Some infants and toddlers may have only a general diagnosis of “developmental delay.”

c. This category does not include eating disorders related to low birth weight and failure to thrive, which we evaluate under that body system (100.00).

12. Trauma- and stressor-related disorders (112.15).

a. These 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 close friend, and the psychological aftermath of clinically significant effects on functioning. Symptoms and signs may include, but are not limited to, distressing memories, dreams, and flashbacks related to the trauma or stressor; avoidant or withdrawn behavior; constriction of play and significant activities; increased frequency of negative emotional states (for example, fear, sadness) or reduced expression of positive emotions (for example, satisfaction, affection); anxiety; irritability; aggression; exaggerated startle response; difficulty concentrating; sleep disturbance; and a loss of previously acquired developmental skills.

b. Examples of disorders that we evaluate in this category include posttraumatic stress disorder, reactive attachment disorder, and other specified trauma- and stressor-related disorders (such as adjustment-like disorders with prolonged duration without prolonged duration of stressor).

c. This category does not include the mental disorders that we evaluate under anxiety and obsessive-compulsive disorders (112.06), and cognitive impairments that result from neurological disorders, such as a traumatic brain injury, which we evaluate under neurocognitive disorders (112.02).

C. What evidence do we need to evaluate your mental disorder?

1. General. We need evidence from an acceptable medical source to establish that you have a medically determinable mental disorder. We also need evidence to assess the severity of your mental disorder and its effects on your ability to function age-appropriately. We will determine the extent and kinds of evidence we need from medical and non-medical sources based on the individual facts about your disorder. For additional evidence requirements for intellectual disorder (112.05), see 112.00H. For our basic rules on evidence, see §§ 416.912, 416.913, and 416.920b of this chapter. For our rules on evaluating opinion evidence, see § 416.927 of this chapter. For our rules on evidence about your symptoms, see § 416.929 of this chapter.

2. Evidence from medical sources. We will consider all relevant medical evidence about your disorder from your physician, psychologist, and other medical sources, which include health care providers such as physician assistants, psychiatric nurse practitioners, licensed clinical social workers, and clinical mental health counselors. Evidence from your medical sources may include:

a. Your reported symptoms.
b. Your developmental, medical, psychiatric, and psychological history.

c. The results of physical or mental status examinations, structured clinical interviews, psychiatric or psychological rating scales, measures of adaptive functioning, or other clinical findings.

d. Developmental assessments, psychological testing, imaging results, or other laboratory findings.

e. Your diagnosis.

f. The type, dosage, and beneficial effects of medications you take.

h. Side effects of medication or other treatment that limit your ability to function.

i. Your clinical course, including changes in your medication, therapy, or other treatment, and the time required for therapeutic effectiveness.

j. Observations and descriptions of how you function during examinations or therapy.

k. Information about sensory, motor, or speech abnormalities, or about your cultural background (for example, language or customs) that may affect an evaluation of your mental disorder.

l. The expected duration of your symptoms and signs and their effects on your ability to function age-appropriately, both currently and in the future.

3. Evidence from you and people who know you. We will consider all relevant evidence about your mental disorder and your daily functioning that we receive from you and from people who know you. If you are too young or unable to describe your symptoms and your functioning, we will ask for a description from the person who is most familiar with you. We will ask about your symptoms, your daily functioning, and your medical treatment. We will ask for information from third parties who can tell us about your mental disorder, but we must have permission to do so. This evidence may include information from your family, caregivers, teachers, other educators, neighbors, clergy, case managers, social workers, shelter staff, or other community support and outreach workers. We will consider whether your statements and the statements from third parties are consistent with the medical and other evidence we have.

4. Evidence from early intervention programs, school, vocational training, work, and work-related programs.

a. Early intervention programs. You may receive services in an Early Intervention Program (EIP) to help you with your developmental needs. If so, we will consider information from your Individualized Family Service Plan (IFSP) and the early intervention specialists who help you.

b. School. You may receive special education or related services at your preschool or school. If so, we will try to obtain information from your school sources when we need it to assess how your mental disorder affects your ability to function. Examples of this information include your Individualized Education Programs (IEPs), your Section 504 plans, comprehensive evaluation reports, school-related therapy progress notes, information from your teachers about how you function in a classroom setting, and information from special educators,
nurses, school psychologists, and occupational, physical, and speech/language therapists about any special education services or accommodations you receive at school.

c. **Vocational training, work, and work-related programs.** You may have recently participated in or may still be participating in vocational training, work-related programs, or work activity. If so, we will try to obtain information from your training program or your employer when we need it to assess how your mental disorder affects your ability to function. Examples of this information include training or work evaluations, modifications to your work duties or work schedule, and any special supports or accommodations you have required or now require in order to work. If you have worked or are working through a community mental health program, sheltered or supported work program, rehabilitation program, or transitional employment program, we will consider the type and degree of support you have received or are receiving in order to work (see 112.00D).

5. **Need for longitudinal evidence.**

   a. **General.** Longitudinal medical evidence can help us learn how you function over time, and help us evaluate any variations in the level of your functioning. We will request longitudinal evidence of your mental disorder when your medical providers have records concerning you and your mental disorder over a period of months or perhaps years (see § 416.912(d) of this chapter).

   b. **Non-medical sources of longitudinal evidence.** Certain situations, such as chronic homelessness, may make it difficult for you to provide longitudinal medical evidence. If you have a severe mental disorder, you will probably have evidence of its effects on your functioning over time, even if you have not had an ongoing relationship with the medical community or are not currently receiving treatment. For example, family members, caregivers, teachers, neighbors, former employers, social workers, case managers, community support staff, outreach workers, or government agencies may be familiar with your mental health history. We will ask for information from third parties who can tell us about your mental disorder, but you must give us permission to do so.

   c. **Absence of longitudinal evidence.** In the absence of longitudinal evidence, we will use current objective medical evidence and all other relevant evidence available to us in your case record to evaluate your mental disorder. If we purchase a consultative examination to document your disorder, the record will include the results of that examination (see § 416.914 of this chapter). We will take into consideration your medical history, symptoms, clinical and laboratory findings, and medical source opinions. If you do not have longitudinal evidence, the current evidence alone may not be sufficient or appropriate to show that you have a disorder that meets the criteria of one of the mental disorders listings. In that case, we will follow the rules in 112.00K.

6. **Evidence of functioning in unfamiliar situations or supportive situations.**
a. **Unfamiliar situations.** We recognize that evidence about your functioning in unfamiliar situations does not necessarily show how you would function on a sustained basis in a school or other age-appropriate setting. In one-time, time-limited, or other unfamiliar situations, you may function differently than you do in familiar situations. In unfamiliar situations, you may appear more, or less, limited than you do on a daily basis and over time.

b. **Supportive situations.** Your ability to function in settings that are highly structured, or that are less demanding or more supportive than settings in which children your age without impairments typically function, does not necessarily demonstrate your ability to function age-appropriately.

c. **Our assessment.** We must assess your ability to function age-appropriately by evaluating all the evidence, such as reports about your functioning from third parties who are familiar with you, with an emphasis on how well you can initiate, sustain, and complete age-appropriate activities despite your impairment(s), compared to other children your age who do not have impairments.

**D. How do we consider psychosocial supports, structured settings, living arrangements, and treatment when we evaluate the functioning of children?**

1. **General.** Psychosocial supports, structured settings, and living arrangements, including assistance from your family or others, may help you by reducing the demands made on you. In addition, treatment you receive may reduce your symptoms and signs and possibly improve your functioning, or may have side effects that limit your functioning. Therefore, when we evaluate the effects of your mental disorder and rate the limitation of your areas of mental functioning, we will consider the kind and extent of supports you receive, the characteristics of any structured setting in which you spend your time (compared to children your age without impairments), and the effects of any treatment. This evidence may come from reports about your functioning from third parties who are familiar with you, and other third-party statements or information. Following are some examples of the supports you may receive:

a. You receive help from family members or other people in ways that children your age without impairments typically do not need in order to function age-appropriately. For example, an aide may accompany you on the school bus to help you control your actions or to monitor you to ensure you do not injure yourself or others.

b. You receive one-on-one assistance in your classes every day; or you have a full-time personal aide who helps you to function in your classroom; or you are a student in a self-contained classroom; or you attend a separate or alternative school where you receive special education services.

c. You participate in a special education or vocational training program, or a psychosocial rehabilitation day treatment or community support program, where you receive training in daily living and entry-level work skills.
d. You participate in a sheltered, supported, or transitional work program, or in a competitive employment setting with the help of a job coach or supervisor.

e. You receive comprehensive “24/7 wrap-around” mental health services while living in a group home or transitional housing, while participating in a semi-independent living program, or while living at home.

f. You live in a residential school, hospital, or other institution with 24-hour care.

g. You receive assistance from a crisis response team, social workers, or community mental health workers who help you meet your physical needs, and who may also represent you in dealings with government or community social services.

2. How we consider different levels of support and structure in psychosocial rehabilitation programs.

a. Psychosocial rehabilitation programs are based on your specific needs. Therefore, we cannot make any assumptions about your mental disorder based solely on the fact that you are associated with such a program. We must know the details of the program(s) in which you are involved and the pattern(s) of your involvement over time.

b. The kinds and levels of supports and structures in psychosocial rehabilitation programs typically occur on a scale of “most restrictive” to “least restrictive.” Participation in a psychosocial rehabilitation program at the most restrictive level would suggest greater limitation of your areas of mental functioning than would participation at a less restrictive level. The length of time you spend at different levels in a program also provides information about your functioning. For example, you could begin participation at the most restrictive crisis intervention level but gradually improve to the point of readiness for a lesser level of support and structure and, if you are an older adolescent, possibly some form of employment.

3. How we consider the help or support you receive.

a. We will consider the complete picture of your daily functioning, including the kinds, extent, and frequency of help and support you receive, when we evaluate your mental disorder and determine whether you are able to use the four areas of mental functioning age-appropriately. The fact that you have done, or currently do, some routine activities without help or support does not necessarily mean that you do not have a mental disorder or that you are not disabled. For example, you may be able to take age-appropriate care of your personal needs, or you may be old enough and able to cook, shop, and take public transportation. You may demonstrate both strengths and deficits in your daily functioning.

b. You may receive various kinds of help and support from others that enable you to do many things that, because of your mental disorder, you might not be able to do independently. Your daily functioning may depend on the special contexts in which you function. For example, you may spend your time among only familiar people or surroundings, in a simple and steady routine or an unchanging
environment, or in a highly structured classroom or alternative school. However, this does not necessarily show whether you would function age-appropriately without those supports or contexts. (See 112.00H for further discussion of these issues regarding significant deficits in adaptive functioning for the purpose of 112.05.)

4. **How we consider treatment.** We will consider the effect of any treatment on your functioning when we evaluate your mental disorder. Treatment may include medication(s), psychotherapy, or other forms of intervention, which you receive in a doctor’s office, during a hospitalization, or in a day program at a hospital or outpatient treatment program. With treatment, you may not only have your symptoms and signs reduced, but may also be able to function age-appropriately. However, treatment may not resolve all of the limitations that result from your mental disorder, and the medications you take or other treatment you receive for your disorder may cause side effects that limit your mental or physical functioning. For example, you may experience drowsiness, blunted affect, memory loss, or abnormal involuntary movements.

**E. What are the paragraph B criteria for children age 3 to the attainment of age 18?**

1. **Understand, remember, or apply information (paragraph B1).** This area of mental functioning refers to the abilities to learn, recall, and use information to perform age-appropriate activities. Examples include: understanding and learning terms, instructions, procedures; following one- or two-step oral instructions to carry out a task; describing an activity to someone else; asking and answering questions and providing explanations; recognizing a mistake and correcting it; identifying and solving problems; sequencing multi-step activities; and using reason and judgment to make decisions. These examples illustrate the nature of the area of mental functioning. We do not require documentation of all of the examples. How you manifest this area of mental functioning and your limitations in using it depends, in part, on your age.

2. **Interact with others (paragraph B2).** This area of mental functioning refers to the abilities to relate to others age-appropriately at home, at school, and in the community. Examples include: engaging in interactive play; cooperating with others; asking for help when needed; initiating and maintaining friendships; handling conflicts with others; stating own point of view; initiating or sustaining conversation; understanding and responding to social cues (physical, verbal, emotional); responding to requests, suggestions, criticism, correction, and challenges; and keeping social interactions free of excessive irritability, sensitivity, argumentativeness, or suspiciousness. These examples illustrate the nature of this area of mental functioning. We do not require documentation of all of the examples. How you manifest this area of mental functioning and your limitations in using it depends, in part, on your age.

3. **Concentrate, persist, or maintain pace (paragraph B3).** This area of mental functioning refers to the abilities to focus attention on activities and stay on task age-
appropriately. Examples include: initiating and performing an activity that you understand and know how to do; engaging in an activity at home or in school at an appropriate and consistent pace; completing tasks in a timely manner; ignoring or avoiding distractions while engaged in an activity or task; changing activities without being disruptive; engaging in an activity or task close to or with others without interrupting or distracting them; sustaining an ordinary routine and regular attendance at school; and engaging in activities at home, school, or in the community without needing an unusual amount of rest. These examples illustrate the nature of this area of mental functioning. We do not require documentation of all of the examples. How you manifest this area of mental functioning and your limitations in using it depends, in part, on your age.

4. Adapt or manage oneself (paragraph B4). This area of mental functioning refers to the abilities to regulate emotions, control behavior, and maintain well-being in age-appropriate activities and settings. Examples include: responding to demands; adapting to changes; managing your psychologically based symptoms; distinguishing between acceptable and unacceptable performance in community- or school-related activities; setting goals; making plans independently of others; maintaining personal hygiene; and protecting yourself from harm and exploitation by others. These examples illustrate the nature of this area of mental functioning. We do not require documentation of all of the examples. How you manifest this area of mental functioning and your limitations in using it depends, in part, on your age.

F. How do we use the paragraph B criteria to evaluate mental disorders in children?

1. General. We use the paragraph B criteria to rate the degree of your limitations. We consider only the limitations that result from your mental disorder(s). We will determine whether you are able to use each of the paragraph B areas of mental functioning in age-appropriate activities in a manner comparable to that of other children your age who do not have impairments. We will consider, for example, the range of your activities and whether they are age-appropriate; how well you can initiate, sustain, and complete your activities; the kinds and frequency of help or supervision you receive; and the kinds of structured or supportive settings you need in order to function age-appropriately (see 112.00D).

2. Degrees of limitation. We evaluate the effects of your mental disorder on each of the four areas of mental functioning. To satisfy the paragraph B criteria, your mental disorder must result in extreme limitation of one, or marked limitation of two, paragraph B areas of mental functioning. See §§ 416.925(b)(2)(ii) and 416.926a(e) of this chapter for the definitions of the terms marked and extreme as they apply to children.

3. Rating the limitations of your areas of mental functioning.
   a. General. We use all of the relevant medical and non-medical evidence in your case record to evaluate your mental disorder: the symptoms and signs of your disorder, the reported limitations in your activities, and any help and support
you receive that is necessary for you to function. The medical evidence may include descriptors regarding the diagnostic stage or level of your disorder, such as “mild” or “moderate.” Clinicians may use these terms to characterize your medical condition. However, these terms will not always be the same as the degree of your limitation in a paragraph B area of mental functioning.

b. **Areas of mental functioning in daily activities.** You use the same four areas of mental functioning in daily activities at home, at school, and in the community. With respect to a particular task or activity, you may have trouble using one or more of the areas. For example, you may have difficulty understanding and remembering what to do; or concentrating and staying on task long enough to do it; or engaging in the task or activity with other people; or trying to do the task without becoming frustrated and losing self-control. Information about your daily functioning in your activities at home, at school, or in your community can help us understand whether your mental disorder limits one or more of these areas; and, if so, whether it also affects your ability to function age-appropriately.

c. **Overall effect of limitations.** Limitation of an area of mental functioning reflects the overall degree to which your mental disorder interferes with that area. The degree of limitation does not necessarily reflect a specific type or number of activities, including activities of daily living, that you have difficulty doing. In addition, no single piece of information (including test results) can establish whether you have extreme or marked limitation of an area of mental functioning.

d. **Effects of support, supervision, structure on functioning.** The degree of limitation of an area of mental functioning also reflects the kind and extent of supports or supervision you receive (beyond what other children your age without impairments typically receive) and the characteristics of any structured setting where you spend your time, which enable you to function. The more extensive the support you need from others (beyond what is age-appropriate) or the more structured the setting you need in order to function, the more limited we will find you to be (see 112.00D).

e. **Specific instructions for paragraphs B1, B3, and B4.** For paragraphs B1, B3, and B4, the greatest degree of limitation of any part of the area of mental functioning directs the rating of limitation of that whole area of mental functioning.

i. To do an age-appropriate activity, you must be able to understand and remember and apply information required by the activity. Similarly, you must be able to concentrate and persist and maintain pace in order to complete the activity, and adapt and manage yourself age-appropriately. Limitation in any one of these parts (understand or remember or apply; concentrate or persist or maintain pace; adapt or manage oneself) may prevent you from completing age-appropriate activities.

ii. We will document the rating of limitation of the whole area of mental functioning, not each individual part. We will not add ratings of the parts
together. For example, with respect to paragraph B3, if you have marked limitation in concentrating, but your limitations in persisting and maintaining pace do not rise to a marked level, we will find that you have marked limitation in the whole paragraph B3 area of mental functioning.

iii. Marked limitation in more than one part of the same paragraph B area of mental functioning does not satisfy the requirement to have marked limitation in two paragraph B areas of mental functioning.

4. How we evaluate mental disorders involving exacerbations and remissions.
   a. When we evaluate the effects of your mental disorder, we will consider how often you have exacerbations and remissions, how long they last, what causes your mental disorder to worsen or improve, and any other relevant information. We will assess whether your mental impairment(s) causes marked or extreme limitation of the affected paragraph B area(s) of mental functioning (see 112.00F2). We will consider whether you can use the area of mental functioning age-appropriately on a sustained basis. We will not find that you function age-appropriately solely because you have a period(s) of improvement (remission), or that you are disabled solely because you have a period of worsening (exacerbation), of your mental disorder.
   b. If you have a mental disorder involving exacerbations and remissions, you may be able to use the four areas of mental functioning at home, at school, or in the community for a few weeks or months. Recurrence or worsening of symptoms and signs, however, can interfere enough to render you unable to function age-appropriately.

G. What are the paragraph C criteria, and how do we use them to evaluate mental disorders in children age 3 to the attainment of age 18?

1. General. The paragraph C criteria are an alternative to the paragraph B criteria under listings 112.02, 112.03, 112.04, 112.06, and 112.15. We use the paragraph C criteria to evaluate mental disorders that are “serious and persistent.” In the paragraph C criteria, we recognize that mental health interventions may control the more obvious symptoms and signs of your mental disorder.

2. Paragraph C criteria.
   a. We find a mental disorder to be “serious and persistent” when there is a medically documented history of the existence of the mental disorder in the listing category over a period of at least 2 years, and evidence shows that your disorder satisfies both C1 and C2.
   b. The criterion in C1 is satisfied when the evidence shows that you rely, on an ongoing basis, upon medical treatment, mental health therapy, psychosocial support(s), or a highly structured setting(s), to diminish the symptoms and signs of your mental disorder (see 112.00D). We consider that you receive ongoing medical treatment when the medical evidence establishes that you obtain medical treatment with a frequency consistent with accepted medical practice for the
type of treatment or evaluation required for your medical condition. We will consider periods of inconsistent treatment or lack of compliance with treatment that may result from your mental disorder. If the evidence indicates that the inconsistent treatment or lack of compliance is a feature of your mental disorder, and it has led to an exacerbation of your symptoms and signs, we will not use it as evidence to support a finding that you have not received ongoing medical treatment as required by this paragraph.

c. The criterion in C2 is satisfied when the evidence shows that, despite your diminished symptoms and signs, you have achieved only marginal adjustment. “Marginal adjustment” means that your adaptation to the requirements of daily life is fragile; that is, you have minimal capacity to adapt to changes in your environment or to demands that are not already part of your daily life. We will consider that you have achieved only marginal adjustment when the evidence shows that changes or increased demands have led to exacerbation of your symptoms and signs and to deterioration in your functioning; for example, you have become unable to function outside of your home or a more restrictive setting, without substantial psychosocial supports (see 112.00D). Such deterioration may have necessitated a significant change in medication or other treatment. Similarly, because of the nature of your mental disorder, evidence may document episodes of deterioration that have required you to be hospitalized or absent from school, making it difficult for you to sustain age-appropriate activity over time.

H. How do we document and evaluate intellectual disorder under 112.05?

1. General. Listing 112.05 is based on the two elements that characterize intellectual disorder for children up to age 18: significantly subaverage general intellectual functioning and significant deficits in current adaptive functioning.

2. Establishing significantly subaverage general intellectual functioning.
   a. Definition. Intellectual functioning refers to the general mental capacity to learn, reason, plan, solve problems, and perform other cognitive functions. Under 112.05A, we identify significantly subaverage general intellectual functioning by the cognitive inability to function at a level required to participate in standardized intelligence testing. Our findings under 112.05A are based on evidence from an acceptable medical source. Under 112.05B, we identify significantly subaverage general intellectual functioning by an IQ score(s) on an individually administered standardized test of general intelligence that meets program requirements and has a mean of 100 and a standard deviation of 15. A qualified specialist (see 112.00H2c) must administer the standardized intelligence testing.
   
b. Psychometric standards. We will find standardized intelligence test results usable for the purposes of 112.05B1 when the measure employed meets contemporary psychometric standards for validity, reliability, normative data, and scope of
measurement; and a qualified specialist has individually administered the test according to all pre-requisite testing conditions.

c. **Qualified specialist.** A “qualified specialist” is currently licensed or certified at the independent level of practice in the State where the test was performed, and has the training and experience to administer, score, and interpret intelligence tests. If a psychological assistant or paraprofessional administered the test, a supervisory qualified specialist must interpret the test findings and co-sign the examination report.

d. **Responsibility for conclusions based on testing.** We generally presume that your obtained IQ score(s) is an accurate reflection of your general intellectual functioning, unless evidence in the record suggests otherwise. Examples of this evidence include: a statement from the test administrator indicating that your obtained score is not an accurate reflection of your general intellectual functioning, prior or internally inconsistent IQ scores, or information about your daily functioning. Only qualified specialists, Federal and State agency medical and psychological consultants, and other contracted medical and psychological experts may conclude that your obtained IQ score(s) is not an accurate reflection of your general intellectual functioning. This conclusion must be well supported by appropriate clinical and laboratory diagnostic techniques and must be based on relevant evidence in the case record, such as:

i. The data obtained in testing;

ii. Your developmental history, including when your signs and symptoms began;

iii. Information about how you function on a daily basis in a variety of settings; and

iv. Clinical observations made during the testing period, such as your ability to sustain attention, concentration, and effort; to relate appropriately to the examiner; and to perform tasks independently without prompts or reminders.

3. **Establishing significant deficits in adaptive functioning.**

a. **Definition.** Adaptive functioning refers to how you learn and use conceptual, social, and practical skills in dealing with common life demands. It is your typical functioning at home, at school, and in the community, alone or among others. Under 112.05A, we identify significant deficits in adaptive functioning based on your dependence on others to care for your personal needs, such as eating and bathing (grossly in excess of age-appropriate dependence). We will base our conclusions about your adaptive functioning on evidence from a variety of sources (see 112.00H3b) and not on your statements alone. Under 112.05B2, we identify significant deficits in adaptive functioning based on whether there is extreme limitation of one, or marked limitation of two, of the paragraph B criteria (see 112.00E; 112.00F).

b. **Evidence.** Evidence about your adaptive functioning may come from:

i. Medical sources, including their clinical observations;
ii. Standardized tests of adaptive functioning (see 112.00H3c);
iii. Third party information, such as a report of your functioning from a
     family member or your caregiver;
iv. School records;
v. A teacher questionnaire;
vi. Reports from employers or supervisors; and
vii. Your own statements about how you handle all of your daily activities.

c. Standardized tests of adaptive functioning. We do not require the results of an
   individually administered standardized test of adaptive functioning. If your case
   record includes these test results, we will consider the results along with all
   other relevant evidence; however, we will use the guidelines in 112.00E and F to
   evaluate and determine the degree of your deficits in adaptive functioning, as
   required under 112.05B2.

d. Standardized developmental assessments. We do not require the results of
   standardized developmental assessments, which compare your level of
   development to the level typically expected for your chronological age. If your
   case record includes test results, we will consider the results along with all other
   relevant evidence. However, we will use the guidelines in 112.00E and F to
   evaluate and determine the degree of your deficits in adaptive functioning, as
   required under 112.05B2.

e. How we consider common everyday activities.
   i. The fact that you engage in common everyday activities, such as caring
      for your personal needs, preparing simple meals, or driving a car, will not
      always mean that you do not have deficits in adaptive functioning as
      required by 112.05B2. You may demonstrate both strengths and deficits
      in your adaptive functioning. However, a lack of deficits in one area does
      not negate the presence of deficits in another area. When we assess
      your adaptive functioning, we will consider all of your activities and your
      performance of them.
   ii. Our conclusions about your adaptive functioning rest on the quality of
       your daily activities and whether you do them age-appropriately. If you
       receive help in performing your activities, we need to know the kind,
       extent, and frequency of help you receive in order to perform them. We
       will not assume that your ability to do some common everyday activities,
       or to do some things without help or support, demonstrates that your
       mental disorder does not meet the requirements of 112.05B2. (See
       112.00D regarding the factors we consider when we evaluate your
       functioning, including how we consider any help or support you receive.)

f. How we consider work activity. The fact that you have engaged in work activity, or
   that you work intermittently or steadily in a job commensurate with your
   abilities, will not always mean that you do not have deficits in adaptive
   functioning as required by 112.05B2. When you have engaged in work activity,
   we need complete information about the work, and about your functioning in
the work activity and work setting, before we reach any conclusions about your adaptive functioning. We will consider all factors involved in your work history before concluding whether your impairment satisfies the criteria for intellectual disorder under 112.05B. We will consider your prior and current work history, if any, and various other factors influencing how you function. For example, we consider whether the work was in a supported setting, whether you required more supervision than other employees, how your job duties compared to others in the same job, how much time it took you to learn the job duties, and the reason the work ended, if applicable.

I. What additional considerations do we use to evaluate developmental disorders of infants and toddlers?

1. **General.** We evaluate developmental disorders from birth to attainment of age 3 under 112.14. We evaluate your ability to acquire and maintain the motor, cognitive, social/communicative, and emotional skills that you need to function age-appropriately. When we rate your impairment-related limitations for this listing (see §§ 416.925(b)(2)(ii) and 416.926a(e) of this chapter), we consider only limitations you have because of your developmental disorder. If you have a chronic illness or physical abnormality(ies), we will evaluate it under the affected body system, for example, the cardiovascular or musculoskeletal system.

2. **Age and typical development in early childhood.**
   a. **Prematurity and age.** If you were born prematurely, we will use your corrected chronological age (CCA) for comparison. CCA is your chronological age adjusted by a period of gestational prematurity. CCA = (chronological age) – (number of weeks premature). If you have not attained age 1, we will correct your chronological age, using the same formula. If you are over age 1, we will decide whether to correct your chronological age, based on our judgment and all the facts of your case (see § 416.924b(b) of this chapter).
   b. **Developmental assessment.** We will use the results from a standardized developmental assessment to compare your level of development with that typically expected for your chronological age. When there are no results from a comprehensive standardized developmental assessment in the case record, we need narrative developmental reports from your medical sources in sufficient detail to assess the limitations resulting from your developmental disorder.
   c. **Variation.** When we evaluate your developmental disorder, we will consider the wide variation in the range of normal or typical development in early childhood. At the end of a recognized milestone period, new skills typically begin to emerge. If your new skills begin to emerge later than is typically expected, the timing of their emergence may or may not indicate that you have a developmental delay or deficit that can be expected to last for 1 year.

3. **Evidence.**
a. **Standardized developmental assessments.** We use standardized test reports from acceptable medical sources or from early intervention specialists, physical or occupational therapists, and other qualified professionals. Only the qualified professional who administers the test, Federal and State agency medical and psychological consultants, and other contracted medical and psychological experts may conclude that the assessment results are not an accurate reflection of your development. This conclusion must be well supported by appropriate clinical and laboratory diagnostic techniques and must be based on relevant evidence in the case record. If the assessment results are not an accurate reflection of your development, we may purchase a new developmental assessment. If the developmental assessment is inconsistent with other information in your case record, we will follow the guidelines in § 416.920b of this chapter.

b. **Narrative developmental reports.** A narrative developmental report is based on clinical observations, progress notes, and well-baby check-ups, and includes your developmental history, examination findings (with abnormal findings noted on repeated examinations), and an overall assessment of your development (that is, more than one or two isolated skills) by the medical source. Although medical sources may refer to screening test results as supporting evidence in the narrative developmental report, screening test results alone cannot establish a diagnosis or the severity of developmental disorder.

4. **What are the paragraph B criteria for 112.14?**
   a. **General.** The paragraph B criteria for 112.14 are slightly different from the paragraph B criteria for the other listings. They are the developmental abilities that infants and toddlers use to acquire and maintain the skills needed to function age-appropriately. An infant or toddler is expected to use his or her developmental abilities to achieve a recognized pattern of milestones, over a typical range of time, in order to acquire and maintain the skills needed to function age-appropriately. We will find that your developmental disorder satisfies the requirements of 112.14 if it results in extreme limitation of one, or marked limitation of two, of the 112.14 paragraph B criteria. (See §§ 416.925(b)(2)(ii) and 416.926a(e) of this chapter for the definitions of the terms marked and extreme as they apply to children.)
   
   b. **Definitions of the 112.14 paragraph B developmental abilities.**
      i. **Ability to plan and control motor movement.** This criterion refers to the developmental ability to plan, remember, and execute controlled motor movements by integrating and coordinating perceptual and sensory input with motor output. Using this ability develops gross and fine motor skills, and makes it possible for you to engage in age-appropriate symmetrical or alternating motor activities. You use this ability when, for example, you grasp and hold objects with one or both hands, pull yourself up to stand, walk without holding on, and go up and down stairs with alternating feet. These examples illustrate the nature of the
developmental ability. We do not require documentation of all of the examples. How you manifest this developmental ability and your limitations in using it depends, in part, on your age.

ii. **Ability to learn and remember.** This criterion refers to the developmental ability to learn by exploring the environment, engaging in trial-and-error experimentation, putting things in groups, understanding that words represent things, and participating in pretend play. Using this ability develops the skills that help you understand what things mean, how things work, and how you can make things happen. You use this ability when, for example, you show interest in objects that are new to you, imitate simple actions, name body parts, understand simple cause-and-effect relationships, remember simple directions, or figure out how to take something apart. These examples illustrate the nature of the developmental ability. We do not require documentation of all of the examples. How you manifest this developmental ability and your limitations in using it depends, in part, on your age.

iii. **Ability to interact with others.** This criterion refers to the developmental ability to participate in reciprocal social interactions and relationships by communicating your feelings and intents through vocal and visual signals and exchanges; physical gestures and contact; shared attention and affection; verbal turn taking; and understanding and sending increasingly complex messages. Using this ability develops the social skills that make it possible for you to influence others (for example, by gesturing for a toy or saying “no” to stop an action); invite someone to interact with you (for example, by smiling or reaching); and draw someone’s attention to what interests you (for example, by pointing or taking your caregiver’s hand and leading that person). You use this ability when, for example, you use vocalizations to initiate and sustain a “conversation” with your caregiver; respond to limits set by an adult with words, gestures, or facial expressions; play alongside another child; or participate in simple group activities with adult help. These examples illustrate the nature of the developmental ability. We do not require documentation of all of the examples. How you manifest this developmental ability and your limitations in using it depends, in part, on your age.

iv. **Ability to regulate physiological functions, attention, emotion, and behavior.** This criterion refers to the developmental ability to stabilize biological rhythms (for example, by developing an age-appropriate sleep/wake cycle); control physiological functions (for example, by achieving regular patterns of feeding); and attend, react, and adapt to environmental stimuli, persons, objects, and events (for example, by becoming alert to things happening around you and in relation to you, and responding without overreacting or underreacting). Using this ability develops the skills you need to regulate yourself and makes it possible for
you to achieve and maintain a calm, alert, and organized physical and emotional state. You use this ability when, for example, you recognize your body’s needs for food or sleep, focus quickly and pay attention to things that interest you, cry when you are hurt but become quiet when your caregiver holds you, comfort yourself with your favorite toy when you are upset, ask for help when something frustrates you, or refuse help from your caregiver when trying to do something for yourself. These examples illustrate the nature of the developmental ability. We do not require documentation of all of the examples. How you manifest this developmental ability and your limitations in using it depends, in part, on your age.

5. **Deferral of determination.**
   a. **Full-term infants.** In the first few months of life, full-term infants typically display some irregularities in observable behaviors (for example, sleep cycles, feeding, responding to stimuli, attending to faces, self-calming), making it difficult to assess the presence, extent, and duration of a developmental disorder. When the evidence indicates that you may have a significant developmental delay, but there is insufficient evidence to make a determination, we will defer making a disability determination under 112.14 until you are at least 6 months old. This deferral will allow us to obtain a longitudinal medical history so that we can more accurately evaluate your developmental patterns and functioning over time. In most cases, when you are at least 6 months old, any developmental delay you may have can be better assessed, and you can undergo standardized developmental testing, if indicated.
   b. **Premature infants.** When the evidence indicates that you may have a significant developmental delay, but there is insufficient evidence to make a determination, we will defer your case until you attain a CCA (see 112.00I2a) of at least 6 months in order to better evaluate your developmental delay.
   c. **When we will not defer a determination.** We will not defer our determination if we have sufficient evidence to determine that you are disabled under 112.14 or any other listing, or that you have an impairment or combination of impairments that functionally equalsthe listings. In addition, we will not defer our determination if the evidence demonstrates that you are not disabled.

**J. How do we evaluate substance use disorders?** If we find that you are disabled and there is medical evidence in your case record establishing that you have a substance use disorder, we will determine whether your substance use disorder is a contributing factor material to the determination of disability (see § 416.935 of this chapter).

**K. How do we evaluate mental disorders that do not meet one of the mental disorders listings?**
1. These listings include only examples of mental disorders that we consider serious enough to result in marked and severe functional limitations. If your severe mental disorder does not meet the criteria of any of these listings, we will consider whether you have an impairment(s) that meets the criteria of a listing in another body system. You may have another impairment(s) that is secondary to your mental disorder. For example, if you have an eating disorder and develop a cardiovascular impairment because of it, we will evaluate your cardiovascular impairment under the listings for the cardiovascular body system.

2. If you have a severe medically determinable impairment(s) that does not meet a listing, we will determine whether your impairment(s) medically equals a listing (see § 416.926 of this chapter).

3. If your impairment(s) does not meet or medically equal a listing, we will consider whether you have an impairment(s) that functionally equals the listings (see § 416.926a of this chapter).

4. Although we present these alternatives in a specific sequence above, each represents listing-level severity, and we can evaluate your claim in any order. For example, if the factors of your case indicate that the combination of your impairments may functionally equal the listings, we may start with that analysis. We use the rules in § 416.994a of this chapter, as appropriate, when we decide whether you continue to be disabled.

112.01 Category of Impairments, Mental Disorders

112.02 Neurocognitive disorders (see 112.00B1), for children age 3 to attainment of age 18, satisfied by A and B, or A and C:

A. Medical documentation of a clinically significant deviation in normal cognitive development or by significant cognitive decline from a prior level of functioning in one or more of the cognitive areas:
   1. Complex attention;
   2. Executive function;
   3. Learning and memory;
   4. Language;
   5. Perceptual-motor; or

AND

B. B. Extreme limitation of one, or marked limitation of two, of the following areas of mental functioning (see 112.00F):
   1. Understand, remember, or apply information (see 112.00E1).
   2. Interact with others (see 112.00E2).
   3. Concentrate, persist, or maintain pace (see 112.00E3).
   4. Adapt or manage oneself (see 112.00E4).
OR

C. Your mental disorder in this listing category is “serious and persistent;” that is, you have a medically documented history of the existence of the disorder over a period of at least 2 years, and there is evidence of both:
   1. Medical treatment, mental health therapy, psychosocial support(s), or a highly structured setting(s) that is ongoing and that diminishes the symptoms and signs of your mental disorder (see 112.00G2b); and
   2. Marginal adjustment, that is, you have minimal capacity to adapt to changes in your environment or to demands that are not already part of your daily life (see 112.00G2c).

I12.03 Schizophrenia spectrum and other psychotic disorders (see 112.00B2), for children age 3 to attainment of age 18, satisfied by A and B, or A and C:

A. Medical documentation of one or more of the following:
   1. Delusions or hallucinations;
   2. Disorganized thinking (speech); or
   3. Grossly disorganized behavior or catatonia.

AND

B. Extreme limitation of one, or marked limitation of two, of the following areas of mental functioning (see 112.00F):
   1. Understand, remember, or apply information (see 112.00E1).
   2. Interact with others (see 112.00E2).
   3. Concentrate, persist, or maintain pace (see 112.00E3).
   4. Adapt or manage oneself (see 112.00E4).

OR

C. Your mental disorder in this listing category is “serious and persistent;” that is, you have a medically documented history of the existence of the disorder over a period of at least 2 years, and there is evidence of both:
   1. Medical treatment, mental health therapy, psychosocial support(s), or a highly structured setting(s) that is ongoing and that diminishes the symptoms and signs of your mental disorder (see 112.00G2b); and
   2. Marginal adjustment, that is, you have minimal capacity to adapt to changes in your environment or to demands that are not already part of your daily life (see 112.00G2c).
112.04 Depressive, bipolar and related disorders (see 112.00B3), for children age 3 to attainment of age 18, satisfied by A and B, or A and C:

A. Medical documentation of the requirements of paragraph 1, 2, or 3:
   1. Depressive disorder, characterized by five or more of the following:
      a. Depressed or irritable mood;
      b. Diminished interest in almost all activities;
      c. Appetite disturbance with change in weight (or a failure to achieve an expected weight gain);
      d. Sleep disturbance;
      e. Observable psychomotor agitation or retardation;
      f. Decreased energy;
      g. Feelings of guilt or worthlessness;
      h. Difficulty concentrating or thinking; or
      i. Thoughts of death or suicide.
   2. Bipolar disorder, characterized by three or more of the following:
      a. Pressured speech;
      b. Flight of ideas;
      c. Inflated self-esteem;
      d. Decreased need for sleep;
      e. Distractibility;
      f. Involvement in activities that have a high probability of painful consequences that are not recognized; or
      g. Increase in goal-directed activity or psychomotor agitation.
   3. Disruptive mood dysregulation disorder, beginning prior to age 10, and all of the following:
      a. Persistent, significant irritability or anger;
      b. Frequent, developmentally inconsistent temper outbursts; and
      c. Frequent aggressive or destructive behavior.

AND

B. Extreme limitation of one, or marked limitation of two, of the following areas of mental functioning (see 112.00F):
   1. Understand, remember, or apply information (see 112.00E1).
   2. Interact with others (see 112.00E2).
   3. Concentrate, persist, or maintain pace (see 112.00E3).
   4. Adapt or manage oneself (see 112.00E4).

OR
C. Your mental disorder in this listing category is “serious and persistent;” that is, you have a medically documented history of the existence of the disorder over a period of at least 2 years, and there is evidence of both:
   1. Medical treatment, mental health therapy, psychosocial support(s), or a highly structured setting(s) that is ongoing and that diminishes the symptoms and signs of your mental disorder (see 112.00G2b); and
   2. Marginal adjustment, that is, you have minimal capacity to adapt to changes in your environment or to demands that are not already part of your daily life (see 112.00G2c).

112.05 Intellectual disorder (see 112.00B4), for children age 3 to attainment of age 18, satisfied by A or B:

A. Satisfied by 1 and 2 (see 112.00H):
   1. Significantly subaverage general intellectual functioning evident in your cognitive inability to function at a level required to participate in standardized testing of intellectual functioning; and
   2. Significant deficits in adaptive functioning currently manifested by your dependence upon others for personal needs (for example, toileting, eating, dressing, or bathing) in excess of age-appropriate dependence.

OR

B. Satisfied by 1 and 2 (see 112.00H):
   1. Significantly subaverage general intellectual functioning evidenced by a or b:
      a. A full scale (or comparable) IQ score of 70 or below on an individually administered standardized test of general intelligence; or
      b. A full scale (or comparable) IQ score of 71-75 accompanied by a verbal or performance IQ score (or comparable part score) of 70 or below on an individually administered standardized test of general intelligence; and
   2. Significant deficits in adaptive functioning currently manifested by extreme limitation of one, or marked limitation of two, of the following areas of mental functioning:
      a. Understand, remember, or apply information (see 112.00E1); or
      b. Interact with others (see 112.00E2); or
      c. Concentrate, persist, or maintain pace (see 112.00E3); or
      d. Adapt or manage oneself (see 112.00E4).

112.06 Anxiety and obsessive-compulsive disorders (see 112.00B5), for children age 3 to attainment of age 18, satisfied by A and B, or A and C:

A. Medical documentation of the requirements of paragraph 1, 2, 3, or 4:
   1. Anxiety disorder, characterized by one or more of the following:
a. Restlessness;
b. Easily fatigued;
c. Difficulty concentrating;
d. Irritability;
e. Muscle tension; or
f. Sleep disturbance.

2. Panic disorder or agoraphobia, characterized by one or both:
   a. Panic attacks followed by a persistent concern or worry about additional
      panic attacks or their consequences; or
   b. Disproportionate fear or anxiety about at least two different situations
      (for example, using public transportation, being in a crowd, being in a line,
      being outside of your home, being in open spaces).

3. Obsessive-compulsive disorder, characterized by one or both:
   a. Involuntary, time-consuming preoccupation with intrusive, unwanted
      thoughts; or;
   b. Repetitive behaviors that appear aimed at reducing anxiety.

4. Excessive fear or anxiety concerning separation from those to whom you are
   attached.

AND

B. Extreme limitation of one, or marked limitation of two, of the following areas
   of mental functioning (see 112.00F):
   1. Understand, remember, or apply information (see 112.00E1).
   2. Interact with others (see 112.00E2).
   3. Concentrate, persist, or maintain pace (see 112.00E3).
   4. Adapt or manage oneself (see 112.00E4).

OR

C. Your mental disorder in this listing category is “serious and persistent;” that is, you have
   a medically documented history of the existence of the disorder over a period of at
   least 2 years, and there is evidence of both:
   1. Medical treatment, mental health therapy, psychosocial support(s), or a highly
      structured setting(s) that is ongoing and that diminishes the symptoms and signs
      of your mental disorder (see 112.00G2b); and
   2. Marginal adjustment, that is, you have minimal capacity to adapt to changes in
      your environment or to demands that are not already part of your daily life (see
      112.00G2c).

I12.07 Somatic symptom and related disorders (see I12.00B6), for children
age 3 to attainment of age 18, satisfied by A and B:
A. Medical documentation of one or both of the following:
   1. Symptoms of altered voluntary motor or sensory function that are not better explained by another medical or mental disorder; or
   2. One or more somatic symptoms that are distressing, with excessive thoughts, feelings, or behaviors related to the symptoms.

AND

B. Extreme limitation of one, or marked limitation of two, of the following areas of mental functioning (see 112.00F):
   1. Understand, remember, or apply information (see 112.00E1).
   2. Interact with others (see 112.00E2).
   3. Concentrate, persist, or maintain pace (see 112.00E3).
   4. Adapt or manage oneself (see 112.00E4).

112.08 Personality and impulse-control disorders (see 112.00B7), for children age 3 to attainment of age 18, satisfied by A and B:

A. Medical documentation of a pervasive pattern of one or more of the following:
   1. Distrust and suspiciousness of others;
   2. Detachment from social relationships;
   3. Disregard for and violation of the rights of others;
   4. Instability of interpersonal relationships;
   5. Excessive emotionality and attention seeking;
   6. Feelings of inadequacy;
   7. Excessive need to be taken care of;
   8. Preoccupation with perfectionism and orderliness; or
   9. Recurrent, impulsive, aggressive behavioral outbursts.

AND

B. Extreme limitation of one, or marked limitation of two, of the following areas of mental functioning (see 112.00F):
   1. Understand, remember, or apply information (see 112.00E1).
   2. Interact with others (see 112.00E2).
   3. Concentrate, persist, or maintain pace (see 112.00E3).
   4. Adapt or manage oneself (see 112.00E4).

112.09 [Reserved]

112.10 Autism spectrum disorder (see 112.00B8), for children age 3 to attainment of age 18, satisfied by A and B:
A. Medical documentation of both of the following:
   1. Qualitative deficits in verbal communication, nonverbal communication, and social interaction; and
   2. Significantly restricted, repetitive patterns of behavior, interests, or activities.

AND

B. Extreme limitation of one, or marked limitation of two, of the following areas of mental functioning (see 112.00F):
   1. Understand, remember, or apply information (see 112.00E1).
   2. Interact with others (see 112.00E2).
   3. Concentrate, persist, or maintain pace (see 112.00E3).
   4. Adapt or manage oneself (see 112.00E4).

112.11 Neurodevelopmental disorders (see 112.00B9), for children age 3 to attainment of age 18, satisfied by A and B:

A. Medical documentation of the requirements of paragraph 1, 2, or 3:
   1. One or both of the following:
      a. Frequent distractibility, difficulty sustaining attention, and difficulty organizing tasks; or
      b. Hyperactive and impulsive behavior (for example, difficulty remaining seated, talking excessively, difficulty waiting, appearing restless, or behaving as if being “driven by a motor”).
   2. Significant difficulties learning and using academic skills; or
   3. Recurrent motor movement or vocalization.

AND

B. Extreme limitation of one, or marked limitation of two, of the following areas of mental functioning (see 112.00F):
   1. Understand, remember, or apply information (see 112.00E1).
   2. Interact with others (see 112.00E2).
   3. Concentrate, persist, or maintain pace (see 112.00E3).
   4. Adapt or manage oneself (see 112.00E4).

112.12 [Reserved]

112.13 Eating disorders (see 112.00B10), for children age 3 to attainment of age 18, satisfied by A and B:
A. Medical documentation of a persistent alteration in eating or eating-related behavior that results in a change in consumption or absorption of food and that significantly impairs physical or psychological health.

AND

B. Extreme limitation of one, or marked limitation of two, of the following areas of mental functioning (see 112.00F):
   1. Understand, remember, or apply information (see 112.00E1).
   2. Interact with others (see 112.00E2).
   3. Concentrate, persist, or maintain pace (see 112.00E3).
   4. Adapt or manage oneself (see 112.00E4).

112.14 Developmental disorders in infants and toddlers (see 112.00B11, 112.00I), satisfied by A and B:

A. Medical documentation of one or both of the following:
   1. A delay or deficit in the development of age-appropriate skills; or
   2. A loss of previously acquired skills.

AND

B. Extreme limitation of one, or marked limitation of two, of the following developmental abilities (see 112.00F):
   1. Plan and control motor movement (see 112.00I4b(i)).
   2. Learn and remember (see 112.00I4b(ii)).
   3. Interact with others (see 112.00I4b(iii)).
   4. Regulate physiological functions, attention, emotion, and behavior (see 112.00I4b(iv)).

112.15 Trauma- and stressor-related disorders (see 112.00B11), for children age 3 to attainment of age 18, satisfied by A and B, or A and C:

A. Medical documentation of the requirements of paragraph 1 or 2:
   1. Posttraumatic stress disorder, characterized by all of the following:
      a. Exposure to actual or threatened death, serious injury, or violence;
      b. Subsequent involuntary re-experiencing of the traumatic event (for example, intrusive memories, dreams, or flashbacks);
      c. Avoidance of external reminders of the event;
      d. Disturbance in mood and behavior (for example, developmental regression, socially withdrawn behavior); and
      e. Increases in arousal and reactivity (for example, exaggerated startle response, sleep disturbance).
2. Reactive attachment disorder, characterized by **two** or all of the following:
   a. Rarely seeks comfort when distressed;
   b. Rarely responds to comfort when distressed; or
   c. Episodes of unexplained emotional distress.

AND

B. Extreme limitation of one, or marked limitation of two, of the following areas of mental functioning (see 112.00F):
   1. Understand, remember, or apply information (see 112.00E1).
   2. Interact with others (see 112.00E2).
   3. Concentrate, persist, or maintain pace (see 112.00E3).
   4. Adapt or manage oneself (see 112.00E4).

OR

C. Your mental disorder in this listing category is “serious and persistent;” that is, you have a medically documented history of the existence of the disorder over a period of at least 2 years, and there is evidence of both:
   1. Medical treatment, mental health therapy, psychosocial support(s), or a highly structured setting(s) that is ongoing and that diminishes the symptoms and signs of your mental disorder (see 112.00G2b); and
   2. Marginal adjustment, that is, you have minimal capacity to adapt to changes in your environment or to demands that are not already part of your daily life (see 112.00G2c).
How to Use Supplemental Doctor Reports to Try a Social Security Case

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HOW TO USE SUPPLEMENTAL DOCTOR REPORTS
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HOW TO USE SUPPLEMENTAL DOCTOR REPORTS TO TRY A SOCIAL SECURITY CASE AND SIMULTANEOUSLY AVOID SHOOTING THE CLIENT IN THE FOOT

INTRODUCTION

In thinking about this topic and how to formulate something that will be worthwhile and meaningful to our peers, one over-riding observation that came to our minds is this. As we grow and evolve in our practices and develop our understandings of what the word “disabled” means in the context of Social Security, we develop our own understandings of the word. As we tackle any potential case or actual case, we have an equation in our minds. We take what we know about an individual (the age, education, work history, documented and undocumented medical problems) – and we start adding all the variables to see if the equation equals disabled or not disabled.

And when it is known, we think about the particular ALJ and what we know about that individual. We consider what the ALJ’s own equation will be. Is he or she reasonable, straightforward, and someone you trust to weigh the medical and other evidence fairly and make the best decision possible? Or, is he or she one of those persons who seems to rely on independent thinking and disregard the weight of the evidence and most of the rules, regulations, and statutes? Or, is the ALJ somewhere in between?

Our point is simple. We all approach every case with what we know and understand. As the representatives of claimants, we rightly assess each case by the sum of all known variables. And we should not be surprised that every single ALJ does the same thing.
Probably the greatest personal frustration I have felt in my 25-plus years of doing this stuff is the variation in the decision making process from one ALJ to another. But the reality of this work is that cases cannot be quantified into some sort of uniform numerical system so that x number of points determines that someone is disabled as opposed to another individual who lacks enough points. And parenthetically, I might add, the inability to quantify all cases into a uniform numerical system greatly frustrates those who would seek to solve the program’s various ills by generalizing the particulars of each human’s medical circumstances. But our experience in this disability arena has been a keen teacher. We can never allow the uniqueness of every individual’s medical circumstances to be depersonalized. And more than anything else, our topic today is about establishing the very real and legitimate uniqueness of our clients’ circumstances.

So how do we practitioners handle, manage, and deal with all the variables of every separate case? The answer is not complicated and really is quite simple.

First, we take enough time with each client so that we genuinely know and understand our client’s life.

Second, we assemble and catalogue the information at hand, and this includes not only the “MER” but also what we have gleaned by getting to know our client.

Third, we put all this information into our equation and make our own assessment of the case, and we ask ourselves if this is OR CAN BE a winnable case.
Fourth, if we are not certain that this is a winning case, we then ask ourselves what we can do to change its posture so that the ALJ will be able to understand the merits. And this, finally, is where our topic today comes in. *What can we do to increase the ALJ’s understanding of this client’s life and disabling impairments?*

I. RULES ON THE SUBMISSION OF EVIDENCE

As we know, effective April 20, 2015, Social Security changed the rules regarding the submission and notification of evidence “relating” to a disability claim (as opposed to the former “material” to a disability claim requirement). See, 20 CFR §§ 404.1512(a), 416.912(a). While a discussion of the changes in rules is not within the scope of this presentation, all practitioners should be familiar with their requirements. The focus here is primarily on the affirmative obligation to submit anything “received” whether it is helpful or harmful to your client’s case. However, “received” does not include oral discussion or conversation with a doctor.

I suggest that our thought process is really not different than before the rules were changed. We have always been searching for legitimate and sufficient ways to establish that the client is disabled, and we continue to do this now. The obvious concern, however, is that by seeking additional information from a doctor we might cause the generation of an adverse opinion that we are duty bound to submit.
II. WHEN IS SUPPLEMENTAL INFORMATION NEEDED AND WHEN SHOULD WE WAIT TO GET IT?

The answers seem obvious and can include:

A. When the evidence is absolutely insufficient (the client has no money and has not seen a doctor in months; lack of objective evidence).

B. When you consider the evidence to be insufficient (the doctor’s notes lack detail or are vague or illegible).

C. When the existing evidence would never be sufficient for the particular ALJ.

D. When there are conflicts in the existing evidence.

E. When there is a significant but undocumented medical problem (such as intellectual functioning or other mental issues that have not been alleged as disabilities).

Even though additional evidence may be needed in a case, consider situations when you might choose to wait to obtain a supplemental report. For instance, if you have an ALJ who will deny your case regardless of what the evidence shows, would you want to introduce additional evidence that he will only discredit in his decision? You might wait to obtain the supplemental report and then submit it on appeal.

Are there times when you advise your client not to attend a consultative examination? What might be your reasons for this? (This issue will be discussed during the audience participation portion).
Whatever our decisions may be, they all come down to making judgment calls. This process is simple to state. We take everything we know about the case and put our experience with it so that we make the best decision we know how to make. But I feel certain that even the most experienced practitioner will sometimes be in doubt about the best way to proceed. I suggest that this is a good time to pick up the phone and call a colleague to get another person’s opinion.

III. WHEN YOU SEEK SUPPLEMENTAL INFORMATION, DO YOU NEED TO EDUCATE THE DOCTOR ABOUT THE SOCIAL SECURITY CONTEXT?

Only if you want to receive helpful information! I almost never encounter a doctor who already understands that Social Security only considers a person’s ability to perform full time work. If a doctor believes her patient can surely do some kind of part time work and you fail to explain that part time work is not a consideration, you probably will never have her actual thoughts about the patient’s ability to do SGA as defined by Social Security. Also, without more information, many doctors will only focus on the patient’s ability to return to the same work previously done. It is crucial that the doctor understand precisely what is needed in the Social Security context.

If a client tells me the doctor said he will write a medical letter, I give the client an information sheet to hand to the doctor. See the box below. Sometimes I contact the doctor myself, but it is always a judgment call. Over the years, I have learned that more meaningful letters are written when clients are directly involved in obtaining the letters. Cost is also a consideration. Doctors sometimes will provide letters to patients at no cost or at less cost than if I make the request. The goal is to obtain meaningful information. How to handle the request is always a judgment call.
GENERAL OBSERVATIONS ABOUT MEDICAL LETTERS
FOR SOCIAL SECURITY

A medical narrative is generally the most useful format. However, there is no prescribed format. Overall, the most important points are:

<table>
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<th>Diagnoses / Conditions (MDI)</th>
<th>Severity</th>
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<th>Vocational Consequences</th>
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Because the focus of Social Security is somewhat unique and geared to vocational considerations, I mention the following points for your information:

C **Diagnoses.** It is acceptable to include a list of all medical diagnoses rather than just the diagnoses relating to your specific treatment.

C **Objective Evidence.** Social Security has a strong preference for objective evidence that supports or confirms diagnoses and findings (specific test results, radiographic results, etc.), and referring to objective evidence is helpful.

C **Total Disability.** To be found disabled, the person has to be totally disabled according to Social Security law. There is no partial or fractional disability, so it is all or nothing. Total disability essentially means that a person must be completely unable to do any full time work, day in, day out, week after week. (This does not necessarily preclude limited, part time work, however.)

C **Duration.** To receive benefits, a person must be disabled (or expected to be disabled) for at least twelve continuous months (or have a condition expected to result in death). The disability, however, does not have to be permanent. As long as the twelve month requirement is met, the person can receive benefits and then cease receiving benefits upon recovery.

C **More than inability to do past work.** Social Security does not focus only on the work a person has done in the past. It also considers whether a person is able to do any other work (given the person’s age, education, work experience and medical limitations).

C **Your medical conclusion.** When this applies, it is helpful for you to mention that your patient

- is unable to do any work at all;
- would be expected to have excessive absences from work;
- would decompensate in work setting;
- would not be able to get along with others; and/or
- would not adapt to changes within work setting.

IV. SAMPLE LETTERS TO DOCTORS
A. LETTER TO ORTHOPEDIC

Dear Doctor xxxx:

I represent Ms. B in her disability matters pending before the Social Security Administration. Ms. B asked to hand deliver this letter to your office, and we are sending the letter directly to her. We recently had a hearing, and the administrative law judge asked me to obtain additional information about her residual functional abilities.

The focus of Social Security is on the **ability to perform competitive, full time work for extended periods**. The enclosed form covers many of the issues that Social Security must address. If you can complete the form, or provide the same information in a narrative, we will be very appreciative. **Please feel free to comment as necessary on the form.**

You may also add any other information that you deem important. Examples of such information could include:

- Would need to stand or sit at will whenever needed.
- Cannot hold head and neck in a fixed position for longer than _____ minutes at the time and no more frequently than ____ (ex., once per hour). (Or perhaps explain that use of a computer would be limited.)
- Would need to lie down at will, and this could be up to ____ times during an eight hour work day (or could be up to ____ hours total during an eight hour work day).
- Due to medical circumstances, would expect absences from work to average at least ___ (ex., 2+) days per month.
- Ms. B should not attempt full time work because ________________ (ex., aggravating spinal and related problems -or- risk too great for causing increased spinal instability, etc.).

As noted, this information will be extremely helpful to the outcome of Ms. B’s Social Security case.

Please call if there are any questions. A medical release is enclosed for your file.


B. LETTER TO PSYCHOLOGIST

Dear Dr. xxxx:

My office represents Mr. D in his disability matters pending before the Social Security Administration. **We have specifically reviewed this file and confirmed that you have never been involved with this case.**

The purpose of this letter is to ask for your expert opinion on the psychological status of Mr. D based on your review of the evidence of record. If you can provide a narrative report that details your findings and opinions, I will be very appreciative.

Additionally, I will appreciate your specifically addressing the following and including the underlying rationale in your narrative:
1- Does Mr. D meet any Listing? (Attached is a copy of Social Security’s Listing of Impairments that deals specifically with mental impairments.)
2- If not, does he equal any Listing?
3- If not, what is his mental residual functional capacity? (Please also complete the attached Mental Residual Functional Capacity form as an attachment to your narrative.)

At all times relevant, Mr. D has had very limited use of his dominant right upper extremity because of traumatic injury. For purposes of your analysis, please assume that the right upper extremity issue is a physical impairment imposing an additional and significant work-related limitation of function. If this assumption becomes part of your analysis, you should obviously state the assumption in your report.

Please find the following medical records attached:

[List each exhibit sent by exhibit number]

My firm’s check number 15776 in the amount of $x.00 is enclosed. Also enclosed is Mr. D’s medical release.

The deadline for me to submit additional information to Social Security is June 15, 201x. If you can provide your narrative within a couple of weeks, that will allow enough time for me to formulate and write my brief.

Please call if you have any questions or need more information. Thank you for your kind assistance.

C. LETTER TO PSYCHIATRIST

Dear Dr. xxxx:

Mr. G is a client whom I represent in his disability matters before the Social Security Administration. You treated him for an extended period of time before his mother passed away in December 2008. We had a hearing, and the judge asked me to contact you to request a narrative summary of your clinical findings.

My impression is that the judge actually agrees that Mr. G is disabled but that he needs the medical reasons to supply the clinical explanation. I will be very appreciative if you can provide a medical letter that discusses your findings.

Additionally, it would be helpful if you would include your opinions about the following points pertaining to the work setting:

Mr. G’s ability to manage time effectively;  
His ability to handle himself in a work setting in an appropriate, reliable, and consistent manner;  
His ability to interact with others appropriately;  
His ability to accept and follow directions and instructions from others effectively;  
His ability to stay focused and to complete tasks successfully.  
*If you have an opinion about this and considering work that is not sheltered, does Mr. G have the ability to perform work that is both full time and successful over the long term?*
So that you may communicate directly with me, I am enclosing a medical release for your file. Also, please forward your statement to me so that payment may be handled in advance.

V. AUDIENCE PARTICIPATION

Our discussion today should generate an assortment of practice tips and ideas for resolving supplemental medical report issues AND simultaneously avoiding pitfalls. We want audience participation with questions, thoughts, advice, and examples. However, we ask for a couple of things: (1) make your comments brief and concise; and (2) stay on point and avoid chasing rabbits.

A. Consultative Evaluations – Are there times when you advise your client not to attend a consultative examination? What are the reasons?

B. Do you use any “magic language” in your letters to doctors to avoid receiving harmful evidence? For example, do you say something like, “If your responses will be favorable to Ms. X’s disability case, please reply in writing to the questions below.” Are there any risks to using this or similar language? Can someone suggest better phrasing?

C. Do you ever submit a series of “yes” and “no” questions to the doctor with a space for comments? Is this a safe or risky approach, or does it just depend?

D. What approaches do you in the audience take? What suggestions and tips do you have?

E. Would it be safer for the representative to take a recorded statement (an audio recording made directly by the attorney representative and without the assistance or even presence of anyone else) of the doctor’s medical opinion?
• Could the client’s legal representative actually do this without creating an inherent and impermissible conflict?

• If you took this approach, how would you present the information to Social Security?

• Under the new rules on evidence, would you be obligated to give Social Security a copy of the audio recording?

• Would there be any difference if the doctor were placed under oath at the beginning of the recorded statement?

• If you reduced the audio recording to a typed transcript, would your obligations to Social Security be any different?

• If you not only reduced the audio recording to a typed transcript but also sent the transcript to the doctor for him to make any corrections or changes needed and then sign and date the transcript and return it to you, what would be your obligations to Social Security after you had received the signed transcript?

F. You decide to hire a court reporter and take a sworn statement. The reporter makes an audio recording of his own voice as he repeats into a microphone everything that you and the doctor say.

• When you leave the doctor’s office, what are your evidentiary duties?

• After the transcript is ready but before you receive it, what are your duties?

• After you receive the transcript, what are your duties?

G. Because the outcome of the case is so very vital to your client and because her apparently wealthy significant other has offered to pay in advance for all expenses that you deem necessary in the case, you decide to take the doctor’s sworn statement before a licensed
court reporter. You proceed, and the session has just ended. You are about to stand up and shake the doctor’s hand.

• Assume the only record made by court reporter was an audio recording of the actual voices of both you and the doctor. At this point in time, what are your evidentiary duties to Social Security?

• Assume the court reporter made both an audio voice recording of the doctor’s and your actual voices in addition to typing the dialogue of you and the doctor on a stenotype machine. You are still just getting up to shake the doctor’s hand. At this point in time, what are your evidentiary duties to Social Security?

• Now you are pulling out of the doctor’s parking lot to return to your office, and you decide to stop for lunch. You get a call from the court reporter saying that, because of a schedule change, he will have the transcript ready and emailed to you in a couple of hours. You thank him and go to lunch. While eating, you suddenly remember that this disability case has a remote DLI issue. In fact, you now realize the sworn statement just made by the doctor brought out information that makes it beyond dispute that your client’s disability could not have begun until a full year after the DLI had passed. What do you do? What are your obligations to Social Security at this moment?

• Uncertain about all the issues including your duties to Social Security, you immediately call the court reporter to tell him not to transcribe the statement until further instructions from you. You only get the reporter’s voicemail, but you leave instructions not to prepare the transcript.
• Your appetite has diminished considerably during the hour and a half you have spent thinking about the case and picking at your food. Just as you finally decide to eat your dessert, your secretary calls and tells you in an elated voice that the hearing in this very case has been cancelled because the ALJ decided to pay the case on the record. You mumble thanks to your secretary. As you stare at the dessert, your phone signals that you have a new email. You see it is from the court reporter. Other than feeling extremely nauseous, what do you do?

VI. CONCLUSION

Making decisions about obtaining and using Supplemental Doctor Reports is like any other part of our legal practices. Often the decisions are simple and straightforward. At other times, complex and tricky issues make the decisions challenging. Experience and dedication to “doing it right” remind us to continue learning at every step so that our clients receive the best representation possible. Through experiences like this seminar, we come together to share our knowledge and learn from our peers so that we become better representatives of those who so desperately need help in navigating the mysteries of Social Security. Thank you very much.
Vocational Issues: A Case Study

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VOCATIONAL ISSUES: A CASE STUDY

Cases come and go, commonly turning on the residual functional capacity, but now and then a case will turn on the outcome at step four of the sequential evaluation. There are cases where you only need to prove that your client cannot return their past work. There are cases where your clients age, education and work experience are so favorable at step five of the sequential evaluation that, as a practical matter, they need only prove that they cannot return to their past work, either as they did it or as it is generally performed in the national economy. What follows is a case illustrating some of the issues that can come up in a case where your client is advanced age and there are favorable vocational guidelines (grids) that offer a favorable outcome.

Age:

Mr. Smith was 57 years old at the time of his hearing. In fact he was of advanced age at every level of the administrative process. Being of advanced age is a very favorable position as Social Securities regulations make certain assumptions about your ability to make adjustments to other work.

If you are a person closely approaching advanced age SSA will consider that your age along with a severe impairment and limited work experience may seriously affect your ability to adjust to other work. If you are at advanced age, that is a person age 55 or older, age significantly affects a person’s ability to adjust to other work.

Education:

Mr. Smith has a High School education, a fact that lends no vocational advantage in this case. SSA generally considers that someone who has a High School education to be someone that can do semi-skilled through skilled work. The issue did not come up on Mr. Smith’s case but there is interesting language in the regulations regarding a limited education, something between a 7th grade and 11th grade education. “Limited education means ability in reasoning, arithmetic, and language skills, but not enough to allow a person with these educational qualifications to do most of the more complex job duties needed in semi-skilled or skilled jobs.” 20 C.F.R. 404.1564(b)(3).

20 C.F.R. 404.1563 explains that SSA considers advancing age to be an increasingly limiting factor in a person’s ability to make an adjustment to other work.
Work Experience:

Mr. Smith listed 3 work experiences when he filed his application: Marine, Deputy Warden and Security Officer. However, SSA considers your work experience applies when it was done within the last 15 years. 20 C.F.R. 404.1565(a). Mr. Smith’s military service ended in 2000, and at the time of his hearing, was outside of the 15 year period. The State Agency listed this work as past relevant work, but did not give an exertional level and did not find that it was something he could still perform.

The 15 year period, is the period immediately “prior to the time of adjudication of the claim or 15 years or more prior to the date the Title II disability status requirements were last met.” Social Security Ruling 82-62. By the date of the hearing Mr. Smith’s military service was outside of the 15 year period and no longer relevant.

There are two rules you should be aware of any time you are representing someone of advanced age. Both are found at 20 C.F.R. 404.1562. If you have no more than a marginal education and work experience of 35 years or more during which you did only arduous unskilled work, and you are not working and no longer able to do this kind of work because of severe impairments, we will consider you unable to do lighter work and therefore disabled. The second rule states – if you have a severe impairment, are of advanced age, have a limited education or less and have no past relevant work, we will find you disabled. “If the evidence shows that you meet this profile we will not need to assess your residual functional capacity or consider the rules in appendix 2” (the grids).

Mr. Smith worked as a “Deputy Warden” at a prison for 8 years- 2000 through December 2008. He described his work as requiring him to hire and assign officers at a work prison. He monitored inmates and handled intake and release of inmates. He would have to lift up to 40 lbs. At his hearing he testified that he was also expected to be able to escort and at times detain inmates. His job did not involve directing operation or maintenance of the facility. He did not recommend parole or discharge, nor did he formulate or institute policies or regulations and he was not involved in the budget of the prison. Those duties were part what a warden does according to the Dictionary of Occupational Titles, DOT 187.117-018.

As Generally Performed…

Mr. Smith’s application was denied initially, and on reconsideration, because SSA found that he could still perform his past work as a “Warden” as “Generally Performed in the National Economy.” SSA reasoned that his past work was sedentary and therefore still within his residual functional capacity.

SSA will find you are not disabled if you can return to your past work, either as you actually performed it or as generally performed in the national economy. 20 C.F.R. 404.1560(b)(2). A job performed by the claimant may have involved functional demands and job duties significantly in excess of those generally required for the
job by other employers throughout the national economy. Under SSA’s test if the claimant cannot perform the excessive functional demands or duties required by his former job, but can perform the functional demands and job duties as generally required by employers throughout the economy, SSA will find the claimant not disabled. Social Security Ruling 82-61. This was the finding at the initial and reconsideration levels in Mr. Smith’s case.

Two Possible Routes

Going into the hearing you know SSA’s position has been that Mr. Smith’s past work was sedentary and described in the DOT as Warden at title 187.117-018. You’ve gone over this job description with Mr. Smith and he has explained that he was not the warden. While he had some duties involving supervision and management, he also had duties of correctional officer, such as escorting prisoners and maintaining order in the prison. The DOT does not list or have a job description for “Deputy Warden.” You may consider arguing that Mr. Smith’s past work was as composite job or try to find a job title that more closely fits the functional demands and job duties of the work he performed.

Composite Jobs

Composite jobs have significant elements of two or more occupations and as such, have no counterpart in the DOT. POMS DI 25005.020 gives some information on how SSA will consider composite jobs.

• If you can accurately describe the main duties of PRW only by considering multiple DOT occupations, the claimant may have performed a composite job.

• If you determine that PRW was a composite job, you must explain why.

• When comparing the claimant’s RFC to a composite job as it was performed, find the claimant capable of performing the composite job only if he or she can perform all parts of the job.

• A composite job will not have a DOT counterpart, so do not evaluate it at the part of step 4 considering work “as generally performed in the national economy.”

• At step 5 of sequential evaluation, a claimant may be able to use skills he or she gained from a composite job to adjust to other work.

Social Security Ruling 82-61 explains that composite jobs have significant elements of two or more occupations and, as such, have no counterpart in the DOT. Such situations will be evaluated according to the particular facts of each individual case. For those instances where available documentation and vocational resource material are not sufficient to determine how a particular job is usually performed, it may be necessary to utilize the services of a vocational specialist or vocational expert.

An administrative law judge may not deem a claimant capable of performing past relevant work by dividing the demands of a composite job into two separate jobs and finding him or her capable of performing the less demanding of the two jobs. See, e.g., Roberts v. Astrue, No. 8:08-CV-120-T-
In deciding whether claimant can perform [her] past relevant work, an ALJ may not separate a composite job into two jobs and fail to focus on all the demands of the composite job.”); see also, e.g., Valencia v. Heckler, 751 F.2d 1082, 1086 (9th Cir. 1985) (“Every occupation consists of a myriad of tasks, each involving different degrees of physical exertion. To classify an applicant’s ‘past relevant work’ according to the least demanding function of the claimant’s past occupations is contrary to the letter and spirit of the Social Security Act.”).

Although the Eleventh Circuit has yet to formulate a test to identify composite jobs, case law from the Middle District of Florida and other jurisdictions proves instructive. When examining a composite job, an ALJ must consider a claimant’s actual responsibilities because “every occupation consists of a myriad of tasks, each involving different degrees of physical exertion.” Gregory v. Astrue, No. 5:07-CV-19-Oc-GRJ, 2008 WL 4372840 at * 6 (M.D. Fla. Sept. 24, 2008). To classify a claimant’s past relevant work according to the least demanding function of claimant’s past occupations is contrary to the Act. Valencia v. Heckler, 751 F.2d 1082, 1086 (9th Cir. 1985). In deciding whether claimant can perform his past relevant work, step four of the sequential evaluation must be resolved in favor of the claimant. Valencia, 751 F.2d at 1087 (it was an error to conclude that claimant could perform duties of agricultural worker merely because he could perform the task of tomato sorting).

Is There Another DOT Title?

The DOT sometimes groups similar jobs together, but not in this case. The Warden job fell under administrative positions (187). Security Guards and Correction Officers are grouped under 372. Correction Officer is 372.667-014 and Correction Officer, Head is 372.137-010. Correction Officer, Head supervises and coordinates activities of correction officers, conducts roll calls, issues duty assignments, directs release or transfer of prisoners, investigates and reports causes of inmate disturbances, and other duties. Correction Officer, Head, is a light job, where the Warden was a sedentary job.

Trasferrable Skills

Assuming you are able to convince the ALJ that Mr. Smith’s past work was more demanding than sedentary, you still have an issue to resolve. If Mr. Smith is limited to no more than sedentary work, but has transferrable skills, the medical vocational guidelines call for finding he is not disabled.

20 C.F.R. 404.1568(d) explains: “We consider you to have skills that can be used in other jobs, when the skilled or semi-skilled work activities you did in past work
can be used to meet the requirements of skilled or semi-skilled work activities of other jobs or kinds of work. This depends largely on the similarity of occupationally significant work activities among different jobs. “

**If Your Client is 55 or Older:**

If you are of advanced age (age 55 or older), and you have a severe impairment(s) that limits you to sedentary or light work, we will find that you cannot make an adjustment to other work unless you have skills that you can transfer to other skilled or semiskilled work (or you have recently completed education which provides for direct entry into skilled work) that you can do despite your impairment(s). We will decide if you have transferable skills as follows. If you are of advanced age and you have a severe impairment(s) that limits you to no more than sedentary work, we will find that you have skills that are transferable to skilled or semiskilled sedentary work *only if the sedentary work is so similar to your previous work that you would need to make very little, if any, vocational adjustment in terms of tools, work processes, work settings, or the industry.* 404.1568(d)(4).

**Social Security Ruling 82-41**

What a "skill" is. A skill is knowledge of a work activity which requires the exercise of significant judgment that goes beyond the carrying out of simple job duties and is acquired through performance of an occupation which is above the unskilled level (requires more than 30 days to learn). It is practical and familiar knowledge of the principles and processes of an art, science or trade, combined with the ability to apply them in practice in a proper and approved manner. This includes activities like making precise measurements, reading blueprints, and setting up and operating complex machinery. A skill gives a person a special advantage over unskilled workers in the labor market. Skills are not gained by doing unskilled jobs, and a person has no special advantage if he or she is skilled or semiskilled but can qualify only for an unskilled job because his or her skills cannot be used to any significant degree in other jobs. A person's acquired work skills may or may not be commensurate with his or her formal educational attainment.

In *Draeger v. Barnhart*, 311 F.3d 468 (2nd Cir. 2002) the court held that an ability to learn and apply rules and procedures; use reason and judgement in dealing with all kinds of people; to think clearly and react quickly in an emergency; to keep physically fit; and to make conclusions based on facts and on one's personal judgment; and to change easily and frequently from one activity to another, were merely traits or aptitudes, not job skills. The court explained that these abilities were not linked to any particular task and had not been refined by occupational experience into an acquired work skill. The court explained that skills and their transferability relate to work experience and that a skill is knowledge of a work activity and is acquired through performance of an occupation.

What "transferability" is. Transferability means applying work skills which a person has demonstrated in vocationally relevant past jobs to meet the requirements of other skilled or semiskilled jobs. Transferability is distinct from the usage of skills recently
learned in school which may serve as a basis for direct entry into skilled work.

How transferability is determined in general. Where transferability is at issue, it is most probable and meaningful among jobs in which: (1) the same or a lesser degree of skill is required, because people are not expected to do more complex jobs than they have actually performed (i.e., from a skilled to a semiskilled or another skilled job, or from one semiskilled to another semiskilled job); (2) the same or similar tools and machines are used; and (3) the same or similar raw materials, products, processes or services are involved. A complete similarity of all these factors is not necessary.

Very Little If Any Vocational Adjustment

To find that a person who is age 55 or over and is limited to sedentary work, or a person who is age 60 and over and limited to light work, has transferrable skills, there must be very little if any vocational adjustment in terms of tools, work processes, work settings or the industry. In order to establish such transferrability the semiskilled or skilled job duties of their past work must be so closely related to other jobs which they can perform that they could be expected to perform these other identified jobs at a high degree of proficiency with a minimal amount of job orientation. Social Security Ruling 82-41.

Medical Factors and Transferability.

All functional limitations included in the RFC (exertional and nonexertional) must be considered in determining transferability. For example, exertional limitations may prevent a claimant from operating the machinery or using the tools associated with the primary work activities of his or her PRW. Similarly, environmental, manipulative, postural, or mental limitations may prevent a claimant from performing semiskilled or skilled work activities essential to a job.

Examples are watchmakers with hand tremors, house painters with severe allergic reactions to paint fumes, craftsmen who have lost eye-hand coordination, construction machine operators whose back impairments will not permit jolting, and business executives who suffer brain damage which notably lowers their IQ's. These factors as well as the general capacity to perform a broad category of work (e.g., sedentary, light or medium) must be considered in assessing whether or not a claimant has transferable work skills. If an impairment(s) does not permit acquired skills to be used, the issue of transferrability of skills can be easily resolved.
TO: GA - Vocational Rehabilitation Agency, Disability Adjudication Services
RE: CASE NUMBER:
DOB: 
APPT DATE/TIME
ADJUDICATOR:
The claimant is a 57-year-old right-handed male who presents for a SS Disability CE. The examination is not performed for diagnostic or treatment purposes. He was identified by Georgia Driver License. The allegations include breathing problems and anemia.

During 1977, while in the Marines, the claimant was training in subzero environments for two weeks. Soon afterwards, he describes frequent sputum production. He has been seen by pulmonologists and he reports scarring at the lungs. There is a frequent cough at night. Of note, there is also history of sleep apneas two times years. He describes two-pillow orthopnea. No hypertension. No known heart disease. No history of tobacco abuse. Inhalers are used and a rescue inhaler is used up to four times per day.

There has been bright red blood and dark blood per rectum and described hematuria since the 1970s. The source of bleeding has not been determined. He reports a history of anemia since the 1970s. He is often fatigued.

The claimant reports ability to perform the following activities independently: feeding, performing personal hygiene, managing funds, tying and untying showlaces, buttoning and unbuttoning shirts and pants. The claimant did drive to the exam today.

Review of Records: Sleep apnea.

PAST MEDICAL HISTORY
Anemia, arthritis, asthma, heart problems, hernia, high cholesterol, lung problems, kidney problems, liver problems, thyroid problems, tuberculosis

PAST SURGICAL HISTORY
Left eye, right shoulder, right elbow, hernia repair, tonsils

FAMILY HISTORY
None

SOCIAL HISTORY
The claimant left school after 13 years. He left his job as a security officer in September of 2013. He denies both tobacco and EtOH.

MEDICATION LIST
Ferrous sulfate, hyoscineamine 0.125mg, fiber, levocetirizine 5mg, levothyroxine NA 0.175mg, fluticasone prop, ProAir, Dymista, tamsulosin HCI 0.4mg, Nexium 50mg

REVIEW OF SYSTEMS
As noted above. Right elbow pain. Pain at the knees.

PHYSICAL EXAMINATION
Ht: 67.5" Wt: 236 lbs P 88 R 24 BP 130/90
Height and weight measurements are without shoes. An adult blood pressure cuff was used.

GENERAL: Cooperative. Does not appear acutely ill. Observed holding a pen without difficulty signing the name. A sheet of paper was picked up without difficulty using each hand. Independent transfers. He is ambulating with a cane. There are braces at the knees. The braces were doffed for the exam. The cane is used due to pain he is experiencing at the knees. There is valgus deformity at the right knee. He is able to ambulate in the exam room without the cane and the gait is antalgic with decreased weight-bearing through the right lower extremity with and
without the cane. It does appear the cane will be necessary for safe independent ambulation. Responds/reacts appropriately to questions/commands.

**S**kin: Soft. Pigmentation appears uniform throughout. No apparent abnormal hair growth/distribution. No rashes or ulcerations.

**Lymphatic**: No palpable pre-auricular, post-auricular, submandibular, submental, cervical, supravclavicular, or epitrochlear nodes.

**Head and Neck**: Normocephalic. The neck is supple. No thyromegaly.

**Eyes**: Visual acuity at the (L) eye is 20/200, and at the (R) eye is 20/10 with corrective lenses. With pinhole testing, 20/100 at the (L) eye and 20/20 at the (R) eye with corrective lenses. Sclerae are not injected. EOMs are intact bilaterally. No rynogamus. Peripherial fields appear intact.

**Ears/Nostrils/Throat**: Able to hear sufficiently to respond appropriately during normal conversational speech, and responds appropriately to verbal commands. The nasal mucosa is intact and moist. The oral mucosa is intact and well hydrated.

**Respiratory**: Respirations are clear and unlabored. No adventitious breath sounds.

**Cardiovascular**: Regular rate and rhythm. Normal S1 and S2. No audibile bruits, murmurs, gallops, rubs or clicks.

**Abdomen**: Soft, nontender, nondistended. No muscle guarding. No bruits. Organomegaly does not appear to be present.

**Spine**: No range of motion deficits at the cervical or lumbar spine.

**Extremities**: No increased temperature at the joints. No varicosities. No brawny edema. There are well-healed surgical scars at the claimant’s medial right elbow and at the posterior right shoulder. There is limited active ROM at digits 4 and 5 of the right hand. Digits 4 and 5 remain in flexion at the PIP at rest. There is limited extension, actively, at the digits and full extension cannot be achieved actively. There are no range of motion deficits at the left upper extremity. Valgus deformity at the right knee as noted above. Positive tenderness at the right knee. The grip is functional bilaterally and opposition is intact at the left hand. At the right opposition is not able to be performed appropriately given the claimant’s limited ability to perform extension of digits 4 and 5 actively. There is no erythema or edema at the limbs.

**Neurological**: Alert and oriented to person, place, time, and situation. Cranial nerves appear to be grossly intact. 5/5 strength grossly at the upper and lower extremities within the available range of motion. Sensation is altered with decreased sensation at the ulnar distribution at the right. The claimant is able to stand on the toes and heels. Tandem walking is able to be performed. Sitting straight leg raise is negative. Reflexes are 2+ at bilateral biceps, brachioradialis, and patella tendons.

**Impression**
1. Respiratory disorder.
2. Anemia
3. Right knee pain.
4. Right ulnar neuropathy.
5. Sleep apnea.

**Summary**
The claimant has undergone detailed examination, with findings noted above. Based upon today’s examination, the estimated ability of the claimant to perform work-related activities is as follows:
1. Lift no more than 10 pounds at a time, with occasional carrying or lifting up to 5 pounds.
2. Stand/walk at least 2 hours during an 8 hour work day.
3. Sit for 6 hours during an 8 hour work day.
4. Grasp, hold, and turn objects due to intact left grip and fine dexterity, and ability to use the hand and fingers for repetitive hand/finger activity; there may be difficulty performing these tasks at the right hand due to deficits noted above.
Section 2 - Information About Your Work

A. List all the jobs that you have had in the 15 years before you became unable to work because of your illnesses, injuries, or conditions.

<table>
<thead>
<tr>
<th>Job Title</th>
<th>Type of Business</th>
<th>Dates Worked (From-To)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. security officer</td>
<td>training school</td>
<td>2009 - 09/2013</td>
</tr>
<tr>
<td>2. warden - Dep-Tq</td>
<td>prison</td>
<td>2000 - 12/2008</td>
</tr>
<tr>
<td>4.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
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<table>
<thead>
<tr>
<th>Job Title No. 1:</th>
<th>security officer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rate of Pay:</td>
<td>$11.09</td>
</tr>
<tr>
<td>Per:</td>
<td></td>
</tr>
<tr>
<td>Hour</td>
<td></td>
</tr>
<tr>
<td>Hours Per Day:</td>
<td>8</td>
</tr>
<tr>
<td>Days Per Week:</td>
<td>5</td>
</tr>
</tbody>
</table>

Describe this job. What did you do all day? (If you need more space, write in the "Remarks" section):

Prepared by food Virus the Smith of Job Corp., assisted in behavior of students. Instructed staff of effects of rule violations.

In this Job, did you:

- Use machines, tools, or equipment? — Yes
- Use technical knowledge or skills? — Yes
- Do any writing, complete reports, or perform duties like this? — Yes, investigate and complete reports

In this Job, how many total hours each day did you:

- Walk? — 2 to 3 hrs
- Stand? — 2 to 3 hrs
- Sit? — 2 to 3 hrs
- Climb? — 0
- Stoop? (Bend down and forward at waist): 2 hrs
- Kneel? (Bend legs to rest on knees): 2 hrs
- Crouch? (Bend legs & back down & forward): 1 hr
- Crawl? (Move on hands & knees): 0
- Handle, grab or grasp big objects? — 1 hr
- Reach? — 2 hrs
- Write, type or handle small objects? — 0

Lifting and Carrying (Explain what you lifted, how far you carried it, and how often you did this):

Heaviest weight you lifted: — 30 lbs

Weight you frequently lifted (By frequently, we mean from 1/3 to 2/3 of the workday):

Did you supervise other people in this job? — Yes

How many people did you supervise? — 1

What part of your time was spent supervising people? — 10 hrs per week

Did you hire and fire employees? — No

Were you a lead worker? — No, an as needed basis, on call as needed.

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Job Title No. 2: Warden

<table>
<thead>
<tr>
<th>Rate of Pay:</th>
<th>$46,000.00</th>
<th>Per.</th>
<th>Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hours Per Day:</td>
<td>10</td>
<td>Days Per Week:</td>
<td>5</td>
</tr>
</tbody>
</table>

Describe this job. What did you do all day? (If you need more space, write in the "Remarks" section):

In this Job, did you:

- Use machines, tools, or equipment?
- Use technical knowledge or skills?

Do any writing, complete reports, or perform duties like this?

In this Job, how many total hours each day did you:

- Walk? - 3 hours
- Stand? - 3 hours
- Sit? - 3 hours
- Climb? - 1 hour
- Stoop? (Bend down and forward at waist): -
- Kneel? (Bend legs to rest on knees): -
- Crouch? (Bend legs & back down & forward): -
- Crawl? (Move on hands & knees): -
- Handle, grasp or grasp big objects? - 1/2 hour
- Reach?: -
- Write, type or handle small objects? - 1 hour daily

Lifting and Carrying (Explain what you lifted, how far you carried it, and how often you did this):

- Heaviest weight you lifted: 90 lbs.

Weight you frequently lifted (By frequently, we mean from 1/3 to 2/3 of the workday):

- Did you supervise other people in this job? - Yes
- How many people did you supervise? -
- What part of your time was spent supervising people? - 10 hours daily
- Did you hire and fire employees? - Yes
- Were you a lead worker? - Yes
Describe this job. What did you do all day? (If you need more space, write in the "Remarks" section.):

In this Job, did you:

Use machines, tools, or equipment? - Yes
Use technical knowledge or skills? - Yes

Do any writing, complete reports, or perform duties like this?

In this Job, how many total hours each day did you:

Walk? - 4 hours
Stand? - 3 hours
Sit? - 2 hours

Climb? - 1 hour

Stoop? (Bend down and forward at waist): - 1 hour
Kneel? (Bend legs to rest on knees): - 1 hour
Crouch? (Bend legs & back down & forward): - 1 hour
Crawl? (Move on hands & knees): - 1 hour

Handle, grab or grasp big objects? - 2 hours

Reach? -

Write, type or handle small objects? - Rarely

Lifting and Carrying (Explain what you lifted, how far you carried it, and how often you did this.):

Heaviest weight you lifted: - 200 lb.

Weight you frequently lifted (By frequently, we mean from 1/3 to 2/3 of the workday.):

Did you supervise other people in this job? - Yes

How many people did you supervise? - 10

What part of your time was spent supervising people? - 10 hours daily

Did you hire and fire employees? - No

Were you a lead worker? - Yes
ASSESSMENT OF THE INDIVIDUAL'S ABILITY TO PERFORM PAST RELEVANT WORK

Past Relevant Work:

Job Title: Warden  
Start Date: 00/00/2000  
End Date: 12/00/2008  
SVP: SVP B  
Strength: Sedentary  
DOT Title: Warden  
DOT Code: 187.117-018

Job Title: US Marine  
Start Date: 00/00/1976  
End Date: 01/00/2000  
DOT Title: Infantry unit leader  
DOT Code: 378.137-010

Additional Past Work Titles:

Job Title: security officer  
Start Date: 2009  
End Date: 09/2013

Does the individual have any past relevant work (PRW)?

Yes

This RFC assessment, based on all of the relevant evidence, is a function-by-function evaluation of the individual's exertional and non-exertional capabilities which are required to perform work activities.

Does the individual have the RFC to perform PRW?

Yes

PRW can be performed as:

Generally Performed in the National Economy

The evidence shows that the individual has some limitations in the performance of certain work activities; however, these limitations would not prevent the individual from performing past relevant work as a/an Warden

DOT Title: Warden

DOT Code: 187.117-018
6. The claimant is unable to perform any past relevant work (20 CFR 404.1565).

The claimant has past relevant work as a security officer [Dictionary of Occupational Titles #372.667-034; Light, Semi-skilled (SVP-3)] and (deputy warden) correctional officer, head [Dictionary of Occupational Titles #372.137-010; Light, Skilled (SVP-6), performed at Medium occasionally]. This work was substantial gainful activity, performed long enough to achieve average performance, and performed within the relevant period.

The vocational expert testified that a person with the same age, education, vocational background, and residual functional capacity as the claimant would be unable to perform the claimant’s past work. I have evaluated the testimony of the vocational expert in light of the provisions of Social Security Ruling 00-4p in finding that testimony to be credible. Accordingly, I find the claimant is unable to perform past relevant work.
9. The claimant's acquired job skills do not transfer to other occupations within the residual functional capacity defined above (20 CFR 404.1568).

The vocational expert testified that the claimant had transferable skills of supervisory record keeping, but these skills do not transfer to corrections type jobs. He would need vocational adjustment.
Legislative and Administrative Update

Barbara Silverstone
NOSSCR
Englewood Cliffs, New Jersey
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Legislative and Administrative Update

Barbara Silverstone
Executive Director
NOSSCR
Englewood Cliffs, NJ

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HOUSE WAYS AND MEANS COMMITTEE

waysandmeans.house.gov

Jurisdiction: The panel oversees revenue measures, including: customs revenue, collection districts, and ports of entry and delivery; reciprocal trade agreements; revenue measures relating to the insular possessions; bonded debt of the United States; deposit of public moneys; transportation of dutiable goods; tax-exempt foundations and charitable trusts; national Social Security, except health care and facilities programs that are supported from general revenues as opposed to payroll deductions and work incentive programs.

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Jurisdiction: Federal Old Age, Survivors’ and Disability Insurance System, the Railroad Retirement System, and employment taxes and trust fund operations relating to those systems. More specifically, the jurisdiction of the Subcommittee on Social Security shall include bills and matters involving Title II of the Social Security Act and chapter 22 of the Internal Revenue Code (the Railroad Retirement Tax Act), as well as provisions in Title VII and Title XI of the act relating to procedure and administration involving the Old Age, Survivors’ and Disability Insurance System.
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SUBCOMMITTEE ON HUMAN RESOURCES (SSI)

Jurisdiction: Public assistance provisions of the Social Security Act, including temporary assistance for needy families, child care, child and family services, child support, foster care, adoption, supplemental security income social services, eligibility of welfare recipients for food stamps and low-income energy assistance; bills and matters relating to Titles I, IV, VI, X, XIV, XVI, XVII, XX and related provisions of titles VII and XI of the Social Security Act; federal-state system of unemployment compensation, and the financing thereof, including the programs for extended and emergency benefits; unemployment compensation under titles III, IX and XII of the Social Security Act, chapters 23 and 23A of the Internal Revenue Code, and the Federal-State Extended Unemployment Compensation Act of 1970 and related provisions

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Sen Johnny Isakson (R-Ga)
Sen Patrick J. Toomey (R-Pa)
Sen. Tim Scott (R-SC)

Democrats

Sen. Sherrod Brown (D-Ohio) ranking Member
Sen. Charles E. Schumer (D-NY)
2017 SOCIAL SECURITY CHANGES

- **Cost-of-Living Adjustment (COLA):**
  Based on the increase in the Consumer Price Index (CPI-W) from the third quarter of 2014 through the third quarter of 2016, Social Security and Supplemental Security Income (SSI) beneficiaries will receive a 0.3 percent COLA for 2017. Other important 2017 Social Security information is as follows:

<table>
<thead>
<tr>
<th></th>
<th>2016</th>
<th>2017</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Tax Rate:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employee</td>
<td>7.65%</td>
<td>7.65%</td>
</tr>
<tr>
<td>Self-Employed</td>
<td>15.30%</td>
<td>15.30%</td>
</tr>
</tbody>
</table>

**NOTE:** The 7.65% tax rate is the combined rate for Social Security and Medicare. The Social Security portion (OASDI) is 6.20% on earnings up to the applicable taxable maximum amount (see below). The Medicare portion (HI) is 1.45% on all earnings. Also, as of January 2013, individuals with earned income of more than $200,000 ($250,000 for married couples filing jointly) pay an additional 0.9 percent in Medicare taxes. The tax rates shown above do not include the 0.9 percent.

- **Maximum Taxable Earnings:**
  Social Security (OASDI only) | $118,500 | $127,200 |
  Medicare (HI only) | No Limit |

- **Quarter of Coverage:**
  $1,260 | $1,300

- **Retirement Earnings Test Exempt Amounts:**
  Under full retirement age | $15,720/yr. | $16,920/yr. |
  | ($1,310/mo.) | ($1,410/mo.) |

**NOTE:** One dollar in benefits will be withheld for every $2 in earnings above the limit.

- The year an individual reaches full retirement age | $41,880/yr. | $44,880/yr. |
  | ($3,490/mo.) | ($3,740/mo.) |

**NOTE:** Applies only to earnings for months prior to attaining full retirement age. One dollar in benefits will be withheld for every $3 in earnings above the limit.

There is no limit on earnings beginning the month an individual attains full retirement age.
Social Security Disability Thresholds:

Substantial Gainful Activity (SGA)

<table>
<thead>
<tr>
<th></th>
<th>Non-Blind</th>
<th>Blind</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$1,130/mo.</td>
<td>$1,170/mo.</td>
</tr>
<tr>
<td>Blind</td>
<td>$1,820/mo.</td>
<td>$1,950/mo.</td>
</tr>
</tbody>
</table>

Trial Work Period (TWP)

|          | $810/mo. | $840/mo. |

Maximum Social Security Benefit: Worker Retiring at Full Retirement Age:

|          | $2,639/mo. | $2,687/mo. |

SSI Federal Payment Standard:

|          | $733/mo. | $735/mo. |
| Individual | $1,100/mo. | $1,103/mo. |

SSI Resources Limits:

|          | $2,000 | $2,000 |
| Individual | $3,000 | $3,000 |

SSI Student Exclusion:

|          | $1,780 | $1,790 |
| Monthly limit | $7,180 | $7,200 |

Estimated Average Monthly Social Security Benefits Payable in January 2017:

<table>
<thead>
<tr>
<th></th>
<th>Before 0.3% COLA</th>
<th>After 0.3% COLA</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Retired Workers</td>
<td>$1,355</td>
<td>$1,360</td>
</tr>
<tr>
<td>Aged Couple, Both Receiving Benefits</td>
<td>$2,254</td>
<td>$2,260</td>
</tr>
<tr>
<td>Widowed Mother and Two Children</td>
<td>$2,686</td>
<td>$2,695</td>
</tr>
<tr>
<td>Aged Widow(er) Alone</td>
<td>$1,296</td>
<td>$1,300</td>
</tr>
<tr>
<td>Disabled Worker, Spouse and One or More Children</td>
<td>$1,990</td>
<td>$1,996</td>
</tr>
<tr>
<td>All Disabled Workers</td>
<td>$1,167</td>
<td>$1,171</td>
</tr>
</tbody>
</table>
FEDERAL REGISTER CITATIONS FOR FINAL RULES.

The federal register with the final rules includes important prefatory material discussing the comments submitted.


Executive Director
Barbara Silverstone

July 5, 2016

Office of Regulations and Reports Clearance
3100 West High Rise Building
6401 Security Blvd.
Baltimore, MD 21235

Docket No. SSA-2016-0015
Evidence From Statutorily Excluded Medical Sources

SUBMITTED VIA REGULATIONS.GOV

The National Organization of Social Security Claimants’ Representatives (NOSSCR) is pleased to submit the following comments regarding the Notice of Proposed Rulemaking (NPRM) published on June 10, 2016 (81 Fed. Reg. 37557). Founded in 1979, NOSSCR is a professional association of attorneys and non-attorney advocates who represent individuals seeking or receiving Social Security disability or Supplemental Security Income (SSI) benefits. NOSSCR members represent these individuals in proceedings before the Social Security Administration and in federal court. NOSSCR is a national organization with a current membership of more than 3,500 members from the private and public sectors and is committed to the highest quality representation for claimants and beneficiaries.

This NPRM was issued to comply with Section 812 of the Bipartisan Budget Act of 2015, which requires the Social Security Administration (SSA) to exclude evidence furnished by certain individuals or entities, “except for good cause as determined by the Commissioner.” The NPRM explains the situations in which SSA could find good cause to include evidence furnished by individuals or entities that would otherwise be excluded under Section 812. For the purposes of these comments, such individuals or entities are described as “excluded providers” and the evidence they furnish as “excluded evidence.”

NOSSCR recognizes the importance of relying on credible medical evidence from trustworthy medical providers when determining whether an individual meets the definition of disability. However, we are pleased that SSA recognizes that not all evidence that is provided by excluded providers is unreliable and is proposing good cause exceptions to permit consideration of otherwise excluded evidence.
Good Cause Situations

The proposed Rule includes five exceptions to the general rule that evidence from an excluded provider may not be considered:

1) The evidence from the medical source consists of evidence of treatment that occurred before the date the source was convicted of a felony under section 208 or under section 1632 of the Act;
2) The evidence from the medical source consists of evidence of treatment that occurred during a period in which the source was not excluded from participation in any Federal health care program under section 1128 of the Act;
3) The evidence from the medical source consists of evidence of treatment that occurred before the date the source received a final decision imposing a CMP, assessment, or both, for submitting false evidence under section 1129 of the Act;
4) The sole basis for the medical source's exclusion under section 223(d)(5)(C) of the Act is that the source cannot participate in any Federal health care program under section 1128 of the Act, but the Office of Inspector General of the Department of Health and Human Services granted a waiver of the section 1128 exclusion; (aligns SSA’s rules with those of HHS and provides a consistent approach regarding evidence from affected medical sources) or
5) The evidence is a laboratory finding about a physical impairment and there is no indication that the finding is unreliable.

We support the first three exceptions, which would allow SSA to consider evidence from treatment that occurred before the date on which the provider met one of the criteria for becoming an excluded provider. This is a sensible policy that should be included in the final rule. Disability determinations are at their most accurate when SSA can consider, and give appropriate weight to, as much evidence as possible. Evidence should be considered if it describes treatment that occurs before a provider became an excluded provider. The treatment may have occurred months, years, or even decades before the provider was excluded. In addition, it may not be possible to generate replacement evidence at a later date. Many disability determinations are made when only older evidence is available. For example, disability must be established before the date last insured in disabled worker claims, age 22 in disabled adult child claims, and age 50 for disabled survivor claims. Many of SSA’s listings of impairments also require evidence from before a certain age or over a certain time span.

We support SSA’s position that evidence can be considered if a waiver from HHS OIG has been granted and commend SSA from seeking ways to keep such programs consistent.

We support the concept of allowing good cause exceptions for objective medical evidence, but are concerned that the fifth exception in the proposed rule is too limited. It is important that SSA give good cause exemptions from the exclusion of evidence to all objective medical evidence. SSA defines “objective medical evidence” in 20 C.F.R. §1529 as “medical signs and laboratory findings as defined in § 404.1528 (b) and (c).” Objective medical evidence is likely to be accurate. If excluded, it cannot be replaced by subsequent treatment or opinions. Unfortunately, the proposed rule would only allow a “laboratory finding” to be considered, and only if the laboratory finding is “about a physical impairment.” Both of these shortcomings should be remedied in the final rule.

The final rule should allow SSA to consider evidence of both medical signs and laboratory findings. The definitions are similar: medical signs are “anatomical, physiological, or
psychological abnormalities which can be observed, apart from your statements (symptoms). Signs must be shown by medically acceptable clinical diagnostic techniques.” Laboratory findings are “anatomical, physiological, or psychological phenomena which can be shown by the use of medically acceptable laboratory diagnostic techniques.” Medical signs are just as objective, and just as important to disability determination, as laboratory findings. Allowing good cause for laboratory findings and not medical signs will create confusion, as the distinction between the two types of evidence is not always clear. For example, it is not readily apparent whether evidence generated by blood pressure readings, height and weight measurements, vision exams, and pulmonary function tests are medical signs or laboratory findings.

The final rule should also not limit consideration of objective medical evidence to physical impairments. As described above, the date on which objective medical evidence of a mental impairment can be critical to disability determination. Listing 12.05, for example, requires evidence of the onset of intellectual disability before age 22. Exclusion of evidence from before that age, even if SSA considers psychological testing performed when the claimant is older, may change whether a claimant’s impairment meets a listing. There is also no reason to distinguish between physical and mental impairments when the evidence submitted may be exactly the same. Under the proposed rule, a CT scan showing a brain tumor could be considered to determine whether a claimant met Listing 13.13 for nervous system cancers. It would not be allowed, however, to “demonstrate the presence of a specific organic factor judged to be etiologically related to the abnormal mental state and loss of previously acquired functional abilities” under Listing 12.02 for organic mental disorders.

The final rule should also clarify SSA’s procedures for determining a good cause exemption. Claimants should not have the responsibility to request good cause; it should be granted automatically by SSA when circumstances dictate. Claimants face physical, cognitive, linguistic, and financial obstacles to requesting good cause exceptions. If SSA grants automatic good cause exemptions, it will avoid the need to create forms, deadlines, and workflow practices for handling claimants’ requests for good cause exemptions. Furthermore, automatic good cause exemptions will help SSA consider the maximum amount of evidence possible, in keeping with the agency’s existing policies about the submission of evidence (see 80 Fed. Reg. 14828) and its goal of making accurate decisions. SSA is also in the best position to know which evidence is submitted by excluded providers—claimants may never see their medical records or the Section 812 declaration if providers submit these directly to SSA.

However, the final rule should explain how SSA should notify claimants and their representatives if evidence is excluded, and offer the opportunity to contest the exclusion. Such a practice will reduce the number of situations in which good cause exemptions are appropriate but not granted, increase the evidence available to SSA for disability determinations, and provide due process to SSI and SSDI claimants.

Identifying Excluded Providers

The proposed rule places the onus for identifying excluded providers on the providers themselves, who are required to “inform [SSA] in writing of their BBA section 812 exclusion(s) each time they submit evidence to [SSA] that relates to a claim for Social Security disability
benefits or payments.” This is the best practice while SSA works to establish its “long-term solution to the administration of BBA section 812” which is “to implement automated evidence matching within our case processing system(s) to identify excludable evidence.” Excluded providers are in the best position to know if they have been excluded, the reason for their exclusion, and the date and other factors relating to their exclusion. A self-reporting requirement is minimally burdensome to SSA and excluded providers, and not burdensome at all to claimants, representatives, and non-excluded providers.

The final rule should make clear that claimants and representatives are to be held harmless if they submit evidence that was provided to them without a Section 812 declaration, even if it is later determined that the provider should have included such a declaration. Claimants and representatives often have no way of knowing whether an individual or entity is an excluded provider. They may submit evidence they received from a provider before the provider was excluded, or they may submit evidence they obtained for purposes other than a disability claim. For example, discharge summaries provided when a claimant leaves the hospital, medical records provided so the claimant can seek a second opinion, or a claimant’s file obtained when a provider closes her practice, would not generally include Section 812 declarations.

Finally, SSA should work towards creating a list of excluded providers and the treatment dates for which good cause exemptions will be granted. This will be of assistance to claimants who are deciding which providers to use or attempting to assess the viability of their claims. However, SSA should not impose any obligation on claimants or representatives to check such a list.

Respectfully submitted,

Barbara Silverstone
Executive Director
Executive Director
Barbara Silverstone

July 5, 2016


Submitted via Regulations.gov

While there is a critical need to address gun violence in the United States, the proposed regulation is not an effective means of doing so. A requirement that SSA refer all individuals who receive Social Security disability or SSI benefits based on a finding that the individual’s mental impairment meets or medically equals the requirements of section 12.00 of the Listing of Impairments, and who are appointed a representative payee, to the National Instant Criminal Background Check System (NICS) is over inclusive and may discourage an individual with a mental impairment from seeking Social Security disability benefits or mental health treatment.

We disagree with SSA’s statement that “there is a reasonable and appropriate fit between the criteria we use to decide whether some of our beneficiaries are disabled and require representative payees… and the Federal mental health prohibitor” and urge SSA to withdraw the proposed rule.

Prohibiting all individuals who meet these two criteria from purchasing guns is over inclusive because, while some individuals with mental impairment may be at risk of violence, there is no automatic connection been meeting a mental impairment listing and needing a representative payee and the propensity for violence. The mental impairment listings are designed to identify individuals who are unable to work on a full time basis, and includes individuals with intellectual disabilities, the residual effects of brain tumors and other organic brain disorders, and other impairments; many of these individuals are not in need of mental health treatment and have shown no propensity for violence. In addition, a determination by SSA that an individual requires a representative payee is focused on financial management skills rather than an individual’s risk of gun violence. SSA is required to appoint a representative payee when a beneficiary is not able to manage his or her benefits. It is not the same standard as the NICS statute that prohibits gun sales to those who have been “adjudicated as a mental defective.”

This proposed rule may dissuade individuals from applying for Social Security disability benefits, which often confer eligibility for health insurance. Even those who do apply for benefits may hesitate to seek mental health care or assessments when they are available, out of fear that
their disability determination will result in a report to the NICS database. Claimants may hesitate to be fully forthcoming with their representatives about their mental health concerns. If the rule is enacted, it may have the counterproductive effect of making it more difficult for individuals with mental illness to attain financial stability and obtain needed mental health treatment. As a result, individuals in need of treatment may forego mental health treatment, yet will still be able to purchase firearms.

Individuals found to meet or equal a mental impairment listing may oppose the appointment of a representative payee. This could cause an increase in beneficiaries who fail to manage their benefits in their own best interests; such individuals will be more at risk of homelessness or lack of food than those who have representative payees to manage their funds. The Social Security Administration, which is currently unable to handle its existing workloads in a timely fashion, will be faced with the additional burden of handling people who are resistant to the details of their favorable disability determinations or the appointment of a representative payee and who believe—correctly or not—that they will be reported to the NICS database.

Any final rule on this topic should include individualized assessments of beneficiaries’ risk of gun violence rather than an automatic referral to the NICS database simply by virtue of meeting the two proposed criteria.

Thus, although NOSSCR abhors gun violence and recognizes SSA’s best intentions, we believe the proposed rule will not be an effective way to reduce gun violence in the United States and will have detrimental effects on claimants, beneficiaries, and the Social Security Administration.

Sincerely,

Barbara Silverstone
Executive Director
Executive Director
Barbara Silverstone

August 9, 2016

Carolyn Colvin
Acting Commissioner
Social Security Administration
6401 Security Boulevard
Baltimore, MD 21235-6401

Submitted on www.regulations.gov


Dear Acting Commissioner Colvin:

These comments are submitted on behalf of the National Organization of Social Security Claimants’ Representatives (NOSSCR).

The National Organization of Social Security Claimants’ Representatives (NOSSCR) is a specialized bar association for attorneys and advocates who represent Social Security Disability Insurance (SSDI) and Supplemental Security Income (SSI) claimants throughout the adjudication process. Since 1979, NOSSCR has been providing continuing legal education to its thousands of members, and public policy advocacy on behalf of its members and the people with disabilities they represent. NOSSCR’s mission is to advocate for improvements in Social Security disability programs and to ensure that individuals with disabilities applying for SSDI and SSI benefits have access to highly qualified representation and receive fair decisions.

Thank you for the opportunity to comment on these proposed regulations. NOSSCR supports having consistent and uniform rules across the nation for the submission of evidence and notice for hearings. NOSSCR has long been on record supporting an increase to the minimum required notice regarding the scheduling of hearings. While we support increasing notice nationwide we urge the period to be 75 days, as is the current practice in Region I under 20 C.F.R. §405. However, NOSSCR has also consistently opposed any proposal to close the record prior to a hearing or one that creates any deadline by which evidence must be submitted in order to be
considered by an Administrative Law Judge (ALJ). NOSSCR believes that excluding evidence that is material to making a determination of disability hurts claimants, is administratively inefficient, will increase waiting times at the Appeals Council level, and increase the number of cases appealed to federal court. NOSSCR therefore urges that the 5 business day rule for submitting written evidence not be expanded nationwide but rather repealed everywhere, including Region I.

Our specific comments on these sections appear below.

I. 20 C.F.R. §404.935 and §416.1435 Submitting written evidence to an administrative law judge.

NOSSCR opposes the changes proposed in these sections for several reasons:

1. Creating an arbitrary deadline for the submission of evidence is inconsistent with the statutory and regulatory duties of the Commissioner to fully develop the record and inconsistent with the duties of claimants to submit all evidence as required in §§404.1512 and 416.912.
2. Excluding material evidence is administratively inefficient and will increase appeals to the Appeals Council and to federal court.
3. The proposed rule ignores the reality that testimony, and sometimes new evidence, is routinely introduced at (and sometimes after) hearings with Administrative Law Judges (ALJ), which requires the opportunity for claimants and representatives to respond.
4. Serious problems and inconsistencies exist with the implementation of 5 business day rule in Region I.

1. Creating an arbitrary deadline for the submission of evidence is inconsistent with the statutory and regulatory duties of the Commissioner to fully develop the record.

a. Statutory Conflict: The rules proposed in these sections are inconsistent with the statutory duties of the Commissioner to make eligibility decisions based on the evidence presented at the hearing. The Social Security Act requires the Commissioner to make decisions “…on the basis of evidence adduced at the hearing…”\(^1\) This language clearly contemplates that new evidence will be introduced at the hearing and is inconsistent with creating an arbitrary deadline for the submission of evidence prior to the hearing.

Before the Administrative Conference of the United States (ACUS) completed its study on the Region I pilot, NOSSCR submitted comments. Excerpts of those comments are included here and we attach the comments in their entirety as Appendix A after these comments.

\(^1\) 42 USC §405(b)(1). That section also specifies that “Evidence may be received at any hearing before the Commissioner of Social Security even though inadmissible under rules of evidence applicable to court procedure,” providing further support for the fact that Congress envisioned that SSA would allow new evidence to be introduced at the hearing (unlike what can be done under Federal rules of court procedure related to discovery).
In the letter to ACUS, NOSSCR included information from the Congressional Research Service (CRS) in support of our position. We noted,

[F]ollowing publication of the July 27, 2005 NPRM on the Disability Service Improvement (DSI) process the House Ways and Means Subcommittee on Social Security asked CRS for information regarding the changes proposed in the NPRM. In its September 21, 2005 memorandum, CRS discussed ‘a possible conflict between the new [sic] rules and the Social Security Act.’ 2 The CRS memorandum notes that proposed 20 C.F.R. § 405.311 “may be in conflict with Section 205(b)(1) of the Social Security Act.” 3 More specifically, the CRS memorandum states:

“The legal issue here is whether the requirement that evidence be submitted 20 days before the ALJ hearing [the time limit in the proposed version of 20 C.F.R. § 405.311] is consistent with the requirement that the Commissioner (or an ALJ delegated by the Commissioner) make a decision ‘on the basis of evidence adduced at the hearing.’” 4

The expansion of the rules currently in place in Region I under the DSI are also inconsistent with Congressional intent regarding 42 U.S.C. § 405(b)(1). A bipartisan October 25, 2005 letter was sent in response to the July 2005 DSI NPRM, by the former Chairman and the former Ranking Member of the House Ways and Means Subcommittee on Social Security, Rep. Jim McCrery and Rep. Sander M. Levin, respectively. The letter discussed several issues that were raised at the Subcommittee’s oversight hearing on September 27, 2005, “which we believe may negatively impact claimants’ rights, may result in further processing delays, and could lead to unfair outcomes.” 5 One of these issues was the “new procedural requirements and deadlines for introducing evidence.” In commenting on testimony presented at the hearing, Rep. McCrery and Rep. Levin noted that:

“[I]nstituting strict new limitations on introduction of evidence may, in some instances, conflict with statute [sic], and ignores the well-documented difficulty in obtaining evidence timely that both the SSA and claimant representatives experience.” 6

In addition, Congressional concern was expressed previously in 1988 regarding restrictions on submission of evidence. A draft NPRM in 1988 included a number of procedural changes, including restrictions on submission of evidence similar to those in the DSI regulations. The House Ways and Means Committee leadership at the time, the former Committee Chairman Dan Rostenkowski and the former Social Security Subcommittee Chairman Andy Jacobs, Jr., sent a letter dated November 21, 1988, to the Secretary of Health and Human Services at the time, Otis R. Bowen, expressing their concerns regarding the 1988 draft NPRM. Referring to the provisions in 42 U.S.C. § 405(b)(1), they stated that the proposed regulations restricting submission of evidence “ignore these explicit provisions of the law.” The Committee then held a hearing on the draft NPRM on December 5, 1988. Following this Congressional criticism, the draft NPRM was not published. (appendix A)

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3 CRS pg.6.
4 Id.
5 Letter from Reps McCrery and Levin (October 25, 2005).
6 Id.
b. **Regulatory Conflict:** The proposed rules contained in these sections are also inconsistent with both the letter and spirit of several existing regulatory provisions governing appeals to ALJs. The Social Security Administration’s goal is to arrive at the right decision at the earliest point possible in the disability determination process. Having ALJs consider all evidence available prior to issuing decisions is essential to achieving that goal. Excluding material, and potentially dispositive evidence because it is not received at least 5 business days prior to a scheduled hearing is counterproductive, hurts applicants, and is administratively inefficient.

The requirement to submit all evidence at least 5 business days prior to a hearing is also inconsistent with a number of existing regulatory provisions:

- **The requirement for applicants to submit all evidence:**
  - “You must inform us about or submit all evidence known to you that relates to whether or not you are blind or disabled. This duty is ongoing and requires you to disclose any additional related evidence about which you become aware.” (20 C.F.R §404.1512(a)) and
  - “You must inform us about or submit all evidence known to you that relates to whether or not you are blind or disabled.” (20 C.F.R. §404.1512(c))

  There is no time limit on this duty placed on applicants prior to the decision being issued. The philosophical underpinnings of the rule in 20 C.F.R. §404.1512 is that ALJs must have all evidence that is available at the time of the hearing so they can reach the correct decision. This is in direct conflict with excluding any probative and material evidence because of an arbitrary deadline. It makes no sense to place a duty on the claimant to submit evidence when at the same time, rules are created which allow an ALJ not to consider that very evidence.

- **The requirement for the Commissioner to fully develop the medical record:** “Before we make a determination that you are not disabled, we will develop your complete medical history for at least the 12 months preceding the month in which you file your application…” (20 C.F.R. §404.1512(d)). Again, this regulation is founded in the concept that the correct decision must be based on all of the evidence. An ALJ must ensure that all the available evidence is in the claimant’s file.

The rest of the regulatory scheme regarding the submission of evidence contemplates that the decision is best made when all evidence is considered. Evidence of the applicant’s medical condition closest in time to the hearing can be essential to proving disability. NOSSCR maintains this is the right approach. Uniformity should be achieved by replacing the current Region I rules with the common sense procedures that are currently in place in the rest of the country.

2. **Excluding material evidence is administratively inefficient and will increase appeals to the Appeals Council and ultimately to Federal court.**
NOSSCR believes that the rules proposed in this section will unnecessarily increase the number of appeals to the Appeals Council and ultimately to Federal court. If the proposed rule results in evidence that could be dispositive and result in an award of benefits being excluded from consideration by an ALJ, it is likely to result in increased appeals to the Appeals Council, and potentially Federal Court. This creates delays that are harmful for claimants, as the wait for Appeals Council review already exceeds a year, and federal courts appeals add additional time. Furthermore, Social Security Ruling 11-1p requires most claimants to choose between appealing to the Appeals Council and filing a new application. Claimants who choose the Appeals Council route, but whose claims are denied, and then file new applications could lose months or years of retroactive benefits even if their new applications are approved. Claimants who reapply instead of requesting Appeals Council review will also lose retroactive benefits, and processing their cases will burden SSA field offices and state agencies.

In addition, because the proposed rule harmonizes the acceptable reasons to grant good cause exceptions between the ALJ and the Appeals Council levels, NOSSCR is concerned that this rule will result in additional appeals to federal court. If the proposed rule is implemented, there will be cases where although dispositive evidence is available to the ALJ at hearing, the ALJ chooses to exclude it. Requiring claimants to appeal to the Appeals Council and federal court unnecessarily prolongs the time such claimants must wait for financial stability and medical insurance, and creates additional work for SSA’s ODAR and OGC components. These outcomes could be avoided entirely if ALJs just consider all evidence available when making the hearings-level decisions.

3. The proposed rule ignores the reality that testimony, and sometimes new evidence, is routinely introduced at (and sometimes after) hearings with Administrative Law Judges (ALJ), which requires the opportunity for claimants and representatives to respond.

ALJ hearings are by their nature fact finding hearings. Claimants and other witnesses, including vocational and medical experts, are routinely asked to provide oral testimony. The expert testimony is not available to applicants or their representatives prior to the hearing. Representatives are not allowed to depose vocational or medical experts prior to the hearing and cannot predict every issue or argument that the expert will raise. Due process demands that applicants and their representatives are provided an opportunity to respond to such evidence, usually through the submission of a written post-hearing memorandum, but also, and sometimes more importantly, with evidence to refute assertions made at the hearing if necessary. The proposed regulations do not provide applicants with an opportunity to respond to the new evidence introduced during the hearing, nor to provide additional evidence to address the arguments that arose during the testimony or cross-examination.

4. Serious Problems and Inconsistencies Exist with Implementation of 5 business day rule in Region I.

7 https://www.ssa.gov/appeals/appeals_process.html#&a0=6
8 See for example, Howe v. Colvin, 147 F.Supp.3d 5 (D.R.I. 2015) where the ALJ refused to accept evidence submitted 4 days prior to the hearing. Almost three years later, a federal court remanded the case to the ALJ to consider the evidence.
The DSI rules in Region I governing the submission of evidence (20 CFR §405.331) give ALJs too much discretion in the application of those rules. This results in serious denials of due process for applicants. NOSSCR members who practice in Region I report serious problems and inconsistencies in the implementation of the rule, including, but not limited to:

- Discrepancies regarding when the actual 5 business day deadline closes;
- ALJs who require evidence of claimants’ current medical conditions but deny records that arrive less than 5 business days before the hearing;
- Different ALJ interpretations of the existing good cause exceptions;
- Some ALJs allow only adverse evidence that comes in after the deadline, others ALJs allow all evidence that comes in after the deadline, and others who fairly apply the good cause exceptions;
- Newer ALJs interpreting the requirement much more strictly than older ALJs.

NOSSCR members expressed significant concern regarding inconsistent implementation of the 5-day evidence submission rule under DSI in Region I in 2013 (see appendix A). NOSSCR members indicate that inconsistent application of the rule and ALJ differences in interpretation continue to this day. A small sample of the concerns expressed include:

NOSSCR member, Maine: Some ALJs do routinely find good cause for untimely submission of evidence. Others routinely find that there is not good cause. I have not seen any ALJs apply the 5-day rule to pre-hearing briefs, which are not evidence. I have seen cases in which all the evidence is not yet marked as exhibits 5 days prior to hearing, even when it was submitted months earlier, which makes it difficult to write an effective pre-hearing brief at an earlier time.

NOSSCR member, Connecticut: There is no consistency between ALJs. Most are making a ritualistic demand for a good cause letter.

NOSSCR member, Maine: It is an arbitrary rule designed to provide a basis for denying claims without considering all relevant evidence, and there is absolutely no benefit to claimants or their representatives. Most ALJs typically do not review the record in cases that they hear until the day of the hearing. Those who are exceptions to this generalization tend to also be lenient about accepting additional evidence later. Post-hearing decisions are often not issued until more than 30 days, or even several months, after hearings are held, and post-decision payment processing is similarly often extremely delayed. Under the present circumstances in which SSA does almost nothing in a timely manner, imposing an arbitrary cutoff date for consideration of evidence upon disability claimants and their representatives is a travesty.

NOSSCR member, Connecticut: The 5-day rule continues to be a source of contention at hearings. Some ALJs allow evidence routinely. Some don’t. This rule is usually applied to medical evidence…. Every ALJ is different.

NOSSCR member, Vermont: Given the requirement to submit all evidence my practice is to do so regardless of date—especially when the medical evidence is truly new or recent. I always accompany these submissions with a letter explaining the reason for late submission. The
cynical view, which I think is true with some ALJs, is they admit the evidence if it supports their
decision (or the way they were leaning) and do not admit it if it conflicts.

NOSSCR member, Massachusetts: Almost without exception, new ALJs misapprehend the rule
to operate as an exclusionary device, rather than one which sets a standard of practice… One
should recall that, for the most part, representatives do the job the state agency could not do. We
obtain those records which have eluded the state agency, despite its multiple requests to
providers. But that does not mean representatives will not also have difficulty obtaining records
on time. I employ one staff member (in my one attorney firm) who spends most of her time
following up with providers who have not responded to requests. The system must have a means
of factoring this truth into the system. In the end, the regulations must reflect, and be
implemented in a way, that is consistent with the “inquisitorial” system of adjudication at
ODAR. It is not an adversarial system with two parties. It is focused on finding the truth, through
the obtaining of all evidence.

NOSSCR member, Maine: The [5 day rules] are not applied consistently by different ALJs.
They are also not applied consistently to different types of evidence by some ALJs, who will go
out of their way to consider any unfavorable evidence they can see and to deny consideration of
favorable evidence whenever they can.

Given these inconsistencies in implementation, NOSSCR urges SSA not to move forward
with implementing this rule nationwide. As discussed above, excluding material evidence is
harmful to claimants and inefficient. SSA should not expand this rule before ensuring that
there is consistent application of the rule and its exceptions in Region I.

For the above reasons, NOSSCR opposes any deadline for the submission of evidence and
urges SSA not to finalize the rule as proposed. Instead, NOSSCR urges SSA to restore
uniformity in evidence submission rules nationally by eliminating the Region I pilot and
removing the 5 business day rule for the entire country.

Should SSA decide to move forward and finalize this rule, NOSSCR urges SSA to also do the
following:

- Add clear language to 20 C.F.R. §§404.935 and 416.1435 indicating that it is SSA’s and
  the ALJs’ duty to fully develop the medical record, and creating a time limit is not meant
to be punitive but to ensure that the ALJ can make a timely decision. The language
should include that it is the preference of SSA to have the ALJ decision made on the
basis of the entire medical record.
- Require that each party make every reasonable effort to ensure that the ALJ receives all
  the evidence. The current proposed regulations 20 C.F.R. §§404.935(a) and 416.1435(a)
requires “every effort” which is nonsensical.
- Add language to the good cause exceptions (20 C.F.R. § 404.935(b) and § 416.1435(b))
to minimize ALJ discretion in whether to accept evidence. For example, what does
“actively and diligently” mean? That should be interpreted the same way by different
ALJs, and it currently is not. This language should reiterate the administration’s duty to ensure a complete record, and should be clarified in both in the final regulation and through clear instructions to ALJs in the HALLEX.

- Provide additional training to ALJs regarding the duty to fully develop the record, the preference for inclusion of all material evidence in the record on which the decision is based, the requirement to include evidence in the record if the ALJ is informed about the evidence prior to the 5-business day deadline as long as the evidence is received prior to issuing the decision, and the parameters of the good cause exceptions.
- Further clarify precisely when the 5-business day deadline occurs to remove ALJ discretion on that matter. For example, is the deadline at the time the hearing is set, the time the hearing office closes, or 11:59 pm local time on the date five business days before a hearing, or some other time? Are days “business days” if the hearing office is closed because of weather, government shutdown, or other event? Ensure that claimants and representatives understand the deadline by including the day, date and time for meeting the requirement to inform SSA about or submit evidence in the hearing notice and in a follow up notice reminding applicants of the deadline not more than 3 weeks and not less than 10 days before the hearing.
- Provide the same good cause requirements as is proposed for the submission of evidence to the submission of objections, subpoena requests, and written statements. The proposed rule does not allow ALJs flexibility in permitting such submissions after their respective deadlines, even for the most compelling of circumstances.

NOSSCR appreciates the inclusion of additional specificity regarding the good cause exceptions in the NPRM under 20 CFR §§404.935(b)(3) and 416.1435(b)(3) . Should SSA move forward with finalizing this rule, NOSSCR fully supports the inclusion of all the additional good cause language, but especially 20 CFR §§ 404.935(b)(3)(iv) and 416.1435(b)(3)(iv), because it recognizes the reality of obtaining medical evidence.

We very strongly support early submission of evidence. However, our members frequently have great difficulty obtaining necessary medical records due to circumstances outside their control. We outlined many of our members’ concerns in our letter to ACUS (see appendix A) and excerpt that letter here. There are many legitimate reasons why the evidence is not provided earlier.\(^9\) Irrespective of the length of notice of a hearing provided to a claimant and her representative, there is no guarantee that medical providers will turn over records within any time period. In addition, cost or access restrictions, e.g., HIPAA requirements, may prevent the ability to obtain evidence in a timely way.

\(^9\) If an ALJ believes that a representative has acted contrary to the interests of the client/claimant, remedies other than closing the record exist to address the representative’s actions. SSA’s current Rules of Conduct already require representatives to submit evidence “as soon as practicable” and to act with “reasonable diligence and promptness” and establish a procedure for handling complaints. 20 C.F.R. §§ 404.1740 and 416.1540. If a representative withholds evidence, waiting to file it later, we believe that it is rare and unjustifiable. But SSA already has the tools to penalize a representative for this behavior without doing irreparable harm to claimants. However, this NPRM would punish the claimant rather than the representative.
Some NOSSCR members employ staff who work full-time doing nothing but sending out requests for records, following up by phone call and fax, and reviewing responses for completeness. Nevertheless, they face numerous obstacles and lengthy delays in a significant number of cases. And for claimants appearing pro se before an ALJ, the problems with developing a complete evidentiary record are even worse.

Problems with developing complete evidentiary files are many and varied, and include the following:

- Physicians who are understaffed, have copying and/or fax machines which are reportedly broken, and/or clearly do not see fulfilling record requests from attorneys as a high priority;
- Physicians who do not want to provide any records until a past-due bill for medical services is paid by the claimant;
- Physicians who will provide only their handwritten and marginally legible treatment notes, but will not take the time to write a letter or complete a form regarding their patients’ impairments and functional limitations, regardless of whether a fee is offered for their services;
- Medical providers submit orders for copies of records to copy services who take longer to copy and send the requested records;
- Hospitals often give requests low priority. They have reduced their medical records staff, which delays responding to requests;
- Hospitals which have either closed or changed ownership, which often results in records being transferred to other sites with no notice to former patients;
- Hospitals which, for good reason, will not release records of inpatient hospitalizations until the attending physician signs the chart, which may take weeks or even months after discharge;
- Hospitals which cannot locate Emergency Room treatment records unless they are given a specific date of treatment, which claimants often cannot remember;
- Hospitals which insist on receiving their own form releases, even when a general HIPAA-compliant form has already been executed by the claimant. As a result, even if a representative has presented a HIPAA-compliant release, they may need to locate their client and obtain his or her signature on a new form. Claimants who are incarcerated, homeless, paranoid, illiterate, hospitalized, or without a phone or reliable transportation face numerous challenges in completing medical release forms for even the most diligent of representatives. Frequently, if the medical records staff finds a problem with the request for information, e.g., it is not detailed enough or a different release form is required, the new request goes to the end of the queue when it is resubmitted;
- Mental health outpatient treatment centers which erroneously claim that HIPAA prohibits them from releasing psychotherapy notes;
- Claimants who, because of mental impairments, are unable to recall all of their treatment sources (e.g., a claimant with a hearing scheduled who, despite repeated questioning, cannot remember what hospital he was psychiatrically admitted to for a period of several weeks);
- Claimants who have used different names in the past, making location of their records difficult if not impossible.
In addition to this non-exhaustive list of problems, it should be noted that virtually all providers expect pre-payment for copies of records. While some states have statutes which limit the charges that can be imposed by providers, many do not. Representatives may be prohibited or unable to advance costs for their clients, and unrepresented claimants may withdraw their requests for records in the face of what are, for them, significant bills which they cannot afford to pay.

These proposed rules also ignore the reality that disability is adjudicated through a decision date. Disability adjudications happen while everything is still in motion and therefore require the ongoing submission of evidence of a continually changing impairment.

A claimant would be at the mercy of an ALJ to find that an exception to “late” submission of evidence has been met. Some ALJs do so. But, as discussed throughout these comments, some ALJs rigidly enforce the five-day deadline and refuse to consider any medical evidence submitted within that time limit and even deny the claim based on an incomplete medical record. And, if the ALJ abuses his or her discretion – which happens – the claimant will have limited recourse within the agency, and in many cases will need to file suit in federal court where a district court judge will be asked to decide not whether the evidence proves disability, but whether the ALJ was wrong to refuse to consider the evidence. As a result, the five-day time limit results in decisions based on incomplete records, which lead to unnecessary appeals to the Appeals Council, and ultimately litigation. These results are not only unfair to claimants but also are administratively inefficient and thus do not advance the Agency’s goals.

Finally, although ALJs have the nominal power to issue subpoenas at 20 C.F.R. §§ 404.1450 and 416.950, they do not have the power to enforce subpoenas with which providers fail to voluntarily comply, and the United States Attorneys’ offices which have such power do not have the resources to devote to such activities.

NOSSCR members also report that it is taking longer for records to be received. One attorney from Massachusetts put it this way:

“The realities of representing claimants in my area presents ever greater challenges in obtaining medical evidence. Copies are more commonly made by copy services, who take much longer to provide evidence than the medical providers had done. In Massachusetts medical records are without charge for SSA claims, but there is an additional step in obtaining them. The copy service wants a copy of SSA documentation to prove that the records are for that purpose. It is more common that the clerical staff for the provider and copy service to insist on their own release form, so they do not have to decide if the form submitted to them is "HIPPA compliant". All of this slows down the obtaining of records/opinions in ways that had not been true in the past. I have represented SSA claimants for 41 years. The delay in obtaining records is worse now than in the past. Unscientifically I would estimate that the response time for large institutions, particularly mental health clinics, exceeds 60 days, whereas it was half that in the past. In the past hospital records could be anticipated to be received within 30 days. Now, the response time is more often 45-60 days, due to the "extra steps" noted above, or other factors internal to those large institutions or the copy services.”
In light of the above, should SSA choose to move forward with finalizing this part of the proposed rule, which we oppose, NOSSCR strongly supports retaining the inclusion of the increased specificity regarding the good cause exceptions and more guidance to ALJs regarding the application of them. More specifically, SSA should retain the one contained in proposed 20 C.F.R. §§ 404.935(b)(3)(iv) and 416.1450(b)(3)(iv) which recognize the realities described above.

It is our contention, however, that with this exception there is no practical reason for the rule. Representatives have a duty to submit all evidence to comply with the requirements of 20 CFR §§ 404.1512(a) and 416.912 and representatives generally submit evidence as soon as they have received it. The reason our members overwhelmingly cite for submitting evidence in close proximity to the hearing is the delay contemplated in 20 C.F.R. §§ 404.935(b)(3)(iv) and 416.1450(b)(3)(iv).

In addition, as mentioned above, NOSSCR urges SSA to provide more direction to ALJs (through the final rule and the HALLEX) so that claimants and their representatives are clear on what it means to have “actively and diligently sought” to obtain the records. Again, it is in everyone’s interest, including SSA, to have a fully developed record on which to make a decision at the ALJ level of appeal. The preference should be to have all relevant evidence on which to make a decision and ALJs should not be able to deny evidence when the delay in providing it (even with 60 or 75-day notice) is due to a delay in receiving the evidence rather than not requesting it in a timely manner or a failure to follow up on a timely request.

Should a time limit for submitting evidence become the final rule, NOSSCR strongly supports retaining in the final rule the part of the proposed rule that allows applicants to meet the requirements of the rule by informing SSA about the evidence at least 5 business days before the hearing. We note that the language “…must inform us about or submit any written evidence…” is required in conformity with the 2015 rules on submission of evidence and is an improvement over the process currently in place for Region I. However, NOSSCR is concerned that, absent strong regulatory provisions, sub-regulatory guidance, and training to ALJs, improvement over current rules governing Region I will not be implemented consistently, if at all. NOSSCR urges SSA to make it clear that if an applicant or her representative informs an ALJ prior to the 5 business day deadline about evidence that is material, the ALJ must consider that evidence when reaching a decision on the case irrespective of whether any of the good cause exceptions are met. SSA may wish to clarify that it is preferable to have the evidence submitted if possible (and NOSSCR members do make every effort to submit evidence as early as possible) but if an exam, test, or other material evidence is known about and the ALJ is informed about it, it must be included in the record with no requirement of good cause to be considered. It is important that SSA make it clear in the final regulation and in the appropriate sub-regulatory guidance including the HALLEX and a Social Security Ruling if necessary that there is no ALJ discretion regarding whether to accept and consider this evidence.

**Unrepresented Claimants:** NOSSCR is very concerned about the impact this new rule could have on unrepresented applicants, especially individuals with intellectual, cognitive, or mental health impairments. Unrepresented claimants are unlikely to be aware of these obligations and
unable in some cases to meet them due to their disability. An individual with a cognitive impairment, for example, might not be able to meet deadlines or may lose important papers as a result of that impairment. NOSSCR urges SSA to consider the impact this proposed rule will have on unrepresented claimants and take steps to provide due process and access to justice for all claimants in relation to this rule. Should SSA move forward with finalizing this part of the rule, NOSSCR urges SSA to:

- Ensure that every unrepresented claimant has a pre-hearing conference at least 45 days before the hearing (due to the reality of obtaining medical records described above) in which the applicant’s obligations are clearly spelled out.
- Ensure that the hearing notice (and the additional notice that NOSSCR recommends above) are clear and easy to understand detailing the requirements, including that the claimant should inform SSA about any outstanding evidence before the deadline in order to have the evidence included in the record.
- Devote additional staff resources to obtaining medical records they are informed about by claimants at pre-hearing conferences, and otherwise developing the records of unrepresented claimants.

II. 20 C.F.R. §§ 404.938 and 416.1438 Notice of a hearing before an administrative law judge

NOSSCR has long been on record in support of increasing the length of time notice is given to applicants prior to the hearing. It is NOSSCR’s position that the length of time should be increased to 75 days and not the 60 days proposed in the rule. NOSSCR members in Region I report that 75 days’ notice is necessary to give applicants and their representatives sufficient time to gather relevant medical evidence, make additional medical appointments if necessary, and to be fully prepared for the hearing.

Footnotes 21-23 of the NPRM argue that notice of 75 days or more increases the number of postponements. NOSSCR disputes that any conclusion regarding the reason why Region I (the only area in the country that the footnotes suggest has a mean of over 75 days’ notice) has more postponements can be derived from that data alone. More postponements could be the result of many factors, including but not limited to:

- The operation of the five business day rule: Our members report that they sometimes will ask for a postponement to ensure that evidence is included in the record because they are in front of an ALJ who does not grant good cause exceptions. This could be causal as much as the length of the notice.
- SSA hearing office closures: There were significant snow storms in Region I during the years provided as evidence for more notice increasing postponements in the footnotes that caused the closure of SSA hearing offices. This could cause the slightly elevated levels of postponements due to the unavailability of ALJs.
- Failure to call representatives to schedule the hearing: Scheduling a hearing without consulting the representative regarding his availability is likely to result in increased
postponements. NOSSCR members report that many offices in Region I do not make scheduling calls.

- Significantly more than 75 days’ notice: The statistics used groups all notice over 75 days together.

Any of the above factors could be the cause of the slightly elevated levels of postponements in Region I – which would argue for not implementing the 5 business day rule and ensuring that all hearing offices call representatives to schedule hearings rather than giving shorter amount of notice to claimants. In addition, it is not clear that the slightly higher percentages of postponements are even statistically significant or would even be evidenced if the data were examined over a longer period of time.

NOSSCR members in Region I urge the retention of the requirement to give 75 days’ notice of the hearing date, including:

- NOSSCR member, Massachusetts: [S]hortening the 75-day notice period to 60 days would make it harder to comply with the 5-day rule. The 75-day advance notice period has been a useful way of making sure that the records are submitted timely. It is important to have that time because medical sources will, in my experience, be less cooperative to representatives who send repeated requests over the one-year period the hearing is pending. That irritates them, and they have communicated that irritation to repeated requests, even when they are necessary. Such irritation leads to further delay in responding to requests, or an outright refusal to respond. For that reason, it is essential that representatives avoid "serial requests" to a medical provider, and to ask for the records - those not already in ODAR's file - just once, if possible.

- NOSSCR member, Maine: I do not think that 60 days would be adequate notice in cases that require significant development of the record. In many cases claimants do not seek or obtain representation until after they receive a hearing notice, so the time in which to obtain medical records, opinions, and other evidence is further truncated…. I have rarely requested hearing postponements. Most of my clients wait more than a year from the date of their hearing request until a hearing is scheduled, and are ready and willing to attend a hearing anytime as soon as possible. In the rare instances when I have requested postponements, the fact that we received 75 days-notice, rather than 60, made absolutely no difference.

- NOSSCR member, Connecticut: Whether it is 75 or 60-day notice is irrelevant so long as ODAR calls in advance to schedule. When ODAR unilaterally schedules, problems often arise. A related problem is that ODAR offices (Hartford in particular) have a habit of scheduling more like 150 than 75 days. Cases scheduled that far out are subject to great unpredictability.

- NOSSCR member, Vermont: I am not sure that 60 days is sufficient to request, obtain, and submit medical updates, especially given the 5-day rule. Of course, it’s better than 20 days…. More notice is generally better and should result in fewer scheduling problems. The only postponements I have seen were requested by ALJs, and very shortly before the hearing because the ALJ finally realized he/she wanted a [medical expert].

- NOSSCR member, Massachusetts: This is the biggest defect in the rule. 90 days would be better for ordering records and scheduling hearings… They are wrong [about
postponements]. Their numbers are based on record breaking snows in New England that caused many postponements. With advance notice, I have fewer than ever.

- NOSSCR member, Connecticut: 75 days is better. There is no reason to reduce the 75-day notice to 60 days. I do not believe the NPRM. We do not need postponements if we are given 75-day notice.

Because of the above, NOSSCR urges SSA to increase the notice requirement to 75 days in the final rule, to require hearing offices to call representatives to schedule hearings to ensure the representative is available on the selected date at the time of scheduling, and to ensure that, if enacted, the 5-business day rule includes the protections NOSSCR recommends above to prevent the need for postponements to have material evidence be included in the record.

III. 20 C.F.R. §§ 404.939 and 416.1439 Objections to the issues.

NOSSCR strongly opposes this provision. In general, hearing notices do not provide specific information regarding the issues that will be raised by the ALJ, vocational experts, or medical experts who might testify at the hearing, and even when included, claimants generally do not understand the notices. Neither applicants nor their representatives are in a position to predict the issues that will be raised in order to preserve the right to object to them. This rule could force representatives to develop a boilerplate notice of possible objections that they would submit in every case in an effort to ensure the ability to object should an issue be raised that merits an objection at the hearing. Unrepresented applicants would likely lose the ability to object, however. This provision would create an additional burden on representatives but without accomplishing anything in terms of administrative efficiency or improving the hearing process, and would disadvantage unrepresented claimants. Furthermore, there is no good cause exception proposed for objections. NOSSCR urges SSA not to include this provision in any final rule.


The standard set out in §§ 404.944(a)(1) and 416.1444(a)(1) conflicts with 20 CFR §§ 404.1512 and 416.912. These proposed rules require an ALJ to “accept as evidence any documents that are material to the issues” while the standard in §§ 404.1512 and 416.912 is evidence that “relates to whether or not you are blind or disabled”.

NOSSCR recommends that requirements on submitting evidence be consistent throughout the regulations to avoid unnecessary confusion.

IV. 20 C.F.R. §§ 404.949 and 416.1449 Time limit on presenting written statements and oral arguments.

NOSSCR opposes the requirement to submit written statements related to the case at least 5 business days in advance of the hearing. A written statement should be able to include reference to all material evidence. As discussed extensively above, it is often not possible, through no fault of the applicant or representative to have all evidence more than 5 business days ahead of the hearing. In addition, as one NOSSCR member from Maine explained, “I have seen cases in
which all the evidence is not yet marked as exhibits 5 days prior to hearing, even when it was submitted months earlier, which makes it difficult to write an effective pre-hearing brief at an earlier time.” Applicants should not be denied due process by the failure of the ALJ and hearing office staff to timely process evidence when it is submitted. Furthermore, should SSA move forward with implementing this provision, which NOSSCR strongly urges it not to, it should include:

- Good cause exceptions that track the good cause exception for late submission of evidence. As mentioned above, a memorandum stating the theory of the case should be based on all material evidence. Applying the good cause exceptions to the late submission of a case memorandum is integral to ensuring that the written statement accurately reflect the record.
- Change the language to “must inform us about or provide a copy of your written statements no later than 5 business days before the date set for the hearing.” Representatives and claimants should be able to inform the ALJ that they may be submitting a written summary or statement of the case after all evidence and testimony is received. The words “for each party” should be omitted because it creates an additional challenge for claimants, who may not have contact information for other parties (for example, a wage-earner’s surviving spouse may not be aware of the wage earner’s children from prior relationships or know how to contact them).

In addition, there cannot be a prohibition to submitting a post-hearing written brief. Many ALJs prefer only perfunctory oral argument at hearing and a substantial post hearing brief including written arguments. Proposed 20 C.F.R. §§ 404.949 and 416.1449 appear to violate 5 U.S.C. §556(d) which states that a claimant “is entitled to present his case or defense by oral or documentary evidence, to submit rebuttal evidence, and to conduct such cross-examination as may be required for a full and true disclosure of the facts.” 10 (emphasis added). The apparent intent (or actual effect whether intended or not) of these proposed regulations is to prevent claimants from presenting rebuttal evidence and commenting on evidence presented at the hearing. This violates the requirements of 5 U.S.C. §556(d) and is antithetical to ensuring that decisions are made considering the entire record.

V. 20 C.F.R. §§ 404.950 and 416.1450 Presenting evidence at a hearing before an administrative law judge.

NOSSCR opposes the requirement to request subpoenas at least 10 business days in advance of a scheduled hearing contained in proposed 20 C.F.R. §§ 404.950(d)(2) and 416.1450(d)(2). It is unrealistic to expect a representative or an applicant to know that far in advance a document will not be received and that a subpoena is required and would result in unnecessary subpoena requests. A NOSSCR member in Massachusetts responded to the proposal by saying, “This rule makes no sense. Many records come in toward the end of the 75-day period. Such a rule would require claimants and their representatives to request completely unneeded subpoenas, leading to entirely wasted administrative time at ODAR. Nothing is lost, on the other hand, by a claimant deferring the subpoena request to the time of the hearing when, among other considerations, a conversation can ensue to determine whether the records are needed or not.” There may also be

10 5 U.S.C §556(d).
post-hearing evidence, such as a VE or ME responding to post-hearing interrogatories that could not be subpoenaed under the proposed rule. The chances of reaching the right decision at the hearing are increased by having all material evidence considered and putting this deadline on the request for subpoenas is antithetical to reaching that goal. Furthermore, there is no good cause exemption for the 10 business day deadline. Claimants who could not read or did not receive the hearing notice, who were hospitalized or incarcerated, who lacked a telephone or were faced with a busy signal when attempting to contact the hearing office to request subpoenas, who underwent medical treatment immediately before the hearing and thus generated more records, who hired a representative fewer than 10 business days before the hearing, or who had other good cause reasons for a later request for a subpoena are completely without recourse under the proposed rule.

VI. 20 C.F.R. §§ 404.970 and 416.1470 Cases the Appeals Council will review

1. 20 C.F.R. §§ 404.970(a)(5) and 416.1470(a)(5)

NOSSCR opposes the proposed limit to submission of evidence to the Appeals Council. The current rule, found at 404.970(b) and 416.1470(b) requires the Appeals Council to consider new and material evidence where it relates to the period on or before the date of the ALJ decision. The proposed rule would add an unnecessary burden, requiring also that the evidence “would change the outcome of the decision.” A claimant must already show that the evidence is new (not part of the record as of the date of the ALJ decision) and material (relates to the period before the ALJ decision). A claimant may be unable to determine whether or not the ALJ would have ruled differently, but deserves to have new and material evidence considered by the Appeals Council.

2. 20 C.F.R. §§ 404.970(b) and 416.1470(b)

NOSSCR reiterates our opposition and concern to imposing a deadline on submission of new and material evidence that the Appeals Council may consider.

3. 20 C.F.R. §§ 404.970(c) and 416.1470(c)

NOSSCR supports the clarity provided in proposed 404.970(c) to create a protective filing date for a new application as of the date that unaccepted evidence was submitted to the Appeals Council.

4. 20 C.F.R. §§ 404.970(d) and 416.1470(d)

As we have previously stated in our comments regarding the CARES plan, NOSSCR is concerned about Appeals Council conducting a hearing to obtain additional evidence rather than remanding the case for a full and fair APA governed hearing conducted by an ALJ. Under SSA’s CARES plan, AAJs would conduct hearings for a discrete subset of cases (remands and non-disability issues). On May 12, 2016 the Senate Committee on Homeland Security and Government Affairs Subcommittee on Regulatory Affairs and Government Management held a hearing on “Examining Due Process in Administrative Hearings” Despite concerns raised by Congress during this hearing about AAJs conducting even those specific types of hearings, proposed 20 CFR 404.970(d) sets no limit on the types or numbers of
cases where the Appeals Council would conduct additional hearing procedures. NOSSCR identified our concerns in our statement for the record:

**The Use of Administrative Appeals Judges**
NOSSCR is deeply committed to ensuring that claimants for Social Security disability benefits receive the due process protections required by all statutes and regulations governing the disability determination process. NOSSCR also believes that the ability to get a fair hearing before an independent adjudicator is vital to claimants. We advocate to maintain the qualified judicial independence of ALJs in the disability determination process. Claimants for disability benefits deserve no less.

…

NOSSCR does have concerns, however, regarding SSA’s plan to use AAJs to hear the discrete subset of cases identified in its CARES plan (remands and non-disability cases). It is important to note, as Ms. Gruber indicated in responses to questions at the hearing, that AAJs will be highly qualified, receive the same training as ALJs, and be required to follow all SSA policy (regulations and sub-regulatory policy including the POMS, the HALLEX, and Social Security Rulings) when deciding cases. Implementation of this aspect of the CARES plan should be carefully monitored to ensure that AAJs are issuing policy-compliant decisions and that their decisions are not unduly influenced by SSA management. SSA must ensure that the decisions made by AAJs are based on the evidence presented and in compliance with all applicable regulations and policy guidelines.

**Conclusion:** NOSSCR opposes the creation of any artificial deadline that excludes material, and possibly dispositive, evidence. NOSSCR firmly posits that the implementation of the 5 business day rule in Region I has provided ALJs with too much discretion and implementation of the rule is inconsistent across ALJs denying due process to certain applicants. NOSSCR strongly opposes expanding the 5 business day rule nationwide as proposed in 20 C.F.R. §404.935 and §416.1435. Rather, NOSSCR urges SSA to end the 5 business day rule in Region I and restore uniform procedures across the nation in that manner. Should SSA move forward with implementing the rule nationwide, NOSSCR urges SSA to also put in place the procedures, sub-regulatory policy, and training suggested above to limit ALJ discretion regarding its application and ensure consistent implementation to protect the due process rights of applicants.

NOSSCR supports increasing the required amount of hearing notice nationwide to 75 days. There is no evidence to support a 60-day notice as proposed in 20 C.F.R. § 404.938 and 416.1438, especially none that speaks to the interplay between the increased notice and 5-business day rule. As discussed above, NOSSCR members do not believe that 60 days is enough notice given the reality of the length of time it takes to receive requested medical records and when claimants often hire representation.
NOSSCR supports efforts by SSA to make hearing procedures uniform across the country and to reduce the backlog of pending cases by reducing the number of postponed hearings. However, NOSSCR maintains that reaching the right decision at the ALJ hearing level is most likely when all material evidence, not only evidence submitted prior to the hearing, is considered at the time the decision is made and when adequate notice is given to claimants and their representatives prior to scheduling a hearing before an administrative law judge.
Appendix A:

NOSSCR letter to the Administrative Conference of the United States:

NATIONAL ORGANIZATION OF
SOCIAL SECURITY CLAIMANTS’ REPRESENTATIVES
(NOSSCR)

560 Sylvan Avenue • Englewood Cliffs, NJ 07632
Telephone: (201) 567-4228 • Fax: (201) 567-1542 • email: nosscr@att.net

Executive Director
Nancy G. Shor

May 1, 2013

Amber Williams
ACUS Attorney Advisor
Administrative Conference of the United States
1120 20th St., NW Suite 706 South
Washington, DC 20036

Re: Comments on the ACUS study assessing the impact of the DSI pilot program in Region I

Dear Ms. Williams:

Thank you for the opportunity to submit comments on the ACUS study assessing the impact of the current Disability Service Improvement (DSI) program in SSA Region I states. While most aspects of DSI as implemented in 2006 have been eliminated, e.g., the Federal Reviewing Official and the Decision Review Board, two hearing level provisions remain: (1) rules that essentially close the record 5 days before the hearing; and (2) providing 75-day notice of the hearing date.

To provide background about our organization, NOSSCR was founded in 1979 and is a professional association of attorneys and other advocates who represent individuals seeking Social Security disability and Supplemental Security Income (SSI) disability benefits. NOSSCR members represent these individuals at all Social Security Administration (SSA) administrative levels and in federal court. We are a national organization with a current membership of more than 4,000 members from the private and public sectors and are committed to the highest quality legal representation for claimants.
When former Commissioner Barnhart initially proposed the DSI changes in July 2005, NOSSCR submitted extensive comments, in addition to Congressional testimony at a House of Representatives hearing on the notice of proposed rulemaking (NPRM). In October 2007, former Commissioner Astrue proposed a broad range of procedural changes to the disability determination process, including nationwide implementation of the DSI provisions to close the record 5 days before the hearing. NOSSCR also submitted extensive, detailed comments to the October 2007 NPRM. If you would like to review these comments, we would be happy to share them with you.

In preparation of these comments, we polled NOSSCR members in Region I states to assess their experiences with DSI. Their responses were generally consistent with the long-standing positions taken by NOSSCR: (1) The 75-day hearing notice provision has generally been well-received; and (2) The limits on submitting evidence prior to the hearing have had a detrimental impact on claimants.

Our comments are discussed in two parts. Part I provides a general overview of NOSSCR's positions on these two provisions. Part II (beginning on page 10) includes further statements of NOSSCR's positions and comments from NOSSCR members in Region I in response to the specific questions you posed in your request for comments.

I. NOSSCR POSITIONS

A. 75-day Hearing Notice

NOSSCR has consistently recommended that the time for providing advance notice of the hearing date be increased from the current 20 days to 75 days. We believe that this increase will allow more time to obtain medical evidence before the hearing and make it far more likely that the record will be complete when the ALJ reviews the file before the hearing. The 75-day time period has been in effect in SSA’s Region I states since August 2006 and, based on reports from our members (see below in response to Question 2), has worked well.

B. Restrictions on Submission of Evidence Violate the Social Security Act and Are Not Fair to Claimants

The DSI regulations create strict limits and procedures for submission of new and material evidence. For many claimants who meet the statutory definition of

13 20 C.F.R. §§ 404.938(a) and 416.1438(a).
14 20 C.F.R. § 405.315(a).
disability, the result could well be a denial based on an incomplete record, which is inconsistent with the goal of the disability determination process to ensure that adjudicators have a complete record when deciding a claim.

Under the DSI regulations, the record essentially closes five business days before the hearing. Evidence submitted after that date is considered “late” and is subject to the following rules:

- Within five business days of the hearing or at the hearing: The ALJ may accept the new evidence if the claimant shows that: (1) SSA’s action misled the claimant; (2) the claimant has a physical, mental, educational, or linguistic limitation that prevented the claimant from submitting the evidence earlier; or (3) some other “unusual, unexpected, or unavoidable circumstance beyond the claimant’s control” prevented earlier filing.

- After the hearing but before the hearing decision: The ALJ may accept and consider new evidence if (1) one of the three exceptions above is met and (2) there is a “reasonable possibility” that the evidence, when considered alone or with the other evidence of record, would “affect” the outcome of the claim.

- Before the Appeals Council (a carry-over after the elimination of the Decision Review Board): The proposed rule is even stricter for submitting evidence to the Appeals Council. The Appeals Council may accept the new evidence only if: (1) SSA’s action misled the claimant; the claimant has a physical, mental, educational, or linguistic limitation; or some other “unusual, unexpected, or unavoidable circumstance beyond the claimant’s control” prevented earlier filing; and (2) there is a “reasonable probability” that the evidence, when considered alone or with the other evidence of record, would “change” the outcome of the claim.

The DSI regulations fail to recognize that there are many legitimate reasons, often beyond the claimant’s or representative’s control, why evidence is not submitted earlier and thus why closing the record or creating unreasonable procedural hurdles is not beneficial to claimants. We have many concerns – both legal and practical – regarding the impact of the restrictions on claimants with disabilities.

1. **Restrictions on the submission of evidence prior to the hearing**
   **Social Security Act**

The Act provides the claimant with the right to a hearing with a decision based on “evidence adduced at the hearing.”¹⁵ 42 U.S.C. § 405(b)(1). Our position is that the DSI regulations conflict with the statute. Current regulations that apply to the rest

of the country comply with the statute by providing that “at the hearing” the claimant “may submit new evidence.” 20 C.F.R. §§ 404.929.

Concerns noted by the Congressional Research Service (CRS) support our position. Following publication of the July 27, 2005 NPRM on the Disability Service Improvement (DSI) process, the House Ways and Means Subcommittee on Social Security asked CRS for information regarding the changes proposed in the NPRM. In its September 21, 2005 memorandum, CRS discussed “a possible conflict between the new [sic] rules and the Social Security Act.” The Proposed Changes to the Social Security Disability Determination and Appeals Process (CRS, Sept. 21, 2005), p. CRS-2. The CRS memorandum notes that proposed 20 C.F.R. § 405.311 “may be in conflict with Section 205(b)(1) of the Social Security Act.” p. CRS-6. More specifically, the CRS memorandum states:

The legal issue here is whether the requirement that evidence be submitted 20 days before the ALJ hearing [the time limit in the proposed version of 20 C.F.R. § 405.311] is consistent with the requirement that the Commissioner (or an ALJ delegated by the Commissioner) make a decision “on the basis of evidence adduced at the hearing.”

p. CRS-6.

The DSI regulation also is inconsistent with Congressional intent regarding 42 U.S.C. § 405(b)(1). A bipartisan October 25, 2005 letter was sent in response to the July 2005 DSI NPRM, by the former Chairman and the former Ranking Member of the House Ways and Means Subcommittee on Social Security, Rep. Jim McCrery and Rep. Sander M. Levin, respectively. The letter discussed several issues that were raised at the Subcommittee’s oversight hearing on September 27, 2005, “which we believe may negatively impact claimants’ rights, may result in further processing delays, and could lead to unfair outcomes.” One of these issues was the “new procedural requirements and deadlines for introducing evidence.” In commenting on testimony presented at the hearing, Rep. McCrery and Rep. Levin noted that:

[I]nstituting strict new limitations on introduction of evidence may, in some instances, conflict with statute [sic], and ignores the well-documented difficulty in obtaining evidence timely that both the SSA and claimant representatives experience.

In addition, Congressional concern was expressed previously in 1988 regarding restrictions on submission of evidence. A draft NPRM in 1988 included a number of procedural changes, including restrictions on submission of evidence similar to those in the DSI regulations. The House Ways and Means Committee leadership at

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the time, the former Committee Chairman Dan Rostenkowski and the former Social Security Subcommittee Chairman Andy Jacobs, Jr., sent a letter dated November 21, 1988, to the Secretary of Health and Human Services at the time, Otis R. Bowen, expressing their concerns regarding the 1988 draft NPRM. Referring to the provisions in 42 U.S.C. § 405(b)(1), they stated that the proposed regulations restricting submission of evidence “ignore these explicit provisions of the law.” The Committee then held a hearing on the draft NPRM on December 5, 1988. Following this Congressional criticism, the draft NPRM was not published.

SSA itself has previously recognized that setting a pre-hearing due date for submission of evidence was abandoned by SSA because it appeared to close the record in contravention of the statute. See 63 Fed. Reg. 41404, 41411-12 (Aug. 4, 1998)(final rule on Rules of conduct and standards of responsibility for representatives, codified at 20 C.F.R. §§ 404.1740 and 416.1540).

2. The proposed changes eliminate the ALJ’s duty to fully and fairly develop the record.

The United States Supreme Court has recognized that ALJs have a “duty of inquiry” based on a claimant’s constitutional and statutory rights to due process. See generally Heckler v. Campbell, 461 U.S. 458, 471 n.1; Richardson v. Perales, 402 U.S. 389, 400 (1971).

All circuit courts of appeals have well-established case law that ALJs have a duty to develop the record, which includes both obtaining sufficient medical evidence and conducting sufficiently detailed questioning at the hearing. The ALJ’s failure to fully develop the record may result in a court remand to obtain the missing information or to consider information that was not considered previously. See, e.g., Pratts v. Chater, 94 F.3d 34 (2nd Cir. 1996); Delorme v. Sullivan, 924 F.2d 841 (9th Cir. 1991); Baker v. Bowen, 886 F.2d 289 (10th Cir. 1989). Because the Social Security appeals process is not adversarial, this duty exists whether a claimant is unrepresented, or is represented by either an attorney or a non-attorney representative. See, e.g., Tonapetyan v. Halter, 242 F.3d 1144 (9th Cir. 2001); Shaw v. Chater, 221 F.3d 126 (2nd Cir. 2000); Henrie v. Dept of HHS, 13 F.3d 359 (10th Cir. 1993); Thompson v. Sullivan, 987 F.2d 1432 (10th Cir. 1993); Smith v. Bowen, 792 F.2d 1547 (11th Cir. 1986); Bishop v. Sullivan, 900 F.2d 1259 (8th Cir. 1990).

This duty is vitiates by the time limit for submitting evidence before the hearing since it is not possible for the ALJ to meet this important responsibility if the requirement/presumption is that all (or virtually all) evidence must be submitted 5 days before the hearing.

3. The DSI regulations give ALJs the discretion to violate claimants’ rights under the Act.
Under the DSI regulations, the ALJ has the discretion to ignore any evidence submitted less than five business days before the hearing. The exceptions are within the discretion of the ALJ and if the ALJ finds that the exceptions are not met, claimants will have no recourse to have the evidence considered other than to file an appeal to the Appeals Council and to federal court from the agency’s “final decision” or to abandon their claims. Such a result conflicts with the goal of ensuring that there is a complete record, especially since there is no claim in the DSI regulations that this evidence is somehow less valuable or probative in determining disability.

The limits do not provide a mechanism to ensure that an ALJ who refuses to accept evidence within 5 business days of the hearing or later does not violate a claimant’s right to a full and fair hearing. The requirements in the DSI regulations for “late” submission are discretionary and there are no criteria to guide ALJ decisions. For example, an ALJ could find that unsuccessful efforts to obtain evidence or other unforeseen circumstances, e.g., hospitalization, do not meet the exceptions to the five-day rule. Under the proposed changes, claimants will be at the mercy of ALJs. Some ALJs may rigidly enforce the 5-day deadline, refuse to consider any evidence after that date, and deny the claim based on an incomplete record. If the ALJ’s discretion is abused, a claimant is forced to appeal first to the Appeals Council and possibly to federal court simply to have the evidence considered. Our members provided a number of examples, provided below, of exactly these types of occurrences.

The preface to the 2007 NPRM describes another exception that allows the ALJ to hold the record open, but this basis also is completely within the ALJ’s discretion: (1) The claimant is “aware” of any additional evidence that could not be timely obtained and submitted before or at the hearing; or (2) the claimant is scheduled to undergo additional medical evaluation after the hearing for any impairment that forms the basis of the disability claim. The claimant “should inform the ALJ of the circumstances during the hearing.” But as far as keeping the record open if a request is made for one of these circumstances, there is no requirement that the ALJ do so: “[T]he ALJ could exercise discretion and choose to keep the record open for a defined period of time ....”\footnote{72 Fed. Reg. 61220.} This exception has not been adopted and, at any rate, was not included in the DSI regulations.

Even in this situation, the ALJ’s discretion could be exercised unfairly to claimants. For example, an ALJ could deny a claimant’s request to keep the record open but then decide to keep the record for his or her own purposes in order to obtain a consultative examination. This exact situation was previously reported by a NOSSCR member in Region I under the DSI regulations.
4. The DSI regulations are inconsistent with the realities of claimants obtaining representation

Many claimants seek and obtain representation shortly before the hearing or after receiving the hearing notice, frequently fewer than 20 days before the hearing. In fact, a large number of claimants seek representation only after receiving an unfavorable ALJ decision. Based on the experience of our members, this is a not an uncommon occurrence since the ALJ hearing is the claimant’s first in-person contact with an adjudicator. Under SSA’s own policies, before a waiver of the right to counsel is considered valid, the ALJ must both send a letter to the claimant in advance explaining that right and confirm on the record at the hearing that the ALJ again told the claimant about the right to counsel and determined that the claimant was competent to understand. HALLEX I-2-6-52A. If the claimant wishes to obtain representation, the ALJ should postpone the hearing. Id.

Many claimants do not understand the complexity of the rules or the importance of being represented until just before their hearing date. Many are overwhelmed by other demands and priorities in their lives and by their chronic illnesses. As a practical matter, when claimants obtain representation shortly before the hearing, the task of obtaining medical evidence is even more difficult. Even a 75-day hearing notice, a change that we strongly support, will not be sufficient if the claimant seeks representation shortly before the hearing. How do the evidence submission restrictions affect an individual who obtains representation within 5 business days of the hearing? Under the DSI regulations, the ALJ would have the discretion to exclude new and relevant evidence.

5. The proposed changes are inconsistent with the realities of obtaining medical evidence

We very strongly support early submission of evidence. However, our members frequently have great difficulty obtaining necessary medical records due to circumstances outside their control. There are many legitimate reasons why the evidence is not provided earlier. The proposed 75-day hearing notice will be a great help in submitting evidence earlier, but there is no requirement that medical providers turn over records within that time period. In addition, cost or access

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18 If an ALJ believes that a representative has acted contrary to the interests of the client/claimant, remedies other than closing the record exist to address the representative’s actions. SSA’s current Rules of Conduct already require representatives to submit evidence “as soon as practicable” and to act with “reasonable diligence and promptness” and establish a procedure for handling complaints. 20 C.F.R. §§ 404.1740 and 416.1540. If a representative withholds evidence, waiting to file it later, we believe that it is rare and unjustifiable. But SSA already has the tools to penalize a representative for this behavior without doing irreparable harm to claimants. However, this NPRM would punish the claimant rather than the representative.
restrictions, e.g., HIPAA requirements, may prevent the ability to obtain evidence in a timely way.

While a five-day requirement is imposed on claimants in the DSI regulations, nothing requires medical providers to turn over records quickly. A claimant would be at the mercy of an ALJ to find that an exception to “late” submission of evidence has been met. Some ALJs do so. But, as discussed below, some ALJs rigidly enforce the five-day deadline and refuse to consider any medical evidence submitted within that time limit and even deny the claim based on an incomplete medical record. And, if the ALJ abuses his or her discretion – which happens – the claimant will have limited recourse within the agency, and in many cases will need to file suit in federal court where a district court judge will be asked to decide not whether the evidence proves disability, but whether the ALJ was wrong to refuse to consider the evidence. As a result, the five-day time limit results in decisions based on incomplete records, which lead to unnecessary litigation. These results are not only unfair to claimants but also are administratively inefficient and thus do not advance the Agency’s goals.

Some of our members employ staff who work full-time doing nothing but sending out requests for records, following up by phone call and fax, and reviewing responses for completeness. Nevertheless, they face numerous obstacles and lengthy delays in a significant number of cases. And for claimants who seek representation after the ALJ decision, having tried to proceed without representation, the problems with developing a complete evidentiary record are even worse.

Problems with developing complete evidentiary files are many and varied, and include the following:

- Physicians who are understaffed, have copying and/or fax machines which are reportedly broken, and/or clearly do not see fulfilling record requests from attorneys as a high priority;
- Physicians who do not want to provide any records until a past-due bill for medical services is paid by the claimant;
- Physicians who will provide only their handwritten and marginally legible treatment notes, but will not take the time to write a letter or complete a form regarding their patients’ impairments and functional limitations, regardless of whether a fee is offered for their services;
- Hospitals often give requests low priority. They have reduced their medical records staff, which delays responding to requests.
- Hospitals which have either closed or changed ownership, which often results in records being transferred to other sites with no notice to former patients;
• Hospitals which, for good reason, will not release records of inpatient hospitalizations until the attending physician signs the chart, which may take weeks or even months after discharge;
• Hospitals which cannot locate Emergency Room treatment records unless they are given a specific date of treatment, which claimants often cannot remember;
• Hospitals which insist on receiving their own form releases, even when a general HIPAA-compliant form has already been executed by the claimant. We have heard from representatives that medical providers have different interpretations of HIPAA requirements and as a result require use of their own forms for authorization to disclose information. This can lead to delays since repeated requests for medical information must be submitted, including delays caused by the need to obtain the claimant’s signature on various versions of release forms. Frequently, if the medical records staff finds a problem with the request for information, e.g., it is not detailed enough or a different release form is required, the new request goes to the end of the queue when it is resubmitted.
• Mental health outpatient treatment centers which erroneously claim that HIPAA prohibits them from releasing psychotherapy notes;
• Claimants who, because of mental impairments, are unable to recall all of their treatment sources (e.g., a claimant with a hearing scheduled who, despite repeated questioning, cannot remember what hospital he was psychiatrically admitted to for a period of several weeks);
• Claimants who have used different names in the past, making location of their records difficult if not impossible.

In addition to this nonexhaustive list of problems, it should be noted that virtually all providers expect pre-payment for copies of records. While some states have statutes which limit the charges that can be imposed by providers, many do not. Moreover, while private attorneys have the resources to advance costs for their clients, many legal services organizations do not, and unrepresented claimants may withdraw their requests for records in the face of what are, for them, significant bills which they cannot afford to pay. Finally, although ALJs have the nominal power to issue subpoenas at 20 C.F.R. §§ 404.1450 and 416.950, they do not have the power to enforce subpoenas with which providers fail to voluntarily comply, and the United States Attorneys’ offices which have such power do not have the resources to devote to such activities.

6. **The proposed changes are inconsistent with the realities of claimants’ medical conditions.**

Claimants’ medical conditions may worsen over time and/or diagnoses may change. Claimants undergo new treatment, are hospitalized, or are referred to different doctors. Some conditions, such as multiple sclerosis, autoimmune disorders or certain mental impairments, may take longer to diagnose definitively. The severity of an impairment and the limitations it causes may change due to a worsening of
the medical condition, e.g., what is considered a minor cardiac problem may be understood to be far more serious after a heart attack is suffered. It also may take time to fully understand and document the combined effects of multiple impairments. Further, some claimants may be unable to accurately articulate their own impairments and limitations, either because they are in denial, lack judgment, simply do not understand their disability, or because their impairment(s), by definition, makes this a very difficult task. By their nature, these claims are not static and a finite set of medical evidence does not exist.

Also, as with some claimants who seek representation late in the process, their disabling impairments make it difficult to deal with the procedural aspects of their claims. Claimants may have difficulty submitting evidence in a timely manner because they are too ill, or are experiencing an exacerbation, or are simply overwhelmed by the demands of chronic illness, including the time and logistical demands of a caregiver or advocate to help submit evidence.

II. RESPONSES FROM NOSSCR MEMBERS IN REGION I

1. What is NOSSCR's view of the current pilot program in Region I?

The general view is that the 75-day notice rule should be implemented nationwide. However, the 5-day rule needs to be either eliminated or modified, as discussed below in response to Question 4.

- From an attorney in Massachusetts: “In practice, it’s ‘14 judges, 14 interpretations’ of these rules … I have to say that my view is that application of the program is not uniform, and for reasons that have to do with idiosyncrasies or practice patterns of individual judges. Another question is exactly what the DSI program applies to: individual initial disability appeals or everything else as well, such as overpayments, living arrangements, continuing disability reviews, Appeals Council remands. The practice seems to be to send out notice of the 5 day rule on every case scheduled for a hearing, and I’m not sure that DSI applies in all instances.”

2. What does NOSSCR think are the benefits, if any, of the current pilot program in Region I for claimants and/or their representatives?

NOSSCR members in Region I generally support the 75-day notice in advance of the hearing.

- From an attorney in Connecticut: “I like the 75 day notice that gives a useful timeframe for acquiring missing records. Hospitals I deal with represent
that they get documents out in 2 weeks, or even a month, but experience is commonly 6 weeks or more.”

- **From an attorney in Connecticut:** “The 75 day notice is good as it provides a timeframe for case development and an early heads-up to the attorney and client.”

- **From an attorney in Connecticut:** “I practice in Connecticut and am very pleased with the 75 day notice of hearings. It gives sufficient time to ‘gear up’ to get the latest opinions and medical records to the ALJs. However, in the Hartford ODAR, we are not called prior to scheduling hearings. At times this results in having hardly any hearings in one month and a lot of hearings in other months. This particular practice, of having no input as to when the hearing is scheduled or to spacing of hearings can be detrimental to the quality of representation (when too many hearings are scheduled closely) ....”

- **From an attorney in Maine:** “Having 75 days’ notice of a hearing enhances the ability to be adequately prepared, both with regard to medical/vocational evidence, and testimonial. It lessens the likelihood of having to ask for a continuance due to scheduling. It is orderly and civilized and of benefit to everyone.

- **From an attorney in Maine:** “The 75-day notice has been great. It makes it much more possible to update medical records, gather medical source statements and be well-prepared for the hearing.”

- **From an attorney in Maine:** “The 75 day notice rule is a wonderful improvement for everyone. I doubt if the ODAR staff will have anything negative to say about it. If the goal is to get everything ready by the time of the hearing, the extra advance notice works well for this purpose. I expect it makes scheduling easier for them and it is better for my firm because we have five attorneys who are doing hearings. In short it has been a win-win.”

- **From an attorney in Maine:** “The 75 day notice provision allows representatives to prepare for hearings in a reasonable, timely manner.”

- **From an attorney in Massachusetts:** “The seventy five day rule has generally enabled diligent advocates to get most evidence in well before the five day deadline.”

- **From an attorney in Massachusetts:** “The 75 day advance notice of hearing is something that should be extended nationally. If an advocate has at least 75 days advance notice, the experience is that it’s much more likely that the record will be fully developed for hearing. It would be even better if SSA would allow advocates to say when the record is ready for hearing – perhaps within a reasonable time frame.”
• **From an attorney in New Hampshire:** The year long delay (more or less, but lately the time is more) between the request for hearing and the date of the hearing, is the problem. Over that period of time, a lot happens, and the record needs to be updated. Generally, it is helpful to know that the claimant will have 75 days time to update the medical record, as sometimes it takes that long.

The ALJ is required to make a disability determination as of the date of the hearing, so updating the records is critical. We cannot update medical records piecemeal, as it costs a minimum of $15.00 per record request [in New Hampshire], even if it is a few pages. We have to have some way to know when to order medical records to minimize the cost to the claimant.”

3. **What does NOSSCR think are the drawbacks, if any, of the current pilot program in Region I for claimants and/or their representatives?**

The general consensus was that the 5-day rule for submitting evidence before the hearing is detrimental to claimants. As demonstrated by the examples below, there is much variation in how the rule is applied by ALJs, with very inconsistent results. As one attorney in Massachusetts said (see response to Question 1 above): “14 judges, 14 interpretations of these rules ... I have to say that my view is that application of the program is not uniform, and for reasons that have to do with idiosyncrasies or practice patterns of individual judges.”

• **From an attorney in Connecticut:** “My position is that the five day rule is a disaster. The [medical] clinics don’t do five day rule and we have just a couple of ALJs who use it as a club to beat up the lawyer and/or client, exposing us to clients who feel their lawyers have failed them. We filed a complaint against the worst of those ALJs.”

• **From an attorney in Connecticut:** “As to the 5 day rule, I have had very little problem with it. In the majority of my cases, because of the 75 day notice, I have been able to gather and submit the evidence prior to the 5 day limit. At times where this has not been possible, I just include a cover letter asking for permission to submit it late. At times I notify the judge that I am anticipating not receiving specific evidence prior to the hearing and ask for permission to submit it late if necessary. So far, no judge has refused my requests.”

• **From an attorney in Connecticut:** “The 5-day rule essentially states that an ALJ’s duty to develop the record stops as of the day of the hearing. It is impossible to square this with the claimant’s right to a fully developed record. Closing of the record – which for practical purposes is the effect of the 5 day rule – in many cases denies the claimant a full and fair adjudication of his or her claim.
Perhaps worse, we deal with ODAR hearing offices that are overworked and understaffed. Actual application of the five day rule will increase the administrative burdens and further strain ODAR staff resources, to no discernible benefit. In the case of a particular ALJ known for rigid adherence to the five day rule, claimant’s counsel requests medical records 40 days before the hearing. With no response on day 31 after the request, counsel requests that the ALJ issue subpoenas to compel the production of the records. Should ODAR staff drop what they are otherwise doing to issue the subpoenas?

The answer is not necessarily to ask for the records when the 75-days notice is received. There are ALJs who will berate counsel for failing to provide up to the minute medical records. If records are requested 75 days before the hearing and are provided quickly by the medical provider, the records will not cover the 60 days or so immediately before the hearing. This scenario has caused at least one ALJ in Connecticut to lace into counsel with barely restrained fury.”

- **From an attorney in Maine:** “The 5 day rule is entirely different [from the 75-day hearing notice rule]. Some ALJ’s will honor it inconsistently -- they will find exceptions to allow in adverse evidence, and ban positive evidence. I am told one ALJ has counted the 5 days to the minute to exclude evidence. Five business days is a week, any way it is sliced. It does not lead to efficient and fair adjudication. Relevant and probative evidence is excluded. This is not ‘world class service’ in a program that is by statute meant to be forgiving to claimants, who are mentally, physically, and financially impaired, in a process that easily takes more than a year to get to the hearing stage.

I have a recent example. I inherited a case in which a psychologist authored a report 2 months before the hearing, then left on vacation. She did not sign her report. Four days before the hearing, she electronically signed her report. Attempts by a colleague to submit the report were denied. The ALJ found conditions not to exist that the psychologist, with more testing than in any consultative examination, documented to exist. The ALJ denied the claim. We now represent the claimant on a re-application. How in the world this is good, for claimants, DDSs, and SSA escapes me. It increases the backlog, beyond being manifestly unfair.

Example 2: In this era of merger, some hospital groups own all the formerly individual practices. Medical records can no longer be obtained from the practice, but through ‘central office,’ at times out of state. We need the full 75 days to get records, because we can count on it taking at least 60 days under the present circumstances of medical record consolidation.
It is one thing to exclude a large parcel of remote evidence that could have been acquired within 75 days, and not made available to the ALJ or a medical expert until the day of the hearing. It is another thing entirely to exclude evidence that is not lengthy, or where there is no medical expert, or which did not exist until shortly before the hearing.

- **From an attorney in Maine:** “The five-day rule is also reasonable, but I feel it is sometimes abused by certain ALJs and needs clarification. One ALJ calculates the five days to the hour. Some have excluded evidence that did not exist until a few days prior to the hearing. To this day, I do not have a real understanding if a brief is covered by the rule. It seems to me that the rule should address these matters and should also allow for the late submission of very small exhibits that would not be too burdensome to review. Dumping hundreds of pages on the ALJ at the last minute is unfair to the Administration, but the gamesmanship employed by some judges as the rule currently exists is equally unfair to my clients and does not serve the larger purpose and spirit of the Social Security Act.”

- **From a representative in Maine:** “The five day rule is treacherous and not claimant friendly. Fair minded and reasonable judges apply it fairly and reasonably. Other judges apply it arbitrarily and capriciously. In Region I, I have heard horror stories about at least one judge who has counted ‘hours’ under the 5 day rule in order to keep evidence out.

In my own experience I had a judge interpret the five day rule as having to have the evidence in by the end of the 6th business day before the hearing. The work up person called me and told me she had been told to ‘unexhibit’ my evidence after first assuring me she had it and it was timely and had been exhibited. I filed a motion stating that I had been misled by ODAR (‘our actions misled you’ — one of the criteria for good cause) based upon the actions of the other ALJs who applied the rule otherwise (as had that very judge in the past). The ALJ wound up issuing an on-the-record decision without mentioning the timely submitted supportive evidence or attaching an exhibits list to the decision. So I could not tell whether the evidence was exhibited, so the issue is a ‘hanging chad’ I may face in the future with this judge.

I have had cases where mentally and physically impaired clients have unintentionally neglected to make me aware of crucial evidence that is often quite dated and could be determinative in cases (multiple childhood psychiatric hospitalizations in multiple hospitals during foster care, childhood surgeries, etc.). Representatives can often find mention of such evidence buried deep within a file during a final review. Of course we should all do our best to comprehensively develop a record but nothing is foolproof and the claimant suffers under the 5 day rule.
On another occasion, a cognitively impaired client told me days before her hearing she had been electrocuted in a work-related accident in the 1970s. I did a superlative job digging up the evidence by going through a one-foot thick, decades old workers compensation file and found the emergency room record, a neurologist's exam and a psychological evaluation – a total of perhaps 7-8 pages that would have taken an extra 5-10 minutes for the very experienced and capable medical expert to review. That judge postponed my client's hearing for another 3 months rather than take the evidence late under the 5 day rule.

Then there are other factors over which we have no control, such as medical opinions rolling in at the last minute from busy doctors, despite the fact the request for opinion evidence went out weeks before the hearing. Some judges will accept an opinion if it is dated after the 5 days, which is reasonable to base it on the date the evidence was generated. How can you submit it before it exists? But other ALJs won't accept it. Representatives may deal with perpetually non-responsive doctors’ offices that we have to keep after and drag medical evidence out of.

But the 5 day rule can keep evidence out that has been hard fought for, and make claimants wait 1 and 1/2 years for the Appeals Council to send the case back with instructions to review the evidence. This recently happened as the AC actually wrote an order stating it was remanding and giving the claimant the opportunity for a new hearing, so the opinion letter was not late anymore! This is a formidable burden placed upon the claimant caught between the representative and the judge. I would rather revert to the 20 days notice and no 5 day rule. Although the 75 day notice without the 5 day evidence deadline would be the most consistent, in my opinion, with this ‘beneficent’ program ....”

- **From an attorney in Maine:** “The 5 day rule has been badly abused by some ALJs ... Some ALJs exercise reasonable judgment when administering the rule, but clients have clearly been hurt by the arbitrary way some ALJs apply the rule.

Before DSI, the obligation of the adjudicators to develop the record was clear. With the adoption of the 5 day rule, ALJs have been permitted to ignore this obligation. ‘Late’ opinion evidence can be excluded very easily by the ALJ who wants to deny a claim.”

- **From an attorney in Maine:** “The 5 day evidence submission requirement eliminates the ALJ’s duty to develop the record, leads to adversarial hearings, and unfairly results in exclusion of relevant evidence.

As an example of problematic results, I have seen a case where the ALJ requested at the hearing that the representative submit records, received them shortly after the hearing, then declined to admit them under the 5 day rule (apparently because they were favorable to the claimant).
I have seen a case where an inexperienced representative submitted several hundred pages of mental health records less than 5 days before the hearing. These were rejected, resulting in the case being heard with no medical evidence of mental health treatment in the record from the preceding year.

I have seen a case where the claimant had undergone one day of neuropsychological testing prior to the hearing, and was scheduled again for more testing the second day after the hearing. The representative was not involved in arranging or scheduling the testing. The ALJ refused to accept the testing even though it was directly relevant to the disability claim.

In addition, the standards for good cause, as well as the precise meaning of “5 business days before,” are unclear and are interpreted inconsistently.”

- From an attorney in Massachusetts: “The five day rule is ridiculous! We do our best to cultivate the evidence in a timely manner but we are at the mercy of the providers much of the time. There is no reason to penalize the claimant because their doctor is on vacation, etc.”

- From an attorney in Massachusetts: “There are two types of evidence which we have trouble with. First, obviously, very recent evidence. Second, functional evaluations are getting harder to obtain and sometimes come in around or even, in rare cases, after the five day limit. In both instances, ALJs take the evidence.

Most of the ALJs in this area are fairly flexible with the five day rule, so long as they see representatives are complying with it generally. I have never had evidence excluded. However, there are a certain few ALJs who relish their role, and the potential it affords them for humiliation [of claimants]. I have heard from other advocates that they use the 5 day rule as a tool for their amusement.

But, by and large, the two rules together [the 75-day notice rule and the 5-day rule] have, in my experience, generally improved practice ... One obvious due process objection is that the ALJ is adjudicating a claim through the date of his decision. An inflexible application of the five day rule would deny a claimant the ability to submit evidence regarding his condition during that same period of time. However, that has not appeared to have occurred in my experience.

The rules are generally good ones. However, they have the potential to be used to hurt claimants ... in really bad ODAR offices, such as exist in places outside this region. On balance, the 75-day notice rule works very well and the 5 day rule generally acts as a good way to guide representatives ....”
• **From an attorney in Massachusetts:** “I cannot say that closing the record 5 business days prior to hearing has been a huge problem in Massachusetts. I think that, combined with at least 75 days advance notice of hearing, many advocates have found that they can develop the record in time. However, I also think that misapplication of the rule is a risk factor for claimants. Here are my concerns and examples of ALJs misconstruing the rule in Region I.

- I have heard of a few cases where ALJs refused to accept evidence prior to hearing but after 5 business days prior to hearing. In one case, it was allegedly the definitive IQ evidence that had not previously been supplied by the provider. Some ALJs have considered a memorandum of facts and law to be covered by the rule and so have not accepted a pre- or post-hearing memorandum.
- Some ALJs have applied the 5 day rule to nondisability cases like SSI financial eligibility appeals.
- Some ALJs have considered the medication list to be covered by the 5 day rule.
- At least one ALJ has said he has no discretion but to close the record 5 business days prior to the scheduled hearing.
- A couple of ALJs have miscounted the 5 days.

Clearly, ALJs need better instruction or reminders or both on the 5 day rule to prevent overly restrictive application if it is going to be kept and/or expanded. The “good cause” rules for submitting new evidence after 5 business days prior to hearing are too restrictive (I refer to them as progressive discipline). Legal services advocates tend to take cases at the ALJ level of appeal and our clients often do not find their way to us in time to have at least 75 days advance notice of hearing. In addition, many medical providers, social service providers, and schools have reduced staff and time to respond to requests for documents, opinion and residual functional capacity information, especially those serving the poorest claimants and those least able to cope.”

• **From an attorney in Massachusetts:** “We have judges who: (1) count Saturday and Sunday as part of the 5 days [i.e., not counting business days only]; (2) end the 5 days on the day of the hearing, or end the five days the day before the hearing; (3) count holidays or don’t count holidays as part of 5 days; (4) review the time evidence is filed, and if filed after the office has closed for the day, don’t count that day; (5) include the representative’s brief and claimant’s medication sheets as subject to the five day rule (the latter can result in it being read at the hearing); (6) never apply an exception to five day rule (I had results of an MRI taken 3 days before the hearing, relevant to case, which the ALJ refused to accept); and (7) will always accept records within the 5 days, finding them relevant.

If access to the electronic folder is not working properly, and evidence does not show up when sent, that can create problems with the 5 day rule as well. In short, just about any permutation of this rule that can happen, will happen.”
• **From an attorney in New Hampshire:** “This rule may be ‘logical’ to have, but it often creates great injustices for claimants who are the most disabled/impaired. When working with individuals with disabilities, the 5 day policy should be an aspirational goal, and not a limiting rule, as it is now.

If evidence is not submitted within the five day rule, critical evidence may be kept out of the administrative record, or the ALJ hearing may be postponed months into the future. Either way, the claimant is harmed. I have many examples of cases where the 5 day rule could not be met. Some examples:

  ○ Claimants sometimes choose medical service providers who are exceedingly slow to send out medical records; sometimes it takes them several months. Some never send them out and subpoenas are necessary, or at least threats of subpoenas are necessary. When time is running out, I will ask claimants to pick up and deliver records, but these claimants need to have the mental and physical capacity to do this, and the most cannot do this. We can’t control when medical records actually become available.

  ○ Some medical providers do not create a ‘record’ for many days or even weeks. We cannot order the medical record if it has not been created yet.

  ○ When the medical record is ordered, it often does not contain the latest information because there is delay in the creation of the record, or there is a delay in the medical record becoming part of the medical records ‘department.’ In other words, some medical facilities have record ‘departments’ and all record requests have to be submitted there. Actual treatment notes, lab results, etc., are not promptly transferred to the ‘records’ department.

  ○ People with organic brain injury, borderline intellectual functioning, mental illness, or other impairments which affect memory frequently ‘forget’ to tell the appointed representative critical information, or they do not know that certain information is critical. Sometimes I will learn new information at the last minute.

  ○ Sometimes claimants have hospitalizations, medical emergencies, or other unexpected events that occur within a month or two of the hearing. They are busy taking care of their emergencies or are otherwise too sick to convey information to me and there is insufficient time to order records for arrival before the hearing date.

  ○ I am representing a person who lives about 1.5 hours from my office. Her main disability is based upon organic brain injury. Her ODAR hearing is scheduled for May 20, 2013. Per usual procedure, I requested updated medical records from Exeter Hospital, near where the claimant lives, on April 8, 2013. I
sent a medical authorization for these records, which is accepted by most providers. On April 26, 2013, I received a letter from the Hospital stating that the medical authorization was not good enough, and that I had to use “their form.” I now have to send the form to the client to sign, she has to send it back to me, and I have to resend the request for records to the hospital. This will cause a minimum of 6-7 days delay, if my client immediately signs the form and returns them to me. But, as my client is brain injured, and she may not do it promptly, or she may not do it all.

○ This problem is an important one to share. When I order medical records on behalf of my client, I have to pay a minimum of $15.00 per request, which covers the first 30 pages, and then I can be charged 50 cents per page thereafter. Consequently, when the record consists of just 5 pages, I still have to pay a minimum of $15.00. This is statutorily allowed by New Hampshire law. My clients are required to reimburse this cost to me. On the other hand, if the claimant requests a copy of his/her records, the provider will often give them a copy for free, as a courtesy. When the medical record is extensive, the cost of medical records can be in the hundreds of dollars, and disability applicants do not have the money to pay. Some claimants will insist on trying to collect their medical records themselves to save these costs. More frequently than not, they fail to accomplish this. This is understandable because of their impairments. When I am allowed by the claimant to take back the responsibility of collecting records, sometimes there is not enough time before the hearing.

○ I have experienced some ALJs who use the 5 day rule in an abusive way. For example, sometimes I will obtain last minute evidence which is simply a few pages of updated information, such as treatment notes that do not materially change the overall analysis. It should not take the ALJ more than 5 minutes to review the new evidence, but the ALJ will insist on the claimant choosing between (1) postponing the case so the ALJ has time to review the new evidence; or (2) going forward with the hearing but leaving the evidence out.”

- **From an attorney in Vermont:** “I, for one, hate the 5 day rule. I don’t mind a request to submit evidence 5 days before the hearing (which is at least 7 days, since it is 5 business days); that much makes sense. But often our clients are still undergoing treatment up to the date of the hearing, and evidence may come in just before, or even after the hearing date. Some ALJs are rigid about the 5 day rule; others will allow additional evidence to be submitted if one explains why it was not available in time for the 5 day rule. We have often discussed the 5 day rule on our informal Vermont listserv, and I believe we are unanimous in the position that it should not be mandatory.”
4. What suggestion(s) does NOSSCR have, if any, for improving the current regulations, policies, and/or practices regarding the current pilot program in Region I?

a. NOSSCR recommendations

We offer the following recommendations for the submission of new evidence:

- **No time limit to submit evidence before the hearing.** This is consistent with the claimant’s statutory right that a decision be based on evidence “adduced at a hearing.” The current rule in effect in non-Region I states allows evidence to be submitted until the hearing. It should be retained nationwide.
- **More notice of the hearing.** We support expanding the 75-day hearing notice nationwide. A 75-day notice requirement would significantly improve the ability to obtain and timely submit evidence.
- **Submission of post-hearing evidence.** If the record is closed after the hearing, there should be a good cause exception that allows a claimant to submit new and material evidence after the hearing. While it benefits claimants to submit evidence as soon as possible, there are many reasons, as discussed earlier, why they are unable to do so and for which they are not at fault. It the record is closed, there should be a simple good cause exception that allows a claimant to submit new and material evidence after the ALJ decision is issued.

The construct used in the federal courts could be adapted. It is important that the regulations do not include an exhaustive list of reasons since each case turns on the facts presented. The “good cause” exception for district court “sentence six” remands for new and material evidence is well-developed. A review of published court decisions shows a wide variety of reasons why evidence was not submitted prior to the court level, including:

- Medical evidence was not available at the time of the hearing.
- The claimant was unrepresented at the hearing and the ALJ did not obtain the evidence.
- Medical evidence was requested but the medical provider delayed or refused to submit evidence earlier.
- The claimant underwent new treatment, hospitalization, or evaluation.
- The impairment was finally and definitively diagnosed.
- The claimant’s medical condition deteriorated.
- Evidence was thought to be lost and then was found.
- The claimant’s limited mental capacity prevented him from being able to determine which evidence was relevant to his claim.
- The existence of the evidence was discovered after the proceedings.
- The claimant was unrepresented at the hearing and lacked the funds to obtain the evidence.
There are many permutations, depending on the circumstances in each case.

b. **Additional recommendations from Region I NOSSCR members**

- **Recommendations from an attorney in Maine:**

  The 5 day rule should be modified to include the following:
  o 5 “calendar” days, not business days.
  o The default position is always to admit the evidence. There needs to be generous admissibility, not a gauntlet. Certainly, it should not be applied to evidence that did not exist 5 days before the hearing.
  o To exclude, there needs to be willful malfeasance on the part of the claimant’s representative; I do not see how malfeasance should ever be imputed to a pro se claimant. That is, some showing that the proffered evidence could have been acquired before but was not. It should be a sufficient response that it was duly requested before or within a week of receipt of the Hearing Notice, but not received through no fault of the claimant or the representative. Extracting evidence, especially opinion evidence, from medical providers, is a lengthy chore, and the delay by medical providers should not be held against claimants.
  o Late evidence that is from an “acceptable medical source” that the record otherwise lacks should be admitted. By definition, it relates back to the time in question [dated before the hearing], and could go to the Appeals Council after an unfavorable ALJ decision. If ALJs are going to flout the intent of the medical source Social Security Ruling [SSR 06-03p – evidence from treating medical sources who are not “acceptable medical sources”] in order to deny claims, when the world is turning toward the increasing use of such sources and decreasing use of doctors and psychologists, then such evidence should always be considered if it exists. Having that black and white is easier than requiring that it be adjudicated that the case turns on whether there is sufficient evidence from an acceptable medical source on which the case turns.
  o Finally, to exclude evidence, the ALJ needs to give reasons in the decision that are particularized rather than relying on the 5-day rule. Articulating a specific reason other than “the evidence is late ... no exceptions to exclusion are found” would seem to be a minimum requirement of due process. Indeed, requiring the ALJ to articulate the reason would establish most of the time that exclusion is arbitrary and capricious and manifestly unjust.

- **Recommendations from an attorney in Maine:**
If the idea of expanding the 5 day rule nationwide cannot be eliminated, then we need much clearer direction as to what is and what is not good cause for missing the deadline.

For example, if the document in question did not, in fact, exist before 5 days before the hearing, it should not be considered late. I once received a letter from a client’s employer that was dated less than 5 days before the hearing. It contained relevant information concerning the details of the employment. It was excluded. We have had many situations where it was the providers who caused delays that caused the missed deadline and their opinion evidence was excluded even though they were acceptable medical sources and the ALJ would otherwise be required to give their opinions special consideration.

In its current form the 5 day rule is too easily abused and the claimants have no effective remedy when evidence is unreasonably excluded even when it is highly probative.

- **From a representative in Maine:**
  ALJs already have the discretion to postpone hearings if representatives come in with huge piles of medical evidence at the last minute. In the final analysis, if the five day rule is retained and expanded, “five business days” needs to be defined more succinctly. For instance, if the hearing office closes at 3:30 or 4:00 or 4:30 p.m., (as office hour changes occur based upon budgetary concerns), but we file evidence by at least 5 p.m., what does that mean, especially if a judge is counting the hours? For example, if we file appeals of Social Security determinations with the federal district court, we have until midnight to meet deadlines. At the very least, if the five day rule is retained and expanded, the “fifth business day” deadline before the hearing means the fifth day before the hearing and ends at midnight.

- **From an attorney in Massachusetts:**
  Clarify the counting of the 5 day rule; expand the list of reasons to waive it; and issue some instruction that the rule is to be applied to ensure that all relevant evidence comes in, to protect the claimant’s right to a *de novo* hearing.

- **From an attorney in Maine:** Eliminate the 5 day evidence submission requirement and revert to provisions in effect in all other Regions.

5. **Does NOSSCR think the current pilot program in Region I should be continued, discontinued, or expanded to other regions? Why or why not? Please explain.**

NOSSCR’s positions are discussed in response to Question 4 and in detail in Part I, *supra*. In general, NOSSCR supports (1) Nationwide expansion of the 75-day
advance notice of hearing; and (2) Elimination of the rule requiring submission of evidence five days before the hearing. If the five day rule is retained, it must be clarified and more policy guidelines issued, prior to expansion beyond Region I, to prevent arbitrary and inconsistent application of the rule by some ALJs.

*   *   *

Thank you for considering our comments and recommendations. We look forwarding to discussing our comments in more detail and answering any questions you have.

Very truly yours,

Nancy G. Shor
Executive Director

Ethel Zelenske
Director of Government Affairs
October 28, 2016

The Honorable Carolyn Colvin
Acting Commissioner of Social Security
Social Security Administration
6401 Security Boulevard
Baltimore, MD 21235

Dear Commissioner Colvin:

We are writing about a series of recent and proposed changes to policies and procedures governing how the Social Security Administration (SSA) evaluates eligibility for disability benefits. We are concerned the changes will have the effect of limiting access to essential income support, including earned benefits, for individuals who meet the statutory eligibility criteria.

The combined effects of these changes would erect new, unwarranted barriers to benefits for severely disabled Americans. The changes are likely to result in individuals being denied benefits to which they are otherwise eligible. In some cases, the denials will be based solely on the inability of individuals struggling with severe illness or disability to navigate already-complex procedural obstacles, and in other cases, individuals will be denied benefits because SSA does not consider the most relevant medical evidence of their disability. This is not the intent of the Social Security Act and is not consistent with the purpose of Social Security and Supplemental Security Income, which is to provide basic economic support to those who, by reason of severe and long-term injury or illness, are unable to support themselves through work.

With hearing waiting times at an all-time high of 543 days, we appreciate that you and your team are making every effort to reduce the unprecedented backlog of pending disability hearings. It is undisputed that SSA requires an adequate number of Administrative Law Judges and support staff to conduct hearings. We understand that hiring has not been sufficient due to the 10-percent reduction in SSA’s operating budget since 2010 (after adjustment for inflation). These new procedural barriers to benefits, however, are not an appropriate response to this problem.

These changes are also inconsistent with SSA’s commitment to data-driven decision making. Little or no data has been presented to support the changes being proposed. There is no evidence that they will reduce delays or improve accuracy and fairness. In fact, making the process more formal, legalistic and adversarial — the result of adopting these changes — could increase delays, as claimants and their representatives would be forced to file additional appeals in order to have the evidence appropriately considered.

The specific changes of concern are:

- Proposed regulation to close the record for submission of evidence (“program uniformity”). This change creates an arbitrary 5-day deadline for the submission of evidence in disability appeals, which is counter to the clear language in the Social Security Act and penalizes claimants who, through no fault of their own, are unable to obtain and submit the evidence before the deadline. It is well known that SSA has difficulty obtaining medical evidence it requests from providers — claimants should not be penalized when they face the same difficulty. Further, experience with this policy in Region 1 reveals significant inconsistencies in the manner in which the 5-day deadline is implemented there. Finally, no evidence is presented that this policy has resulted in faster processing or more accurate decisions; its adoption is likely to result in further delays, as claimants are forced to pursue additional appeals or file new applications in order to have all relevant evidence considered. Program uniformity is a worthy goal and we recommend that SSA apply the evidence rules that exist in the rest of the country in Region I, rather than arbitrarily barring evidence needed to fully evaluate whether an individual meets the eligibility criteria.

- Proposed revision to rules regarding evaluation of medical evidence — This proposed rule makes a number of beneficial changes to expand the list of acceptable medical sources and to clarify and update some of SSA’s terminology.

However, the proposal also contains a radical, unwarranted and untested change: it would eliminate the longstanding recognition that evidence provided by medical providers who have examined and treated the claimant is generally of a higher value than medical opinions issued by those who have never examined the claimant, or have only examined them briefly.

Existing regulations explain the strong rationale for giving significant weight to opinions from individuals who have examined the claimant, and especially those who provided ongoing medical care to them: “since these sources are likely to be the medical professionals most able to provide a detailed, longitudinal picture of your medical impairment(s) and may bring a unique perspective to the medical evidence that cannot be obtained from the objective medical findings alone or from reports of individual examinations, such as consultative examinations or brief hospitalizations.” (Code of Federal Regulations, section 404.1527(c)(2))

The proposed rule would regard evidence from a claimant’s own medical providers as on par with one-time Consultative Examinations arranged by SSA, or paper file reviews by SSA consultants. Indeed, the proposal suggests that prior administrative medical findings by SSA consultants — which are essentially second-hand forms of evidence, based on whatever medical evidence is available in a claimant’s application for benefits, even if incomplete — are equivalent in probative value to actual medical evidence provided by someone with an established, treating relationship with the claimant. A treating source is
far more likely to provide an accurate diagnosis, prognosis, and evaluation of the effect of the individual’s impairment on their ability to function in the workplace than a generalist performing a brief exam, or a consultant reviewing and evaluating the often-incomplete medical file at SSA.

Furthermore, adoption of the proposed rule would result in less transparency and public confidence in SSA’s decision making, because it eliminates a number of existing requirements for adjudicators to explain why they accepted or rejected conflicting evidence. Under the proposal, evidence from a claimant’s own doctors could be summarily rejected, without explanation or justification, if there is other evidence in the file that the adjudicator is able to use. Without requirements for articulation, the public can have no confidence that all evidence will be fairly considered. The proposed rule gives adjudicators too much individual discretion to dismiss key evidence without providing a rationale, and will lead to increasing inconsistency in how claimants are evaluated by different decision makers.

It is well-documented that failure to fully comply with SSA’s existing, sensible rules that require adjudicators to explain and justify how they weigh evidence, especially evidence from the applicant’s own health care providers, is a common source of remands from the Appeals Council and the federal courts. However, the solution is not to abandon a long-established, clearly-structured, and transparent method of weighing multiple pieces of evidence. Instead, SSA should withdraw this portion of the proposed rule and focus on increased training and compliance with its existing policy — adding clarifications where necessary but not abandoning the policy itself.

- **Social Security Ruling 11-1p** – This ruling changed a policy which had been in place since 1999, which permitted claimants to continue pursuing an appeal within SSA even if they also chose to file a new application for benefits. Appellants often do this in hopes of receiving at least some income to survive on while they wait for appeals to be heard. The ruling eliminated this option. The real-world effect of this was to force claimants to make the difficult choice between pursuing an appeal that could take several years but could eventually provide back benefits and retroactive medical coverage, or foregoing these potential benefits by filing a new application, with only the prospect of future benefits. We note that claimants whose appeals are in Federal court are not barred from simultaneously filing a new application. We urge the restoration of prior policy, in recognition of the lengthy delays at both the hearing level (543 days) and the Appeals Council (362 days), and the often cespasive economic situation of a severely-disabled individual who has been unable to work for so long.

We expect that SSA will carefully consider all comments and concerns, without arbitrary deadlines due to the upcoming change in Administration. As you know, SSA disability programs support the most vulnerable. Great care, deliberation and substantial evidence should guide any changes that could impact full and fair adjudication.

We applauded other recent steps SSA has taken to improve accuracy, consistency and policy compliance in the disability programs, but these proposed regulations go too far. They are inconsistent with both the fundamental purpose of the programs — to provide income to those whose impairments render them unable to work — and the real world in which claimants live, with all the attendant challenges of obtaining evidence and navigating the complex application and appeals process.

Sincerely,

[Signatures]

Ron Wyden
Ranking Member
Committee on Finance
U.S. Senate

Sander M. Levin
Ranking Member
Committee on Ways and Means
U.S. House of Representatives

Sherrod Brown
Ranking Member
Subcommittee on Social Security, Pensions, and Family Policy
Committee on Finance
U.S. Senate

Xavier Becerra
Ranking Member
Subcommittee on Social Security
Committee on Ways and Means
U.S. House of Representatives

Patty Murray
Ranking Member
Committee on Health, Education, Labor and Pensions, and Subcommittee on Labor, Health and Human Services, Education, and Related Agencies
Committee on Appropriations
U.S. Senate

Lloyd Doggett
Ranking Member
Subcommittee on Human Resources
Committee on Ways and Means
U.S. House of Representatives

Rosa L. DeLauro
Ranking Member
Subcommittee on Labor, Health and Human Services, Education, and Related Agencies
Committee on Appropriations
U.S. House of Representatives
Ms. Sharon Parrott  
Associate Director for Education, Income Maintenance and Labor  
Office of Management and Budget  
725 17th Street Northwest  
Washington, D.C. 20503

Dear Ms. Parrott:

I am writing you regarding the Social Security Administration’s (SSA’s) proposed rule aimed at improving program uniformity in the hearing and appeals process. I applaud the efforts of SSA to simplify and make this process uniform across the Country.

However, I believe the provision that would require all evidence to be submitted five days prior to a hearing could cause unintended consequences.

As a former criminal court judge, I can understand the time needed by SSA employees to review records, but I feel that this requirement could place an undue burden on applicants.

Medical records and other materials can often be difficult to obtain, and the medical community is not under any statute that requires the release of these records in a timely manner.

I would be concerned that applicants who are not represented by counsel may not know about this requirement and if they do, they may not have the mental or physical capacity to obtain these records on their own. In addition, economic constraints or lack of access to proper transportation could cause delays in receiving these documents. Although the proposed rule suggests a “good cause” exception in some circumstances, it seems likely that Administrative Law Judges will not uniformly apply
this exception. Furthermore, several other deadlines in the proposed rule—for requesting subpoenas, objecting to issues raised in the hearing notice, and submitting written statements—lack any good cause exceptions.

Again, I appreciate the Administration’s efforts to improve the hearing and appeals process in order to help those who need it the most but do not feel that these provisions of the proposed rule will be helpful in achieving SSA’s goals. Thank you for your consideration of my comments.

With kindest regards, I am

Yours truly,

[Signature]

JOHN J. DUNCAN, JR.
Member of Congress

JJD:dw

Co: Judy Chesser, Deputy Commissioner, Office of Legislation and Congressional Affairs, Social Security Administration
November 1, 2016

Carolyn Colvin
Acting Commissioner
Social Security Administration
6401 Security Boulevard
Baltimore, MD 21235-6401

Submitted on www.regulations.gov


Dear Acting Commissioner Colvin:

These comments are submitted on behalf of the National Organization of Social Security Claimants’ Representatives (NOSSCR). NOSSCR is a specialized bar association for attorneys and advocates who represent Social Security Disability Insurance (SSDI) and Supplemental Security Income (SSI) claimants throughout the adjudication process. Since 1979, NOSSCR has been providing continuing legal education to its thousands of members, and public policy advocacy on behalf of its members and the people with disabilities they represent. NOSSCR’s mission is to advocate for improvements in Social Security disability programs and to ensure that individuals with disabilities applying for SSDI and SSI benefits have access to highly qualified representation and receive fair decisions.

Thank you for the opportunity to comment on the proposed regulations contained in this Notice of Proposed Rulemaking (NPRM). While NOSSCR generally supports SSA’s efforts to keep its rules current with changes in the national healthcare workforce, simplify and reorganize its rules for ease of use, and allow SSA to continue to make accurate and consistent decisions, these proposed rules will not accomplish those goals. NOSSCR objects to many aspects of the
proposed rules regarding the evaluation of medical evidence and urges SSA not to move forward with finalizing these regulations. NOSSCR’s general objections are as follows:

- These rules will not lead to more accurate decisions or decrease processing time. If anything, they will lead to more appeals, more remands, and more delays. The process of training adjudicators on this complex new regulation and adapting SSA systems to comply with it will be difficult, time-consuming, and expensive.
- SSA should continue requiring disability determinations to provide the rationale for how the decision was made. The provisions in this proposed rule that remove the responsibility of adjudicators to explain how they weigh certain evidence and prior administrative decisions, for example, is likely to increase appeals and court remands rather than decrease them. Courts will not be able to determine whether “substantial evidence” supports SSA’s decision unless adjudicators adequately explain how they arrived at their decisions.
- Some of the provisions contained in this NPRM conflict with the Social Security Act.
- Some of the changes proposed in this NPRM are not evidence based and do not rely on current data. For example, to our knowledge, SSA has not attempted a test in which it adjudicates a sample of claims under the current and proposed rule and compares the speed and accuracy of determinations under each set of policies.

NOSSCR urges SSA not to move forward with or to alter many of the provisions contained in this NPRM. Specifically:

- **Acceptable Medical Sources (20 CFR §404.1502(a) and §416.902(a))**: NOSSCR strongly supports SSA’s proposal to add audiologists and licensed advance practice registered nurses (APRNs) to the list of “acceptable medical sources.” However, NOSSCR urges for more expansion, including physician assistants (PAs), licensed clinical social workers (LCSWs), chiropractors, and physical therapists, based on the reality of who in the current healthcare workforce provides treatment.
- **Decisions by other governmental agencies and nongovernmental entities (20 CFR §404.1504 and §416.920b)**: NOSSCR opposes SSA’s proposed revisions to how decisions by other governmental agencies and nongovernmental entities are considered. SSA should continue to require adjudicators to articulate whether and to what extent medical opinions and prior administrative medical findings are considered.
- **How SSA Considers Evidence (20 CFR §404.1520c and §416.920c)**: Many changes in the NPRM are premised on the idea that individuals no longer have long-standing or strong relationships with treating sources. NOSSCR disagrees with that premise. Many disability claimants and beneficiaries have important relationships with their treating providers. As SSA recognizes when proposing expanding “acceptable medical sources,” treating sources are not (and truly never were) all physicians. NOSSCR supports the current rule, which requires adjudicators to give treating source opinions from acceptable medical sources controlling weight in most circumstances; when such opinions are not given controlling weight, the adjudicator must explain why not. NOSSCR also supports giving additional weight to opinions from acceptable medical sources than from those who perform a single examination or a review of a paper file, even in situations where controlling weight may not be appropriate. The inability of some SSA adjudicators to
adequately explain how they weighed conflicting evidence does not justify treating all evidence equally, but rather argues for better training and supervision of adjudicators.

NOSSCR urges SSA to withdraw the proposals to eliminate the treating source rule and to no longer give controlling weight, or any special consideration, to evidence received from a treating acceptable medical source. It is NOSSCR’s position that the relationship a claimant has with a treating source means treating source opinions deserve more weight than the opinions of an individual who performs a single examination or reviews a claimant’s paper file. Should SSA move forward with eliminating controlling weight for treating sources, NOSSCR urges that the agency retain the rest of the current framework for giving treating sources additional weight and adopt the suggestions contained in these comments. NOSSCR fully supports expanding the list of acceptable medical sources, but urges SSA to go further than proposed and include additional treating sources as acceptable. Our specific comments to the proposed rules appear below.

I. Definition of “Acceptable Medical Source” (20 CFR §404.1502(a) and §416.902(a))

NOSSCR fully supports SSA’s proposal to add audiologists and APRNs to the list of acceptable medical sources. We further support expanding the list to include physician assistants (PAs) and licensed clinical social workers (LCSWs). The licensing, education, and training requirements for PAs are sufficient and consistent nationwide. Per the American Academy of Physician Assistants (AAPA), for initial licensure of PAs, all states require, at a minimum, graduation from an accredited PA program and passage of the Physician Assistant National Certifying Exam (PANCE), which is administered by the National Commission on Certification of Physician Assistants (NCCPA).¹

Likewise, for LCSWs, all states have a minimum educational requirement of a Master of Social Work degree and require passage of one of four of the exams offered by the Association of Social Work Boards (ASWB), typically the clinical exam.² Similar to APRNs, supervised post-degree experience is an additional requirement for LCSWs in most states, ranging from 3,000 hours to 24 months.³ In addition, a substantial number of people with mental health conditions and psychiatric disabilities have LCSWs as their primary mental health care providers. The National Association of Social Workers estimates that 60% of mental health professionals are clinical social workers, compared to 10% who are psychiatrists, 23% who are psychologists, and 5% who are nurses.⁴ An LCSW is often the provider best able to offer an informed and detailed opinion about the mental health of a Social Security disability claimant or beneficiary. Therefore, NOSSCR supports the addition of audiologists and APRNs to the list of acceptable medical sources, and would support adding both PAs and LCSWs to this list.

NOSSCR recommends the final rule specifically state that Nurse Practitioners are acceptable medical sources. This will avoid confusion. There are numerous examples of nurse practitioners

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¹ https://www.aapa.org/become-a-pa/.
³ Id.
⁴ https://www.socialworkers.org/pressroom/features/issue/mental.asp.
being the primary treating source for patients⁵ and specifically naming them in the category of APRN would clarify their role.

We appreciate SSA’s willingness to add other medical professionals to the list of acceptable medical sources. This recognizes the fact that many patients today are treated by other professionals in addition to, or instead of, MDs—either by choice or necessity.

NOSSCR recommends that SSA also include chiropractors and physical therapists as acceptable medical sources within the specific scope of practice requirement. Doing so not only recognizes the way many people receive medical care today, but would also create a uniform rule and reduce the number of cases filed in federal courts, which are ultimately remanded due to the ALJ’s failure to give proper consideration to medical evidence provided by these sources. Including them specifically in the list of acceptable medical sources would clarify the rule. These medical professionals are also subject to strict education and licensing requirements. For example, in Santiago v. Bowen, 715 F.Supp.614 (S.D.N.Y. 1989) the court noted the rigorous four-year training of chiropractors, which is the same length as medical school, and the licensing requirements in the state of New York. In Barrett v. Barnhart, 355 F.3d 1065 (7th Cir. 2004), the court recognized that patients are more likely to seek relief from chronic problems from a physical therapist than an orthopedist. Properly trained physical therapists can provide personalized treatment and often have ongoing treatment relationship with their patients.

II. Decisions by other governmental agencies and nongovernmental entities (20 CFR § 404.1504 and 20 CFR § 416.920b)

The NPRM, if finalized, would allow SSA adjudicators to not provide any analysis in their disability and blindness determinations about how they considered decisions made by other governmental agencies or nongovernmental entities that an individual is disabled, blind, or unemployable. The proposed rule would also clarify that SSA is not bound by these other agencies’ and entities’ decisions.

NOSSCR opposes the proposal to rescind Social Security Ruling (SSR) 06-03p and change how disability decisions from other governmental agencies and nongovernmental entities (“other agencies”) are considered. We believe that SSR 06-03p was correct when it said “These decisions, and the evidence used to make these decisions, may provide insight into the individual's mental and physical impairment(s)” (emphasis added); the decisions themselves, and not just the evidence used to make the decisions, have value. NOSSCR recognizes that other agencies have different standards for determining disability and agree that SSA need not be bound by other agencies’ determinations, but we believe SSA adjudicators should, as SSR 06-

⁵ See, e.g., Voigt v. Colvin, 781 F.3d 871 (7th Cir. 2015); Shontos v. Barnhart, 328 F.3d 418 (8th Cir. 2003): Nurse practitioners and therapists are "other medical sources" whose opinions are considered medical opinions, pursuant to 20 §§CFR 404.1527(a)(2) and 404.1513(d)(1). Although some courts have found that nurse practitioners are only acceptable medical sources under the current regulations if they work under the supervision of physicians, SSA could and should make regulations that consider nurse practitioners to be acceptable medical sources when they work independently as well. This would reflect the nature of some claimants' treatment and not penalize claimants for the diverse working environments of the medical professionals who know them best.
03p currently requires, “explain the consideration given to these decisions in the notice of
decision for hearing cases and in the case record for initial and reconsideration cases.” This is in
keeping with the Social Security Act, which requires the agency to make determinations “on the
basis of evidence adduced at the hearing.” Allowing adjudicators to ignore this specific class of
evidence does not comport with the Social Security Act.

It is not accurate to say, as does the preamble to the proposed rule, that “other governmental
agencies’ or nongovernmental entities’ decisions give us little indication whether a claimant is
more or less likely to be found disabled or blind under the Act.” Although the probative value of
other agencies’ or entities’ decisions will obviously vary, SSA’s own research shows that
veterans with 100% disability ratings or an IU ratings are substantially more likely to be found
disabled than the general population of SSDI applicants.6

NOSSCR continues to support SSA’s current policy of expediting claims for those classified as
“military casualty/wounded warriors” and for veterans with 100% permanent and total disability
compensation ratings from the VA. Given that veterans with 100% disability compensation
ratings have a high award rate for Social Security disability benefits when they do apply,7 we
urge SSA to continue considering VA disability ratings and other agency decisions when making
disability determinations and not just in determining the order in which claims are processed.

NOSSCR agrees that some claimants’ files may not have complete information about the reasons
underlying another agency’s determination. But some files do contain this information, and we
disagree with the proposed rule, which would release adjudicators from the need to consider it
when it does appear. In addition, another agency’s disability determination may include other
information that may be important for assessing medical and non-medical criteria for Social
Security disability benefits. Such a determination could include information about a claimant’s
income, work history, marital status, or immigration status. It could include an adjudicator’s
observations of the claimant or information about the medical treatment a claimant receives.
Modifying 20 CFR §§404.1504 and 416.904 to state that SSA “will not provide any analysis in
our determinations and decisions about how we consider decisions made by other governmental
agencies or nongovernmental entities” means that claimants and their representatives will have
no way of knowing whether the SSA adjudicator reviewed the evidence at all, or whether the
adjudicator gleaned these or other important pieces of information from the determination. The
proposed rule does not forbid consideration of other agencies’ determinations, so it is possible
that an SSA adjudicator would consider another agency’s determination but not state that they
did so. An adjudicator could, conversely, fail to consider another agency’s determination and
never explain why. It will be impossible to know, therefore, whether the adjudicator’s decision
was based on substantial evidence. This change would take SSA decisions further away from the
standards articulated in numerous federal court cases, including the Ninth and Fourth Circuit
cases cited in footnote 42 of the NPRM. These cases require the agency to provide great or
substantial weight to VA determinations, absent reasoned and fact-specific explanations.
Changing the rules so that adjudicators are not required to give any weight to VA determinations
and never have to explain their reasoning on this topic would therefore lead to more appeals and
probably more remands.

6 See https://www.ssa.gov/policy/docs/ssb/v74n3/v74n3p1.html Chart 16.
7 See id. at Chart 4.
A better approach than the one proposed in the NPRM would be to provide additional training and more quality reviews of adjudicators’ decisions. Helping DDS examiners and Administrative Law Judges (ALJs) to articulate how they weighed these decisions is consistent with the jurisprudence in cases where other agencies’ decisions were at issue. NOSSCR urges SSA to preserve SSR 06-03p, withdraw this regulatory proposal, increase the training provided to adjudicators regarding articulating how other agencies’ or entities’ decisions were weighed, and conduct more quality reviews of written decisions to identify training needs.

III. How we consider and articulate medical opinions and prior administrative medical findings. (20 CFR § 404.1520c and 20 CFR §416.920c)

NOSSCR strongly opposes the changes proposed in this section. NOSSCR supports the current rule, which requires adjudicators to give treating source opinions from acceptable medical sources controlling weight in most circumstances; when such opinions are not given controlling weight, the adjudicator must explain why not. NOSSCR urges SSA not to change these rules. The reasons provided in the preamble to the proposed rule are not compelling. It is NOSSCR’s position that the proposed changes will reduce accuracy of decisions and will undermine the legitimacy of decisions by making them significantly less transparent. This proposed rule would give adjudicators excessive discretion with little direction as to how it should be applied. SSA’s current rules on the topic are clearer, and the treating physician rule already has safeguards in place to ensure that the only medical opinions given controlling weight are those that are consistent and well-supported by the record. As such, NOSSCR urges SSA to refrain from adopting this proposed rule.

A. The Proposed Changes Are Inconsistent with the Social Security Act

As the Supreme Court noted in Black and Decker v. Nord, 538 U.S.822, (2003) (Black & Decker) “The treating physician rule at issue here was originally developed by Courts of Appeals….” based on the requirements in the Social Security Act itself. SSA cannot eliminate the need to give more weight to treating sources than to non-treating sources through the regulatory process, because courts will likely continue to impose a treating physician rule of some kind, as they did before SSA introduced its 1991 regulations. The Act’s specific requirement that “the Commissioner of Social Security shall make every reasonable effort to obtain from the individual’s treating physician (or other treating health care provider) all medical evidence, including diagnostic tests, necessary in order to properly make such determination, prior to evaluating medical evidence obtained from any other source on a consultative basis” implies that Congress recognized special knowledge that a treating source can provide regarding a claimant’s impairments and the inherent value in this medical evidence. This section indicates that special consideration should be given to the opinion of a treating physician or other treating health care provider. Prior to the 1991 regulatory scheme enacted to codify the treating physician rule, courts certainly interpreted it that way. It is likely that courts will respond to a regulatory

9 Section 223; 42 USC 423(d)(5)(B).
change that places treating sources on equal footing with non-treating sources the same way they did before 1991.

SSA’s reliance on *Black and Decker*) in the NPRM is misplaced and does not support an elimination of the entire evidence evaluation framework currently in place. Neither does the Administrative Conference of the United States (ACUS) report SSA commissioned in 2013.¹⁰ ACUS, when reviewing SSA’s treating physician rule, relied on a phrase in *Black & Decker*:

“And if a consultant engaged by a plan may have an 'incentive' to make a finding of 'not disabled,' so a treating physician, in a close case, may favor a finding of 'disabled.’” In the preamble to the NPRM, SSA interpreted this statement to mean that treating sources are more likely to find that the claimant is disabled. But this is not what the Supreme Court meant. In *Black & Decker*, the Court made a comparison: if doctors paid by benefit plans might lean towards finding a claimant not to be disabled, it would follow that treating doctors might be more inclined to find a patient is disabled. But the Court does not say anything about a “built-in evidentiary bias.” Instead, the Court simply held that SSA’s treating physician rule is not applicable in ERISA cases. The Court reasoned that SSA has regulations which govern the weight to be applied to a treating physician’s opinion in a Social Security disability claim. But because no similar Department of Labor regulations exist, and because the ERISA statute itself does not contain any reference to evidence from a treating source (in contrast to the Social Security Act), the Supreme Court held that the courts cannot require application of a treating physician rule to employee benefit claims made under ERISA. *Black & Decker* should not be read to conclude that treating physicians cannot issue unbiased medical opinions regarding their patients, nor that the current regulatory provisions creating the additional weight given to treating sources is inappropriate or needs to be changed.

### B. Increasing Complexity of Cases and Size of Files Do Not Justify Changing the Regulatory Framework for Evaluation of Evidence

One reason put forth by SSA for eliminating the current treating source rule is that some claims files are too large for adjudicators to properly consider all of the evidence.¹¹ SSA also asserts that people now see more specialists and often submit evidence from a variety of sources, making it harder for adjudicators to apply the treating source rule. NOSSCR recommends that SSA instruct its adjudicators on how to weigh opinions from multiple treating sources instead of eliminating the rule altogether. If the current rule no longer reflects current treatment scenarios, it should be revised to account for the current situation of managed care and multiple treating sources (including but not limited to physicians), while still granting controlling weight to the opinion of a long-time treating source or primary care provider. People may have multiple providers because they have multiple impairments. It is possible to create a rule that allows adjudicators to give opinions more weight when they are evaluating the impairment for which a provider provided treatment.


¹¹ “Due to voluminous case records in some cases, it is not always administratively feasible for us to articulate how we considered each of the factors for all the medical opinions and prior administrative medical findings in a claim while still offering timely customer service to our claimants.”
Assessing numerous, at times conflicting, statements and evaluating the probative nature of each in accordance with laws and regulations is the very job of an adjudicator. The fact that adjudicators are tasked with making many findings is not a reason to change the weight given to evidence. In addition, the proposed framework would not simplify this task; it would give less guidance and more discretion to adjudicators on how to weigh evidence. It would then remove the requirement that the adjudicator articulate how he or she did so, unless the adjudicator has to assess the persuasiveness of the evidence.

The issue of “voluminous case files” cannot be allowed to reduce adjudicators’ responsibilities or the due process given to claimants. The proposed rule could amount to a denial of a claimant’s right to have his or her case decided on the totality of the evidence and a violation of the adjudicator’s long-standing duty to make a decision based on all of the evidence in the record.\textsuperscript{12} Case files are longer for many reasons, including SSA’s all evidence rule,\textsuperscript{13} long processing times, and the repetitive nature of electronic medical records. People with long claims files are no less likely to be disabled, and no less deserving of due process, than people with short claims files. NOSSCR again notes that adjudicators are required to make a decision based on all of the evidence in the record. If there is too much evidence, then SSA might consider revising the recently enacted rules requiring submission of all evidence and reduce hearing-level processing times. These have resulted in voluminous files. Allowing adjudicators to disregard relevant evidence, or no longer requiring them to articulate how they considered that evidence, are not acceptable solutions.

Instead of removing the articulation requirements, SSA should give adjudicators and their support staff the training and support they need to do their important work properly. Removing adjudicators’ responsibility to “show their work” will not reduce appeals and remands. A federal judiciary that currently remands many cases to the Commissioner due to articulation errors is unlikely to be more deferential to an agency that simply stops articulating at all. In fact, the courts might even find these regulations to be impermissible. The Commissioner cannot, by regulation, remove adjudicators’ statutory duty to consider the entire medical record and articulate how a decision is reached.

\textbf{C. Treating Source Relationships Still Exist and Should Be Afforded Additional Weight}

As mentioned above, NOSSCR disputes the assertion that the nature of healthcare has changed to the point that treating source no longer deserve additional more weight. Although it is true, in certain cases, that some people no longer have a primary care physician, many people who have chronic conditions and disabilities have ongoing relationships with some type of healthcare provider. Those providers might be APRNs, PAs, LSCWs, physical therapists, or audiologists.

\begin{footnotes}
\item[13] 20 CFR §§ 404.1512(a) and 416.912(a).
\end{footnotes}
(just to name a few) rather than doctors, but the treating relationship is still important and still deserves the value placed on it by the existing treating source rules.

The 2013 ACUS report cites several studies indicating some people change their primary care providers due to insurance changes or personal preference, but those studies actually showed that many people keep their providers for long periods of time—certainly long enough to establish a relationship exceeding what one might encounter in a consultative examination or file review. It is also possible that as the Affordable Care Act allows more people to obtain medical insurance and carry it with them between jobs, and as more Baby Boomers qualify for Medicare (with several years in which they might apply for or receive SSDI, due to the increase in the full retirement age), some people are experiencing more consistent medical treatment than they did in the past. Although the way some patients receive medical care has changed since the current rules were issued in 1991, if a patient does have a long-standing relationship with a long-time treating source, the opinion of such a medical source should continue to be given its current weight. The ACUS report does not deny the importance of a long-standing treating source/patient relationship when one does exist.

The relationship between an individual and their treating provider is special and the opinions of treating providers deserve more weight than the opinion of someone who either examines an individual once or only reviews the claims file. The evidence from a treating source is generally more persuasive because treating providers treat. A provider would not prescribe medication, recommend tests, give advice, refer to a specialist, perform surgery, or provide other treatments unless they found the patient’s reports and their own observations and conclusions persuasive enough to require these actions.

In 1991, SSA stated that a treating source opinion “tends to have a special, intrinsic value because treating sources are likely to be the medical professionals most able to provide a detailed, longitudinal picture of a claimant’s medical history and may bring a unique perspective to the medical evidence.” SSA fails to make the case in this proposed rule that what it said in 1991 is no longer true. Many insurance companies today require that patients receive a referral from their primary care physician. This physician, often the “gatekeeper” and coordinator of the various treatments that a patient receives from specialists, can provide an opinion based on medical evidence from several treating specialists.

It is NOSSCR’s position that when a treating or primary care source relationship does exist, the current rules continue to be appropriate. Furthermore, it should be possible for SSA to give controlling weight to one provider for one impairment and another provider for another

14 ACUS, supra note 10, at fn.221. For example, the ACUS paper describes a 2003 study by Paul Nutting et al. as “summarizing studies showing that only about 50% of surveyed patients reported continuity of regular physician,” but Nutting’s study itself states that “In the practice settings examined in this report, more than 90% of patients saw their regular physician. In these family practices it appears that patients were able to achieve continuity for many of those visits in which it is hypothesized to be important.”

15 56 Fed. Reg. at 36934 and 36961.
impairment, or to reconcile opinions that differ or conflict. Assessing multiple pieces of evidence, reconciling inconsistencies, and arriving at a policy-compliant decision is precisely the job of an adjudicator.

**D. Treating Source Opinions Should Still Receive Additional Weight Even if Not Controlling Weight**

NOSSCR strongly urges SSA to retain the current framework giving treating source opinions controlling weight when supported and consistent. If the agency chooses not to, NOSSCR urges SSA to maintain the rest of the framework for giving treating sources more weight than non-treating medical sources. SSA fails to provide a compelling rationale that treating source opinions should be placed on an even level with those of someone who completes a consultative examination (CE) or a file review, as the proposed rules would do. Even if a treating relationship is short, it is still longer than a CE or a file review.

SSA fails to explain why the factors adjudicators must currently use to determine what weight to give opinion evidence need to be altered, or why the order in which the factors are applied should be changed. The first factors to be examined should continue to be whether the source has examined the claimant and the nature and length of the treatment relationship, followed by whether the opinions are supported and consistent. NOSSCR supports continuing to include whether or not the treating source is a specialist as a factor in determining whether to give controlling or additional weight to a treating source.

However, NOSSCR strongly opposes two factors the NPRM would use to evaluate the persuasiveness of evidence: familiarity with SSA rules and having completed a review of the entire file. These factors tip the scale toward MC and CE opinions and SSA does not provide a compelling rationale for including these factors. These two factors reflect the role of the adjudicator – being familiar with SSA rules and reviewing the entire file – and not the role of a medical source, especially because knowledge of SSA’s policies is generally not required except to make a determination that is reserved for the Commissioner.

SSA fails to provide any convincing reasons as to why being able to review the whole file and knowing SSA’s policies should be considered on an equal level to the other factors. To the contrary, the opinion of a specialist who has an ongoing relationship with the claimant, on a condition within the specialist’s area of expertise, is likely to be more accurate than the opinion of a generalist who knows SSA’s policies and reviewed the whole file in regard to that particular impairment. In addition, SSA’s proposed rules provide no explanation of the relative importance of the factors. Does SSA envision that reviewing the whole file is as important as whether the source examined the claimant? The proposed rule is less clear than the current rules and may result in more appeals and remands.

Some opinions are written down long before a case file even exists but that does not make them less persuasive. At the same time, when a MC reviews a file at the initial level, given the extremely long delays waiting for hearings, it is likely that the individual’s conditions have

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16 See 20 CFR §404.1527(a)
changed and significantly more evidence is in the file. The MC reviewed the entire file at the time of the initial decision, but not the entire file by the time an ALJ makes a decision. As written, an ALJ could find the MC opinion more persuasive, even though the MC reviewed a record lacking material evidence available at the time of the appeal.

Although NOSSCR strongly opposes any dilution of the current treating physician rule, should the proposed rule be adopted, we disagree with the concept that, in place of a long standing treatment relationship, supportability and consistency will be the most important factors to consider when evaluating the evidentiary value of medical opinions and prior administrative medical findings. The treatment relationship and specialization (when appropriate) are more important factors, as they are under the current framework.

IV. Other Proposed Changes

A. Your Medical Source (20 CFR §404.1519h, i and 20 CFR § 416.919h, i)

NOSSCR supports SSA’s proposal stating that the preference for consultative examinations will be any of a claimant’s medical sources. We also support SSA’s proposal to use the existing standard to decide whether to select the claimants’ medical source for the consultative examination.

B. How We Consider Evidence (20 CFR §404.1520b and §416.920b)

NOSSCR opposes proposed 20 CFR §§404.1520b and 416.920b that would replace the word “weigh” with “consider”. Although SSA’s stated reason for changing the language is to avoid confusion when “weigh” is used in many places, in fact these two words have different meanings. While “consider” means simply to think about, “weigh” means to assess the importance of a piece of evidence in relation to other evidence. Therefore, this proposed change in language would, in effect, allow adjudicators simply to think about the evidence rather than determine which evidence is more persuasive or important.

C. Statements on Issues Reserved to the Commissioner (20 CFR 404.1520b(c)(3) and 416.920b(c)(3))

If SSA issues a final rule on this topic, we urge it to include a statement explaining that evidence including statements on issues reserved to the Commissioner should not be completely disregarded. Instead, the statements on issues reserved to the Commissioner should be given their appropriate weight, and other statements, findings, or opinions should be given their appropriate weight.

We also urge SSA to clarify that merely using terms that appear in listings, domains, the medical-vocational grids, or elsewhere in SSA’s law and regulations does not indicate that a statement is on issues reserved to the Commissioner. Words like “moderate,” “marked,” “sedentary,” and other terms are frequently used by medical providers and others. An adjudicator
need not be bound to others’ conclusions on issues reserved to the Commissioner. But adjudicators should be cautioned not to ignore statements that are on issues not reserved to the Commissioner just because they use words that appear in SSA’s own laws and policies. As an example, “Mrs. Smith is restricted to sedentary work” is a statement on issues reserved to the Commissioner, but “Mr. Jones has led a more sedentary lifestyle since his accident and can no longer climb stairs or stand without a cane” is not.

**Conclusion**

NOSSCR urges SSA to withdraw most of this NPRM and to only move forward with the expansion of acceptable medical sources. We urge the agency to further expand the list with the inclusion of PAs and LCSWs, as well as chiropractors and physical therapists. NOSSCR strongly opposes the proposed changes to the way SSA will consider decisions by other governmental agencies and entities, and the changes SSA proposes to make to how evidence from treating and non-treating sources will be evaluated.

SSA also proposed to rescind the following SSRs: 96-2p, 96-5p, and 96-6p. Because NOSSCR opposes the changes in the regulations that would render these rulings inconsistent, and because NOSSCR finds that these Rulings provide adequate explanation of the rules on evaluating and weighing medical evidence, NOSSCR opposes the recission of these rulings.

NOSSCR emphatically supports maintaining the current rule recognizing the “intrinsic value” of the treating source/patient relationship and urges SSA to continue to afford such opinions controlling weight when the requirements for consistency and supportability are met. Should SSA choose to move forward with eliminating the controlling weight aspect of the way it currently evaluates evidence from treating sources, NOSSCR urges SSA to maintain the rest of the current regulatory framework for giving treating sources additional weight over non-treating sources based on the nature and the length of the treating relationship.

Thank you for considering these comments.

Sincerely,

Barbara Silverstone
Executive Director
SOCIAL SECURITY ADMINISTRATION  
20 CFR Parts 404 and 416  
[Docket No. SSA–2012–0035]  
RIN 0960–AH51  
Revisions to Rules Regarding the Evaluation of Medical Evidence  
AGENCY: Social Security Administration.  
ACTION: Final rules.  
SUMMARY: We are revising our medical evidence rules. The revisions include redefining several key terms related to evidence, revising our rules about acceptable medical sources (AMS), revising how we consider and articulate our consideration of medical opinions and prior administrative medical findings, revising our rules about medical consultants (MC) and psychological consultants (PC), revising our rules about treating sources, and reorganizing our evidence regulations for ease of use. These revisions conform our rules to the requirements of the Bipartisan Budget Act of 2015 (BBA), reflect changes in the national healthcare workforce and in the manner that individuals receive medical care, and emphasize the need for objective medical evidence in disability and blindness claims. We expect that these changes will simplify our rules to make them easier to understand and apply, and allow us to continue to make accurate and consistent disability determinations and decisions.  
DATES: These final rules are effective on March 27, 2017.  
SUPPLEMENTARY INFORMATION:  
Background  
We are revising and making final the rules regarding the evaluation of medical evidence that we proposed in a notice of proposed rulemaking (NPRM) published in the Federal Register on September 9, 2016 (81 FR 62560). In the preamble to the NPRM, we discussed the revisions we proposed and the bases for the proposals. To the extent that we are adopting those revisions as we proposed them, we are not repeating that information here. Interested readers may refer to the preamble to the NPRM, available at http://www.regulations.gov by searching for document number SSA–2012–0035–0001.  
To help clarify our current policies found in SSR 06–03p and 416.913. We changed the title from “statements from nonmedical sources” as proposed to “evidence from nonmedical sources” for clarity. We revised the definition for brevity and to explain that we may receive evidence from nonmedical sources either directly from the nonmedical source or indirectly, such as from forms and our administrative records.  
6. We clarified that a statement(s) about whether or not an individual has a severe impairment(s) is a statement on an issue reserved to the Commissioner in final 404.1520(c)(3) and 416.920(c)(3).  
7. We revised final 404.1520c(a)–(b) and 416.920c(a)–(b) to clarify that, while we consider all evidence we receive, we have specific articulation requirements about how we consider medical opinions and prior administrative medical findings.  
8. For claims filed on or after March 27, 2017, we are revising our rules to state that our adjudicators will articulate how they consider medical opinions from all medical sources, regardless of whether or not the medical source is an AMS, in final 404.1520c and 416.920c.  
9. We revised the factors for considering medical opinions and prior administrative medical findings in final 404.1520c and 416.920c to both emphasize that there is not an inherent persuasiveness to evidence from MCs, PCs, or CE sources over an individual’s own medical source(s), and vice versa, and to highlight that we continue to consider a medical source’s longstanding treatment relationship with the individual.  
10. We added regulatory text in final 404.1520c(d) and 416.920c(d) for claims filed on or after March 27, 2017, that there is no requirement to articulate how we considered evidence from nonmedical sources about an individual’s functional abilities and limitations using the rules for considering and articulating our consideration of medical opinions found in final 404.1520c and 416.920c.  
11. We clarified the section headings and introductory text in final 404.1520c, 404.1527, 416.920c, and 416.927 about the implementation process.  
12. We added regulatory text in final 404.1527(f) and 416.927(f) for claims filed before March 27, 2017, about how we consider and articulate our consideration of opinions from medical sources who are not AMSs, and from nonmedical sources. We are adding our current policies found in SSR 06–03p, which explains how we consider and when we articulate our consideration of opinions from medical sources who are not AMSs and from nonmedical sources.
under our current rules, into the final rules for these claims.

13. We revised the criteria for which audiologists may perform audiometric testing in sections 2.00B and 102.00B of the Listings to be consistent with our revision to recognize licensed audiologists as AMSs. We now state that audiometric testing must be performed by, or under the direct supervision of, a licensed audiologist or otolaryngologist.

14. We did not adopt our proposal to recognize independently practicing psychologists with master’s-level education as qualified to be PCs. Instead, we will continue to follow our current policies about who is qualified to be a PC, which generally require a doctorate-level education degree, in final 404.1616 and 416.1016.

15. We made a number of nonsubstantive revisions relating to the revisions listed above, as part of our effort to reorganize our regulations for ease of use, to use consistent terminology throughout our rules, to reflect revisions to regulatory text made by other rules since publication of the NPRM, and for clarity. Because of these revisions, these final rules retain only two programmatic distinctions between AMSs and medical sources, who are not AMSs in our regulations for claims filed on or after March 27, 2017. First, we need objective medical evidence from an AMS to support that a medical impairment meets a Listing.4 Second, in a few instances, we need specific evidence from an AMS to establish that an individual’s impairment meets a Listing.4

Effect on Certain Social Security Rulings (SSR)

We will also rescind the following SSRs that are otherwise inconsistent with or duplicative of these final rules:

- SSR 96–2p; Titles II and XVI: Giving Controlling Weight to Treating Source Medical Opinions.5
- SSR 96–5p; Titles II and XVI: Medical Source Opinions on Issues Reserved to the Commissioner.6
- SSR 96–6p; Titles II and XVI: Consideration of Administrative Findings of Fact by State Agency Medical and Psychological Consultants and Other Program Physicians and Psychologists at the Administrative Law Judge and Appeals Council Levels of Administrative Review; Medical Equivalence.7
- SSR 96–3p; Titles II and XVI: Considering Opinions and Other Evidence from Sources Who Are Not “Acceptable Medical Sources” in Disability Claims; Considering Decisions on Disability by Other Recognized Local and Nongovernmental Agencies.8

In addition, because we will rescind SSR 96–6p, we will publish a new SSR that will discuss certain aspects of how administrative law judges (ALJ) and the Appeals Council (AC) must obtain evidence sufficient to make a finding of medical equivalence.

Public Comments

We received 383 comments on the NPRM, which are available for public viewing at http://www.regulations.gov. These comments were from:

- Individual citizens and claimant representatives;
- Members of Congress;
- Various professional organizations, such as the American Speech-Language Hearing Association (ASHA), American Psychological Association Practice Organization, American Academy of Pediatrics, American Optometric Association, and the American Association for Justice;
- National groups representing claimant representatives, such as the National Organization of Social Security Claimants’ Representatives, the National Coalition of Social Security and SSI Advocates, and the National Association of Disability Representatives;
- Advocacy groups, such as the Consortium for Citizens with Disabilities, The Arc, the Community Legal Services of Philadelphia, and the North Carolina Coalition to End Homelessness; and
- Organizations representing our employees and employees of State agencies, such as the National Council of Disability Determination Directors, National Association of Disability Examiners, and the Association of Administrative Law Judges.

While we received several public comments in support of our proposed rules, we received many public comments that opposed our proposed revisions and that suggested alternative solutions to the policy changes we proposed. Among the most common concerns that the public comments raised were that:

- We should recognize additional medical sources as AMSs;

- The NPRM appeared to favor evidence from MCs, PCs, and consultative examination (CE) providers over evidence from an individual’s own medical sources;

- We should continue to value or emphasize the individual’s relationship with a treating source, including giving controlling weight to the medical source statements of treating sources in certain situations; and

- We should provide written analysis about medical opinions from all of an individual’s own medical sources, regardless of whether the medical source is an AMS.

We carefully considered the comments. We strive to have clear and fair rules because our adjudicative process is non-adversarial.9 To help maintain the fairness of our rules and our administrative review process, we have made several revisions in these final rules.

We discuss below the significant comments we received. Because some of the comments were long, we have condensed, summarized, and paraphrased them. We have tried to summarize the commenters’ views accurately, and to respond to the significant issues raised by the commenters that were within the scope of the NPRM.

Sections 404.1502 and 416.902—Definitions for This Subpart

Comment: We received several comments about our proposal to recognize Advanced Practice Registered Nurses (APRN) as acceptable medical sources (AMS). While most of these commenters supported our proposal, a few commenters said that APRN qualifications were not equivalent to those of physicians, who are AMSs. Another commenter asked us to specify in the regulatory text that APRNs include Nurse Practitioners (NP) to reduce confusion.

Response: We agree with the comments that supported our proposal to recognize APRNs as AMSs for purposes of our programs. Although APRNs are not physicians, including APRNs as AMSs reflects the modern primary healthcare delivery system, including how healthcare is delivered in many rural areas.10 In addition, the Institute of Medicine recommended Federal agencies recognize the advanced level of care provided by APRNs.11

- • [Part 408 Subpart P Appendix 1.]
- • See 42 U.S.C. 423(d)(3) and 1382c(a)(3)(B).
- • See, for example, our rules for xeroderma pigmentosum in Listings 8.07A and 108.07A.
- • 61 FR 34490 (July 2, 1996).
- • 61 FR 34471 (July 2, 1996).
- • 61 FR 34466 (July 2, 1996).
- • 61 FR 34471 (July 2, 1996).
- • 61 FR 34466 (July 2, 1996).
- • 61 FR 34490 (July 2, 1996).
- • Current 404.900(b) and 416.1400(b).
- • Committee on the Robert Wood Johnson Foundation Initiative on the Future of Nursing, at
Furthermore, State licensure requirements for APRNs are rigorous. To receive APRN licensure, all States require these medical sources to be registered nurses and to have earned advanced nursing educational degrees. In addition, nearly all States require APRNs to maintain and maintain national certification by a standard advanced nursing credentialing agency.\textsuperscript{14} and this certification requires extensive education and training.\textsuperscript{3} Despite minor variability in names and licensure requirements, a growing number of States are adopting the Consensus Model for APRN Regulation from the American Association of Nurse Practitioners, which defines the standards for licensure, accreditation, certification, education, and practice.\textsuperscript{7} We appreciate the suggestion to specify in our rules that APRNs include NPs, we did not adopt it. As we stated in the preamble to the NPRM,\textsuperscript{15} APRNs include four types of medical sources: Certified Nurse Midwife, NP, Certified Registered Nurse Anesthetist, and Clinical Nurse Specialist. Although the majority of States use the APRN title, a minority of States use other similar titles, such as Advanced Practice Nursing and Advanced Registered Nurse Practitioner. We will maintain a current list of State-specific APRN titles in our subregulatory instructions to help our adjudicators identify the appropriate titles for APRNs.

\textbf{Comment:} Several commenters supported our proposal to include audiologists as AMSs. One commenter also supported the addition of audiologists as providers who could perform the elocution examination in order to establish the medically determinable impairment that causes hearing loss. Another commenter asked us to recognize that audiologists’ scope of practice includes impairments of balance disturbance.

\textbf{Response:} We agree with these commenters. We included audiologists as AMSs at the NPRM and continued to use of licensed audiologist-performed otologic examinations under Listings 2.00 and 102.00 in these final rules.\textsuperscript{16}

We also revised the final regulatory text to recognize that audiologists’ scope of practice generally includes evaluation, examination, and treatment of certain balance impairments that result from the audio-vestibular system. However, some impairments involving balance involve several different body systems that are outside the scope of practice for audiologists, such as those involving muscles, bones, joints, vision, nerves, heart, and blood vessels.

Therefore, we did not adopt the final 404.1502 and 416.902 to state that licensed audiologists are AMSs for impairments of hearing loss, auditory processing disorders, and balance disorders within the licensed scope of practice.\textsuperscript{17}

\textbf{Comment:} Two commenters asked us to recognize audiologists as AMSs if they did not have State licensure but did have certification from the American Board of Audiology (ABA) or a Certificate of Clinical Competence in Audiology (CCC-A) from ASHA.

\textbf{Response:} We did not accept this comment because our existing practice has been to rely on State professional education and licensure requirements that are largely consistent with each other when we have expanded the AMS list.\textsuperscript{18} While we appreciate the background provided by the commenter, we do not find it the scope of practice for audiologists, such as those involving muscles, bones, joints, vision, nerves, heart, and blood vessels.

Therefore, we did not adopt the final 404.1502 and 416.902 to state that licensed audiologists are AMSs for impairments of hearing loss, auditory processing disorders, and balance disorders within the licensed scope of practice.\textsuperscript{17}

\textbf{Comment:} The American Optometric Association suggested that we modify our AMS definition of optometrists to refer to the scope of practice as defined by the State. We are adopting this proposal as State chooses to change its scope of practice laws, we would not need to go through the rulemaking process to change our regulations if a State chooses to change its scope of practice laws in the future.

\textbf{Response:} We agree with this comment, and we revised the final regulatory text about optometrists as AMSs. Specifically, we revised the proposed regulatory text for AMS optometrists to read, “Licensed optometrist for impairments of visual disorders, or measurement of visual acuity and visual fields only, depending on the scope of practice in the State in which the optometrist practices.”

\textbf{Comment:} We received comments from several commenters, including the American Association of Physician Assistants, recommending that we add physician assistants (PA) to the AMS list. These commenters supported this recommendation by stating that PAs receive extensive medical education (approximately 27 months), have at least 2,000 hours of supervised clinical practice, are recognized as primary care providers, and must pass the Physician Assistant National Certifying Examination (PANCE).

\textbf{Response:} We received many other public comments on the criteria we use to add AMSs and whether we should add other medical sources, such as licensed clinical social workers (LCSW), to the AMS list. Most of these commenters supported recognizing LCSWs as AMSs, and they suggested we also add a wide variety of other medical sources and nonmedical sources, stating that doctors of optometry can serve as an AMS according to their State’s scope of practice laws, we would not need to go through the rulemaking process to change our regulations if a State chooses to change its scope of practice laws in the future.
including licensed marriage and family therapists (LMFT), registered nurses (RN), licensed professional counselors (LPC), physical therapists (PT), chiropractors, and even healthcare professionals without medical licensure.

Response: We value these comments, and we will continue to monitor licensure requirements for the medical sources the commenters suggested that we add. At this time, however, we have determined that the scope of practice for these medical sources does not merit the increased level of consistency or rigor in terms of education, training, certification, and scope of practice.

Many of the comments that asked us to expand the AMS list to these additional medical sources said we should recognize these medical sources as AMSs so we could begin to consider their evidence in our adjudicative process. However, as we stated in the NPRM, we currently consider all relevant evidence we receive from all medical sources regardless of AMS status. However, as we noted above, we need objective medical evidence from an AMS to establish that an individual has a medically determinable impairment as defined by the Social Security Act (Act).

Additionally, many comments focused upon the prevalence of these sources in the healthcare system, particularly for individuals who have mental impairments, are poor, or are experiencing homelessness. Comments that did address licensing requirements, training, and education for these medical sources did not demonstrate that they have sufficiently consistent and rigorous national licensing requirements for education, training, certification, and scope of practice that is equivalent to the current and final list of AMSs.

For RNs, licensure typically can be obtained with education at or below the bachelor’s degree level.18 This is in contrast to the current and new AMSs, for whom more rigorous education, training, and credentialing requirements are necessary.

For LCSWs, LPCs, LMFTs, PTs, and chiropractors, States significantly vary on titles, the required hours of experience for licensure, and the scope of practice, such as clinical and non-clinical practice. Our current and new AMSs have licensure requirements that are more nationally consistent, which is essential for us to administer a national disability program.

As to the comments that asked us to recognize nonmedical sources as AMSs, our rules require an AMS to be a “medical source” as defined in 404.1502 and 416.902. Therefore, we did not adopt those suggestions. Although we will not recognize the additional suggested medical sources as AMSs at this time, we will continue to consider evidence from these medical sources under these final rules when we evaluate the severity of an individual’s impairments and its effect on the individual.

Comment: One commenter agreed with our proposed definition of “medical source” in proposed 404.1502 and 416.902. The commenter said including licensure and certification requirements as specified by State or Federal law would help to ensure that medical sources who provide evidence to us are qualified and practicing lawfully. Another commenter asked us to recognize a camera medical practice as a medical source instead of its individual providers because some individuals receive treatment from multiple medical sources employed by the same medical practice.

Response: We agree with the first comment, and we are adopting our proposed definition of “medical source” in these final rules. However, we did not adopt the second comment because a medical source is an individual, not an entity, under our current rules.20 Although we request evidence from medical practices, an entire practice itself is not capable of evaluating, examining, or treating an individual’s impairments. A medical practice would not be able to perform a consultative examination at our request, or provide a medical opinion about an individual’s functional abilities or limitations. Ultimately, individual medical practitioners and not their employing entities perform these functions. For these reasons, we did not adopt the recommendation to recognize an entire medical practice as a medical source.

Comment: Several commenters opposed our proposal to remove the term “treating source” from our regulations. One commenter opposed our proposal to recognize all of the medical sources that an individual identifies as his or her medical source instead of using the term “treating source” for AMSs as defined in our current rules.

Response: While we acknowledge the importance of the relationship between an individual and his or her own medical sources, we are adopting our proposed regulatory text in these final rules. As part of our revisions to align our rules with how individuals now receive healthcare, it is appropriate to remove the distinction between a “treating source”—who must be an AMS—and the other medical sources from whom an individual may choose to receive evaluation, examination, or treatment. This will allow us to select an individual’s own medical source, regardless of AMS status, to be a preferred source to conduct a consultative examination (CE) if the medical source meets our other requirements for CE sources in final 404.1519h and 416.919h.

Comment: One commenter requested that we specify that licensed mental health care providers who are working within the scope of practice permitted by law will be a type of healthcare worker, and therefore a medical source. Another commenter was concerned that the proposed regulatory definition of nonmedical source would cause confusion when a licensed mental health care provider works at a homeless shelter or social service agency instead of a medical practice.

Response: We agree that the definition of medical source includes licensed mental health care providers working within the scope of practice permitted by law. The definition of medical source in final 404.1502 and 416.902 is sufficiently broad to include licensed mental health care providers without the need to amend the regulatory definition. We do not consider the employer of a source to determine whether a source is a medical source. Instead, we look to whether the source meets the definition of a medical source. Part of our final definition of a “medical source” is that the source is working within the licensed scope of his or her practice. Therefore, when an individual is licensed as a healthcare worker by a State and is working within the scope of his or her practice under State or Federal law, we will consider the source to be a medical source.

Comment: Some commenters raised concern about the language in proposed sections 404.1502 and 416.902 that define “objective medical evidence” as “signs, laboratory findings, or both.” The commenters indicated that the proposed language appeared to state a new requirement that would make it “extremely difficult” to establish the existence of mental impairments and
imperfections related to migraine headaches. The commenters suggested that we also consider a person’s diagnosis, statement of symptoms, and medical source opinions to establish the existence of an impairment. One commenter thought the exclusion of symptoms from “objective medical evidence” conflicted with our recent final rules “Revised Medical Criteria for Evaluating Mental Disorders.” Those final rules include references to symptoms of mental impairments in the introductory text and criteria of the mental disorders listings.

Response: We understand the commenter’s concerns that we should not disadvantage individuals with mental and headache-related impairments, and clarifications of our current policy will not change how we establish these medically determinable impairments.

The proposed definition of objective medical evidence in proposed 404.152(f) and 416.902(k) is consistent with our current rules. We currently define objective medical evidence as signs and laboratory findings.22 To clarify our current policy, we redefine objective medical evidence as signs, laboratory findings, or both to make clear that signs alone or laboratory findings alone are objective medical evidence.

Our current rules require objective medical evidence consisting of signs or laboratory findings to establish impairments, including mental and headache-related impairments.23 Current 404.1508 and 416.908 states that “[a] physical or mental impairment must be established by medical evidence consisting of signs, symptoms, and laboratory findings, not only by your statement of symptoms.” Thus, even under our current rules, mental and headache-related impairments must be established by objective medical evidence. These final rules merely clarify this current policy.

Another current policy that we are clarifying in the definition of “signs” in these final rules is that one or more medically demonstrable phenomena that indicate specific psychological abnormalities that can be observed, apart from your statements, such as abnormalities of behavior, mood, thought, memory, orientation, development, or perception, can be “signs” that establish a medically determinable impairment. Additionally, psychological test results are laboratory findings that may establish medically determinable cognitive impairments.

Once we establish the existence of an impairment, we use evidence from all sources to determine the severity of the impairment and make the appropriate findings in the sequential evaluation process, such as whether an impairment meets the criteria of a Listing. This includes statements of symptoms, diagnoses, proxies, and medical opinions.

Our recent final rules “Revised Medical Criteria for Evaluating Mental Disorders” discuss an individual’s symptoms in the context of our assessments of the severity of a mental impairment and whether the mental impairment satisfies the listing criteria. However, we make these assessments after we determine that objective medical evidence establishes the existence of the mental impairment. Under our current rules, the proposed rules, and these final rules, an individual’s statement of his or her symptoms cannot establish the existence of an impairment.

Sections 404.1504 and 416.904—Decisions by Other Governmental Agencies and Nongovernmental Entities

Comment: While a few commenters agreed with our proposal not to provide analysis about decisions by other governmental agencies and nongovernmental entities in our decisions and determinations, other commenters disagreed. Some commenters disputed that the decisions are inherently neither valuable nor persuasive. Some commenters stated these decisions are important evidence that we should always discuss because the rules or purposes of other disability programs are similar to our programs, while other commenters said we should discuss the decisions because they may be more or less probative to our decisionmaking due to the different standards used. Some commenters suggested we provide additional training to our adjudicators about the standards used by other governmental agencies and nongovernmental entities. Other commenters asserted that the Department of Veterans Affairs (VA) 100% disability ratings and Individual Unemployability (IU) ratings are highly probative to our decisionmaking by pointing to our own research showing veterans are substantially more likely to be found disabled than the general population of applicants. A few commenters said we should adopt a VA 100% disability rating or have a rebuttable presumption that someone with a VA disability rating is entitled to disability under the Act.

Response: While we acknowledge the commenters’ concerns, we are adopting our proposal in these final rules. As we stated in the notice of proposed rulemaking (NPRM), there are four reasons why we are not requiring our adjudicators to explain their consideration of these decisions: (1) the Act’s purpose and specific eligibility requirements for disability and blindness differ significantly from the purpose and eligibility requirements of other programs; (2) the other agency or entity’s decision may not be in the record or may not include any explanation of how the decision was made, or what standards applied in making the decision; (3) our Federal courts have interpreted and applied our rules and Social Security Ruling (SSR) 06–03p differently in different jurisdictions.25

Although we are not requiring adjudicators to provide written analysis about how they consider the decisions from other governmental agencies and nongovernmental entities, we do agree with the commenters that underlying evidence that other governmental agencies and nongovernmental entities use to support their decisions may be probative of whether an individual is disabled or blind under the Act. In sections 404.1504 and 416.904 of the proposed rules, we provided that we would consider in our determination or decision the relevant supporting evidence under the other governmental agency or nongovernmental entity’s decision that we receive as evidence in a claim. We clarify in final 404.1504 and 416.904 that we will consider all of the supporting evidence underlying the decision from another government agency or nongovernmental entity’s decision that we receive as evidence in accordance with final 404.1513(a)(1)–(4) and 416.913(a)(1)–(4).

We are not adopting the suggestion that we should train our adjudicators on the various standards of other governmental agencies and nongovernmental entities that make disability or blindness decisions. Even with increased training, the actual decision reached under different standards is inherently neither valuable nor persuasive to determine whether an individual is disabled or blind under the requirements in the Act, for the

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22 See current 404.1508 and 416.908, as published on August 20, 1980 at 45 FR 55584, pp. 55586 and 55623.
23 See current 404.1508 and 416.908, as published on August 20, 1980 at 45 FR 55584, pp. 55586 and 55623.
24 81 FR at 62564–65.
25 81 FR 66137 (Sept. 26, 2016).
reasons we discussed in the preamble to the NPRM.\textsuperscript{25} Furthermore, while we did not rely on the research cited in a few comments to propose these rules, upon review of that research,\textsuperscript{26} we disagree with the commenters’ summary of it. Specifically, our researchers studied the interaction of our rules and the VA’s disability standards, focusing upon VA 100% disability ratings and IU ratings. They concluded VA and SSA disability programs serve different purposes for populations that overlap. While individuals with a VA rating of 100% or IU have a slightly higher allowance rate under our programs than members of the general population, nearly one-third are denied benefits based on our rules for evaluating medical (or medical-vocational) considerations. This data also supports our conclusion that these ratings alone are neither inherently valuable nor persuasive in our disability evaluation because they give us little substantive information to consider. Fortunately, the VA and the Department of Defense (DoD) share medical records electronically with us, and our adjudicators obtain the medical evidence documenting DoD and VA treatment and evaluations to evaluate these claims.

Comment: Two commenters asked whether individuals and their representatives would need to submit evidence of a disability, blindness, or employability decision by another governmental agency or nongovernmental entity to us because our rules would state these decisions are inherently neither valuable nor persuasive to us. Response: We appreciate the opportunity to clarify this matter. Under current and final 404.1512(a) and 416.912(a), an individual must inform us about or submit all evidence known to him or her that relates to whether or not he or she is blind or disabled. Similarly, under current 404.1740(b)(1) and 416.1540(b)(1), an appointed representative must act with reasonable promptness to help obtain the information or evidence that the individual must submit under our regulations, and forward the information or evidence to us for consideration as soon as practicable. A disability, blindness, or employability decision by another government agency or nongovernmental entity may not relate to whether or not an individual is blind or disabled under our rules. Nevertheless, as explained above, our adjudicators will consider the relevant supporting evidence underlying the other governmental agency or nongovernmental entity’s decision. When an individual informs us about another government agency’s or nongovernmental entity’s decision, we will identify and consider, or will assist in developing, the supporting evidence that the other agency or entity used to make its decision. We may also use that evidence to expedite processing of claims for Wounded Warriors and for veterans with a 100% disability compensation rating, as we do under our current procedures.\textsuperscript{27}

Sections 404.1512 and 416.912—Responsibility for Evidence

Comment: We received one comment about the regulatory text in proposed 404.1512(a)(2) and 416.912(a)(2). The commenter asked us to revise this rule to require our adjudicators to develop evidence from the time before an individual’s date last insured through the date of our determination or decision, even when this date last insured occurs many years earlier. The commenter also suggested that proposed 404.1512(a)(2) and 416.912(a)(2) could be inconsistent with the Act’s requirement in 42 U.S.C. 423(d)(5)(A) that an individual has the burden to provide us with evidence sufficient to make that he or she is under a disability.

Response: We did not adopt this comment because the regulatory text in proposed 404.1512(a)(2) and 416.912(a)(2) is identical to the current text in 404.1513(e) and 416.913(e). We proposed this language verbatim for proposed 404.1512(a)(2) and 416.912(a)(2) as part of our effort to reorganize our rules. We did not propose any substantive revision. An individual does have the burden to prove he or she is disabled, and this regulatory text is consistent with that requirement of the Act. Our current policies about how to develop a claim with a date last insured in the past are found in our subregulatory instructions.\textsuperscript{28}

Comment: A few commenters asked us increase the 10 to 20 calendar day timeframe for medical sources to respond to our initial request for evidence in proposed 404.1512(b)(1)(i) and 416.912(b)(1)(i). Some commenters suggested different periods between 20 to 30 calendar days as a more reasonable time for medical sources to respond, and they suggested that a longer timeframe would reduce our costs associated with for consultative examinations (CE). Another commenter suggested we include five additional days for mailing time.

Response: While we appreciate these comments, we did not adopt them. When we develop evidence in a claim, we make every reasonable effort to get evidence from an individual’s own medical sources. Under our current rules in 404.1512(d)(1) and 416.912(d)(1), this requirement includes giving medical sources 10 to 20 calendar days to respond to our initial request for evidence before we make a follow-up attempt. After the follow-up attempt, our regulations provide for an additional 10 days, for a minimum of at least 20 to 30 days in total. In our experience, our current rules provide an adequate amount of time to submit records because most medical sources provide the requested evidence within this period. Our current rules in 404.1512(e) and 416.912(e) generally require us to wait until after this period to request a CE, and the final rules in 404.1512(b)(2) and 416.912(b)(2) retain this requirement.

With the increasing use of electronic health records and electronic records transfer, we receive an increasing amount of medical evidence the same day that we request it. We are committed to expanding our electronic transfer capacity for medical records through ongoing expansion of the use of Health Information Technology. The expanded use of Health Information Technology means that we do not have an administrative need to make the change to the rules that the commenters suggested.

Sections 404.1513 and 416.913—Categories of Evidence

Comment: One commenter disagreed with our proposal to exclude “symptoms, diagnosis, and prognosis”
from the definition of “medical opinion” and instead categorize these as “other medical evidence.” The commenter expressed concern that most medical sources, unless prompted to fill out a functional questionnaire, do not specifically address functional abilities and limitations in their notes; rather, medical sources normally include symptoms, diagnoses, and prognoses. This commenter indicated that as a result, unrepresented individuals would be disadvantaged because they may not know to ask medical sources to complete the functional questionnaires. The commenter also said some medical sources refuse to fill out such forms or perhaps charge extra for completing the forms, which is outside the individual’s control. This commenter asserted that without a form or letter from a medical source, we are more likely to schedule a consultative examination (CE) and to disregard the medical source’s evidence in the hearing decision.

Response: We understand the concerns expressed in these comments; however, we did not adopt the recommendation to retain “symptoms, diagnosis, and prognosis” in the definition of “medical opinions.” Diagnoses and prognoses do not describe how an individual functions. It is also not appropriate to categorize symptoms as medical opinions because they are subjective statements made by the individual, not by a medical source, about his or her condition.

As for the commenter’s concerns about the effect of these final rules on unrepresented individuals, our current practice is consistent with the Act’s requirements that we make every reasonable effort to obtain evidence from all of an individual’s medical sources. We make every reasonable effort to develop evidence about an individual’s complete medical history from the individual’s own medical sources prior to evaluating medical evidence obtained from any other source on a consultative basis, regardless of whether the individual is represented or not. Regardless of an individual’s financial situation, diagnoses and prognoses do not describe how an individual functions and symptoms are subjective statements made by the individual, not a medical source, about his or her impairments.

Comment: One commenter supported the clarification in the proposed rules that all medical sources, not just acceptable medical sources (AMS), can provide evidence that we will categorize as being evidence from medical sources.

Response: We are adopting this comment, and we are adopting the clarification in these final rules.

Comment: A few commenters opposed our proposed category of evidence that we called “statements from nonmedical sources” in proposed 404.1513(a)(4) and 416.913(a)(4) because they wanted us to consider evidence from unlicensed staff who are part of social service agencies and public mental health systems separately from evidence from individuals, family members, and neighbors. Another commenter stated the proposed rule would threaten the functional assessment by eliminating the need for the adjudicator to explain how he or she considers functional evidence, particularly offered by nonmedical sources. A few commenters asserted this revision would disadvantage child claimants who have evidence from nonmedical sources, such as educators.

Response: We want to reassure these commenters that this proposal to use one category of evidence for these nonmedical sources, which we are adopting in these final rules, will not disadvantage individuals in our programs. We proposed the single category of evidence, which we renamed in these final rules as “evidence from nonmedical sources,” to reflect that there are no policy differences in how we consider this type of evidence. We agree that evidence from nonmedical sources who are part of social service agencies and public mental health systems may be valuable, and we consider this evidence. However, this evidence is not inherently more or less valuable than evidence from any other kind of nonmedical source, such as individuals, family members, and neighbors.

Sometimes, the individual, family members, and other nonmedical sources of evidence can provide helpful longitudinal evidence about how an impairment affects a person’s functional abilities and limitations on a daily basis. In claims for child disability, we often receive functional evidence from nonmedical sources, such as testimony, evaluations, and reports from parents, teachers, school personnel, community organizations, and public and private social welfare agency personnel. Depending on the unique evidence in each claim, it may be appropriate for an adjudicator to provide written analysis about how he or she considered evidence from nonmedical sources, particularly in claims for child disability.

Because we consider all evidence we receive, we are not adopting the suggestion to use separate categories of evidence for different kinds of nonmedical sources or for rules about which nonmedical sources’ evidence is inherently more valuable than others’ evidence.

Our adjudicators will continue to assess an individual’s ability to function under these final rules using all evidence we receive from all sources, including nonmedical sources. Having one category of evidence instead of two for nonmedical sources will not affect our rules for assessing an individual’s functional abilities.

In response to these and other public comments, both the title and definition of this category of evidence is different from that which we proposed. We decided to simplify, shorten, and clarify that this category of evidence includes any evidence from any nonmedical source that we receive, and that we may receive it in any manner.

For example, this category of evidence includes data from our administrative records about an individual’s earnings history and information resulting from data matching with other government agencies that relates to any issue in a claim, such as births and marriage history.

We list and define the categories of evidence in final 404.1513(a)(1)–(5) and 416.913(a)(1)–(5). The following chart displays the categories:
Sections 404.1519h and 416.919h—Your Medical Source

Comment: Many commenters supported our proposal to broaden the preference for consultative examination (CE) sources from “treating sources” to any of an individual’s own medical sources who are otherwise qualified to perform the CE.

Response: We agree with these comments. In order to perform a CE, an individual’s medical sources must be qualified, equipped and willing to perform the examination or tests for the designated payment and send in timely, complete reports. This aligns with the current requirements for all CE providers and does not significantly change our current process. If these standards are met, it is our preference to use an individual’s own medical source to perform a CE.

Sections 404.1520b and 416.920b—How We Consider Evidence

Comment: One commenter opposed proposed 404.1520b(c)(2) and 416.920b(c)(2), under which we would not provide written analysis about disability examiner findings at subsequent adjudicative levels of appeal, as we do for prior administrative medical findings.

Response: Because this is our current policy, we did not adopt this comment. At each level of the administrative process, we conduct a new review of the evidence whenever we issue a new determination or decision. While some disability examiners now make some administrative medical findings at the initial and reconsideration levels under temporary legal authority, this authority is scheduled to end pursuant to the Bipartisan Budget Act of 2015 (BBA) section 832. See Modifications to the Disability Determination Procedures: Extension of Testing of Some Disability Redesign Features, 81 FR 58544 (August 25, 2016).

Comment: A few commenters suggested that we continue the current practice of not giving any special significance to opinions on issues reserved to the Commissioner instead of adopting our proposal in 404.1520b(c)(3) and 416.920b(c)(3) that we not provide any analysis about how we consider statements on issues reserved to the Commissioner. These commenters also stated that the final rule should clarify that adjudicators will consider the context of a medical source’s use of terms in our laws and regulations, such as “moderate,” “marked,” and “sedentary.”

Response: We agree that adjudicators should consider the context of a source’s use of terms in our laws and regulations to determine if it qualifies as a statement on an issue reserved to the Commissioner or another kind of evidence, such as a medical opinion. We frequently receive documents from medical sources that contain different categories of evidence, such as a treatment note that includes a laboratory finding, a medical opinion, and a statement on an issue reserved to the Commissioner. When we receive a document from a medical source that contains multiple categories of evidence, we will consider each kind of evidence according to its applicable rules. We will not consider an entire document to be a statement on an issue reserved to the Commissioner simply because the document contains a statement on an issue that is reserved to the Commissioner. However, we are not revising our rules to add text about considering context or to provide examples because we intend to further clarify and provide examples, as appropriate, in our subregulatory instructions.

We are not adopting the suggestion to require adjudicators to assign weight to a statement on an issue reserved to the Commissioner. Because we are responsible for making the determination or decision about whether an individual meets the statutory definition of disability, these statements are neither valuable nor persuasive for us. Therefore, our adjudicators will continue to review all evidence and consider the context of a source’s use of terms in our regulations, but they are not required to articulate how they considered statements on an issue reserved to the Commissioner.

We are also not revising our rules to omit the phrase “statements that you are or are not . . . able to perform regular or continuing work” from final 404.1520b(c)(3) and 416.920b(c)(3). We are responsible for assessing an individual’s RFC, including how our programmatic terms apply to evidence we receive.

Comment: One commenter asked us to state that when an administrative law judge (ALJ) asks a medical expert about whether an impairment(s) medically equals an impairment(s) in the Listings, that is a medical opinion and not a statement on an issue reserved to the Commissioner.

Response: Because we are not revising this current policy in these final rules, we are not adopting the comment. When a medical expert, or any other medical source, opines about whether an individual’s impairment(s) medically equals an impairment(s) in the Listings, we consider that statement to be a statement on an issue reserved to the Commissioner under our current policy.

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<td>Medical sources</td>
<td>Signs, laboratory findings, or both. A statement about what an individual can still do despite his or her impairment(s) and whether the individual has one or more impairment-related limitations or restrictions in one or more specified abilities.</td>
</tr>
<tr>
<td>Medical opinion</td>
<td>Medical sources</td>
<td>All other evidence from medical sources that is not objective medical evidence or a medical opinion. A finding, other than the ultimate determination about whether the individual is disabled, about a medical issue made by an MC or PC at a prior administrative level in the current claim.</td>
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<td>Evidence from nonmedical sources</td>
<td>Nonmedical sources</td>
<td>All evidence from nonmedical sources.</td>
</tr>
<tr>
<td>Prior administrative medical finding</td>
<td>MCs and PCs</td>
<td>Medical opinion ............................... Medical sources .................................. A statement about what an individual can still do despite his or her impairment(s) medically equals an impairment(s) in the Listings, or regular or continuing work’ as an example of a statement on an issue reserved to the Commissioner. These commenters cautioned against adjudicators dismissing medical opinions as issues reserved for the Commissioner simply because they use the same terms in our laws and regulations. The commenters suggested we include an example in our rules. Another commenter said we should not include “statements that you are or are not . . . able to perform regular or continuing work” as an example of a statement on an issue reserved to the Commissioner in proposed 404.1520b(c)(3) and 416.920b(c)(3) because it is probative for us. Therefore, our adjudicators will continue to review all evidence and consider the context of a source’s use of terms in our regulations, but they are not required to articulate how they considered statements on an issue reserved to the Commissioner. Because we are responsible for making the determination or decision about whether an individual meets the statutory definition of disability, these statements are neither valuable nor persuasive for us. Therefore, our adjudicators will continue to review all evidence and consider the context of a source’s use of terms in our regulations, but they are not required to articulate how they considered statements on an issue reserved to the Commissioner. Because we are not revising our rules to omit the phrase “statements that you are or are not . . . able to perform regular or continuing work” from final 404.1520b(c)(3) and 416.920b(c)(3). We are responsible for assessing an individual’s RFC, including how our programmatic terms apply to evidence we receive.</td>
</tr>
</tbody>
</table>
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For example, if we receive a medical report that contains a medical opinion and a statement on an issue reserved to the Commissioner, we will articulate how we considered the medical opinion according to its rules but not articulate how we considered the statement on an issue reserved to the Commissioner.

In addition, we will issue a new Social Security Ruling that will discuss certain aspects of how ALJs and the AC must obtain evidence sufficient to make a finding of medical equivalence.

Comment: One commenter opposed our terminology of a statement on an issue reserved to the Commissioner because it is “reserved for the ALJ, not the Commissioner.”

Response: We did not adopt this comment. Whenever an adjudicator at any level of our administrative process makes a disability or blindness determination or decision, he or she is acting pursuant to authority delegated by the Commissioner.34 Our adjudicators do not have authority independent of the authority given to them pursuant to a lawful delegation of authority.

Sections 404.1520c and 416.920c—How We Consider and Articulate Medical Opinions and Prior Administrative Medical Findings for Claims Filed on or After March 27, 2017

Prior Administrative Medical Findings

Comment: Two commenters had concerns about our policies for considering prior administrative findings, such as the severity of an individual’s symptoms, failure to follow prescribed treatment, and drug addiction and alcoholism. The commenters stated that medical evidence should be provided solely by medical professionals and suggested that prior administrative medical findings are not made by medical sources.

Response: The three categories of evidence from medical sources and prior administrative medical findings must be made by medical sources. Prior administrative medical findings are made by medical sources who are State or Federal agency medical consultants or psychological consultants. This is our current policy in current 404.1527(0)(1) and 416.927(0)(1). Our rules in current 404.1527(2) and 416.927(2) require us to consider and articulate our consideration of prior administrative medical findings using the same factors we use to consider medical opinions.

Under section 221(h) of the Act, as amended by the Bipartisan Budget Act of 2015 (BBA) section 832, we are now required to make “every reasonable effort” to ensure that a qualified physician (in cases involving a physical impairment) or a qualified psychiatrist or psychologist (in cases involving a mental impairment) has completed the medical review of the case and any applicable residual functional capacity (RFC) assessment. In final 404.1520c, 404.1527, 416.920c, and 416.927, we explain in detail how we will consider and articulate our consideration of prior administrative medical findings.

Comment: One commenter asked us to consider opinions from the Appeals Council’s (AC) Medical Support Staff (MSS) as prior administrative medical findings. Respondent: Although our current policies allow adjudicators at the hearings and AC levels of review to obtain medical expert evidence, including MSS opinions at the AC, we did not adopt this comment for two reasons. First, expert medical opinions obtained at the same level of adjudication could not be a prior administrative medical finding. Second, medical expert evidence obtained at the hearings or AC levels does not amount to our own medical findings; instead, our adjudicators at these levels are responsible for determining whether an individual is disabled. They must consider expert medical opinions obtained at the same level under the standard for evaluating medical opinions.

Comment: A few commenters asked how our rules for considering prior administrative medical findings would apply to claims decided previously, considering the legal principle of res judicata, which means an issue definitively settled by a prior determination or decision. Respondent: We appreciate this comment, and we have revised the final rules to address this question. These final rules do not affect our current policies about res judicata. Prior administrative medical findings are evidence in the current claim. To help clarify this point, we have revised the prior administrative medical findings evidence category’s definition in final 404.1513(a)(5) and 416.913(a)(5) to specify that this is a category of evidence in the current claim.

Comment: One commenter asserted that allowing administrative law judges (ALJ) to consider prior administrative medical findings means that individuals at the hearings level do not get a new and independent review of their claims.

Response: We did not make any specific changes based on these comments. A new decision means that adjudicators at subsequent levels of the administrative review process (i.e., reconsideration, hearing, and AC) do not need to defer to the findings or conclusions of prior adjudicators. Instead, they make new findings and conclusions. Currently, adjudicators at all levels of the administrative review process consider prior administrative medical findings as part of conducting a new and independent review when they issue a determination or decision.35 Based on our experience administering our programs, we have found that our adjudicators reasonably consider prior administrative medical findings as part of the evidence in the claim and do not automatically favor or disfavor this evidence simply because the medical source is a medical consultant (MC) or a psychological consultant (PC).

Treaty Source Rule

Comment: Multiple commenters asked us to retain the current treating source rule, while some commenters agreed with our proposal to eliminate it. Those who wanted us to retain the treating source rule said that evidence from a treating source has special intrinsic value due to the nature of the medical source’s relationship with the claimant. They also said that the current rules contain an appropriate inherent hierarchy to give the most weight to treating sources, then to examining sources like CE sources, and the least weight to nonexamining sources, such as MCs and PCs. One commenter said without this hierarchy, our adjudicators would have a more difficult time evaluating evidence.

One organization that represents claimant representatives noted that if we do not keep the treating source rule, the treatment relationship should be a more important factor for consideration of medical opinions and prior administrative medical findings than the factors of supportability and consistency. Another commenter disagreed with our reasons for revising the factors for considering medical opinions and prior administrative medical findings.

34 See current 20 404.1512(b)(vii), 404.1527(c)(1)(i) and (iii), 416.912(b)(vii), and 416.927(2)(i)(ii) and (iii).

35 See current 404.1512(b)(vii), 404.1527(c)(1)(i) and (iii), 416.912(b)(vii), and 416.927(2)(i)(ii) and (iii).
The commenters who supported changing our rules agreed with our proposal to consider the supportability and consistency factors as the most important factors in assessing persuasiveness. These commenters said that this approach better reflects the actual state of health care today and alters adjudicators to focus more on the content of the evidence than on the source. Response: While we understand the perspectives presented in these comments, we are not retaining the treating source rule in final 404.1520c and 416.920c. Instead of ending the current treating source rule in 1991, the healthcare delivery system has changed in significant ways that require us to reexamine our policies in order to reflect this reality. Many individuals receive health care from multiple medical sources, such as from coordinated and managed care organizations, instead of from one treating AMS. These individuals less frequently develop a sustained relationship with one treating physician. Indeed, many of the medical sources from whom an individual may seek evaluation, examination, or treatment do not qualify to be “treating sources” as defined in current 404.1502 and 416.902 because they are not AMSs. These final rules recognize these fundamental changes in healthcare delivery and revise our rules accordingly.

Courts reviewing claims under our current rules have focused more on whether we sufficiently articulated the weight we gave treating source opinions, rather than on whether substantial evidence supports our final decision. As the Administrative Conference of the United States (ACUS) Final Report explains, in reviewing final agency decisions, are reconciled and may instead of applying the substantial evidence standard of review, which is intended to be highly deferential standard to us.

In addition, our experience adjudicating claims using the treating source rule since 1991 has shown us that the two most important factors for determining the persuasiveness of medical opinions are consistency and supportability. The extent to which a medical source’s opinion is supported by relevant objective medical evidence and the source’s supporting explanation—supportability—and the extent to which the opinion is consistent with the evidence from other medical sources and nonmedical sources in the claim—consistency—are also more objective measures that will foster the fairness and efficiency in our administrative process that these rules are designed to ensure. These factors also form the foundation of the current treating source rule, and we believe that it is appropriate to continue to keep these factors as the most important ones we consider in our evaluation of medical opinions and prior administrative medical findings. Because we currently consider all medical opinions and opinions using these factors, we disagree that considering these factors as the most important factors will make evaluating evidence more difficult. Furthermore, to reflect modern healthcare delivery, we will articulate in our determinations and decisions how we consider medical opinions from all of an individual’s medical sources, not just those who may qualify as “treating sources” as we do under current 404.1527(c)(2) and 416.927(c)(2).

Moreover, these final rules in 404.1520c(c)(3) and 416.920c(c)(3) retain the relationship between the medical source and the claimant as one of the factors we consider as we evaluate the persuasiveness of a medical opinion. These final rules also continue to allow an adjudicator to consider an individual’s own medical source’s medical opinion to be the most persuasive medical opinion if it is both well-supported and the source’s explanation, and is consistent with other evidence, as described in final 404.1520c and 416.920c. Finally, our current rules do not create an automatic hierarchy for treating sources, examining sources, then nonexamining sources to which we must mechanically adhere. For example, adjudicators can currently find a treating source’s medical opinion is not well-supported or is inconsistent with the other evidence and give it little weight, while also finding a medical opinion from an examining source, such as a consultative examiner, or nonexamining source, such as a medical or psychological consultant, is supported and consistent and entitled to great weight. These final rules help eliminate confusion about a hierarchy of medical sources and instead focus adjudication more on the persuasiveness of the content of the evidence. Comment: Instead of ending the treating source rule, some commenters asked us to reflect modern healthcare delivery by requiring our adjudicators to provide written analysis about how they consider medical opinions from any medical source from whom an individual chooses to receive evaluation, examination, or treatment, regardless of whether the medical source is an AMS. Response: We carefully considered these comments, and we are adopting them. We agree that our rules need to reflect modern healthcare delivery, and that is a main reason we are ending the treating source rule. We further agree that our rules should reflect that individuals’ own medical sources may not be AMSs. Therefore, these final rules state that we will consider and articulate our consideration of all medical opinions, regardless of AMS status, consistent with the standard we set forth for AMSs in proposed 404.1520c and 416.920c.

Under proposed sections 404.1520c(b)(4) and 416.920c(b)(4), we said that we would articulate how we consider the medical opinion(s) from a medical source who is not an AMS only if we found it to be well-supported and consistent with the record and more valuable and persuasive than the medical opinion(s) and prior administrative medical findings from all of the AMSs in the individual’s case record. We are not adopting proposed 404.1520c(b)(4) and 416.920c(b)(4) in these final rules in order to ensure that our rules on articulation reflect the realities of the current healthcare delivery system. Comment: A few commenters opposed our proposal to end the treating source rule because they said the proposed rules would create arbitrary and inconsistent decisionmaking. Response: We disagree with these comments because these final rules require our adjudicators to consider all of the factors in final 404.1520c and 416.920c for all medical opinions and, at a minimum, to articulate how they considered the supportability and consistency factors for all of a medical source’s medical opinions and prior administrative medical findings.

These final rules improve upon our current rules in several ways. For example, we will require our adjudicators to articulate how they consider medical opinions from all medical sources, regardless of AMS status, to reflect the changing nature of
healthcare delivery. Therefore, we expect these final rules will enhance the quality and consistency of our decisionmaking, and they will provide individuals with a better understanding of our determinations and decisions.

Comment: Some commenters suggested that instead of changing the treating source rule, we should provide our adjudicators with additional training about it, and increase our quality control measures, so that there are fewer appeals and remands about this issue.

Response: We agree with the comments to provide training and quality control measures to ensure policy compliance with our rules, but we are adopting our proposal to end the treating source rule for claims filed on or after March 27, 2017. The suggestion that we not end the treating source rule would neither align our policies with the current state of medical practice, nor would we expect it to result in substantially fewer appeals and remands about this issue.

To account for the changes in the way healthcare is currently delivered, we are adopting rules that focus more on the content of medical opinions and less on weighing treatment relationships against each other. This approach is more consistent with current healthcare practice.

Additionally, we provide extensive training on our rules, and we will provide adjudicators with appropriate training on these final rules. In part because of our extensive training efforts, the work of our adjudicators is policy compliant and highly accurate. For example, in fiscal year 2015, the accuracy rate of our initial determinations was nearly 98 percent, and the overall rate at which the AC has agreed with hearing decisions has increased in recent years. We are committed to ensuring our disability adjudicators remain policy compliant; therefore, we will continue our existing ongoing efforts to train adjudicators on best practices for applying our policies, including the policies in these final rules.

Comment: A few commenters said that we should not adopt our proposed rules because the process of training our adjudicators and adapting our computer systems to comply with them will be daunting, time-consuming, and expensive.

Response: We are not adopting this comment. We believe that the changes we made to our rules will be beneficial to the administration of our programs because they will make our rules easier to understand and apply and will allow us to continue to make accurate and consistent decisions, while acknowledging the changing healthcare landscape. We agree that providing comprehensive training and updating our software to reflect the revisions in these final rules are critical, and we are confident that we will be able to provide the necessary training and software changes in a timely manner. Among our existing employees are dedicated teams that provide in-house training and software enhancements for all of our regulatory revisions. We are currently training our employees and are updating our systems to be ready for when these final rules become effective. We will also undertake quality control monitoring to ensure the training and software updates are effective and working as we intend.

Comment: One commenter requested that we clarify what “consistency” means when considering medical opinions and prior administrative findings. The commenter also recommended that we consider the consistency and treatment relationship with the claimant factors equally. The commenter explained, “Given the brevity of some of these treatment relationships, medical sources may reasonably come to different conclusions about the claimant’s impairments and functioning.”

Response: While we acknowledge that determining the consistency of medical opinions may be challenging in certain claims, we did not adopt this suggestion. Our adjudicators now use the consistency factor when they consider medical opinions and medical findings from MCs and PCs. Consistent with that approach, proposed and final 404.1520c and 416.920C explain that the more consistent a medical opinion or prior administrative medical finding is with the evidence from other medical sources and nonmedical sources in the claim, the more persuasive the medical opinion or prior administrative medical finding is.

Moreover, our use of the word “consistent” in the regulations is the same as the plain language and common definition of “consistent.” This includes consideration of factors such as whether the evidence conflicts with other evidence from other medical sources and whether it contains an internal conflict with evidence from the same medical source. We acknowledge that the symptom severity of some impairments may fluctuate over time, and we will consider the evidence in the claim that may reflect on this as part of the consistency factor as well. Thus, the appropriate level of articulation will necessarily depend on the unique circumstances of each claim.

The supportability and consistency factors provide a more balanced and objective framework for considering medical opinions than focusing upon the factors of consistency and the medical source’s relationship with the individual. A medical opinion without supporting evidence, or one that is inconsistent with evidence from other sources, will not be persuasive regardless of who made the medical opinion.

Our final rules provide an appropriate framework to evaluate situations when multiple medical sources provide medical opinions that are not consistent. Our adjudicators will consider all of the factors when they determine how persuasive they find a medical opinion, and these factors are based on the current factors in our rules.

Comment: One commenter said the proposed rules did not contain sufficient guidance about when we would explain how we would consider opinions from sources who are not AMRs in claims with a filing date before the effective date of these final rules. The commenter expressed concern that more claims would be remanded if we did not include more policies from Social Security Rule (SSR) 06–03p, which are rescinded. These final rules. A few other commenters asked us to retain the policies in SSR 06–03p about considering and providing written analysis about opinions from sources who are not AMRs for all claims.

Response: We agree with this comment, and we revised the final regulatory text about claims filed both before and after the effective date of these rules, March 27, 2017, to ensure we have provided clear and comprehensive guidance to our adjudicators and the public.

Under SSR 06–03p, we consider opinions from medical sources who are not AMRs and from nonmedical sources using the same factors we use to evaluate medical opinions from AMRs. We state that an adjudicator generally should explain the weight given to opinions from these sources, or otherwise ensure that the discussion of the evidence in the determination or decision allows an individual or subsequent reviewer to follow the adjudicator’s reasoning, when such opinions may have an effect on the outcome of the case. In addition, when an adjudicator determines that an opinion from one of these sources is entitled to greater weight than a medical opinion from a treating source, the adjudicator must explain the reasons in the determination or decision if the determination is less than fully
favorable under our current rules. In these final rules, we have included these policies from SSR 06–03p into final 404.1527 and 416.927 for claims filed before March 27, 2017.

In the NPRM, 38 we did not propose a rule that would have required our adjudicators to articulate how they considered evidence from nonmedical sources because these sections only discuss medical opinions, which come from medical sources. In response to the comment asking us to include guidance about how we will consider and provide articulation about how we considered evidence from nonmedical sources, we have made two changes. First, for claims filed before March 27, 2017, we have added a new paragraph, sections 404.1527(c) and 416.927(c), which explains how we will consider, and articulate our consideration of, opinions from medical sources who are not AMSs and from nonmedical sources. Second, we are also including regulatory text about evidence from nonmedical sources for claims filed on or after March 27, 2017. For these claims, new sections 404.1527(c)(d) and 416.927(c)(d) state that, “We are not required to articulate how we considered evidence from nonmedical sources using the regulations in” sections 404.1520c(a)-(c) and 416.920c(a)-(c) of the rules. This change clarifies our original intent.

Specifically, aside from where our regulations elsewhere may require the adjudicator to articulate how we consider evidence from nonmedical sources, such as when we evaluate symptoms, 39 there is no requirement for us to articulate how we considered evidence from nonmedical sources about an individual’s functional limitations and abilities, using the rules in final 404.1520c and 416.920c.

Comment: We received a comment from ACUS asking us to revise the preamble and our rules to reflect that the ACUS Assembly voted to adopt two of its principal recommendations from the ACUS Final Report 40 in the ACUS Conference Recommendations. 41 Another commenter asked us to disregard the ACUS Final Report and ACUS Conference Report because, he asserted, ACUS is unfamiliar with the realities that individuals face in daily life.

Response: We value the expertise ACUS provides to help improve Federal agencies’ administrative processes, and specifically in this rulemaking process, 42 and we appreciate ACUS’ continued interest in helping us improve the ways we administer our programs. At this time, we are adopting most of the ACUS Conference Recommendation that relate to the treating source rule in these final rules. The ACUS Final recommendation encourages us to use “notice-and-comment rulemaking to eliminate the controlling weight aspect of the treating source rule in favor of a more flexible approach based on specific regulatory factors” that are in our current rules. This recommendation also said that our adjudicators should articulate the bases for the weight given to medical opinions “in all cases.”

We base the factors we will use to evaluate medical opinions in these final rules, which are based on notice-and-comment rulemaking, on the factors in our current rules. In response to ACUS’s recommendation that our adjudicators should articulate the reasons for the weight given to medical opinions in all cases, we have revised final 404.1520c(b) and 416.920c(b) to state that we will articulate in our determination or decision how persuasive we find all of the medical opinions and all of the prior administrative medical findings in an individual’s case record. We also provide specific articulation requirements for medical opinions from all medical sources, regardless of whether the medical source is an AMS. The second ACUS recommendation asked us to both: (1) Recognize nurse practitioners (NP), physician assistants (PA), and licensed clinical social workers (LCSW) as AMSs consistent with their respective State law-based licensure and scope of practice, and (2) issue a policy statement that clarifies the value and weight to be afforded to opinions from NPs, PAs, and LCSWs. 43

As stated above, we are recognizing PAs and ARNPs, which includes NPs, as AMSs in these final rules. At this time, we are not recognizing LCSWs as AMSs, for the reasons we discussed previously.

With respect to ACUS’s recommendation that we assign an inherent value to medical opinions from these medical sources, we will explain how we considered the medical opinions from these medical sources because we are not adopting our proposal to base the articulation requirements on whether the medical source is an AMS.

Comment: One commenter asked us to retain a separate practice for child claims because pediatricians still have important treatment relationships with child claimants. Another commenter asked us to give controlling weight to teacher assessments in child claims.

Response: While we are not adopting these comments, we expect pediatricians have a valuable role in many child claims. Final sections 404.1520c(c) and 416.920c(c) explain that we will continue to consider the medical source’s area of specialty and a medical source’s relationship with an individual, including a child, as part of our evaluation of medical opinions. However, a treating pediatrician’s relationship with a child patient is not sufficiently different from a treating doctor’s relationship with an adult patient to warrant having a separate rule for evaluating medical opinions from treating pediatricians. Because we are moving away from applying the treating source rule for all medical sources, we are not expanding the treating source rule to give controlling weight to nonmedical sources like teachers.

Comment: One commenter suggested that instead of revising our rules about treating sources, we make additional efforts to develop evidence from treating sources, such as sending them functional questionnaires and asking them for medical opinions.

Response: We did not adopt this comment because our current practice is consistent with the Act’s requirements that we make every reasonable effort to obtain evidence from all of an individual’s medical sources. 44

Comment: One commenter asked us to replace “consider” with “evaluate” and asserted that “consider” is a vague term.

Response: We did not adopt this comment because the use of the term “consider” is consistent with our current rules, and it is easily distinguishable from the articulation requirements. Adoption of the term “evaluate” could imply a need to provide written analysis, which is not what we intend. Therefore, we have

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38 81 FR at 62583–84 and 62592–93.
39 See current 404.1529 and 416.929.
42 ACUS is “an independent federal agency dedicated to improving the administrative process through consensus-driven applied research, providing nonpartisan expert advice and recommendations for improvement of Federal agency procedures.” About the Administrative Conference of the United States (ACUS), available at http://www.acus.gov/about-administrative-conference-united-states.acus.
43 42 U.S.C. 421(d)(5)(B) and 1382a(a)(1)(H)(i).
44 See, for example, 404.1520b and 416.820b.
Comment: One commenter offered an alternative approach to ending the treating source rule. The alternative approach would continue to give controlling weight to treating physician opinions in most circumstances, significantly limit how persuasive we could find a CE source’s opinions, and limit the role of MCs and PCs to identifying when additional medical evidence is needed to adjudicate a claim.

Response: We are not adopting this suggestion because it is not consistent with section 221(h) of the Act, as amended by BBA section 832. As we noted earlier in the preamble, under section 221(h) of the Act, we are now required to make “every reasonable effort” to ensure that a qualified physician (in cases involving a physical impairment) or a qualified psychiatrist (in cases involving a mental impairment) has completed the medical review of the case and any applicable residual functional capacity (RFC) assessment, not just identify when additional medical evidence is needed to adjudicate a claim.

Furthermore, the suggestion would not bring our rules into alignment with the reality of healthcare delivery. Our rules focus on the content of the medical opinions in evidence, rather than on the source of the evidence. The commenter’s proposal would require us to adopt the opinions of either a treating physician or a consultative examiner to determine if the claimant meets our statutory definition of disability. This would confer upon these other sources the authority to make the determination or decision that we are required to make, and would be an abdication of our statutory responsibility to determine whether the person meets the statutory definition of disability.

Comment: A few commenters said we should never consider evidence from our MCs and PCs to be more persuasive than evidence from an individual’s own medical sources, may not have.

Response: In the preamble to the NPRM, we provided a list of sources of evidence in footnote 119, which refers readers to the ACUS Final Report. If we revised the final rules in several ways, such as to require adjudicators to articulate how they considered medical opinions from all medical sources, rather than only from AMs, in final section III.A. of its Final Report include:

- Sharyn J. Potter & John B. McKinlay, From a Relationship to Encounter: An Examination of Longitudinal and Lateral Dimensions in the Doctor-Patient Relationship, 61 SOC. SCI. & MED. 465, 466–470 (2005). These authors described the long-running changes to doctor-patient relationship in cases involving a mental impairment has completed the medical review of the case.

- John W. Saulz & Waled Albadawi, Interpersonal Continuity of Care and Patient Satisfaction: A Critical Review, 2 ANNALS OF FAM. MED. 445, 445 (Sept./Oct. 2004). This article reports that, “Changes in the American healthcare system during the past decade have made it increasingly difficult to establish such long-term trusting relationships between physicians and patients. Some authors have questioned whether a personal model of care is feasible, as health plans increasingly have required provider changes for economic reasons.”

- Paul Nutting et al., Continuity of Primary Care: To Whom Does it Matter and When?, 1 ANNALS OF FAM. MED. 149, 154 (Nov. 2003) This article states, “The current organizational and financial restructuring of the health care system creates strong pressures against continuity with employers changing plans, and plans changing providers. Forced disruption in continuity of care is common, particularly for those with a managed care type of insurance.”

There are other similar sources of evidence establishing that individuals less frequently develop a sustained relationship with one treating physician now on pages 25–28 of the ACUS Final Report, including in the footnotes.

Comment: Some commenters opined that increasing complexity in cases and voluminous files were reasons we provided in support of our proposed rules about how we would articulate our consideration of medical opinions. As explained elsewhere in this preamble, we received comments raising concern with certain aspects of the proposed articulation requirements. As a result, we revised the final rules in several ways, such as to require adjudicators to articulate how they considered medical opinions from all medical sources, rather than only from AMs, in final section III.A. of its Final Report.

As we explained in the preamble to the NPRM, it is not administratively feasible for us to articulate how we considered all of the factors for all of the medical opinions and prior administrative medical findings in all claims. As we noted earlier in the preamble, our goal in these final rules is to continue to ensure that our adjudicative process is both fair and efficient. We have an obligation to treat each claimant as an individual and to decide his or her claim fairly. We also have an obligation to all individuals to provide them with timely, accurate determinations and decisions.

Our experience since 1991 using the treating source rule shows that the articulation requirement in the current rule, which requires adjudicators to address each opinion, rather than addressing the opinions on a source-level, does not always foster those two goals. Accordingly, we believe it is appropriate to revise the articulation requirement in our current rules. We believe that the changes we have made from the NPRM address the concerns raised by the commenters, while still allowing us to ensure that our administrative process is both fair and efficient.

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47 Id. at 26, footnote 205.
48 Id. at 26, footnote 206.
49 Id. at 28, footnote 220.
Articulation Requirements

Comment: A few commenters expressed concern with the factors that we proposed to consider when evaluating medical opinions and prior administrative medical findings. One commenter indicated that we should not elevate consistency above the other factors. Another commenter thought that the consistency factor would automatically make a longitudinal record subject to being found inconsistent. Other commenters said we should continue to use our existing factors, or first consider the factor of a longstanding treatment relationship, to evaluate the persuasiveness of medical opinions and prior administrative medical findings. Some commenters were concerned with our proposal to add “understanding our policy” and “familiarity with the record” to our list of factors because they may appear to favor evidence from our MCs and PCs over an individual’s own medical sources.

Response: We agree, in part, with these comments. We are adopting our proposal to consider supportability and consistency as the two most important factors when we evaluate the persuasiveness of medical opinions and prior administrative medical findings. Our experience adjudicating claims demonstrates that these factors are more objective measures than the relationship with the claimant factor and are the same factors we look to as part of the current treating source rule. While we agree that there is no hierarchy to the remaining factors, we did not revise our rules to include this language in the regulatory text. Instead, we agree with the comments that we should revise the regulatory text to eliminate any appearance that inherently favor evidence from MCs or PCs over evidence from an individual’s own medical sources, and vice versa. Therefore, we made several revisions to the regulatory text in final 404.1520c and 416.920c.

We revised the issues within the “relationship with the claimant” factor to read: length of the treatment relationship, frequency of examinations, purpose of the treatment relationship, and extent of the treatment relationship. This underscores our recognition that an individual’s own medical source may have a unique perspective of an individual’s impairments based on the issues listed, such as a long treatment relationship. We will consider the unique evidence in each claim that tend to support or weaken how persuasive we find these issues.

Similarly, under both our current rules and the proposed rules, we may consider a medical source’s familiarity with the entire record and his or her understanding of our policy. In our proposed rules, we proposed to separately list “understanding our policy” and “familiarity with the record” as individual factors instead of examples of “other factors” as in the current rules. Some commenters were concerned that this change favored our MCs and PCs, who often review all evidence in a claim and are trained in our policies. This was not our intent, and we proposed to reorganize the factors to clarify, not change, our policy on this point. Therefore, we agree with the comments that it would be best to list these issues within “other factors.”

We also recognize that new evidence submitted after an MC or PC provided a prior administrative medical finding may affect how persuasive that finding is at subsequent levels of adjudication. We are adding in final 404.1520c(5) and 416.920c(5) that when we consider a medical source’s familiarity with the other evidence in a claim, we will also consider whether new evidence we receive after the medical source made his or her medical opinion or prior administrative medical finding makes the medical opinion or prior administrative medical finding more or less persuasive.

Additionally, we recognize that evidence from a medical source who has a longstanding treatment relationship with an individual may contain some inconsistencies over time due to fluctuations in the severity of an individual’s impairments. Our adjudicators will consider this possibility as part of evaluation of the consistency factor, as they do so under our current rules. We will also include this issue within our training to our adjudicators.

Comment: Some commenters were concerned that, by moving away from assigning a specific weight to opinions and prior administrative medical findings, we would add subjectivity into the decisionmaking process and said we would only require our adjudicators to think about the evidence but not provide written analysis. Other commenters suggested that by requiring articulation on only two factors—supportability and consistency—our decisions would not sufficiently inform the individual or a reviewing Federal court of the decisionmaker’s reasoning, which would lead to more appeals to and remands from the courts.

Response: While we understand the concerns in these comments, we are adopting our proposal to look to the

51 These commenters asserted that Black & Decker reflected positively on the 1991 treating source rule regulations, and that many courts support the treating source rule’s deferential standard.

52 Because the opinion notes that, “the assumption that the opinions of a treating physician warrant greater credit than the opinions of plan consultants may make scant sense when, for example, the relationship between the claimant and the treating physician has been of short duration, or when a specialist engaged by the plan has expertise the treating physician lacks. And if a consultant engaged by a plan may have an ‘incentive’ to make a finding of ‘not disabled,’ so a treating physician, in a close case, may favor a finding of ‘disabled.’” 53 Although the Black & Decker court was referring to medical consultants contracted under ERISA plans, the concerns about short treatment relationships and lack of specialization are equally applicable in the context of disability adjudication under our rules.

54 Notably, ACUS agrees with our interpretation of the discussions in these opinions. Additionally, setting aside the Court’s decision in Black and Decker, the other rationale we provided in the NPRM for revising our policy on how we consider treating source and other medical source opinions remains compelling.

Comment: Some commenters, including the authors of a law review article mentioned in section VI.D.5 of the NPRM preamble, submitted comments stating we had inaccurately presented parts of the content of that article and their position on the treating physician rule.

Response: We appreciate the commenters’ concerns and their interest in our programs and this rulemaking proceeding. We regret the mischaracterization of the authors’ position in their article. We note that the other rationale discussed in the NPRM and these final rules remains compelling.


56 81 FR 62572.

57 58 U.S. at 832.

58 See ACUS Final Report at 43.

pursiveness of medical opinions and prior administrative medical findings for claims filed on or after March 27, 2017. Our current regulations do not specify which weight, other than controlling weight in a specific situation, we should assign to medical opinions. As a result, our adjudicators have used a wide variety of terms, such as significant, great, more, little, and less. The current rules have led to adjudicative challenges and varying court interpretations, including a doctrine by some courts that supplants the judgment of our decisionmakers and credits as true a medical opinion in some cases.

By moving away from assigning a specific weight to medical opinions, we are clarifying both how we use the terms “weight” and “weight” in final 404.1520c(a), 404.1527, 416.920c(a), and 416.927 and also clarifying that adjudicators should focus on whether they find medical opinions and prior administrative medical findings in final 404.1520c and 416.920c. Our intent in these rules is to make it clear that it is never appropriate under our rules to “credit-as-true” any medical opinion.

We are also stating in final 404.1520c(b) and 416.920c(b) what minimum level of articulation we will provide in our determinations and decisions to provide sufficient rationale for a reviewing adjudicator or court. In light of the level of articulation we expect from our adjudicators, we do not believe that these final rules will result in an increase in appeals or remands from the courts.

Comment: We received various comments regarding our proposal in sections 404.1520c(b) and 416.920c(b) about when we would articulate how we considered medical opinions from medical sources who are not AMSs. A few commenters supported our proposal. However, several other commenters, including Members of Congress, expressed concern with the proposed changes. Some commenters said the changes would result in less transparency because adjudicators would have “too much individual discretion to dismiss key evidence without providing a rationale.” Other commenters said that our proposed rules would not allow reviewing courts to determine whether evidence supports our decisions.

Response: We partially adopted these comments, and we appreciate the perspective of the commenters who expressed concern with the proposed rules. We are committed to having a transparent, fair, and balanced adjudicative process that ensures that every entitled individual receives the disability benefits or payments and that every individual understands why he or she is not entitled to benefits. We agree with the majority of commenters that we should articulate how we consider medical opinions from any of an individual’s own medical sources, regardless of whether that source is an AMS.

Therefore, we revised final 404.1520c(b) and 416.920c(b) to require our adjudicators to articulate how they consider medical opinions from all medical sources, regardless of AMS status. This revision helps align our rules with current medical practice and recognizes that individuals may obtain evaluation, examination, or treatment from medical sources who are not AMSs.

To account for this change, we are not adopting proposed 404.1520c(b)(4) and 416.920c(b)(4) in these final rules, which would have stated standards about when we would articulate how we considered medical opinions from medical sources who are not AMSs. We also revised final 404.1520c(a)–(b) and 416.920c(a)–(b) to clarify that there is a difference between considering evidence and articulating how we consider evidence. We consider all evidence we receive, but we have a reasonable articulation standard for determinations and decisions that does not require written analysis about how we considered each piece of evidence.

We expect that the articulation requirements in these final rules will allow a subsequent reviewer or a reviewing court to trace the path of an adjudicator’s reasoning, and will not impede a reviewer’s ability to review a determination or decision, or a court’s ability to review our final decision.

Comment: One commenter asked for clarification about what we meant by “medical source.” In proposed 404.1520c(b)(1) and 416.920c(b)(1), particularly when an entity provides us with evidence. The commenter asked if we were referring to the same health care provider, the same clinic, the same medical group, or the same hospital.

Response: Under both our current and these final rules, only an individual, not an entity, can be a medical source. When an entity provides us with evidence from multiple medical sources, we will evaluate each medical source’s evidence separately instead of considering the evidence as coming from one source.

Comment: One commenter agreed with our proposal to require an adjudicator to discuss other relevant factors when we find two medical sources’ medical opinion(s) or prior administrative medical finding(s) equally persuasive. Another comment asserted that the NPRM did not provide much guidance as to when medical opinions are both equally well-supported and consistent with the record.

Response: We agree with the first commenter that this requirement provides an appropriate standard about when an adjudicator has discretion to discuss the other relevant factors. Because the content of evidence, including medical opinions and prior administrative medical findings, varies with each unique claim, it would not be appropriate to set out a detailed rule for when this situation may occur. We expect that each adjudicator will use his or her discretion to determine when this situation occurs.

The final rules include sufficient guidance to adjudicators in determining whether this situation exists. Under final sections 404.1520c(b)(3) and 416.920c(b)(3), the medical opinions or prior administrative medical findings must be “both equally well-supported” under sections 404.1520c(c)(1) or 416.920c(c)(1) “and consistent with the record” under sections 404.1520c(c)(2) or 416.920c(c)(2). In addition, the opinions or prior administrative medical findings must not be “exactly the same.” Under these circumstances, we will articulate how we considered the other most persuasive factors in sections 404.1520c(c)(3)–(c)(5) or 416.920c(c)(3)–(c)(5) for those medical opinions or prior administrative medical findings in the determination or decision.

Comment: One commenter thought we would no longer provide rationale about why we did not adopt a medical opinion from an individual’s doctor. A few commenters believed that the proposed rule would reduce our articulation burden and would increase inconsistency in how we evaluate individuals.

Response: While we understand some commenters were concerned about these issues, these final rules continue the requirement in current 404.1527 and 416.927 to articulate how we consider medical opinions from an individual’s own doctor. In fact, these final rules enhance the current requirements in several ways, such as requiring articulation about medical opinions from all of an individual’s medical sources, making consistency and supportability the most important factors, and clarification of the factors themselves. These improvements will increase the consistency in how we evaluate claims, and we also expect them to reduce remands.
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**Comment:** One commenter asked us to adopt the medical opinions of highly-specialized doctors without considering the other factors.

**Response:** After careful consideration, we are not adopting this comment. The specialization of the medical source who provides a medical opinion or prior administrative medical findings is one of the factors we consider when we evaluate how persuasive a medical opinion or prior administrative medical finding is. Under our current rules in 404.1527(c) and 416.927(c), we consider several factors when we decide what “weight” to give to a medical opinion, and we do not consider the specialization of the medical source in isolation. Evaluating the persuasiveness of a medical opinion requires consideration of several factors and in context of all of the evidence in the claim.

**Comment:** One commenter asked us to add a factor for considering medical opinions that would inquire about whether the individual is indigent, because such individuals cannot afford psychotherapy.

**Response:** We are not adopting this comment because the factors for considering medical opinions and prior administrative medical findings relate to the persuasiveness of the evidence presented, not to the financial status of the individual. We will consider and explain how we considered medical opinions of an individual’s medical sources regardless of whether the medical evaluation, examination, or treatment occurred in a free or low cost health clinic for indigent individuals.

**Comment:** One commenter asked whether we intended to make two separate findings about the value and persuasiveness of medical opinions, or whether we intended to require one finding. The commenter opposed requiring two separate findings for each medical opinion because that would increase the articulation burden on our adjudicators.

**Response:** We appreciate the question and the opportunity to clarify that we are not requiring two separate findings. Our adjudicators need only explain how persuasive they found a medical opinion or prior administrative medical finding in their determinations or decisions. As we stated in final 404.1520c(b) and 416.920c(b), “[w]e will articulate in our determination or decision how persuasive we find all of the medical opinions and all of the prior administrative medical findings in your case record.” There is no requirement that our adjudicators provide a second analysis about how valuable a medical opinion or prior administrative medical finding is.

**Comment:** A few commenters said that our proposed rules about how we would articulate how we considered medical opinions, and that we would not articulate our consideration of disability examiner findings, statements on issues to the Commissioner, and decisions by other governmental agencies and nongovernmental entities, violated due process and 42 U.S.C. 405(b), which requires us to include in a determination or decision that is not fully favorable to an individual, a statement of the case, in understandable language, setting forth a discussion of the evidence, and stating the reason(s) upon which we based the determination or decision. Some commenters said reviewing courts would increase the number of remands because they would be unable to review our adjudicators’ rationale.

**Response:** Our current rules, the proposed rules, and these final rules are consistent with and further the goals of 42 U.S.C. 405(b) and the principles of due process. The statute does not require us to explain every piece of evidence we receive. Instead, section 405(b) requires us to include in a determination that is not fully favorable to an individual, a statement of the case, in understandable language, setting forth a discussion of the evidence, and stating the reason(s) upon which we based the determination or decision. The intent of the statute was not to impose a burdensome articulation requirement. Rather, the intent was to remedy a prior concern that individuals were receiving notices that their claims for disability benefits had been denied without any personalized articulation of the evidence.

We will articulate how we considered the medical opinions from all medical sources and prior administrative medical findings in a claim. This articulation will include the supportability and consistency factors, which generally includes an assessment of the supporting objective medical evidence and other medical evidence, and how consistent the medical opinion or prior administrative medical findings is with other evidence in the claim. Therefore, the final rules are consistent with the intent of the statute that we provide a statement of the case, setting forth a discussion of the evidence, and stating the reasons upon which we based the determination.

As to the comments that these rules do not provide due process, these final rules do not violate the Due Process Clause of the Fifth Amendment to the Constitution. The final rules do not categorize individuals based on their characteristics or deprive an individual of a protected property interest. The rules also ensure that our procedures are fair and provide individuals with appropriate procedural protections. Nothing in constitutional principles of equal protection is inconsistent with the final rules.

**Comment:** We received a few comments raising concern about the interactions between the proposed rules and some Federal statutes, and the interactions between the proposed rules and judicial review. A few commenters said our proposed rules were in conflict with 42 U.S.C. 405(g). One commenter said our proposed rules were in conflict with 42 U.S.C. 404(a). One commenter said our proposed rules violated the Ninth Circuit’s “credit-as-true doctrine.” Another commenter said the treating source rule provides for uniformity between Federal courts and us and minimizes delays to claimants by limiting unnecessary court reviews. A few commenters said courts would continue to defer to evidence from a claimant’s own medical sources regardless of the context of our rules.

**Response:** We do not agree with these comments. 42 U.S.C. 404(a) and 405(g) do not directly apply to the proposed or final regulatory sections. 42 U.S.C. 404(a) addresses how we assess underpayments and overpayments, and nothing in these final rules address these issues. Similarly, 42 U.S.C. 405(g) addresses procedures for individuals to appeal their decisions to Federal court, and these final rules do not affect these rights.

Federal courts are bound to uphold our decisions when they are supported by substantial evidence and when we have applied the appropriate legal standards in our decisions. While a court has the authority to review the validity of our regulations, the fact that some courts previously have adopted a credit as true rule does not mean that we are required to adopt such a rule in
our regulations. Those courts that have adopted the credit as true rule have not done so based on any specific requirement of the Act, and the statute does not mandate that we apply such a rule.

In our view, the credit as true rule supplants the legitimate decisionmaking authority of our adjudicators, who make determinations or decisions based on authority delegated by the Commissioner. The credit as true rule is neither required by the Act nor by principles of due process. It is also inconsistent with the general rule that, when a court finds an error in an administrative agency’s decision, the proper course of action in all but rare instances is to remand the case to the agency for further proceedings. Accordingly, we decline to adopt the credit as true rule here.

We expect that courts will defer to these regulations, which we adopted through notice and comment rulemaking procedures pursuant to the Commissioner’s exceptionally broad rulemaking authority under the Act. The rules are essential for our administration of a massive and complex nationwide disability program where the need for efficiency is self-evident. The rules are neither arbitrary nor capricious, nor do they exceed the bounds of reasonableness. Under these circumstances, we are confident that our rules are valid.

Comment: A few commenters asked us to require MCs and PCs to identify what medical evidence they reviewed and disclose the amount of time spent reviewing each claimant’s file to enable later decisionmakers to assess the supportability and consistency factors more effectively. These commenters also asked us to instruct our adjudicators to consider the completeness of the record at the time of review and the time spent reviewing the record when evaluating prior administrative medical findings.

Response: While we agree that the specific evidence an MC or PC reviewed is probative, we did not accept this comment because MCs and PCs are required to evaluate all of the evidence in the claim file at the time they make their medical findings under our rules. Consistent with 42 U.S.C. 405(b), our current rules also require that when we make an initial determination, our written notice will explain in simple and clear language what we have determined and the reasons for and the effect of our determination. When we make a determination of disability that is in whole or in part unfavorable to an individual, our rules also require our written notice to “contain in understandable language a statement of the case setting forth the evidence on which our determination is based.”

Adjudicators at subsequent levels of appeal can also determine what evidence already existed in the claim file when the MC or PC made his or her medical findings by reviewing data in the claims folder.

We also did not adopt the suggestion to measure and document MC and PC review time to help subsequent adjudicators consider supportability and consistency of their adjudicative findings because review time does not provide information about supporting evidence or consistency of the evidence.

Sections 404.1521 and 416.921—Establishing That You Have a Medically Determinable Impairment

Comment: One commenter asked us to align our requirements for establishing an impairment with the International Classification of Functioning (ICF) used by the World Health Organization. The ICF is a framework for describing and organizing information on functioning and disability. The commenter suggested that if we were to align our requirements for establishing an impairment with the ICF, medical sources who provide evidence to us could use a standardized language and conceptual basis for the definition and measurement of health and disability.

Response: While we are always looking for ways to improve how we adjudicate disability claims, we are not adopting the comment at this time. It is unclear how the ICF would be helpful in our adjudication of disability claims because the ICF’s definition of disability differs from the requirements in the Act. The Act defines disability as “the inability to engage in substantial gainful activity by reason of any medically determinable physical or mental impairment, which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months.”

In contrast, the ICF views “disability and functioning as outcomes of interactions between health conditions (diseases, disorders and injuries) and contextual factors.” Included in these contextual factors “are external environmental factors (for example, social attitudes, architectural characteristics, legal and social structures, as well as climate, terrain, and so forth); and internal personal factors, which include gender, age, coping styles, social background, education, profession, past and current experience, overall behaviour pattern, character and other factors that influence how disability is experienced by the individual.”

Therefore, an individual could have a “disability” as contemplated by the ICF without meeting the Act’s definition of disability.

Sections 404.1522 and 416.922—What We Mean by an Impairment(s) That Is Not Severe

Comment: One commenter stated that, “controlling law on the statutory interpretation of ‘severe’ is that it should have the ‘minimalist effect’ on the activities of daily living.”

Response: We did not adopt this comment because we proposed to move the current definition from current 404.1521(a) and 416.921(a) into proposed 404.1522(a) and 416.922(a) as part of the effort to reorganize our regulations for ease of use, not to change the current definition. The definition of “non-severe” impairment in our regulations has been the same since 1980, and it has been substantially the same since we first defined the term in 1980. The U.S. Supreme Court upheld the regulatory definition in Bowen v. Yueck.

Sections 404.1523 and 416.923—Multiple Impairments

Comment: One commenter opposed proposed 404.1523 and 416.923, which explains how we consider an individual’s multiple impairments, because he said we would not consider all impairments in combination.

Response: We decided to adopt these proposed revisions as part of our effort to make our rules easier to understand and use. These sections combine content from current 404.1522, 404.1523, 416.922, and 416.923 without any substantive change in language. These current sections discuss related issues—our policies for considering claims involving multiple impairments.

See National Cable and Telecommunications Ass’n v. Brand X Internet Services, 545 U.S. 967, 982 [2005].

See 5 U.S.C. 553 and E.O. 12866, as supplemented by E.O. 13563.

See National Cable and Telecommunications Ass’n v. Brand X Internet Services, 545 U.S. 967, 982 [2005].


Id.

See 50 FR 8726, 8728 [March 5, 1985].

See 45 FR 55566, 55588 [August 20, 1980].

Under the final rules, as under the current rules, we will consider the combined effect of all of the individual’s impairments without regard to whether any such impairment, if considered separately, would be of sufficient severity when we determine whether an individual’s physical or mental impairment or impairments are of a sufficient medical severity that such impairment or impairments could be the basis of eligibility. We do find a medically severe combination of impairments, we will consider the combined impact of the impairments throughout the disability determination process. Since our final rules require us to consider the combined effect of an individual’s impairments, we are adopting the text as proposed in final 404.1523 and 416.923.

Sections 404.1527 and 416.927—Evaluating Opinion Evidence for Claims Filed Before March 27, 2017

Comment: One commenter suggested that the phrase “typical for your condition(s)” as part of the definition of “treating source” in proposed 404.1527 and 416.927, which will be applied to claims filed before March 27, 2017, should include the population of individuals who can afford psychotherapy as frequently as those who can afford to pay for more frequent sessions.

Response: We are not adopting this comment. The definition of “treating source” in proposed 404.1527 and 416.927, including the words “typical for your condition(s),” comes from our current definition of treating source in current 404.1502 and 416.902. We will continue to apply our current rules for evaluating evidence from a treating source, including this definition, to claims filed before March 27, 2017. We moved this definition to proposed 404.1527 and 416.927 to locate together more of the rules that we will use for claims filed before March 27, 2017.

For claims filed on or after March 27, 2017, the rules for considering medical opinions will not use the term “treating source” or the phrase “typical for your condition(s).”

Sections 404.1616 and 416.1016—Medical Consultants and Psychological Consultants

Comment: Several commenters opposed our proposal to recognize master’s level psychologists licensed for independent practice as psychological consultants (PC) in proposed 404.1616 and 416.1016. These commenters stated that speech-language pathologists are highly qualified to assess level of functional impairment and ability related to communication disorders; therefore, we have retained them as AMSs. However, section 221(h) of the Act, as amended by BBA section 832, states that we must make every reasonable effort to ensure that a qualified physician (in cases involving a physical impairment) or a qualified speech-language pathologist (in cases involving a mental impairment) completes the medical portion of the case review. A speech-language pathologist is not a “qualified physician” and therefore section 221(h) of the Act does not authorize us to recognize them as MCs or PCs.

Response: We agree that speech-language pathologists are highly qualified to assess level of functional impairment and ability related to communication disorders; therefore, we have retained them as AMSs. However, section 221(h) of the Act, as amended by BBA section 832, states that we must make every reasonable effort to ensure that a qualified physician (in cases involving a physical impairment) or a qualified speech-language pathologist (in cases involving a mental impairment) completes the medical portion of the case review. A speech-language pathologist is not a “qualified physician” and therefore section 221(h) of the Act does not authorize us to recognize them as MCs or PCs.

To hold retain the expertise of non-physician AMSs like speech-language pathologists, we created the role of a medical advisor in our subregulatory instructions. These medical sources can review the evidence in the claim and provide case analysis that the adjudicative team will consider as evidence from a medical source in accordance with final 404.1513(a), 404.1520b, 404.1520c, 404.1527, 416.913(a), 416.920b, 416.920c, and 416.927, as appropriate. However, we are not adopting the suggestion to require Speech-Language Pathologist medical advisor input in every claim involving communication disorders at this time. The adjudicative team will use its professional judgment to determine whether to consult with a medical advisor(s) and how to consider medical advisor input on any case.

Comment: One commenter asked us to revise our rules to state that an MC who is a pediatrician must evaluate any child claim involving a physical impairment and cited section 1614(a)(3)(I) of the Act, which mandates that we make reasonable efforts to have a qualified pediatrician or other appropriate specialist evaluate a child’s case. Another commenter asked us to allow licensed physicians such as development/behavioral pediatricians, child neurologists, and some primary care providers to act as PCs in a child claim involving a mental impairment because there is a shortage of child psychologists and psychiatrists. Another commenter opposed our rules that authorize psychiatrists to review physical impairment.

Response: While we appreciate the commenters’ concerns, we did not adopt the proposed regulations.
them because our current rules are already sufficient and consistent with the Act. Consistent with the Act’s requirements in section 1614(a)(5)(I), our current rules already state that we will make reasonable efforts to ensure that a qualified pediatrician or other individual who specializes in a field of medicine appropriate to the child’s impairment(s) evaluates the case of the child. The Act does not require us to have only a pediatrician be an MC in child claims involving a physical impairment(s).

Section 221(h) of the Act, as amended by BBA section 832, and 404.1527, 416.920c, and 416.927. The Act requires us to have at least one qualified pediatrician or other individual who specializes in a field of medicine appropriate to the child’s impairment(s) evaluate the case of the child.

Section 832(h) of the Act creates the medical advisor role in our Disability Determination Service (DDS) has unique staffing considerations. Due to the continually changing nature of the medical profession, any future guidance we may issue about which medical specialties may review claims involving specific impairments would be best placed in our subregulatory instructions.

Comment: A few commenters wanted us to recognize optometrists and psychologists as MCs. They said that BBA section 832’s requirement that a licensed physician review claims involving physical impairments still authorized us to have optometrists and psychologists as MCs.

Response: We recognize the specialized expertise that these medical sources can bring to claims, which is why we authorized them to be MCs prior to BBA section 832’s effective date. However, neither optometrists nor psychologists are qualified physicians, as is required by section 221(h) of the Act, as amended by BBA section 832. To retain access to their expertise, we created the medical advisor role in our subregulatory instructions so that DDSs may continue to request their expert analysis on claims.

Other Comments

Comment: Several commenters opposed the proposed policy changes in the NPRM that were inconsistent with the following Social Security Rulings (SSR): 96–2p, 96–5p, and 96–6p. Therefore, those commenters opposed rescinding the same SSRs.

Response: We explained in detail above and (as appropriate) in the preamble to our proposed rules, our reasons for adopting the policies in these final rules. Because the policies we are adopting in these final rules are inconsistent with those SSRs, we are rescinding them.

Comment: Some commenters disagreed with our proposed implementation process. These commenters said it would be difficult for adjudicators to follow different rules based on the filing date of the claim. One commenter said all claims should follow the new policies on the effective date, or in the alternative, fewer of the current policies should apply to claims filed before the effective date. The commenter also said that we should apply the proposed new policies about decisions from other governmental agencies and nongovernmental entities and about statements on issues reserved to the Commissioner to all claims.

Response: We carefully considered these comments and decided to implement these final rules consistent with our proposed implementation process. We are aware that individuals who filed claims before the effective date of these final rules may have requested evidence, including medical opinions from “treating sources,” based on our current policies. We are also cognizant that some of our existing rules may have engendered reliance interests that we need to consider. We proposed to implement some of these rules differently from our usual practice in recognition of these factors, which we believe still apply. However, to help adjudicators identify which rules they should follow, we revised the titles and introductory text in final 404.1520c, 404.1527, 416.920c, and 416.927.

Comment: A commenter stated that some of the changes proposed in the NPRM were not evidence-based or supported by “current data.” The commenter also raised concern about the speed and accuracy of disability determinations that we would make under the proposed rules, although the commenter did not specify which policies were of concern.

Response: We appreciate and agree with the commenter’s desire for evidence-based policies, and for efficient, fair, and policy-compliant disability determinations. We have explained at length in the preamble the reasons and the support for the policy changes. The primary reason that we are updating our rules is to reflect the current ways in which people receive medical treatment. As we implement these final rules, we will continue our current internal procedures for monitoring the quality and quantity of determinations to ensure that adjudicators continue to apply our rules timely and accurately.

Comment: One commenter asserted that we are required to include an analysis under the Regulatory Flexibility Act because the proposals would have a significant economic impact on a substantial number of small entities, such as law firms and nonprofit organizations.

Response: We did not adopt this comment because we are only required to perform a Regulatory Flexibility Act analysis if small entities will be subject to the proposed rule. The comment did not explain how these final rules may have a significant economic impact on a substantial number of small entities. “Congress ‘did not intend to require that every agency consider every indirect effect that any regulation might have on small businesses in any stratum of the national economy.’” Only individuals may receive disability or blindness benefits under titles II and XVI of the Act. An individual who applies for disability or blindness benefits may enter into an agreement with an individual representative to help him or her with the claim, which may include a fee for services provided. However, our current regulations do not recognize any entities as representatives.

Therefore, as authorized by the Regulatory Flexibility Act, we correctly certified below that these final rules will not have a significant economic impact on a substantial number of small entities because they affect individuals only.

Comment: Several commenters stated that the proposed rules would not make our decisions more accurate or decrease the time it takes for us to adjudicate a claim. These commenters also asserted that the proposed rules would create more appeals and delays.

73 See current 404.1520 and 416.1520.

74 See current 404.1705 and 416.1505.

75 4 S.C. 6505(b).
Response: We disagree that these rules will make our decisions less accurate or will increase the time it takes for us to adjudicate a claim. These final rules clarify some existing policies and revise others for increased transparency and balance. As we discussed at length above, we expect that the changes we are adopting in these final rules will further the fair and timely administration of our programs. We have made a number of changes to the proposed rules to address concerns raised by commenters about aspects of the proposed rules, and to enhance our goal of ensuring that we adjudicate claims fairly, accurately, and in a timely manner.

Executive Order 12866, as Supplemented by Executive Order 13563

We consulted with the Office of Management and Budget (OMB) and determined that these final rules meet the criteria for a significant regulatory action under Executive Order 12866, as supplemented by Executive Order 13563. Therefore, OMB reviewed these final rules.

Regulatory Flexibility Act

We certify that these final rules will not have a significant economic impact on a substantial number of small entities because they affect individuals only. Therefore, a regulatory flexibility analysis is not required under the Regulatory Flexibility Act, as amended.

Paperwork Reduction Act

These final rules do not create any new or affect any existing collections and, therefore, do not require OMB approval under the Paperwork Reduction Act.

List of Subjects

20 CFR Part 404

Administrative practice and procedure, Blind, Disability benefits, Old-Age, Survivors, and Disability Insurance, Reporting and recordkeeping requirements, Supplemental Security Income (SSI).

Carolyn W. Colvin,
Acting Commissioner of Social Security.

For the reasons set out in the preamble, we are amending part 404 subparts J, P, and Q, and part 416 subparts I, J, and N as set forth below:

PART 404—FEDERAL OLD-AGE, SURVIVORS AND DISABILITY INSURANCE (1950–)

Subpart J—Determinations, Administrative Review Process, and Reopening of Determinations and Decisions

1. The authority citation for subpart J of part 404 continues to read as follows:

Authority: Secs. 202(a)–(b) and (d)–(h), 216(i), 221(a) and (b)–(j), 222(c), 223, and 702(a)(5) of the Social Security Act (42 U.S.C. 402(a)–(b) and (d)–(h), 416(i), 421(a) and (b)–(j), 422(c), 423, 425, and 9012(a)(5)); sec. 211(b), Pub. L. 104–183, 110 Stat. 2105, 2189; sec. 202, Pub. L. 108–203, 118 Stat. 509 (42 U.S.C. 902 note).

2. In §404.906(b)(2), revise the fourth sentence to read as follows:

§404.906 Testing modifications to the disability determination procedures.

* * * * *

(b) * * *

[2] * * * * However, before an initial determination is made in any case where there is evidence which indicates the existence of a mental impairment, the decisionmaker will make every reasonable effort to ensure that a qualified psychologist or psychologist has completed the medical portion of the case review and any applicable residual functional capacity assessment pursuant to our existing procedures (see §404.1617). * * * *

3. In §404.942, revise paragraph (f)(1) to read as follows:

§404.942 Prehearing proceedings and decisions by attorney advisors.

* * * * *

(f) * * * *

(1) Authorize an attorney advisor to exercise the functions performed by an administrative law judge under §§404.1513a, 404.1520a, 404.1526, and 404.1546. * * * *

Subpart P—Determining Disability and Blindness

4. The authority citation for subpart P of part 404 is revised to read as follows:

Authority: Secs. 202, 205(a)–(b) and (d)–(h), 216(i), 221(a) and (b)–(j), 222(c), 223, and 702(a)(5) of the Social Security Act (42 U.S.C. 402, 405(a)–(b) and (d)–(h), 416(i), 421(a) and (b)–(j), 422(c), 423, 425, and 9012(a)(5)); sec. 211(b), Pub. L. 104–183, 110 Stat. 2105, 2189; sec. 202, Pub. L. 108–203, 118 Stat. 509 (42 U.S.C. 902 note).

5. Revise §404.1502 to read as follows:

§404.1502 Definitions for this subpart.

As used in the subpart—

Acceptable medical source means a medical source who is:

(1) Licensed physician (medical or osteopathic doctor);

(2) Licensed psychologist, which includes:

(i) A licensed or certified psychologist at the independent practice level; or

(ii) A licensed or certified school psychologist, or other licensed or certified individual with another title who performs the same function as a school psychologist in a school setting, for impairments of intellectual disability, learning disabilities, and borderline intellectual functioning only;

(3) Licensed optometrist for impairments of visual disorders, or measurement of visual acuity and visual fields only, depending on the scope of practice in the State in which the optometrist practices;

(4) Licensed podiatrist for impairments of the foot, or foot and ankle only, depending on whether the State in which the podiatrist practices permits the practice of podiatry on the foot only, or the foot and ankle;

(5) Qualified speech-language pathologist for speech or language impairments only. For this source, qualified means that the speech-language pathologist must be licensed by the State professional licensing agency, or be fully certified by the State education agency in the State in which he or she practices, or hold a Certificate of Clinical Competence in Speech-Language Pathology from the American Speech-Language-Hearing Association;

(6) Licensed audiologist for impairments of hearing loss, auditory processing disorders, and balance disorders within the licensed scope of practice only (with respect to claims filed (see §404.614) on or after March 27, 2017);

(7) Licensed Advanced Practice Registered Nurse, or other licensed advanced practice nurse with another title, for impairments within his or her licensed scope of practice only (with respect to claims filed (see §404.614) on or after March 27, 2017); or

(8) Licensed Physician Assistant for impairments within his or her licensed
You or your means, as appropriate, the person who applies for benefits or for a period of disability, the person for whom an application is filed, or the person who is receiving benefits based on disability or blindness. § 404.1503 [Amended]

6. In § 404.1503, remove paragraph (e).

7. Revise § 404.1504 to read as follows:

§ 404.1504 Decisions by other governmental agencies and nongovernmental entities.

Other governmental agencies and nongovernmental entities—such as the Department of Veterans Affairs, the Department of Defense, the Department of Labor, the Office of Personnel Management, State agencies, and private insurers—make disability, blindness, employability, Medicaid, workers’ compensation, and other benefits decisions for their own programs using evidence underlying the other evidence.

We will consider all of the supporting evidence from your medical source or sources and entities that maintain your medical records. We will make every reasonable effort to help you get medical evidence from your own medical sources or entities that maintain your medical sources’ evidence when you apply. We will not provide any analysis in our determination or decision about a decision made by any other governmental agency or a nongovernmental entity about whether you are disabled, blind, employable, or entitled to any benefits based on its rules, it is not binding on us and is not our decision about whether you are disabled or blind under our rules.

Therefore, in claims filed (see § 404.614) on or after March 27, 2017, we will not provide any analysis in our determination or decision about a decision made by any other governmental agency or a nongovernmental entity about whether you are disabled, blind, employable, or entitled to any benefits. However, we will consider all of the supporting evidence underlying the other governmental agency or nongovernmental entity’s decision that we receive as evidence in your claim in accordance with § 404.1513(a)(1) through (4):

§ 404.1508 [Removed and reserved]

8. Remove and reserve § 404.1508.

9. Revise § 404.1512 to read as follows:

§ 404.1512 Responsibility for evidence.

(a) Your responsibility.

(1) General. In general, you have to prove to us that you are blind or disabled. You must inform us about or submit all evidence known to you that relates to whether or not you are blind or disabled (see § 404.1513). This duty is ongoing and requires you to disclose any additional related evidence about which you become aware. This duty applies at each level of the administrative review process.

(2) Completeness. The evidence in your case record must be complete and detailed enough to allow us to make a determination or decision about whether you are disabled or blind. It must allow us to determine—

(i) The nature and severity of your impairment(s) for any period in question;

(ii) Whether the duration requirement described in § 404.1509 is met; and

(iii) Your residual functional capacity to do work-related physical and mental activities, when the evaluation steps described in § 404.1520(e) or (f)(1) apply.

(b) Our responsibility.

(1) Development. Before we make a determination that you are not disabled, we will develop your complete medical history for at least the 12 months preceding the month in which you file your application unless there is a reason to believe that development of an earlier period is necessary or unless you say that your disability began less than 12 months before you filed your application. We will make every reasonable effort to help you get medical evidence from your own medical sources or entities that maintain your medical sources’ evidence when you give us permission to request the reports.

(i) Every reasonable effort means that we will make an initial request for evidence from your medical source or entity that maintains your medical source’s evidence, and, at any time between 10 and 20 calendar days after the initial request, if the evidence has not been received, we will make one
follow-up request to obtain the medical evidence necessary to make a determination. The medical source or entity that maintains your medical source’s evidence will have a minimum of 10 calendar days from the date of our follow-up request to reply, unless our experience with that source indicates that a longer period is advisable in a particular case.

(ii) Complete medical history means the records of your medical source(s) covering at least the 12 months preceding the month in which you file your application. If you say that your disability began less than 12 months before you filed your application, we will develop your complete medical history beginning with the month you say your disability began unless we have reason to believe your disability began earlier. If applicable, we will develop your complete medical history for the 12-month period prior to the month you were last insured for disability insurance benefits (see §404.130), the month ending the 7-year period you may have to establish your disability and you are applying for widow’s or widower’s benefits based on disability (see §404.335(c)(1)), or the month you attain age 22 and you are applying for child’s benefits based on disability (see §404.350).

(2) Obtaining a consultative examination. We may ask you to attend one or more consultative examinations at our expense. See §§404.1517 through 404.1519(f) for the rules governing the consultative examination process. Generally, we will not request a consultative examination until we have made every reasonable effort to obtain evidence from your own medical sources. We may order a consultative examination while awaiting receipt of medical source evidence in some instances, such as when we know a source is not productive, is uncooperative, or is unable to provide certain tests or procedures. We will not evaluate this evidence until we have made every reasonable effort to obtain evidence from your medical sources.

(3) Other work. In order to determine under §404.1520(g) that you are able to adjust to other work, we must provide evidence about the existence of work in the national economy that you can do (see §§404.1560 through 404.1569a), given your residual functional capacity (which we have already assessed, as described in §404.1520(e)), age, education, and work experience.

10. Revise §404.1513 to read as follows:

§404.1513 Categories of evidence.

(a) What we mean by evidence. Subject to the provisions of paragraph (b), evidence is anything you or anyone else submits to us or that we obtain that relates to your claim. We consider evidence under §§404.1520(b), 404.1520(c) (or under §404.1527 for claims filed (see §404.614) before March 27, 2017). We evaluate evidence we receive according to the rules pertaining to the relevant category of evidence. The categories of evidence are:

1. Objective medical evidence. Objective medical evidence is medical signs, laboratory findings, or both, as defined in §404.1502(f).

2. Medical opinion. A medical opinion is a statement from a medical source about what you can still do despite your impairment(s) and whether you have one or more impairment-related limitations or restrictions in the following abilities:

(i) Your ability to perform physical demands of work activities, such as sitting, standing, walking, lifting, carrying, pushing, pulling, or other physical functions (including manipulative or postural functions, such as reaching, handling, stooping, or crouching);

(ii) Your ability to perform mental demands of work activities, such as understanding; remembering; maintaining concentration, persistence, or pace; carrying out instructions; or responding appropriately to supervision, co-workers, or work pressures in a work setting.

(iii) Your ability to perform other demands of work, such as seeing, hearing, or using other senses; and

(iv) Your ability to adapt to environmental conditions, such as temperature extremes or fumes. (For claims filed (see §404.614) before March 27, 2017, see §404.1527(a) for the definition of medical opinion.)

3. Other medical evidence. Other medical evidence is evidence from a medical source that is not objective medical evidence or a medical opinion, including judgments about the nature and severity of your impairments, your medical history, clinical findings, diagnosis, treatment prescribed with response, or prognosis. (For claims filed (see §404.614) before March 27, 2017, other medical evidence does not include a diagnosis, prognosis, or a statement that reflects a judgment(s) about the nature and severity of your impairment(s)).

4. Evidence from nonmedical sources. Evidence from nonmedical sources is any information or statement(s) from a nonmedical source (including you) about any issue in your claim. We may receive evidence from nonmedical sources either directly from the nonmedical source or indirectly, such as from forms we receive and our administrative records.

(b) Prior administrative medical finding. A prior administrative medical finding is a finding, other than the ultimate determination about whether you are disabled, about a medical issue made by our Federal and State agency medical and psychological consultants at a prior level of review (see §404.900) in your current claim based on their review of the evidence in your case record, such as:

(i) The existence and severity of your impairment(s);

(ii) The existence and severity of your symptoms;

(iii) Statements about whether your impairment(s) meets or medically equals any listing in the Listing of Impairments in Part 404, Subpart P, Appendix 1;

(iv) Your residual functional capacity;

(v) Whether your impairment(s) meets the duration requirement; and

(vi) How failure to follow prescribed treatment (see §404.1530) and drug addiction and alcoholism (see §404.1535) relate to your claim.

4. Exceptions for privileged communications. We will not consider any communication announced privileged in this section.

(1) The privileged communications listed in paragraphs (b)(1)(i) and (b)(1)(ii) of this section are not evidence, and we will neither consider nor provide any analysis about them in your determination or decision. This exception for privileged communications applies equally whether your representative is an attorney or a non-attorney.

(i) Oral or written communications between you and your representative that are subject to the attorney-client privilege, unless you voluntarily disclose the communication to us.

(ii) Your representative’s analysis of your claim, unless he or she voluntarily discloses it to us. This analysis means information that is subject to the attorney work product doctrine, but it does not include medical evidence, medical opinions, or any other factual matter that we may consider in determining whether or not you are entitled to benefits (see paragraph (b)(2) of this section).

(2) The attorney-client privilege generally protects confidential communications between an attorney and his or her client that are related to providing or obtaining legal advice. The attorney work product doctrine generally protects an attorney’s analyses, theories, mental impressions, and notes. In the context of your
disability claim, neither the attorney-client privilege nor the attorney work product doctrine allow you to withhold factual information, medical opinions, or other medical evidence that we may consider in determining whether or not you are entitled to benefits. For example, if you tell your representative about the medical sources you have seen, your representative cannot refuse to disclose the identity of those medical sources to us based on the attorney-client privilege. As another example, if your representative asks a medical source to complete an opinion form related to your impairment(s), symptoms, or limitations, your representative cannot withhold the completed opinion form from us based on the attorney work product doctrine. The attorney work product doctrine would not protect the source’s opinions on the completed form, regardless of whether or not your representative used the form in his or her analysis of your claim or made handwritten notes on the face of the report.

1. Add § 404.1513a to read as follows:

§ 404.1513a Evidence from our Federal or State agency medical or psychological consultants.

The following rules apply to our Federal or State agency medical or psychological consultants that we consult in connection with administrative law judge hearings and Appeals Council reviews:

(a) In claims adjudicated by the State agency, a State agency medical or psychological consultant may make the determination of disability together with a State agency disability examiner or provide medical evidence to a State agency disability examiner when the disability examiner makes the initial or reconsideration determination alone (see § 404.1615(c)). The following rules apply:

(1) When a State agency medical or psychological consultant makes the determination together with a State agency disability examiner at the initial or reconsideration level of the administrative review process as provided in § 404.1615(c)(1), he or she will consider the evidence in your case record and make administrative findings about the medical issues, including, but not limited to, the existence and severity of your impairment(s), the existence and severity of your symptoms, whether your impairment(s) meets or medically equals the requirements for any impairment listed in appendix 1 to this subpart, and your residual functional capacity. These administrative medical findings are based on the evidence in your case but are not in themselves evidence at the level of the administrative review process at which they are made. See § 404.1513(a)(5).

(2) When a State agency disability examiner makes the initial determination alone as provided in § 404.1615(c)(3), he or she may obtain medical evidence from a State agency medical or psychological consultant about one or more of the medical issues listed in paragraph (a)(1) of this section. In these cases, the State agency disability examiner will consider the medical evidence of the State agency medical or psychological consultant under §§ 404.1520b, 404.1520c, and 404.1527.

(3) When a State agency disability examiner makes a reconsideration determination alone as provided in § 404.1615(c)(3), he or she will consider prior administrative medical findings made by a State agency medical or psychological consultant at the initial level of the administrative review process, and any medical evidence provided by such consultants at the initial and reconsideration levels, about one or more of the medical issues listed in paragraph (a)(1) of this section under §§ 404.1520b, 404.1520c, and 404.1527.

(b) Administrative law judges are responsible for reviewing the evidence and making administrative findings of fact and conclusions of law. They will consider prior administrative medical findings and medical evidence from our Federal or State agency medical or psychological consultants as follows:

(1) Administrative law judges are not required to adopt any prior administrative medical findings, but they must consider this evidence according to §§ 404.1520b, 404.1520c, and 404.1527, as appropriate, because our Federal or State agency medical or psychological consultants are highly qualified and experts in Social Security disability evaluation.

(2) Administrative law judges may also ask for medical evidence from expert medical sources. Administrative law judges will consider this evidence under §§ 404.1520b, 404.1520c, and 404.1527, as appropriate.

(c) When the Appeals Council makes a decision, it will consider prior administrative medical findings according to the same rules for considering prior administrative medical findings as administrative law judges follow under paragraph (b) of this section.

12. Revise § 404.1518 (c) to read as follows:

§ 404.1518 If you do not appear at a consultative examination.

* * *

(c) Objections by your medical source(s). If any of your medical sources tell you that you should not take the examination or test, you should tell us at once. In many cases, we may be able to get the information we need in another way. Your medical source(s) may agree to another type of examination for the same purpose.

13. Revise § 404.1519g (a) to read as follows:

§ 404.1519g Who we will select to perform a consultative examination.

(a) We will purchase a consultative examination only from a qualified medical source. The medical source may be your own medical source or another medical source. If you are a child, the medical source we choose may be a pediatrician.

* * *

14. Revise § 404.1519h to read as follows:

§ 404.1519h Your medical source.

When, in our judgment, your medical source is qualified, equipped, and willing to perform the additional examination or test(s) for the few schedule payment, and generally furnishes complete and timely reports, your medical source will be the preferred source for the purchased examination or test(s).

15. Revise § 404.1519i to read as follows:

§ 404.1519i Other sources for consultative examinations.

We will use a different medical source than your medical source for a purchased examination or test in situations including, but not limited to, the following:

(a) Your medical source prefers not to perform such an examination or does not have the equipment to provide the specific data needed;

(b) There are conflicts or inconsistencies in your file that cannot be resolved by going back to your medical source;

(c) You prefer a source other than your medical source and have a good reason for your preference;

(d) We know from prior experience that your medical source may not be a productive source, such as when he or she has consistently failed to provide complete or timely reports; or

(e) Your medical source is not a qualified medical source as defined in § 404.1519g.

16. Revise § 404.1519j(c)(6) to read as follows:
§ 404.1519n Informing the medical source of examination scheduling, report content, and signature requirements.

We will inform the medical source of the examination scheduling, report content, and signature requirements.

(a) Complete and consistent evidence. If all of the evidence we receive, including all medical opinion(s), is complete and consistent, we will make a determination or decision based on that evidence.

(b) Incomplete or inconsistent evidence. In some situations, we may not be able to make our determination or decision because the evidence in your case record is insufficient or inconsistent. We consider evidence to be insufficient when it does not contain all the information we need to make our determination or decision. We consider evidence to be inconsistent when it conflicts with other evidence, contains an internal conflict, is ambiguous, or when the medical evidence does not appear to be based on medically acceptable clinical or laboratory diagnostic techniques. If the evidence in your case record is insufficient or inconsistent, we may need to take the additional actions in paragraphs (b)(1) through (4) of this section.

(1) If any of the evidence in your case record, including any medical opinion(s) and prior administrative medical findings, is inconsistent, we will consider the relevant evidence and see if we can determine whether you are disabled based on the evidence we have.

(2) If the evidence is consistent but we have insufficient evidence to determine whether you are disabled, or if after reviewing the evidence we determine we cannot reach a conclusion about whether you are disabled, we will determine the best way to resolve the inconsistency or insufficiency. The action(s) we take will depend on the nature of the inconsistency or insufficiency. We will try to resolve the inconsistency or insufficiency by taking any one or more of the actions listed in paragraphs (b)(2)(i) through (b)(2)(iv) of this section. We might not take all of the actions listed below. We will consider any additional evidence we receive together with the evidence we already have.

(i) We may recontact your medical source. We may choose not to seek additional evidence or clarification from a medical source if we know from experience that the source either cannot or will not provide the necessary evidence. If we obtain medical evidence over the telephone, we will send the telephone report to the source for review, signature, and return;

(ii) We may request additional existing evidence;

(iii) We may ask you to undergo a consultative examination at our expense (see §§ 404.1517 through 404.1519t); or

(iv) We may ask you or others for more information.

(3) When there are inconsistencies in the evidence that we cannot resolve or when, despite efforts to obtain additional evidence, the evidence is insufficient to determine whether you are disabled, we will make a determination or decision based on the evidence we have.

(c) Evidence that is inherently neither valuable nor persuasive. Paragraphs (c)(1) through (c)(3) apply in claims filed (see §404.614) on or after March 27, 2017. The examination process, the absence of a medical opinion in a consultative examination report will not make the report incomplete. See §404.1513(a)(3); and

* * * * *

§ 404.1520a Evaluation of mental impairments.

(a) Complete and consistent evidence. * * * *

(b) Incomplete or inconsistent evidence. * * *

(1) If any of the evidence in your case record, including any medical opinion(s), is inconsistent, we will consider the relevant evidence and see if we can determine whether you are disabled based on the evidence we have.

(2) If the evidence is consistent but we have insufficient evidence to determine whether you are disabled, or if after reviewing the evidence we determine we cannot reach a conclusion about whether you are disabled, we will determine the best way to resolve the inconsistency or insufficiency. The action(s) we take will depend on the nature of the inconsistency or insufficiency. We will try to resolve the inconsistency or insufficiency by taking any one or more of the actions listed in paragraphs (b)(2)(i) through (b)(2)(iv) of this section. We might not take all of the actions listed below. We will consider any additional evidence we receive together with the evidence we already have.

(i) We may recontact your medical source. We may choose not to seek additional evidence or clarification from a medical source if we know from experience that the source either cannot or will not provide the necessary evidence. If we obtain medical evidence over the telephone, we will send the telephone report to the source for review, signature, and return;

(ii) We may request additional existing evidence;

(iii) We may ask you to undergo a consultative examination at our expense (see §§ 404.1517 through 404.1519t); or

(iv) We may ask you or others for more information.

(3) When there are inconsistencies in the evidence that we cannot resolve or when, despite efforts to obtain additional evidence, the evidence is insufficient to determine whether you are disabled, we will make a determination or decision based on the evidence we have.

(c) Evidence that is inherently neither valuable nor persuasive. Paragraphs (c)(1) through (c)(3) apply in claims filed (see §404.614) on or after March 27, 2017. Because the evidence listed in paragraphs (c)(1) through (c)(3) of this section is inherently neither valuable nor persuasive to the issue of whether you are disabled or blind under the Act, we will not provide any analysis about how we considered such evidence in our determination or decision, even under §404.1520c:

(1) Decisions by other governmental agencies and nongovernmental entities. See §404.1504.

(2) Disability examiner findings. Findings made by a State agency disability examiner made at a previous level of adjudication about a medical issue, vocational issue, or the ultimate determination about whether you are disabled.

(3) Statements on issues reserved to the Commissioner. The statements listed in paragraphs (c)(3)(i) through (c)(3)(viii) of this section would direct our determination or decision that you are or are not disabled or blind within the meaning of the Act, but where we are responsible for making the determination or decision about whether you are disabled or blind:

(i) Statements that you are or are not disabled, blind, able to work, or able to perform regular or continuing work;

(ii) Statements about whether or not you have a severe impairment(s);

(iii) Statements about whether or not your impairment(s) meets the duration requirement (see §404.1509);

(iv) Statements about whether or not your impairment(s) meets or medically equals any listing in the Listing of Impairments in Part 404, Subpart P, Appendix 1;

(v) Statements about what your residual functional capacity is using our programmatic terms about the functional exertional levels in Part 404, Subpart P, Appendix 2, Rule 200.00 instead of descriptions about your functional abilities and limitations (see §404.1545);

(vi) Statements about whether or not your residual functional capacity prevents you from doing past relevant work (see §404.1560);

(vii) Statements that you do or do not meet the requirements of a medical-vocational rule in Part 404, Subpart P, Appendix 2; and

(viii) Statements about whether or not your disability continues or ends when we conduct a continuing disability review (see §404.1594).

(d) * * *

§ 404.1520b How we consider evidence.

After we review all of the evidence relevant to your claim, we make findings about what the evidence shows.

(a) Complete and consistent evidence. If all of the evidence we receive, including all medical opinion(s), is consistent and there is sufficient evidence for us to determine whether you are disabled, we will make our determination or decision based on that evidence.

(b) Incomplete or inconsistent evidence. In some situations, we may not be able to make our determination or decision because the evidence in your case record is insufficient or inconsistent. We consider evidence to be insufficient when it does not contain all the information we need to make our determination or decision. We consider evidence to be inconsistent when it conflicts with other evidence, contains an internal conflict, is ambiguous, or when the medical evidence does not appear to be based on medically acceptable clinical or laboratory diagnostic techniques. If the evidence in your case record is insufficient or inconsistent, we may need to take the additional actions in paragraphs (b)(1) through (4) of this section.

(1) If any of the evidence in your case record, including any medical opinion(s) and prior administrative medical findings, is inconsistent, we will consider the relevant evidence and see if we can determine whether you are disabled based on the evidence we have.

(2) If the evidence is consistent but we have insufficient evidence to determine whether you are disabled, or if after reviewing the evidence we determine we cannot reach a conclusion about whether you are disabled, we will determine the best way to resolve the inconsistency or insufficiency. The action(s) we take will depend on the nature of the inconsistency or insufficiency. We will try to resolve the inconsistency or insufficiency by taking any one or more of the actions listed in paragraphs (b)(2)(i) through (b)(2)(iv) of this section. We might not take all of the actions listed below. We will consider any additional evidence we receive together with the evidence we already have.

(i) We may recontact your medical source. We may choose not to seek additional evidence or clarification from a medical source if we know from experience that the source either cannot or will not provide the necessary evidence. If we obtain medical evidence over the telephone, we will send the telephone report to the source for review, signature, and return;

(ii) We may request additional existing evidence;

(iii) We may ask you to undergo a consultative examination at our expense (see §§ 404.1517 through 404.1519t); or

(iv) We may ask you or others for more information.

(3) When there are inconsistencies in the evidence that we cannot resolve or when, despite efforts to obtain additional evidence, the evidence is insufficient to determine whether you are disabled, we will make a determination or decision based on the evidence we have.

(c) Evidence that is inherently neither valuable nor persuasive. Paragraphs (c)(1) through (c)(3) apply in claims filed (see §404.614) on or after March 27, 2017. Because the evidence listed in paragraphs (c)(1) through (c)(3) of this section is inherently neither valuable nor persuasive to the issue of whether you are disabled or blind under the Act, we will not provide any analysis about how we considered such evidence in our determination or decision, even under §404.1520c:

(1) Decisions by other governmental agencies and nongovernmental entities. See §404.1504.

(2) Disability examiner findings. Findings made by a State agency disability examiner made at a previous level of adjudication about a medical issue, vocational issue, or the ultimate determination about whether you are disabled.

(3) Statements on issues reserved to the Commissioner. The statements listed in paragraphs (c)(3)(i) through (c)(3)(viii) of this section would direct our determination or decision that you are or are not disabled or blind within the meaning of the Act, but we are responsible for making the determination or decision about whether you are disabled or blind:

(i) Statements that you are or are not disabled, blind, able to work, or able to perform regular or continuing work;

(ii) Statements about whether or not you have a severe impairment(s);

(iii) Statements about whether or not your impairment(s) meets the duration requirement (see §404.1509);

(iv) Statements about whether or not your impairment(s) meets or medically equals any listing in the Listing of Impairments in Part 404, Subpart P, Appendix 1;

(v) Statements about what your residual functional capacity is using our programmatic terms about the functional exertional levels in Part 404, Subpart P, Appendix 2, Rule 200.00 instead of descriptions about your functional abilities and limitations (see §404.1545);

(vi) Statements about whether or not your residual functional capacity prevents you from doing past relevant work (see §404.1560);

(vii) Statements that you do or do not meet the requirements of a medical-vocational rule in Part 404, Subpart P, Appendix 2; and

(viii) Statements about whether or not your disability continues or ends when we conduct a continuing disability review (see §404.1594).

(d) * * *
controlling weight, to any medical opinion(s) or prior administrative medical finding(s), including those from your medical sources. When a medical source provides one or more medical opinions or prior administrative medical findings, we will consider those medical opinions or prior administrative medical findings from that medical source together using the factors listed in paragraphs (c)(1) through (c)(5) of this section, as appropriate. The most important factors we consider when we evaluate the persuasiveness of medical opinions and prior administrative medical findings are supportability (paragraph (c)(1) of this section) and consistency (paragraph (c)(2) of this section). We will articulate how we considered the medical opinions and prior administrative medical findings in your claim according to paragraph (b) of this section.

(b) How we articulate our consideration of medical opinions and prior administrative medical findings. We will articulate in our determination on a case-by-case basis how persuasive we find all of the medical opinions and all of the prior administrative medical findings in your case record. Our articulation of the facts will include the following:

(1) Source-level articulation. Because many claims have voluminous case records containing many types of evidence from different sources, it is not administratively feasible for us to articulate in each determination or decision how we considered all of the factors for all of the medical opinions and prior administrative medical findings in your case record. Instead, when a medical source provides multiple medical opinion(s) or prior administrative medical finding(s), we will articulate how we considered the medical opinions or prior administrative medical findings from that medical source together in a single analysis using the factors listed in paragraphs (c)(1) through (c)(5) of this section, as appropriate. We are not required to articulate how we considered each medical opinion or prior administrative medical finding from one medical source individually.

(2) Most important factors. The factors of supportability (paragraph (c)(1) of this section) and consistency (paragraph (c)(2) of this section) are the most important factors we consider when we determine how persuasive we find a medical source’s medical opinions or prior administrative medical findings to be. Therefore, we will explain how we considered the supportability and consistency factors for a medical source’s medical opinions or prior administrative medical findings in your determination or decision. We may, but are not required to, explain how we considered the factors in paragraphs (c)(3) through (c)(5) of this section, as appropriate, when we articulate how we consider medical opinions and prior administrative medical findings in your case record.

(3) Equally persuasive medical opinions or prior administrative medical findings about the same issue. When we find that two or more medical opinions or prior administrative medical findings about the same issue are both equally well-supported (paragraph (c)(1) of this section) and consistent with the record (paragraph (c)(2) of this section) but are not exactly the same, we will articulate how we considered the other most persuasive factors in paragraphs (c)(3) through (c)(5) of this section for those medical opinions or prior administrative medical findings in your determination or decision.

(c) Factors. We will consider the following factors when we consider the medical opinion(s) and prior administrative medical finding(s) in your case:

(1) Supportability. The more relevant the objective medical evidence and supporting explanations presented by a medical source are to support his or her medical opinion(s) or prior administrative medical finding(s), the more persuasive the medical opinions or prior administrative medical finding(s) will be.

(2) Consistency. The more consistent a medical opinion(s) or prior administrative medical finding(s) is with the evidence from other medical sources and nonmedical sources in the claim, the more persuasive the medical opinion(s) or prior administrative medical finding(s) will be.

(3) Relationship with the claimant. This factor combines consideration of the issues in paragraphs (c)(3)(i) through (v) of this section.

(i) Length of the treatment relationship. The length of time a medical source has treated you may help demonstrate whether the medical source has a longitudinal understanding of your impairment(s).

(ii) Frequency of examinations. The frequency of your visits with the medical source may help demonstrate whether the medical source has a longitudinal understanding of your impairment(s).

(iii) Purpose of the treatment relationship. The purpose for treatment you received from the medical source may help demonstrate the level of knowledge the medical source has of your impairment(s).

(iv) Extent of the treatment relationship. The kinds and extent of examinations and testing the medical source has performed or ordered from specialists or independent laboratories may help demonstrate the level of knowledge the medical source has of your impairment(s).

(v) Examining relationship. A medical source who has a better understanding of your impairment(s) if he or she examines you than if the medical source only reviews evidence in your folder.

(4) Specialization. The medical opinion or prior administrative medical finding of a medical source who has received advanced education and training to become a specialist may be more persuasive about medical issues related to his or her area of specialty than the medical opinion or prior administrative medical finding of a medical source who is not a specialist in the relevant area of specialty.

(5) Other factors. We will consider other factors that tend to support or contradict a medical opinion or prior administrative medical finding. This includes, but is not limited to, evidence showing a medical source has familiarity with the other evidence in the claim or an understanding of our disability program’s policies and evidentiary requirements. When we consider a medical source’s familiarity with the other evidence in a claim, we will also consider whether new evidence we receive after the medical source made his or her medical opinion or prior administrative medical finding makes the medical opinion or prior administrative medical finding more or less persuasive.

(d) Evidence from nonmedical sources. We are not required to articulate how we considered evidence from nonmedical sources using the requirements in paragraphs (a)–(c) in this section.

20. Revise §404.1521 to read as follows:

§404.1521 Establishing that you have a medically determinable impairment(s).

If you are not doing substantial gainful activity, we will then determine whether you have a medically determinable physical or mental impairment(s) (see §404.1520(a)(4)(iii)). Your impairment(s) must result from anatomical, physiological, or psychological abnormalities that can be shown by medically acceptable clinical and laboratory diagnostic techniques. Therefore, a physical or mental impairment must be established by objective medical evidence from an
§ 404.1523 Multiple impairments.

(a) Unrelated severe impairments. We cannot combine two or more unrelated severe impairments to meet the 12-month duration test. If you have a severe impairment(s) and then develop another unrelated severe impairment(s) but neither one is expected to last for 12 months, we cannot find you disabled, even though the two impairments in combination last for 12 months.

(b) Concurrent impairments. If you have two or more concurrent impairments that, when considered in combination, are severe, we must determine whether the combined effect of your impairments can be expected to continue to be severe for 12 months. If one or more of your impairments improves or is expected to improve within 12 months, so that the combined effect of your remaining impairments is no longer severe, we will find that you do not meet the 12-month duration test.

(c) Combined effect. In determining whether your physical or mental impairment or impairments are of a sufficient medical severity that such impairment or impairments could be the basis of eligibility under the law, we will consider the combined effect of all of your impairments without regard to whether any such impairment, if considered separately, would be of sufficient severity. If we do find a medically severe combination of impairments, we will consider the combined impact of the impairments throughout the disability determination process. If we do not find that you have a medically severe combination of impairments, we will consider the combined effect of the impairments自助于您。我们假定您已经具备了相关的医学知识，并准备了足够的医学证据。

§ 404.1522 What we mean by an impairment(s) that is not severe.

(a) Non-severe impairment(s). An impairment or combination of impairments is not severe if it does not significantly limit your physical or mental ability to do basic work activities.

(b) Basic work activities. When we talk about basic work activities, we mean the abilities and aptitudes necessary to do most jobs. Examples of these include—

(1) Physical functions such as walking, standing, sitting, lifting, pushing, pulling, reaching, carrying, or handling;

(2) Capacities for seeing, hearing, and speaking;

(3) Understanding, carrying out, and remembering simple instructions;

(4) Use of judgment;

(5) Responding appropriately to supervision, co-workers and usual work situations; and

(6) Dealing with changes in a routine work setting.

§ 404.1524 Evaluating medical evidence for claims filed before March 27, 2017.

Who is responsible for determining medical equivalence? In cases where the State agency or other designated State agency (as defined in § 404.615) has the overall responsibility for making disability determinations, except as provided in paragraph (d) of this section, the State agency or other designated State agency (as defined in § 404.615) has the overall responsibility for making disability determinations. If you treated a State agency or other designated State agency (as defined in § 404.615) has the overall responsibility for making disability determinations, except as provided in paragraph (d) of this section, the State agency or other designated State agency (as defined in § 404.615) has the overall responsibility for making disability determinations.
evaluate every medical opinion we receive. Unless we give a treating source’s medical opinion controlling weight under paragraph (c)(2) of this section, we consider all of the following factors in deciding the weight we give to any medical opinion.

(1) Examining relationship. Generally, we give more weight to the medical opinion of a source who has examined you than to the medical opinion of a medical source who has not examined you.

(2) Treatment relationship. Generally, we give more weight to medical opinions from sources who have treated you, since these sources are likely to be the medical professionals most able to provide a detailed, longitudinal picture of your medical impairment(s) and may bring a unique perspective to the medical evidence that cannot be obtained from the objective medical findings alone or from reports of individual examinations, such as consultative examinations or brief hospitalizations. If we find that a treating source’s medical opinion on the issue(s) of the nature and severity of your impairment(s) is well-supported by medically acceptable clinical and laboratory diagnostic techniques and is not inconsistent with the other substantial evidence in your case record, we will give it controlling weight. When we do not give the treating source’s medical opinion controlling weight, we apply the factors listed in paragraphs (c)(2)(i) and (c)(2)(ii) of this section, as well as the factors listed in paragraphs (c)(3) through (c)(6) of this section in determining the weight to give the medical opinion. We will always give good reasons in our notice of determination or decision for the weight we give your treating source’s medical opinion.

(i) Length of the treatment relationship and the frequency of examination. Generally, the longer a treating source has treated you and the more times you have been seen by a treating source, the more weight we will give to the source’s medical opinion. When the treating source has seen you a number of times and long enough to have obtained a longitudinal picture of your impairment, we will give the medical source’s medical opinion more weight than we would give it if it were from a nontreating source.

(ii) Nature and extent of the treatment relationship. Generally, the more knowledge a treating source has about your impairment(s) the more weight we will give to the source’s medical opinion. We will look at the treatment the source has provided and at the kinds and extent of examinations and testing the source has performed or ordered from specialists and independent laboratories. For example, if your ophthalmologist notices that you have complained of neck pain during your eye examinations, we will consider his or her medical opinion with respect to your neck pain, but we will give it less weight than that of another physician who has treated you for the neck pain. When the treating source has reasonable knowledge of your impairment(s), we will give the source’s medical opinion more weight than we would give it if it were from a nontreating source.

(3) Supportivity. The more a medical source presents relevant evidence to support a medical opinion, particularly medical signs and laboratory findings, the more weight we will give that medical opinion. The better an explanation a source provides for a medical opinion, the more weight we will give that medical opinion. Furthermore, because nonexamining sources have no examining or treating relationship with you, the weight we will give their medical opinions will depend on the degree to which they provide supporting explanations for their medical opinions. We will evaluate the degree to which these medical opinions consider all of the pertinent evidence in your claim, including medical opinions of treating and other examining sources.

(4) Consistency. Generally, the more consistent a medical opinion is with the record as a whole, the more weight we will give to that medical opinion.

(5) Specialization. We generally give more weight to the medical opinion of a specialist about medical issues related to his or her area of specialty than to the medical opinion of a source who is not a specialist.

(6) Other factors. When we consider how much weight to give to a medical opinion, we will also consider any factors you or others bring to our attention, or of which we are aware, which tend to support or contradict the medical opinion. For example, the amount of understanding of our disability programs and their evidentiary requirements that a medical source has, regardless of the source of that understanding, and the extent to which a medical source is familiar with the other information in your case record are relevant factors that we will consider in deciding the weight to give to a medical opinion.

(d) Medical source opinions on issues reserved to the Commissioner. Opinions from medical sources, on issues reserved to the Commissioner, are not medical opinions, as defined under the rules in §404.1513a. Opinions from medical sources are not considered in determining if you are “disabled” or “unable to work” for purposes of 20 CFR 404.1520(a)(4)(i). We may require you to bring a unique perspective to the medical evidence that cannot be obtained from the objective medical findings alone or from reports of individual examinations, such as consultative examinations or brief hospitalizations. If we find that a treating source’s medical opinion on the issue(s) of the nature and severity of your impairment(s) is well-supported by medically acceptable clinical and laboratory diagnostic techniques and is not inconsistent with the other substantial evidence in your case record, we will give the source’s medical opinion controlling weight. When we do not give the treating source’s medical opinion controlling weight, we apply the factors listed in paragraphs (c)(2)(i) and (c)(2)(ii) of this section, as well as the factors listed in paragraphs (c)(3) through (c)(6) of this section in determining the weight to give the medical opinion. We will always give good reasons in our notice of determination or decision for the weight we give your treating source’s medical opinion.

(i) Length of the treatment relationship and the frequency of examination. Generally, the longer a treating source has treated you and the more times you have been seen by a treating source, the more weight we will give to the source’s medical opinion. When the treating source has seen you a number of times and long enough to have obtained a longitudinal picture of your impairment, we will give the medical source’s medical opinion more weight than we would give it if it were from a nontreating source.

(ii) Nature and extent of the treatment relationship. Generally, the more knowledge a treating source has about your impairment(s) the more weight we will give to the source’s medical opinion. We will look at the treatment the source has provided and at the kinds and extent of examinations and testing the source has performed or ordered from specialists and independent laboratories. For example, if your ophthalmologist notices that you have complained of neck pain during your eye examinations, we will consider his or her medical opinion with respect to your neck pain, but we will give it less weight than that of another physician who has treated you for the neck pain. When the treating source has reasonable knowledge of your impairment(s), we will give the source’s medical opinion more weight than we would give it if it were from a nontreating source.

(3) Supportivity. The more a medical source presents relevant evidence to support a medical opinion, particularly medical signs and laboratory findings, the more weight we will give that medical opinion. The better an explanation a source provides for a medical opinion, the more weight we will give that medical opinion. Furthermore, because nonexamining sources have no examining or treating relationship with you, the weight we will give their medical opinions will depend on the degree to which they provide supporting explanations for their medical opinions. We will evaluate the degree to which these medical opinions consider all of the pertinent evidence in your claim, including medical opinions of treating and other examining sources.

(4) Consistency. Generally, the more consistent a medical opinion is with the record as a whole, the more weight we will give to that medical opinion.

(5) Specialization. We generally give more weight to the medical opinion of a specialist about medical issues related to his or her area of specialty than to the medical opinion of a source who is not a specialist.

(6) Other factors. When we consider how much weight to give to a medical opinion, we will also consider any factors you or others bring to our attention, or of which we are aware, which tend to support or contradict the medical opinion. For example, the amount of understanding of our disability programs and their evidentiary requirements that a medical source has, regardless of the source of that understanding, and the extent to which a medical source is familiar with the other information in your case record are relevant factors that we will consider in deciding the weight to give to a medical opinion.

(e) Evidence from our Federal or State agency medical or psychological consultants. The rules in §404.1513a apply except that when an administrative law judge gives controlling weight to a treating source’s medical opinion, the administrative law judge is not required to explain in the decision the weight he or she gave to the prior administrative medical findings in the claim.

(f) Opinions from medical sources who are not acceptable medical sources and from nonmedical sources.

(1) Consideration. Opinions from medical sources who are not acceptable medical sources and from nonmedical sources may reflect the source’s judgment about some of the same issues addressed in medical opinions from acceptable medical sources. Although we will consider the opinions using the same factors as listed in paragraph (c)(1) through (c)(6) of this section, not every factor for weighing opinion evidence will apply in every case because the evaluation of an opinion from a medical source who is not an acceptable medical source or from a nonmedical source depends on the
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particular facts in each case. Depending on the particular facts in a case, and after applying the factors for weighing opinion evidence, an opinion from a medical source who is not an acceptable medical source or from a nonmedical source may outweigh the medical opinion of an acceptable medical source, including the medical opinion of a treating source. For example, it may be appropriate to give more weight to the opinion of a medical source who is not an “acceptable medical source” if he or she has seen the individual more often than the treating source, has provided better supporting evidence and a better explanation for the opinion, and the opinion is more consistent with the evidence as a whole.

(2) Articulation: The adjudicator generally should explain the weight given to opinions from these sources or otherwise ensure that the discussion of the evidence in the determination or decision allows a claimant or subsequent reviewer to follow the adjudicator’s reasoning, when such opinions may have an effect on the outcome of the case. In addition, when an adjudicator determines that an opinion from such a source is entitled to greater weight than a medical opinion from a treating source, the adjudicator must explain the reasons in the notice of decision in hearing cases and in the notice of determination (that is, in the personalized disability notice) at the initial and reconsideration levels, if the determination is less than fully favorable.

§ 404.1528 [Removed and Reserved]

26. Remove and reserve § 404.1528.

27. In § 404.1529, revise paragraph (a), the second and third sentences of paragraph (c)(1), the introductory text of paragraph (c)(3), and the third sentence of paragraph (c)(4) to read as follows:

§ 404.1529 How we evaluate symptoms, including pain.

(a) General: In determining whether you are disabled, we consider all your symptoms, including pain, and the extent to which your symptoms can reasonably be accepted as consistent with the objective medical evidence and other evidence. We will consider all of your statements about your symptoms, such as pain, and any description your medical sources or nonmedical sources may provide about how the symptoms affect your activities of daily living and your ability to work. However, statements about your pain or other symptoms will not alone establish that you are disabled. There must be objective medical evidence from an acceptable medical source that shows you have a medical impairment(s) which could reasonably be expected to produce the pain or other symptoms alleged and that, when considered with all of the other evidence (including statements about the intensity and persistence of your pain or other symptoms which may reasonably be accepted as consistent with the medical signs and laboratory findings), would lead to a conclusion that you are disabled. In evaluating the intensity and persistence of your symptoms, including pain, we will consider all of the available evidence, including your medical history, the medical signs and laboratory findings, and statements about how your symptoms affect you. We will then determine the extent to which your alleged functional limitations and restrictions due to pain or other symptoms can reasonably be accepted as consistent with the medical signs and laboratory findings and other evidence to decide how your symptoms affect your ability to work.

We will consider the medical opinions as explained in § 404.1520c.

(3) Consideration of other evidence.

Because symptoms sometimes suggest a greater severity of impairment than can be shown by objective medical evidence alone, we will carefully consider any other information you submit about your symptoms. The information that your medical sources or nonmedical sources provide about your pain or other symptoms (e.g., what may precipitate or aggravate your symptoms, what medications, treatments or other methods you use to alleviate them, and how the symptoms may affect your pattern of daily living) is also an important indicator of the intensity and persistence of your symptoms. Because symptoms, such as pain, are subjective and difficult to quantify, any symptoms-related functional limitations and restrictions that your medical sources or nonmedical sources report, which can reasonably be accepted as consistent with the objective medical evidence and other evidence, will be taken into account as explained in paragraph (c)(4) of this section in reaching a conclusion as to whether you are disabled. We will consider all of the evidence presented, including information about your prior work record, your statements about your symptoms, evidence submitted by your medical sources, and observations by our employees and other persons.

Section 404.1520c explains in detail how we consider medical opinions and prior administrative medical findings about the nature and severity of your impairment(s) and any related symptoms, such as pain. Factors relevant to your symptoms, such as pain, which we will consider include:

We will consider whether there are any inconsistencies in the evidence and the extent to which there are any conflicts between your statements and the rest of the evidence, including your history, the signs and laboratory findings, and statements by your medical sources or other persons about how your symptoms affect you.

28. Revise § 404.1530(a) to read as follows:

§ 404.1530 Need to follow prescribed treatment.

(a) * * * A determination that you must follow treatment prescribed by your medical source(s) if this treatment is expected to restore your ability to work.

29. Amend § 404.1579 by revising the second sentence of paragraph (b)(1) and the second sentence of paragraph (b)(4) to read as follows:

§ 404.1579 How we will determine whether your disability continues or ends.

(b) * * * * A determination that there has been a decrease in medical severity must be based on improvement in the symptoms, signs, and/or laboratory findings associated with your impairment(s), * * * * * * * * * * * * *

* * * * * We will consider all evidence you submit and that we obtain from your medical sources and nonmedical sources, * * * * * * * * * * * * *

30. Amend § 404.1594 by revising the sixth sentence in Example 1, the second sentence of paragraph (b)(6), and the fourth sentence of paragraph (c)(3)(v) to read as follows:

§ 404.1594 How we will determine whether your disability continues or ends.

(b) * * * * A determination that there has been a decrease in medical severity* * * * * * * * * * * * *

(1) * * * * A determination that there has been a decrease in medical severity must be based on improvement in the symptoms, signs, and/or laboratory findings associated with your impairment(s), * * * * * * * * * * * * *

* * * * * We will consider all evidence you submit and that we obtain from your medical sources and nonmedical sources, * * * * * * * * * * * * *

31. Amend § 404.1594 by revising the second sentence of paragraph (b)(1) and the second sentence of paragraph (b)(4) to read as follows:

§ 404.1579 How we will determine whether your disability continues or ends.

(b) * * * * A determination that there has been a decrease in medical severity must be based on improvement in the symptoms, signs, and/or laboratory findings associated with your impairment(s), * * * * * * * * * * * * *

* * * * * We will consider all evidence you submit and that we obtain from your medical sources and nonmedical sources, * * * * * * * * * * * * *

32. Revise § 404.1530(a) to read as follows:

§ 404.1530 Need to follow prescribed treatment.

(a) * * * A determination that you must follow treatment prescribed by your medical source(s) if this treatment is expected to restore your ability to work.

29. Amend § 404.1579 by revising the second sentence of paragraph (b)(1) and the second sentence of paragraph (b)(4) to read as follows:

§ 404.1579 How we will determine whether your disability continues or ends.

(b) * * * * A determination that there has been a decrease in medical severity must be based on improvement in the symptoms, signs, and/or laboratory findings associated with your impairment(s), * * * * * * * * * * * * *

* * * * * We will consider all evidence you submit and that we obtain from your medical sources and nonmedical sources, * * * * * * * * * * * * *

30. Amend § 404.1594 by revising the sixth sentence in Example 1, the second sentence of paragraph (b)(6), and the fourth sentence of paragraph (c)(3)(v) to read as follows:

§ 404.1594 How we will determine whether your disability continues or ends.

(b) * * * * A determination that there has been a decrease in medical severity* * * * * * * * * * * * *

(1) * * * * A determination that there has been a decrease in medical severity must be based on improvement in the symptoms, signs, and/or laboratory findings associated with your impairment(s), * * * * * * * * * * * * *

* * * * * We will consider all evidence you submit and that we obtain from your medical sources and nonmedical sources, * * * * * * * * * * * * *
must be based on improvement in the symptoms, signs, and/or laboratory findings associated with your impairment(s).

Example 1: * * * When we reviewed your claim, your medical source, who has treated you, reported that he or she had seen you regularly every 2 to 3 months for the past 2 years. * * *

(6) * * * We will consider all evidence you submit and that we obtain from your medical sources and nonmedical sources. * * *

(c) * * *

(3) * * * If you are able to engage in substantial gainful activity, we will determine whether an attempt should be made to reconstruct those portions of the missing file that were relevant to our most recent favorable medical decision (e.g., work history, medical evidence, and the results of consultative examinations). * * *

31. Amend Appendix I to subpart P of part 404 as follows:

a. Revise the second, third, and fourth sentences of 2.00B.1.a;

b. Revise 2.00B.1.b;

c. Revise 2.00B.1.c;

d. Revise the fourth sentence of 7.00H;

e. Revise the second sentence of 8.00C.2;

f. Revise the first sentence 8.00E.3.a;

g. Revise 12.00C.1;

h. Revise the fourth sentence of 14.00H;

i. Revise the second, third, and fourth sentences of 102.00B.1.a;

j. Revise 102.00B.1.b;

k. Revise 102.00B.1.c;

l. Revise the fourth sentence of 107.00G;

m. Revise the second sentence of 108.00C.2;

n. Revise the first sentence 108.00E.3.a;

o. Revise 112.00C.1;

p. Revise the fourth sentence of 114.00H.

The revisions read as follows:

Appendix I to Subpart P of Part 404—

2.00 * * *

B. * * *

1. * * *

a. * * * We generally require both an otologic examination and audiometric testing to establish that you have a medically determinable impairment that causes your hearing loss. You should have this audiometric testing within 2 months of the otologic examination. Once we have evidence that you have a medically determinable impairment, we can use the results of later audiometric testing to assess the severity of your hearing loss without another otologic examination. * * *

b. The otologic examination must be performed by a licensed physician (medical or osteopathic doctor) or audiologist. It must include your medical history, your description of how your hearing loss affects you, and the physician’s or audiologist’s description of the appearance of the external ears (pinnae and external ear canals), evaluation of the tympanic membranes, and assessment of any middle ear abnormalities. 

c. Audiometric testing must be performed by, or under the direct supervision of, a licensed audiologist or an otolaryngologist. * * *

7.00 * * *

H. * * * (See sections 404.1521, 404.1529, 416.921, and 416.929 of this chapter.) * * *

8.00 * * *

C. * * *

3. * * * We assess the impact of symptoms as explained in §§ 404.1521, 404.1529, 416.921, and 416.929 of this chapter. * * *

E. * * *

3. a. General. We need documentation from an acceptable medical source to establish that you have a medically determinable impairment.* * *

12.00 * * *

C. * * *

1. General. We need objective medical evidence from an acceptable medical source to establish that you have a medically determinable mental disorder. We also need evidence to assess the severity of your mental disorder and its effects on your ability to function in a work setting. We will determine the extent and kinds of evidence we need from medical and nonmedical sources based on the individual facts about your disorder. For additional evidence requirements for intellectual disorder (12.05), see 12.00H. For our basic rules on evidence, see §§ 404.1512, 404.1513, 404.1520, 404.1528, 404.1529, 416.921, and 416.929 of this chapter. For our rules on evaluating medical opinions, see §§ 404.1520; 404.1527; 416.921; and 416.929 of this chapter. For our rules on evidence about your symptoms, see §§ 404.1529 and 416.929 of this chapter. * * *

14.00 * * *

H. * * * See §§ 404.1521, 404.1529, 416.921, and 416.929. * * *

102.00 * * *

B. * * *

1. * * * We generally require both an otologic examination and audiometric testing to establish that you have a medically determinable impairment that causes your hearing loss. You should have this audiometric testing within 2 months of the otologic examination. Once we have evidence that you have a medically determinable impairment, we can use the results of later audiometric testing to assess the severity of your hearing loss without another otologic examination. * * *

Subpart Q—Determinations of Disability

32. The authority citation for subpart Q of part 404 continues to read as follows:

Authority: Secs. 205(a), 221, and 726(a)(5) of the Social Security Act (42 U.S.C. 405(a), 421, and 902(a)(5)).

§ 404.1615 [Amended]

33. In § 404.1615, remove paragraph (d) and redesignate paragraphs (e) through (g) as paragraphs (d) through (f).
§ 404.1616 Medical consultants and psychological consultants.

(a) What is a medical consultant? A medical consultant is a member of a team that makes disability determinations in a State agency. At least 1 year of which must be clinical experience as a psychologist in a health service.

(b) What qualifications must a medical consultant have? A medical consultant is a licensed physician, as defined in § 404.1520(a)(1).

(c) What is a psychological consultant? A psychological consultant is a member of a team that makes disability determinations in a State agency. At least 1 year of which must be clinical experience as a psychologist in a health service providers in psychology recognized by the Council on Post-Masters degree. The Commissioner of Social Security deems appropriate; and

35. In § 404.1617, revise the section heading and paragraph (a) to read as follows:

§ 404.1617 Reasonable efforts to obtain review by a physician, psychiatrist, and psychologist.

(a) When the evidence of record indicates the existence of a physical impairment, the State agency must make every reasonable effort to ensure that a medical consultant completes the medical portion of the case review and any applicable residual function capacity assessment. When the evidence of record indicates the existence of a mental impairment, the State agency must make every reasonable effort to ensure that a psychological consultant completes the medical portion of the case review and any applicable residual functional capacity assessment. The State agency must determine if additional physicians, psychologists, and psychiatrists are needed to make the necessary reviews. When it does not have sufficient resources to make the necessary reviews, the State agency must attempt to obtain the resources needed. If the State agency is unable to obtain additional physicians, psychologists, and psychiatrists because of low salary rates or fee schedules, it should attempt to raise the State agency’s levels of compensation to meet the prevailing rates for these services. If these efforts are unsuccessful, the State agency will seek assistance from us. We will assist the State agency as necessary. We will also monitor the State agency’s efforts and where the State agency is unable to obtain the necessary services, we will make every reasonable effort to provide the services using Federal resources.

PART 416—SUPPLEMENTAL SECURITY INCOME FOR THE AGED, BLIND, AND DISABLED

Subpart I—Determining Disability and Blindness

36. The authority citation for subpart I of part 416 continues to read as follows:

Authority: Secs. 221(m), 702(a)(5), 1611, 1614, 1619, 1631(a), (c), (d)(1), and (p), and 1633 of the Social Security Act [42 U.S.C. 421(m), 702(a)(5), 1382, 1382c, 1382h, 1383(a), (c), (d)(1), and (p), and 1383b]; secs. 4(c) and 5 of the Medicare Act [42 U.S.C. 1395b note, 423 note, and 1395h].
(c) Child means a person who has not attained age 18.

(d) Commissioner means the Commissioner of Social Security or his or her authorized designee.

(e) Disability redetermination means a redetermination of your eligibility based on disability using the rules for new applicants appropriate to your age, except the rules pertaining to performance of substantial gainful activity. For individuals who are working and for whom a disability redetermination is required, we will apply the rules in §§416.906 through 416.269. In conducting a disability redetermination, we will not use the rules for determining whether disability continues set forth in §416.994 or §416.987. (See §416.987.)

(f) Impairment(s) means a medically determinable physical or mental impairment or a combination of medically determinable physical or mental impairments.

(g) Laboratory findings means one or more anatomical, physiological, or psychological abnormalities that can be shown by the use of medically acceptable laboratory diagnostic techniques. Diagnostic techniques include chemical tests (such as blood tests), electrophysiological studies (such as electrocardiograms and electroencephalograms), medical imaging (such as X-rays), and psychological tests.

(h) Marked and severe functional limitations, when used as a phrase, means the standard of disability in the Social Security Act for children claiming SSI benefits based on disability. It is a level of severity that meets, medically equals, or functionally equals the listings. (See §§416.906, 416.924, and 416.926a.) The words “marked” and “severe” when used as part of the phrase marked and severe functional limitations is not the same as the meaning of the separate terms “marked” and “severe” used elsewhere in 404 and 416. (See §§416.924(c) and 416.926a(e).)

(i) Medical source means an individual who is licensed as a healthcare worker by a State and working within the scope of practice permitted under State or Federal law, or an individual who is certified by a State as a speech-language pathologist or a school psychologist and acting within the scope of practice permitted under State or Federal law.

(j) Nonmedical source means a source of evidence who is not a medical source. This includes, but is not limited to:

(1) You;

(2) Educational personnel (for example, school teachers, counselors, early intervention team members, developmental center workers, and daycare center workers);

(3) Public and private social welfare agency personnel; and

(4) Family members, caregivers, friends, neighbors, employers, and clergy.

(k) Objective medical evidence means signs, laboratory findings, or both.

(l) Signs means one or more anatomical, physiological, or psychological abnormalities that can be observed, apart from your statements (symptoms). Signs must be shown by medically acceptable clinical or diagnostic techniques. Psychiatric signs are medically demonstrable phenomena that indicate specific psychological abnormalities, e.g., abnormalities of behavior, mood, thought, memory, orientation, development, or perception and must also be shown by observable facts that can be medically described and evaluated.

(m) State agency means an agency of a State designated by that State to carry out the disability or blindness determination function.

(n) Symptoms means your own description of your physical or mental impairment.

(o) The listings means the Listing of Impairments in appendix 1 of subpart P of part 404 of this chapter. When we refer to an impairment(s) that “meets, medically equals, or functionally equals the listings,” we mean that the impairment(s) meets or medically equals the severity of any listing in appendix 1 of subpart P of part 404 of this chapter, as explained in §§416.925 and 416.926, or that it functionally equals the severity of the listings, as explained in §416.926a.

(p) We or us means, as appropriate, the Social Security Administration or the State agency making the disability or blindness determination.

(q) You, your, me, my and I mean, as appropriate, the person who applies for benefits, the person for whom an application is filed, or the person who is receiving benefits based on disability or blindness.

§416.903 Who makes disability and blindness determinations.

(a) Determinations for childhood impairments. In making a determination under title XVI with respect to the disability of a child, we will make reasonable efforts to ensure that a qualified pediatrician or other individual who specializes in a field of medicine appropriate to the child’s impairment(s) evaluates the case of the child.

39. Revise §416.904 to read as follows:

§416.904 Decisions by other governmental agencies and nongovernmental ties.

Other governmental agencies and nongovernmental entities—such as the Department of Veterans Affairs, the Department of Defense, the Department of Labor, the Office of Personnel Management, State agencies, and private insurers—make disability, blindness, employability, Medicaid, workers’ compensation, and other benefits decisions for their own programs using their own rules. Because a decision by any other governmental agency or a nongovernmental entity about whether you are disabled, blind, employable, or entitled to any benefits is based on its rules, it is not binding on us and is not our decision about whether you are disabled or blind under our rules. Therefore, in claims filed (see §416.325) on or after March 27, 2017, we will not provide any analysis in our determination or decision about a decision made by any other governmental agency or a nongovernmental entity about whether you are disabled, blind, employable, or entitled to any benefits. However, we will consider all of the supporting evidence underlying the other governmental agency or nongovernmental entity’s decision that we receive as evidence in your claim in accordance with §416.913(a)(1) through (4).

§416.908 [Removed and reserved].

40. Remove and reserve §416.908.

41. Revise §416.912 to read as follows:

§416.912 Responsibility for evidence.

(a) Your responsibility.

(1) General. In general, you have to prove to us that you are blind or disabled. You must inform us about or submit all evidence known to you that relates to whether or not you are blind or disabled (see §416.913). This duty is ongoing and requires you to disclose any additional related evidence about
which you become aware. This duty applies at each level of the administrative review process, including the Appeals Council level if the evidence relates to the period on or before the date of the administrative law judge hearing decision. We will consider only impairment(s) you say you have or about which we receive evidence. When you submit evidence received from another source, you must submit that evidence in its entirety, unless you previously submitted the same evidence to us or we instruct you otherwise. If we ask you, you must inform us about:

(i) Your medical source(s);
(ii) Your age;
(iii) Your education and training;
(iv) Your work experience;
(v) Your daily activities both before and after the date you say that you became disabled;
(vi) Your efforts to work; and
(vii) Any other factors showing how your impairment(s) affects your ability to work, or, if you are a child, your functioning. In §§ 416.960 through 416.969, we discuss in more detail the evidence we need when we consider vocational factors.

(2) Completeness. The evidence in your case record must be complete and detailed enough to allow us to make a determination or decision about whether you are disabled or blind. It must allow us to determine—

(i) The nature and severity of your impairment(s) for any period in question;
(ii) Whether the duration requirement described in § 416.909 is met; and
(iii) Your residual functional capacity to do work-related physical and mental activities, when the evaluation steps described in §§ 416.920(e) or (f)(1) apply, or, if you are a child, how you typically function compared to children your age who do not have impairments.

(3) Statutory blindness. If you are applying for benefits on the basis of statutory blindness, we will require an examination by a physician skilled in diseases of the eye or by an optometrist, whichever you may select.

(b) Our responsibility.

(1) Development. Before we make a determination that you are not disabled, we will develop your complete medical history for at least the 12 months preceding the month in which you file your application unless there is a reason to believe that development of an earlier period is necessary or unless you say that your disability began less than 12 months before you filed your application. We will make every reasonable effort to help you get medical evidence from your own medical sources and entities that maintain your medical sources’ evidence when you give us permission to request the record.

(i) Every reasonable effort means that we will make an initial request for evidence from your medical source or entity that maintains your medical source’s evidence, and, at any time between 10 and 20 calendar days after the initial request, if the evidence has not been received, we will make one follow-up request to obtain the medical evidence needed to make a determination. The medical source or entity that maintains your medical source’s evidence will have a minimum of 10 calendar days from the date of our follow-up request to reply, unless our experience with that source indicates that a longer period is advisable in a particular case.

(ii) Complete medical history means the records of your medical source(s) covering at least the 12 months preceding the month in which you file your application. If you say that your disability began less than 12 months before you filed your application, we will develop your complete medical history beginning with the month you say your disability began unless we have reason to believe your disability began earlier.

(2) Obtaining a consultative examination. We may ask you to attend one or more consultative examinations at our expense. See §§ 416.917 through 416.919f for the rules governing the consultative examination process.

Generally, we will not request a consultative examination until we have made every reasonable effort to obtain evidence from your own medical sources. We may order a consultative examination while awaiting receipt of medical source evidence in some instances, such as when we know a source is not productive, is uncooperative, or is unable to provide certain tests or procedures. We will not evaluate this evidence until we have made every reasonable effort to obtain evidence from your medical sources.

(3) Other work. In order to determine under § 416.920(g) that you are able to adjust to other work, we must provide evidence about the existence of work in the national economy that you can do (see §§ 416.960 through 416.969a), given your residual functional capacity (which we have already assessed, as described in § 416.920(e)), age, education, and work experience.

■ 42. Revise § 416.913 to read as follows:

§ 416.913 Categories of evidence.

(a) What we mean by evidence. Subject to the provisions of paragraph (b), evidence is anything you or anyone else submits to us or that we obtain that relates to your claim. We consider evidence under §§ 416.920b, 416.920c (or under § 416.927 for claims filed (see § 416.325) before March 27, 2017). We evaluate evidence we receive according to the rules pertaining to the relevant category of evidence. The categories of evidence are:

(1) Objective medical evidence.

Objective medical evidence is medical signs, laboratory findings, or both, as defined in § 416.902(k).

(2) Medical opinion. A medical opinion is a statement from a medical source about what you can still do despite your impairment(s) and whether you have one or more impairment-related limitations or restrictions in the abilities listed in paragraphs (a)[2][1][A] through (D) and (a)[2][2][1][A] through (F) of this section. (For claims filed (see § 416.325) before March 27, 2017, see § 416.927(a) for the definition of medical opinion.)

(i) Medical opinions in adult claims are about impairment-related limitations and restrictions in:

(A) Your ability to perform physical demands of work activities, such as sitting, standing, walking, lifting, carrying, pushing, pulling, or other physical functions (including manipulative or postural functions, such as reaching, handling, stooping, or crouching);

(B) Your ability to perform mental demands of work activities, such as understanding; remembering; maintaining concentration, persistence, or pace; carrying out instructions; or responding appropriately to supervision, co-workers, or work pressures in a work setting;

(C) Your ability to perform other demands of work, such as seeing, hearing, or using other senses; and

(D) Your ability to adapt to environmental conditions, such as temperature extremes or fumes.

(ii) Medical opinions in child claims are about impairment-related limitations and restrictions in your abilities in the six domains of functioning:

(A) Acquiring and using information (see § 416.926a(g));

(B) Attending and completing tasks (see § 416.926a(h));

(C) Interacting and relating with others (see § 416.926a(i));

(D) Moving about and manipulating objects (see § 416.926a(j));

(E) Caring for yourself (see § 416.926a(k)); and

(F) Using senses (see § 416.926a(l)).
(F) Health and physical well-being (see § 416.926a(a)).

(3) Other medical evidence. Other medical evidence is evidence from a medical source that is not objective medical evidence or a medical opinion, including judgments about the nature and severity of your impairment(s).

(iv) Whether your impairment(s) meets or medically equals the listings in Appendix 1.

(v) If you are an adult, your residual functional capacity.

(vi) Whether your impairment(s) meets the duration requirement; and

(vii) How failure to follow prescribed treatment (see § 416.930) and drug addiction and alcoholism (see § 416.935) relate to your claim.

(b) Exceptions for privileged communications.

(1) The privileged communications listed in paragraphs (b)(1)(i) and (b)(1)(ii) of this section are not evidence, and we will not consider them in your determination or decision. This exception for privileged communications applies equally whether your representative is an attorney or a non-attorney.

(i) Oral or written communications between you and your representative that are subject to the attorney-client privilege, unless you voluntarily disclose the communication to us.

(ii) Your representative’s analysis of your claim, unless he or she voluntarily discloses it to us. This analysis means information that is subject to the attorney work product doctrine, but it does not include medical evidence, medical opinions, or any other factual matter that we may consider in determining whether or not you are entitled to benefits (see paragraph (b)(2) of this section).

(2) The attorney-client privilege generally protects confidential communications between an attorney and his or her client that are related to providing or obtaining legal advice. The attorney work product doctrine generally protects an attorney’s analyses, theories, mental impressions, and notes. In the context of your disability claim, neither the attorney-client privilege nor the attorney work product doctrine allow you to withhold factual information, medical opinions, or other medical evidence that we may consider in determining whether or not you are entitled to benefits. For example, if you tell your representative about the medical sources you have seen, your representative cannot refuse to disclose the identity of those medical sources to us based on the attorney-client privilege. As another example, if your representative asks a medical source to complete an opinion form related to your impairment(s), symptoms, or limitations, your representative cannot withhold the completed opinion form from us based on the attorney work product doctrine. The attorney work product doctrine would not protect the source’s opinions on the completed form, regardless of whether or not your representative used the form in his or her analysis of your claim or made handwritten notes on the face of the report.

43. Add § 416.913a to read as follows:

§ 416.913a Evidence from our Federal or State agency medical or psychological consultants.

The following rules apply to our Federal or State agency medical or psychological consultants that we consult in connection with administrative law judge hearings and Appeals Council reviews:

(a) In claims adjudicated by the State agency, a State agency medical or psychological consultant may make the determination of disability together with a State agency disability examiner or provide medical evidence to a State agency disability examiner when the disability examiner makes the initial or reconsideration determination alone (see § 416.1015(c) of this part). The following rules apply:

(1) When a State agency medical or psychological consultant makes the determination together with a State agency disability examiner at the initial or reconsideration level of the administrative review process as provided in § 416.1015(c)(1), he or she will consider the evidence in your case record and make administrative findings about the medical issues, including, but not limited to, the existence and severity of your impairment(s), the existence and severity of your symptoms, whether your impairment(s) meets or medically equals the requirements for any impairment listed in appendix 1 to this subpart, and your residual functional capacity. These administrative medical findings are based on the evidence in your case but are not in themselves evidence at the level of the administrative review process at which they are made. See § 416.913(a)(5).

(2) When a State agency disability examiner makes the initial determination alone as provided in § 416.1015(c)(3), he or she may obtain medical evidence from a State agency medical or psychological consultant about one or more of the medical issues listed in paragraph (a)(1) of this section. In these cases, the State agency disability examiner will consider the medical evidence of the State agency medical or psychological consultant under §§ 416.920b, 416.920c, and 416.927.

(3) When a State agency disability examiner makes a reconsideration determination alone as provided in § 416.1015(c)(3), he or she will consider prior administrative medical findings made by a State agency medical or psychological consultant at the initial level of the administrative review process, and any medical evidence provided by such consultants at the initial and reconsideration levels, about one or more of the medical issues listed in paragraph (a)(1) of this section under §§ 416.920b, 416.920c, and 416.927.

(b) Administrative law judges are responsible for reviewing the evidence and making administrative findings of fact and conclusions of law. They will consider prior administrative medical findings and medical evidence from our Federal or State agency medical or psychological consultants as follows:
(1) Administrative law judges are not required to adopt any prior administrative medical findings, but they must consider this evidence according to §§416.920b, 416.920c, and 416.927, as appropriate, because our Federal or State agency medical or psychological consultants are highly qualified and experts in Social Security disability evaluation.

(2) Administrative law judges may also ask for medical evidence from expert medical sources. Administrative law judges will consider this evidence under §§416.920b, 416.920c, and 416.927, as appropriate.

(c) When the Appeals Council makes a decision, it will consider prior administrative medical findings as administrative law judges follow under paragraph (b) of this section.

44. Revise §416.919 paragraph (c) to read as follows:

§416.919 If you do not appear at a consultative examination.

* * * * *

(c) Objections by your medical source(s). If any of your medical sources tell you that you should not take the examination or test, you should tell us at once. In many cases, we may be able to get the information we need in another way. Your medical source(s) may agree to another type of examination for the same purpose.

45. Revise §416.919g(a) to read as follows:

§416.919g Who we will select to perform a consultative examination.

(a) We will purchase a consultative examination only from a qualified medical source. The medical source may be your own medical source or another medical source. If you are a child, the medical source we choose may be a pediatrician.

* * * * *

46. Revise §416.919h to read as follows:

§416.919h Your medical source.

When, in our judgment, your medical source is qualified, equipped, and willing to perform the additional examination or test(s) for the fee schedule payment, and generally furnishes complete and timely reports, your medical source will be the preferred source for the purchased examination or test(s).

47. Revise §416.919i to read as follows:

§416.919i Other sources for consultative examinations.

We will use a different medical source than your medical source for a purchased examination or test in situations including, but not limited to, the following:

(a) Your medical source prefers not to perform such an examination or does not have the equipment to provide the specific data needed;

(b) There are conflicts or inconsistencies in your file that cannot be resolved by going back to your medical source;

(c) You prefer a source other than your medical source and have a good reason for your preference;

(d) We know from prior experience that your medical source may not be a productive source, such as when he or she has consistently failed to provide complete or timely reports; or

(e) Your medical source is not a qualified medical source as defined in §416.919g.

48. Revise §416.919n paragraph (c)(6) to read as follows:

§416.919n Informing the medical source of examination scheduling, report content, and signature requirements.

* * * * *

(c) * * *

(6) A medical opinion. Although we will ordinarily request a medical opinion as part of the consultative examination process, the absence of a medical opinion in a consultative examination report will not make the report incomplete. See §416.913(a)(3); and

* * * * *

49. In §416.920a, revise the second sentence of paragraphs (b)(1) and (d)(1) to read as follows:

§416.920a Evaluation of mental impairments.

* * * * *

(b) * * *

(1) * * * See §416.921 for more information about what is needed to show a medically determinable impairment. * * *

* * * * *

(d) * * *

(1) If we rate the degrees of your limitation as “none” or “mild,” we will generally conclude that your impairment(s) is not severe, unless the evidence otherwise indicates that there is more than a minimal limitation in your ability to do basic work activities (see §416.922).

* * * * *

50. Revise §416.920b to read as follows:

§416.920b How we consider evidence.

After we review all of the evidence relevant to your claim, we make findings about what the evidence shows.

(a) Complete and consistent evidence. If all of the evidence we receive, including all medical opinion(s), is consistent and there is sufficient evidence for us to determine whether you are disabled, we will make our determination or decision based on that evidence.

(b) Incomplete or inconsistent evidence. In some situations, we may not be able to make our determination or decision because the evidence in your case record is insufficient or inconsistent. We consider evidence to be insufficient when it does not contain all the information we need to make our determination or decision. We consider evidence to be inconsistent when it conflicts with other evidence. An internal conflict, is ambiguous, or when the medical evidence does not appear to be based on medically acceptable clinical or laboratory diagnostic techniques. If the evidence in your case record is insufficient or inconsistent, we may need to take the additional actions in paragraphs (b)(1) through (4) of this section.

(1) If any of the evidence in your case record, including any medical opinion(s) and prior administrative medical findings, is inconsistent, we will consider the relevant evidence and see if we can determine whether you are disabled based on the evidence we have.

(2) If the evidence is consistent but we have insufficient evidence to determine whether you are disabled, or if after considering the evidence we determine we cannot reach a conclusion about whether you are disabled, we will determine the best way to resolve the inconsistency or insufficiency. The action(s) we take will depend on the nature of the inconsistency or insufficiency. We will try to resolve the inconsistency or insufficiency by taking any one or more of the actions listed in paragraphs (b)(2)(i) through (b)(2)(iv) of this section. We might not take all of the actions listed below. We will consider any additional evidence we receive together with the evidence we already have.

(i) We may recontact your medical source. We may choose additional evidence or clarification from a medical source if we know from experience that the source either cannot or will not provide the necessary evidence. If we obtain medical evidence over the telephone, we will send the telephone report to the source for review, signature, and return.
(ii) We may request additional existing evidence;
(iii) We may ask you to undergo a consultative examination at our expense (see §§ 416.917 through 416.919); or
(iv) We may ask you or others for more information.
(3) When there are inconsistencies in the evidence that we cannot resolve or when, despite efforts to obtain additional evidence, the evidence is insufficient to determine whether you are disabled, we will make a determination or decision based on the evidence we have:
(i) Statements that you are or are not disabled or blind under the Act, we will not provide any analysis about how we considered such evidence in our determination or decision, even under § 416.920c:
(1) Decisions by other governmental agencies and nongovernmental entities. See § 416.904.
(2) Disability examiner findings. Findings made by a State agency disability examiner made at a previous level of adjudication about a medical issue, vocational issue, or the ultimate determination about whether you are disabled.
(3) Statements on issues reserved to the Commissioner. The statements listed in paragraphs (c)(1)(i) through (c)(3)(ix) of this section would direct our determination or decision that you are or are not disabled or blind within the meaning of the Act, but we are responsible for making the determination or decision about whether you are disabled or blind:
(i) Statements about whether or not you are disabled, blind, able to work, or able to perform regular or continuing work;
(ii) Statements about whether or not your impairment(s) meets the duration requirement (see § 416.909);
(iii) Statements about whether or not your impairment(s) meets or medically equals any listing in the Listing of Impairments in Part 404, Subpart P, Appendix 1;
(v) If you are a child, statements about whether or not your impairment(s) functionally equals the listings in Part 404 Subpart P Appendix 1 (see § 416.926a);
(vi) If you are an adult, statements about what your residual functional capacity is using our programmatic terms about the functional exertional levels in Part 404, Subpart P, Appendix 2, Rule 200.00 instead of descriptions about your functional abilities and limitations (see § 416.945);
(vii) If you are an adult, statements about whether or not your residual functional capacity prevents you from doing past relevant work (see § 416.960);
(viii) If you are an adult, statements that you do or do not meet the requirements of a medical-vocational rule in Part 404, Subpart P, Appendix 2; and
(ix) Statements about whether or not your disability continues or ends when we conduct a continuing disability review (see § 416.994).

51. Add § 416.920c to read as follows:

§ 416.920c How we consider and articulate medical opinions and prior administrative medical findings for claims filed on or after March 27, 2017.

For claims filed (see § 416.325) on or after March 27, 2017, the rules in this section apply. For claims filed before March 27, 2017, the rules in § 416.927 apply.

(a) How we consider medical opinions and prior administrative medical findings. We will not defer or give any specific evidentiary weight, including controlling weight, to any medical opinion(s) or prior administrative medical finding(s), including those from your medical sources. When a medical source provides one or more medical opinions or prior administrative medical findings, we will consider those medical opinions or prior administrative medical findings from that medical source together using the factors listed in paragraphs (c)(1) through (c)(5) of this section, as appropriate. The most important factors we consider when we evaluate the persuasiveness of medical opinions and prior administrative medical findings are supportability (paragraph (c)(1) of this section) and consistency (paragraph (c)(2) of this section). We will articulate how we considered the medical opinions and prior administrative medical findings in your claim according to paragraph (b) of this section.

(b) How we articulate our consideration of medical opinions and prior administrative medical findings.

We will articulate in our determination or decision how persuasive we find all of the medical opinions and all of the prior administrative medical findings in your case record. Our articulation requirements are as follows:

(1) Source-level articulation. Because many claims have voluminous case records containing many types of evidence from different sources, it is not administratively feasible for us to articulate in each determination or decision how we considered all of the factors for all of the medical opinions and prior administrative medical findings in your case record. Instead, when a medical source provides multiple medical opinion(s) or prior administrative medical finding(s), we will articulate how we considered the medical opinions or prior administrative medical findings from that medical source together in a single analysis using the factors listed in paragraphs (c)(1) through (c)(5) of this section, as appropriate. We are not required to articulate how we considered each medical opinion or prior administrative medical finding from one medical source individually.

(2) Most important factors. The factors of supportability (paragraph (c)(1)) of this section) and consistency (paragraph (c)(2) of this section) are the most important factors we consider when we determine how persuasive we find a medical source’s medical opinions or prior administrative medical findings to be. Therefore, we will explain how we considered the supportability and consistency factors for a medical source’s medical opinions or prior administrative medical findings in your determination or decision. We may, but are not required to, explain how we considered the factors in paragraphs (c)(3) through (c)(5) of this section, as appropriate, when we articulate how we consider medical opinions and prior administrative medical findings in your case record.

(3) Equally persuasive medical opinions or prior administrative medical findings about the same issue.

When we find that two or more medical opinions or prior administrative medical findings about the same issue are both equally well-supported (paragraph (c)(1) of this section) and consistent with the record (paragraph (c)(2) of this section) but are not exactly the same, we will articulate how we considered the other most persuasive factors in paragraphs (c)(3) through (c)(5) of this section for those medical opinions or prior administrative medical findings in your determination or decision.

(c) Factors. We will consider the following factors when we consider the medical opinion(s) and prior administrative medical finding(s) in your case:

(1) Supportability. The more relevant the objective medical evidence and supporting explanations presented by a medical source are to support his or her medical opinion(s) or prior
administrative medical finding(s), the more persuasive the medical opinions or prior administrative medical finding(s) will be.

(2) Consistency. The more consistent a medical opinion(s) or prior administrative medical finding(s) is with the evidence from other medical sources and nonmedical sources in the claim, the more persuasive the medical opinion(s) or prior administrative medical finding(s) will be.

(3) Relationship with the claimant. This factor combines consideration of the issues in paragraphs (c)(3)(i)–(v) of this section.

(i) Length of the treatment relationship. The length of time a medical source has treated you may help demonstrate whether the medical source has a longitudinal understanding of your impairment(s).

(ii) Frequency of examinations. The frequency of your visits with the medical source may help demonstrate whether the medical source has a longitudinal understanding of your impairment(s).

(iii) Purpose of the treatment relationship. The purpose for treatment you received from the medical source may help demonstrate the level of knowledge the medical source has of your impairment(s).

(iv) Extent of the treatment relationship. The kinds and extent of examinations and testing the medical source has performed or ordered from specialists or independent laboratories may help demonstrate the level of knowledge the medical source has of your impairment(s).

(v) Examining relationship. A medical source may have a better understanding of your impairment(s) if he or she examines you than if the medical source only reviews evidence in your folder.

(4) Specialization. The medical opinion or prior administrative medical finding of a medical source who has received advanced education and training to become a specialist may be more persuasive about medical issues related to his or her area of specialty than the medical opinion or prior administrative medical finding of a medical source who is not a specialist in the relevant area of specialty.

(5) Other factors. We will consider other factors that tend to support or contradict a medical opinion or prior administrative medical finding. This includes, but is not limited to, evidence showing a medical source has familiarity with the other evidence in the claim or an understanding of our disability program’s policies and evidentiary requirements. When we consider a medical source’s familiarity with the other evidence in a claim, we will also consider whether new evidence we receive after the medical source made his or her medical opinion or prior administrative medical finding makes the medical opinion or prior administrative medical finding more or less persuasive.

(d) Evidence from nonmedical sources. We are not required to articulate how we considered evidence from nonmedical sources using the requirements in paragraphs (a) through (c) in this section.

§ 416.921 Establishing that you have a medically determinable impairment(s).

If you are not doing substantial gainful activity, we will determine whether you have a medically determinable physical or mental impairment(s) (see § 416.920(a)(4)(i)(A)). Your impairment(s) must result from anatomical, physiological, or psychological abnormalities that can be shown by medically acceptable clinical and laboratory diagnostic techniques. Therefore, a physical or mental impairment must be established by objective medical evidence from an acceptable medical source. We will not use your statement of symptoms, a diagnosis, or a medical opinion to establish the existence of an impairment(s). After we establish that you have a medically determinable impairment(s), then we determine whether your impairment(s) is severe.

§ 416.922 What we mean by an impairment(s) that is not severe in an adult.

(a) Non-severe impairments. An impairment or combination of impairments is not severe if it does not significantly limit your physical or mental ability to do basic work activities.

(b) Basic work activities. When we talk about basic work activities, we mean the abilities and aptitudes necessary to do most jobs. Examples of these include—

(1) Physical functions such as walking, standing, sitting, lifting, pushing, pulling, reaching, carrying, or handling;

(2) Capacities for seeing, hearing, and speaking;

(3) Understanding, carrying out, and remembering simple instructions;

(4) Use of judgment;

(5) Responding appropriately to supervision, co-workers and usual work situations; and

(6) Dealing with changes in a routine work setting.

§ 416.923 Multiple impairments.

(a) Unrelated severe impairments. We cannot combine two or more unrelated severe impairments to meet the 12-month duration test. If you have a severe impairment(s) and then develop another unrelated severe impairment(s) but neither one is expected to last for 12 months, we cannot find you disabled, even though the two impairments in combination last for 12 months.

(b) Concurrent impairments. If you have two or more concurrent impairments that, when considered in combination, are severe, we must determine whether the combined effect of your impairments can be expected to continue to be severe for 12 months. If one or more of your impairments improves or is expected to improve within 12 months, so that the combined effect of your remaining impairments is no longer severe, we will find that you do not meet the 12-month duration test.

(c) Combined effect. In determining whether your physical or mental impairment or impairments are of a sufficient medical severity that such impairment or impairments could be the basis of eligibility under the law, we will consider the combined effect of all of your impairments without regard to whether any such impairment, if considered separately, would be of sufficient severity. If we do find a medically severe combination of impairments, we will consider the combined impact of the impairments throughout the disability determination process. If we do not find that you have a medically severe combination of impairments, we will determine that you are not disabled (see §§ 416.920 and 416.924).

§ 416.924a Considerations in determining disability for children.

(a) Basic considerations. We consider all evidence in your case record (see § 416.913). The evidence in your case record may include information from medical sources (such as your pediatrician or other physician; psychologist; qualified speech-language pathologist; and physical, occupational, and rehabilitation therapists) and nonmedical sources (such as your parents, teachers, and other people who know you).
(1) In cases where the State agency or other designee of the Commissioner makes the initial or reconsideration disability determination, a State agency medical or psychological consultant or other designee of the Commissioner (see § 416.1016 of this part) has the overall responsibility for determining medical equivalence.

(2) For cases in the disability hearing process or otherwise decided by a disability hearing officer, the responsibility for determining medical equivalence rests with either the disability hearing officer or, if the disability hearing officer’s reconsideration determination is changed under § 416.1418 of this part, with the Associate Commissioner for Disability Policy or his or her delegate.

(3) For cases at the administrative law judge or Appeals Council level, the responsibility for deciding medical equivalence rests with the administrative law judge or Appeals Council.

58. Amend § 416.924b by revising the first sentence of paragraph (b)(3) to read as follows:

§ 416.924b Age as a factor of evaluation in the sequential evaluation process for children.

59. Amend § 416.926a by revising the second sentence of paragraph (b)(3) to read as follows:

§ 416.926a Functional equivalence for children.

60. Revise § 416.927 to read as follows:

§ 416.927 Evaluating opinion evidence for claims filed before March 27, 2017.

For claims filed (see § 416.325) before March 27, 2017, the rules in this section apply. For claims filed on or after March 27, 2017, the rules in § 416.920c apply.

(a) Definitions.

(1) Medical opinions. Medical opinions are statements from acceptable medical sources that reflect judgments about the nature and severity of your impairment(s), including your symptoms, diagnosis and prognosis, what you can still do despite impairment(s), and your physical or mental restrictions.

(2) Treating source. Treating source means your own acceptable medical source who provides you, or has provided you, with medical treatment or evaluation and who has, or has had, an ongoing treatment relationship with you. Generally, we will consider that you have an ongoing treatment relationship with an acceptable medical source when the medical evidence establishes that you see, or have seen, the source with a frequency consistent with accepted medical practice for the type of treatment and/or evaluation required for your medical condition(s).

(c) How we weigh medical opinions. Regardless of its source, we will evaluate every medical opinion we receive. Unless we give a treating source’s medical opinion controlling weight under paragraph (c)(2) of this section, we consider all of the following factors in deciding the weight we give to any medical opinion.

(1) Examining relationship. Generally, we give more weight to the medical opinion of a source who has examined you than to the medical opinion of a medical source who has not examined you.

(2) Treatment relationship. Generally, we give more weight to medical opinions from your treating sources, since these sources are likely to be the medical professionals most able to provide a detailed, longitudinal picture of your medical impairment(s) and may bring a unique perspective to the medical evidence that cannot be obtained from the objective medical findings alone or from reports of individual examinations, such as consultative examinations or brief hospitalizations. If we find that a treating source’s medical opinion on the issue(s) of the nature and severity of your impairment(s) is well-supported by medically acceptable clinical and laboratory diagnostic techniques and is not inconsistent with the other substantial evidence in your case record, we will give it controlling weight. When we do not give the treating source’s medical opinion controlling weight, we apply the factors listed in paragraphs (c)(2)(i) and (ii) and (c)(2)(iii) to (c)(2)(v) to (c)(2)(vii) of this section.
(c)(2)(ii) of this section, as well as the factors in paragraphs (c)(3) through (c)(6) of this section in determining the weight to give the medical opinion. We will always give good reasons in our notice of determination or decision for the weight we give your treating source’s medical opinion.

(5) Specialization. We generally give more weight to the medical opinion of a specialist about medical issues related to his or her area of specialty than to the medical opinion of a source who is not a specialist.

(6) Other factors. When we consider how much weight to give to a medical opinion, we will also consider any factors you or others bring to our attention, or of which we are aware, which tend to support or contradict the medical opinion. For example, the amount of understanding of our disability programs and their evidentiary requirements that a medical source has, regardless of the source of that understanding, and the extent to which a medical source is familiar with the other information in your case record are relevant factors that we will consider in deciding the weight to give to a medical opinion.

(d) Medical source opinions on issues reserved to the Commissioner. Opinions on some issues, such as the examples that follow, are not medical opinions, as described in paragraph (a)(1) of this section, but are, instead, opinions on issues reserved to the Commissioner because they are administrative findings that are dispositive of a case; i.e., that would direct the determination or decision of disability.

(1) Opinions that you are disabled. We are responsible for making the determination or decision about whether you meet the statutory definition of disability. In so doing, we review all of the medical findings and other evidence that support a medical source’s statement that you are disabled. A statement by a medical source that you are “disabled” or “unable to work” does not mean that we will determine you are disabled.

(2) Other opinions on issues reserved to the Commissioner. We use medical sources, including your treating source, to provide evidence, including opinions, on the nature and severity of your impairment(s). Although we consider opinions from medical sources on issues such as whether your impairment(s) meets or equals the requirements of any impairment(s) in the Listing of Impairments in appendix 1 to subpart P of part 404 of this chapter, your residual functional capacity (see §§ 416.945 and 416.946), or the application of vocational factors, the final responsibility for deciding these issues is reserved to the Commissioner.

(3) We will not give any special significance to the source of an opinion on issues reserved to the Commissioner described in paragraphs (d)(1) and (d)(2) of this section.

(e) Evidence from our Federal or State agency medical or psychological consultants. The rules in §416.913a apply except that when an administrative law judge gives controlling weight to a treating source’s medical opinion, the administrative law judge is not required to explain in the decision the weight he or she gave to the prior administrative medical findings in the claim.

(f) Opinions from medical sources who are not acceptable medical sources and from nonmedical sources.

(1) Consideration. Opinions from medical sources who are not acceptable medical sources and from nonmedical sources, including your treating source, will give to the source’s medical opinion. We will look at the treatment history with you, and the kinds and extent of examinations and testing the source has performed or offered from specialists and independent laboratories. For example, if your ophthalmologist notices that you have complained of neck pain during your eye examinations, we will consider his or her medical opinion with respect to your neck pain, but we will give it less weight than that of another physician who has treated you for the neck pain. When the treating source has reasonable knowledge of your impairment(s), we will give the source’s medical opinion more weight than we would give it if it were from a nontreating source.

(2) Supportability. The more a medical source presents relevant evidence to support a medical opinion, particularly medical signs and laboratory findings, the more weight we will give that medical opinion. The better an explanation a source provides for a medical opinion, the more weight we will give that medical opinion. Furthermore, because nonexaming sources may have a more personalized disability notice at the
§ 416.929 How we evaluate symptoms, including pain.

(a) General. In determining whether you are disabled, we consider all your symptoms, including pain, and the extent to which your symptoms can reasonably be expected to be consistent with the objective medical evidence and other evidence. We will consider all of your statements about your symptoms, such as pain, and any description your medical sources or nonmedical sources provide about the symptoms, which could reasonably be expected to produce the pain or other symptoms alleged and that, when considered with all of the other evidence (including statements about the intensity and persistence of your pain or other symptoms which may reasonably be expected to be consistent with the medical signs and laboratory findings), would lead to a conclusion that you are disabled. In evaluating the intensity and persistence of your symptoms, including pain, we will consider all of the available evidence, including your medical history, the medical signs and laboratory findings, and statements about how your symptoms affect you. We will then determine the extent to which your alleged functional limitations and restrictions due to pain or other symptoms can reasonably be accepted as consistent with the medical signs and laboratory findings and other evidence to decide how your symptoms affect your ability to work (or if you are a child, your functioning). However, statements about your pain or other symptoms will not alone establish that you are disabled. There must be objective medical evidence from an acceptable medical source that shows you have a medical impairment(s) which could reasonably be expected to produce the pain or other symptoms alleged and that, when considered with all of the other evidence (including statements about the intensity and persistence of your pain or other symptoms which may reasonably be expected to be consistent with the medical signs and laboratory findings), would lead to a conclusion that you are disabled. In evaluating the intensity and persistence of your symptoms, including pain, we will consider all of the available evidence, including your medical history, the medical signs and laboratory findings, and statements about how your symptoms affect you. We will then determine the extent to which your alleged functional limitations and restrictions due to pain or other symptoms can reasonably be accepted as consistent with the medical signs and laboratory findings and other evidence to decide how your symptoms affect your ability to work (or if you are a child, your functioning).

(b) * * * When we reviewed your

(c) * * * In evaluating the intensity and persistence of your symptoms, we consider all of the available evidence from your medical sources and nonmedical sources about how your symptoms affect you. We also consider the medical opinions as explained in § 416.920c. * * *

(3) Consideration of other evidence. Because symptoms sometimes suggest a greater severity of impairment than can be shown by objective medical evidence alone, we will carefully consider any other information you may submit about your symptoms. The information that your medical sources or nonmedical sources provide about your pain or other symptoms (e.g., what may precipitate or aggravate your symptoms, what medications, treatments or other methods you use to alleviate them, and how the symptoms may affect your pattern of daily living) is also an important indicator of the intensity and persistence of your symptoms. Because symptoms, such as pain, are subjective and difficult to quantify, any symptom-related functional limitations and restrictions that your medical sources or nonmedical sources report, which can reasonably be accepted as consistent with the objective medical evidence and other evidence, will be taken into account as explained in paragraph (c)(4) of this section in reaching a conclusion as to whether you are disabled. We will consider all of the evidence presented, including information about your prior work record, your statements about your symptoms, evidence submitted by your medical sources, and observations by our employees and other persons. If you are a child, we will also consider all of the evidence presented, including evidence submitted by your medical sources, and any related evidence about your symptoms, such as pain. Factors relevant to your symptoms, such as pain, which we will consider include:

* * * * *

(4) * * * We will consider whether there are any inconsistencies in the evidence and the extent to which there are any conflicts between your statements and the rest of the evidence, including your history, the signs and laboratory findings, and statements by your medical sources or other persons about how your symptoms affect you. * * *

§ 416.930 Need to follow prescribed treatment.

(a) What treatment you must follow. In order to get benefits, you must follow treatment prescribed by your medical source(s) if this treatment is expected to restore your ability to work. * * * * *

(b) * * * See § 416.912(b)(1)(i) concerning what we mean by every reasonable effort. * * * * See § 416.912(b)(1)(ii).

§ 416.993 Medical evidence in continuing disability review cases.

* * * * *

(b) * * * See § 416.994(b)(1)(i).

Example 1: * * * When we reviewed your

§ 416.994 How we will determine whether your disability continues or ends.

* * * * *

(b) * * *

(1) * * *

(i) * * * A determination that there has been a decrease in medical severity must be based on changes (improvement) in the symptoms, signs, or laboratory findings associated with your impairment(s).

Example 1: * * * When we reviewed your

§ 416.994a How often we review your disability.

* * * * *

(b) * * * See § 416.912(b)(1)(i).

(1) * * *

(i) * * * We will review your

§ 416.994a How often we review your disability.

* * * * *

(b) * * * See § 416.912(b)(1)(i).

(1) * * *

(i) * * * We will review your

§ 416.994a How often we review your disability.

* * * * *

(b) * * * See § 416.912(b)(1)(i).

(1) * * *

(i) * * * We will review your

§ 416.994a How often we review your disability.

* * * * *

(b) * * * See § 416.912(b)(1)(i).

(1) * * *

(i) * * * We will review your

§ 416.994a How often we review your disability.

* * * * *

(b) * * * See § 416.912(b)(1)(i).

(1) * * *

(i) * * * We will review your

§ 416.994a How often we review your disability.

* * * * *

(b) * * * See § 416.912(b)(1)(i).

(1) * * *

(i) * * * We will review your
The authority citation for subpart J of part 416 continues to read as follows:

Authority: Secs. 702(a)(5), 1614, 1631, and 1633 of the Social Security Act (42 U.S.C. 902(a)(5), 1382c, 1383, and 1383b).

§ 416.1015 [Amended]

67. The authority for subpart J of part 416 continues to read as follows:

(a) * * *

(b) * * *

(c) * * *

(2) The terms symptoms, signs, and laboratory findings are defined in § 416.902.

(d) * * *

(1) What we mean by treatment that is medically necessary. Treatment that is medically necessary means treatment that is expected to improve or restore your functioning and that was prescribed by your medical source. If you do not have a medical source, we will decide whether there is treatment that is medically necessary that could have been prescribed by a medical source. The treatment may include (but is not limited to)—

Subpart J—Determinations of Disability

67. The authority citation for subpart J of part 416 continues to read as follows:

Authority: Secs. 702(a)(5), 1614, 1631, and 1633 of the Social Security Act (42 U.S.C. 902(a)(5), 1382c, 1383, and 1383b).

§ 416.1017 Reasonable efforts to obtain review by a qualified psychiatrist or psychologist.

(a) When the evidence of record indicates the existence of a physical impairment, the State agency must make every reasonable effort to ensure that a medical consultant completes the medical portion of the case review and any applicable residual functional capacity assessment. When the evidence of record indicates the existence of a mental impairment, the State agency must make every reasonable effort to ensure that a psychological consultant completes the medical portion of the case review and any applicable residual functional capacity assessment. The State agency must determine if additional physicians, psychologists, and psychologists are needed to make the necessary reviews. When it does not have sufficient resources to make the necessary reviews, the State agency must attempt to obtain the resources needed. If the State agency is unable to obtain additional physicians, psychologists, and psychologists because of low salary rates or fee schedules, it should attempt to raise the State agency’s levels of compensation to meet the prevailing rates for these services. If these efforts are unsuccessful, the State agency will seek assistance from us. We will assist the State agency as necessary. We will also monitor the State agency’s efforts and where the State agency is unable to obtain the necessary services, we will make every reasonable effort to provide the services using Federal resources.

Subpart N—Determinations, Administrative Review Process, and Reopening of Determinations and Decisions

71. The authority for subpart N continues to read as follows:


72. In § 416.1406(b)(2), revise the fourth sentence to read as follows:

§ 416.1406 Testing modifications to the disability determination procedures.

(a) * * *

(b) * * *

(2) * * *

(2) However, before an initial determination is made in any case where there is evidence which indicates the existence of a mental impairment, the decisionmaker will make every reasonable effort to ensure that a qualified psychologist or psychologist who has completed the medical portion of the case review and any applicable residual functional capacity assessment about all physical impairment(s) in a claim.

What qualifications must a medical consultant have? A medical consultant is a licensed physician, as defined in § 416.902(a)(1).

What is a medical consultant? A medical consultant is a member of a team that makes disability determinations in a State agency (see § 416.1015), or who is a member of a team that makes disability determinations for us when we make disability determinations ourselves. The medical consultant completes the medical portion of the case review and any applicable residual functional capacity assessment. When the evidence of record indicates the existence of a physical impairment, the State agency must make every reasonable effort to ensure that a medical consultant completes the medical portion of the case review and any applicable residual functional capacity assessment. When the evidence of record indicates the existence of a mental impairment, the State agency must make every reasonable effort to ensure that a psychological consultant completes the medical portion of the case review and any applicable residual functional capacity assessment. The State agency must determine if additional physicians, psychologists, and psychologists are needed to make the necessary reviews. When it does not have sufficient resources to make the necessary reviews, the State agency must attempt to obtain the resources needed. If the State agency is unable to obtain additional physicians, psychologists, and psychologists because of low salary rates or fee schedules, it should attempt to raise the State agency’s levels of compensation to meet the prevailing rates for these services. If these efforts are unsuccessful, the State agency will seek assistance from us. We will assist the State agency as necessary. We will also monitor the State agency’s efforts and where the State agency is unable to obtain the necessary services, we will make every reasonable effort to provide the services using Federal resources.

What qualifications must a psychological consultant have? A psychological consultant can be either a licensed psychiatrist or psychologist. We will only consider a psychologist qualified to be a psychological consultant if he or she:

(1) Is licensed or certified as a psychologist at the independent practice level of psychology by the State in which he or she practices; and

(2) Possesses a doctorate degree in psychology from a program in clinical psychology of an educational institution accredited by an organization recognized by the Council on Postsecondary Accreditation; and

(2) Possesses 2 years of supervised clinical experience as a psychologist in health service, at least 1 year of which is post-masters degree.

(e) Cases involving both physical and mental impairments. In a case where there is evidence of both physical and mental impairments, the medical consultant will evaluate the physical impairments in accordance with paragraph (a) of this section, and the psychological consultant will evaluate the mental impairment(s) in accordance with paragraph (c) of this section.

70. Revise § 416.1017(a) to read as follows:

73. In § 416.1442, revise paragraph (f)(1) to read as follows:

§ 416.1442 Prehearing proceedings and decisions by attorney advisors.

(f) * * * *

(1) Authorize an attorney advisor to exercise the functions performed by an administrative law judge under §§ 416.913a, 416.920a, 416.926, and 416.946.

[FR Doc. 2017–00455 Filed 1–17–17; 8:45 am]
BILLING CODE 4191–02–P
1. What is NOSSCR?

- The mission of the National Organization of Social Security Claimants' Representatives (NOSSCR) is to advocate for improvements in Social Security disability programs and to ensure that individuals with disabilities applying for Social Security Disability and SSI benefits have access to highly qualified representation and receive fair decisions.

- Some things we’re working on:
  - Representative fee issues
  - Recognize firms as representatives
  - Continue to clarify “all evidence” rules
  - Comment and listening sessions on proposed regulations
  - Meetings with Congress and SSA

- NOSSCR Conference June 7-10 in DC – includes Hill Day visits
Who is in charge at Social Security?

Nancy Berryhill, new Acting Commissioner, effective January 23, 2017 (formerly Deputy Commissioner for Operations)
Patrick Nagel, new Chief ALJ, effective January 9, 2017)
David Black new Senior White House Advisor. (formerly SSA General Counsel and most recently was a member of the Agency Review Team following the election.
Mike Korkey new White House Liaison. (Previously Senior Advisor to former Deputy Commissioner Jim Lockhart. SSA advisor during George W Bush administration)
Subject to change:
• Terrie Gruber, Deputy Commissioner, ODAR Office of Disability Adjudication and Review
• Dan Callahan, Acting General Counsel, Office of General Counsel
• Beatrice Dismam Acting Chief of Staff, Office of the Commissioner
• Marianna LaCanfora Acting Deputy Commissioner, Office of Retirement and Disability Policy

Who’s in charge in Congress?

• House Ways and Means
  • Kevin Brady (R-TX), chair
  • Richard Neal (D-MA), ranking member
    • Tom Price (R-GA) (nominated to be Sec’y HHS), John Lewis (D-Ga), Carlos Curbelo (R-FL), Terri Sewell (D-Ala) sit on this committee
  • Social Security Subcommittee
    • Sam Johnson (R-TX, Chair), John Larson (D-CT) Ranking Member
      • Vern Buchanan (R-Fla.) sits on this sub committee
  • Human Resources Subcommittee (SSI)
    • Adrian Smith (R-Ne, Chair), Danny Davis, Ill (D-Ill, ranking member)
      • Carlos Curbelo (R-FL), Terri Sewell (D-Ala) sit on this subcommittee
    • Subcommittee on oversight
      • Vern Buchanan (R-Fla), Chairman, John Lewis (D-Ga, ranking member)

• Senate Finance:
  • Oren Hatch (R-UT), chairman
  • Ron Wyden (D-OR), ranking member
    • Sen. Johnny Isakson (R-Ga) sits on this committee
  • Social Security, Pensions and Family Policy Subcommittee – rosters not complete
    • Dean Heller (R-Nev) Chairman, Sherrod Brown (D.OH) Ranking Member
      • Johnny Isakson (R-Ga.) sits on this subcommittee
Final Rules

• Ensuring Program Uniformity at the Hearing and Appeals Council Levels of the Administrative Review Process
• Revisions to Rules Regarding the Evaluation of Medical Evidence
• Evidence From Excluded Medical Sources of Evidence
• Unsuccessful Work Attempts and Expedited Reinstatement Eligibility
  • Technical correction published January 23 (82 FR 7648)
• Implementation of the NICS Improvement Amendments Act of 2007
• **Revisions to Rules of Conduct and Standards of Responsibility for Appointed Representatives were withdrawn from review by OMB on January 9, 2017**

Revised Listings

• Mental Impairment Listings
  • Published September 26, 2016
  • Effective January 17, 2017 (delayed so SSA could update its systems)
• HIV Listings.
  • Published December 2, 2016.
  • Effective January 17, 2017
Evaluation of Medical Evidence (elimination of treating physician rule)

• 82 FR 5844 (Jan. 18, 2017)
• New rules are effective on March 27, 2017
  • Note that for several topics what matters is whether the claim was filed on or after the effective date; it's not based on when the hearing occurs or when a determination is issued
  • Please tell NOSSCR if ALJs are attempting to apply this regulation or the program uniformity rules on claims when they shouldn't be

Evaluation of Medical Evidence

• main points:
  • Acceptable medical sources
  • Non-SSA determinations
  • Treating sources
  • Evaluation of opinions
  • Statements reserved to the Commissioner

• Additionally, SSRs 96-2p, 96-5p, 96-6p, and 06-03p are rescinded
  • A new SSR will be issued about how ALJs and the Appeals Council “must obtain evidence sufficient to make a finding of medical equivalence”
Evaluation of Medical Evidence

• Who is an acceptable medical source (AMS)?
  • Advance Practice Registered Nurses (APRN): this includes Certified Nurse Midwife, Nurse Practitioner, Certified Registered Nurse Anesthetist, and Clinical Nurse Specialist (within the scopes of their practice only)
  • “Licensed audiologists are AMSs for impairments of hearing loss, auditory processing disorders, and balance disorders within the licensed scope of practice only” (prefatory matter to final rule) – listings changed on the topic of who can perform certain hearing tests
  • “Licensed optometrist for impairments of visual disorders, or measurements of visual acuity and visual fields only, depending on the scope of practice in the State in which the optometrist practices” (404.1502 and 416.902)
  • Physician Assistants (PA) (this is a change from the proposed rule)

Evaluation of Medical Evidence

• Proposal to change requirements about who can be a Psychological Consultant (PC) was not included in the final rule
• Despite many comments in support, LCSWs have NOT been added as AMSs
• “We will consider and articulate our consideration of all medical opinions, regardless of AMS status” (prefatory matter) (this is a change from the proposed rule)
  • Claims filed before March 27: new 404.1527(f) and 416.927(f) explain how SSA will consider, and articulate its consideration of opinions from non-AMS medical sources and nonmedical sources
  • Claims filed on or after March 27: new 404.1520c(d) and 416.920c(d) say “We are not required to articulate how we considered evidence from nonmedical sources using the requirements in” sections 404.1520c(a)-(c) and 416.920c(a)-(c) of the rules
Evaluation of Medical Evidence

• How should adjudicators handle determinations from other governmental agencies and nongovernmental entities?
  • VA benefits, workers comp, etc.
  • New 404.1504 for claims filed on or after March 27: “we will not provide any analysis in our determination or decision about a decision made by any other governmental agency or a nongovernmental entity about whether you are disabled, bind, employable, or entitled to any benefits. However, we will consider all of the supporting evidence underlying the other governmental agency or nongovernmental entity’s decision that we receive as evidence in your claim”
  • This goes against the law of several circuits, especially in the VA context, so it will remain to be seen what deference courts give to the new regulation
  • Still must submit or inform about all evidence that “relates” to disability determination, but prefatory matter indicates that not all determinations may relate

Evaluation of Medical Evidence

• Weighing of evidence
  • 404.1513: five categories of evidence: objective medical evidence, medical opinion, other medical evidence, evidence from nonmedical sources, and prior administrative findings
  • The treating source rule will not be applied to claims filed on or after March 27 – people contemplating applying for benefits may prefer to file before that date in order to preserve the treating physician rule for their claims
  • “It is never appropriate under our rules to ‘credit-as-true’ any medical opinion” (prefatory text)
    • This is a rather direct challenge to the Ninth Circuit line of cases
  • The goal instead is to focus on the “persuasiveness” of evidence from different medical sources, based on “supportability and consistency” – those are the only factors that require articulation under the new rules, except when multiple opinions are equally well-supported and consistent (of course, what persuades one adjudicator may not be what persuades another)
Evaluation of Medical Evidence

weighing of evidence, con’t

- Eliminate the “treating physician rule,” and instead consider the persuasiveness of medical opinions and prior administrative medical findings equally using specific factors (with supportability and consistency as the 2 most important factors)
  - So, opinions from treating sources will be considered in the exact same manner as those from state agency consultants who have never seen or even spoken to the claimant, which ignores the value of the doctor-patient relationship
  - This is SSA’s attempt to give greater value to its own consultants, who routinely deny claims
  - Very anti-claimant!

Evaluation of Medical Evidence

- Weighing of evidence (cont.)
  - Additional factors used in weighing medical evidence, if they are of equal supportability and consistency:
    - “Relationship with the claimant” including length of the treatment relationship, examining relationship, frequency of examinations, purpose of treatment relationship, and extent of treatment relationship
    - “Additionally, we recognize that evidence from a medical source who has a longstanding treatment relationship with an individual may contain some inconsistencies over time due to fluctuations in the severity of an individual’s impairments” (prefatory matter)
  - Specialization of the source
  - “Other factors” including “understanding our policy” and “familiarity with the record”
    - The prefatory matter states that it was not SSA’s intent to favor MCs or PCs, and final 404.1520(c)(5) and 416.920(c)(5) note that adjudicators will consider whether new evidence received after the medical source made his or her medical opinion or prior administrative medical finding makes the medical opinion or prior administrative medical finding more or less persuasive
Evaluation of Medical Evidence

• Weighing of Evidence, con’t

• Prefatory matter notes that the final rule changed to “emphasize that there is not an inherent persuasiveness to evidence from MCS, PCs, or CE sources over an individual’s own medical source(s), and vice versa, and to highlight that we continue to consider a medical source’s longstanding treatment relationship with the individual” (emphasis added)

• Given that the treating physician rule was implemented by SSA in 1991 because so many courts were requiring it, it will be interesting to see how courts address these new regulations
  • Will the courts look favorably upon the statement in the prefatory matter that “it is not administratively feasible for us to articulate how we considered all of the factors for all of the medical opinions and prior administrative medical findings in all claims”?
  • New 404.1519h says “your medical source will be the preferred source” for CE’s and other purchased tests if qualified, equipped, and willing to do so” It may become even more helpful now to have treating sources perform CE’s

Evaluation of Medical Evidence

• Statements reserved to the Commissioner
  • Listed in 404.1520b(c)(3)
  • “We will not consider an entire document to be a statement on an issue to the Commissioner simply because the document contains a statement on an issue that is reserved to the Commissioner” (prefatory matter)
  • Adjudicators are not required to articulate how they considered statements on such issues – the final rule is not very clear on whether adjudicators must described which statements they find to be on issues reserved to the Commissioner
Evaluation of Medical Evidence

• One other note
  • New 404.1512 clarifies what SSA will do to develop the record: make an initial request and then follow-up once 10 to 20 days later
  • Again, it will be interesting to see how federal courts treat this and whether they feel it satisfies the agency’s duty to develop

UWAs and EXRs

• 81 FR 71367 (Oct. 17, 2016)
• New UWA rules took effect on Nov. 16, 2016 but new EXR rules don’t take effect until April 17, 2017
• UWA rules simplified – removed the additional requirements used to evaluate work attempts that lasted between 3 and 6 months and now use the 3-month standard for all work attempts that last 6 months or less
  • Pro-claimant change!
• EXR rules now allow previously entitled individuals to request EXR in the same month they stop performing SGA
• NOSSCR supported changes by signing on to CCD comments
Gun Control Regs

• 81 FR 91702 (Dec. 19, 2016)
  • Over 90,000 comments received to proposed rule
• New rules take effect on January 18, 2017 BUT compliance is not required until December 19, 2017. Congress or new administration could block. Update 1/25/2017 - Congress is reviewing these regs.
• Final rules implement provisions of the NICS Improvement Amendments Act of 2007 (NIAA) that require Federal agencies to provide relevant records to the Attorney General for inclusion in the National Instant Criminal Background Check System (NICS)
• SSA will report individuals to NICS who receive disability benefits based on a mental impairment that meets or medically equals a mental listing (section 12.00) AND requires a representative payee for receipt of benefits
• Inclusion on the NICS database restricts the individual’s ability to purchase firearms and certain explosives. Does not take away already owned guns.

“Bad Doc” rule

• Evidence from Statutorily Excluded Providers (81 FR 37557)
  • SSA required to exclude information from “bad docs” by BBA, but SSA allowed to grant good cause exemptions
  • NOSSCR submitted own comments and CCD borrowed heavily from them
Program Uniformity

- 81 FR 90987 (Dec. 16, 2016)
- New rules take effect on January 17, 2017 BUT compliance is not required until May 1, 2017
- Final rules require:
  - Claimants and their reps to submit evidence, or inform SSA about it, at least 5 business days before the hearing, unless an exception applies (aka 5-day rule)
  - NOSSCR repeatedly opposed this
  - At least 75 days notice of a scheduled hearing (currently 20 days)
- “Inform” option
- Good cause exceptions (also apply to objecting to the issues (5 days), subpoena requests (10 days) and written pre-hearing statements (5 days))
- 5-day rule does NOT apply to post-hearing statements

Will Congress curtail any regs?

- January 20th letter from the White House
- No new regulations may be sent to the Office of Federal Register (OFR) until an agency head appointed or designated by the President reviews and approves the regulation.
- Regulations that have been sent to the OFR but not published in the Federal Register must be immediately withdrawn from the OFR for review and approval
- Regulations that have been published but have not taken effect: (wt of medical evidence rule)
  - temporarily postpone their effective date for 60 days after January 20, 2017. Where appropriate agencies should consider proposing for notice and comment a rule to delay the effective date for regulations beyond that 60-day period.
HIV Listings

• 81 FR 86915 (Dec. 2, 2016)
• New listings take effect on January 17, 2017
• Both adult (section 14.00) and children (section 114.00) immune system disorders listings updated
  • As well as introductory text of digestive, hematological, skin and cancer body systems listings to update references to HIV infection
• Key revisions include:
  • Revised and expanded introductory text to the immune system disorders body system for evaluating HIV infections in both adults and children
  • Created listings 14.11 and 114.11 for HIV infections
  • Reserved listings 14.08 and 114.08, the current HIV listings
  • Added new criteria for adults and children for evaluation of HIV infections under the listings
  • Removed criteria for HIV infections that no longer represent impairments that are of listing-level severity

Mental Listings

• 81 FR 66137 (Sept. 26, 2016)
• New listings take effect on January 17, 2017
• Both adult (section 12.00) and children (section 112.00) listings updated
• Key revisions include:
  • Addition of eating disorders (12.13 and 112.13) and trauma- and stressor-related disorders (12.15 and 112.15) listings
  • Separation of neurodevelopmental disorders from listing 12.10 into its own listing (12.11 and 112.11)
  • Removal of substance addiction disorders altogether (12.09 and 112.09 now RESERVED)
  • Paragraphs A, B and C criteria changed for all mental listings
<table>
<thead>
<tr>
<th>Current ADULT listings titles</th>
<th>New ADULT listings titles</th>
</tr>
</thead>
<tbody>
<tr>
<td>12.02 Organic mental disorders</td>
<td>12.02 Neurocognitive disorders</td>
</tr>
<tr>
<td>12.03 Schizophrenic, paranoid and other psychotic disorders</td>
<td>12.03 Schizophrenia spectrum and other psychotic disorders</td>
</tr>
<tr>
<td>12.04 Affective disorders</td>
<td>12.04 Depressive, bipolar and related disorders</td>
</tr>
<tr>
<td>12.05 Intellectual disability</td>
<td>12.05 Intellectual disorder</td>
</tr>
<tr>
<td>12.06 Anxiety-related disorders</td>
<td>12.06 Anxiety and obsessive-compulsive disorders</td>
</tr>
<tr>
<td>12.07 Somatoform disorders</td>
<td>12.07 Somatic symptom and related disorders</td>
</tr>
<tr>
<td>12.08 Personality disorders</td>
<td>12.08 Personality and impulse-control disorders</td>
</tr>
<tr>
<td>12.09 Substance addiction disorders</td>
<td>12.09 RESERVED</td>
</tr>
<tr>
<td>12.10 Autistic disorder and other pervasive developmental disorder</td>
<td>12.10 Autism spectrum disorder</td>
</tr>
<tr>
<td></td>
<td>12.11 Neurodevelopmental disorders</td>
</tr>
<tr>
<td></td>
<td>12.12 RESERVED</td>
</tr>
<tr>
<td></td>
<td>12.13 Eating disorders</td>
</tr>
<tr>
<td></td>
<td>12.15 Trauma- and stressor-related disorders</td>
</tr>
</tbody>
</table>

What bills could be introduced?

- **The good**
  - Social Security 2100 Act and other expansion legislation
  - SSI Restoration Act
  - But they will likely not pass or even progress through committee

- **The bad**
  - SSI
    - Could happen through reconciliation
    - Child SSI: “Better Way” idea
    - CBO “options report” scores eliminating the program entirely; block grants or piecemeal changes more likely
  - Title II
    - Raise retirement age
    - Change or eliminate grids
    - Government representative
    - Lots of other changes possible
Why is SSI especially at risk?

- Reconciliation and the Byrd rule
- Use as a pay-for
- Not an “earned benefit”
- Child SSI’s Inclusion in Paul Ryan’s “Better Way” plan

How much administrative funding will SSA get for the rest of FY 2017?

- 10/10/10 fact: 10% decrease in funding (inflation-adjusted) for over 10% increase in beneficiaries (mostly retirees) since 2010. Few staff for more beneficiaries
- As caseloads rise, administrative costs are now under 1.3% of benefits paid (previously was 1.4%; both are far below private insurers)
- Currently operating under a continuing resolution – funding through April 28, 2017. Across the board reduction of almost .2 percent. Expect more cuts after April 28.
  - Hiring freeze, limited overtime
- CR includes a one time $150 million for backlog reduction – use for CARES initiatives

Payment Service centers Backlog grows – post decision work
## Administrative Budget FY08-17

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>08</th>
<th>09</th>
<th>10</th>
<th>11</th>
<th>12</th>
<th>13</th>
<th>14</th>
<th>15</th>
<th>16</th>
<th>POTUS 2017</th>
<th>House 2017</th>
<th>Senate 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Limitation on Administrative Expenses (LAE) ($ billions)</td>
<td>9.7</td>
<td>10.5</td>
<td>11.4</td>
<td>11.4</td>
<td>11.0</td>
<td>11.7</td>
<td>11.8</td>
<td>12.2</td>
<td>13.1</td>
<td>11.9</td>
<td>12.5</td>
<td></td>
</tr>
<tr>
<td>Research and Demonstration ($ millions)</td>
<td>27</td>
<td>35</td>
<td>49</td>
<td>43</td>
<td>8</td>
<td>17</td>
<td>47</td>
<td>83</td>
<td>101</td>
<td>112</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Office of the Inspector General ($ millions)</td>
<td>92</td>
<td>98</td>
<td>103</td>
<td>102</td>
<td>102</td>
<td>97</td>
<td>102</td>
<td>103</td>
<td>106</td>
<td>58</td>
<td>182</td>
<td></td>
</tr>
</tbody>
</table>

9/29: Continuing resolution (0.496% cut except to program integrity) through 12/9.  
12/9 : CR through 4/28 (0.1901% cut, with $150m for reducing ODAR backlog)

## Will President Trump issue an FY 2018 budget request?

- The president is required to do so by the first Monday in February, according to the Budget and Accounting Act of 1921 (as amended).
- There is no penalty for missing the deadline.
- President Obama frequently missed this deadline.
- Paul Ryan called this “an unprecedented disrespect for the law” in 2012.
- Presidents are often late in their first year in office, but some media sources have suggested President Trump may not make a request at all.
What are President Trump’s positions on Social Security?

- “Did you know that one out of every 20 people in America now claims disability? That adds up to $170 billion a year in disability checks. Between 2005 and 2009, it is estimated that $25 billion were eaten up in fraudulent Social Security Disability Insurance filings. On and on, scam after scam it goes; as always, taxpayers are the ones getting stiffed.”
- “It’s not unreasonable for people who paid into a system for decades to expect to get their money’s worth— that’s not an “entitlement,” that’s honoring a deal. We as a society must also make an ironclad commitment to providing a safety net for those who can’t make one for themselves.”
- “I’m ok with [means testing]”
- “I would never support what has to be the craziest ideas in the history of U.S. politics: allowing the government to invest Social Security retirement funds in the stock market.”
- “Privatization would be good for all of us”
- “I would impose a one-time, 14.25% tax on individuals and trusts with a net worth over $10 million. [We could pay off the national debt and] use the rest of the savings—$100 billion—to bolster the Social Security Trust Fund.”

How big will backlogs get?

- Long waits for everything at SSA.
  - Over 3 million item backlog at program service centers.
  - Representatives waiting a long time for payment of fees.
  - Wait times on 800 number and in field offices have increased.

- Over 1.13 million hearing requests are currently pending; 1st decline in a long time was August 2016.

- Program Service centers – post entitlement. Pending increased from 1.5 million to 3 million.
How long will people wait for ALJ hearings?

- National average processing time (as of November 2016) for hearings: 560 days. Peaked at the end of FY16, declined, and now rising again.

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>National Average Processing Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>2008</td>
<td>509 (September only)</td>
</tr>
<tr>
<td>2009</td>
<td>491</td>
</tr>
<tr>
<td>2010</td>
<td>426</td>
</tr>
<tr>
<td>2011</td>
<td>360</td>
</tr>
<tr>
<td>2012</td>
<td>353</td>
</tr>
<tr>
<td>2013</td>
<td>396 (September only)</td>
</tr>
<tr>
<td>2014</td>
<td>422</td>
</tr>
<tr>
<td>2015</td>
<td>480</td>
</tr>
<tr>
<td>2016</td>
<td>543</td>
</tr>
</tbody>
</table>

Processing Times

<table>
<thead>
<tr>
<th>Hearing Office</th>
<th>Cases Pending</th>
<th>Processing Time (FYTD 12/30/16)</th>
<th>Processing Time (FYTD 12/25/15)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Atlanta Downtown</td>
<td>12220</td>
<td>619</td>
<td>617</td>
</tr>
<tr>
<td>Atlanta North</td>
<td>7380</td>
<td>562</td>
<td>580</td>
</tr>
<tr>
<td>Chattanooga</td>
<td>7449</td>
<td>535</td>
<td>569</td>
</tr>
<tr>
<td>Columbia</td>
<td>6688</td>
<td>664</td>
<td>623</td>
</tr>
<tr>
<td>Covington</td>
<td>5874</td>
<td>623</td>
<td>597</td>
</tr>
<tr>
<td>Macon</td>
<td>5911</td>
<td>542</td>
<td>540</td>
</tr>
<tr>
<td>Savannah</td>
<td>7120</td>
<td>586</td>
<td>540</td>
</tr>
<tr>
<td>Tallahassee</td>
<td>4414</td>
<td>595</td>
<td>591</td>
</tr>
</tbody>
</table>

Hearing Offices in Atlanta region that serve Georgia Field Offices.
Source: http://www.ssa.gov/appeals/DataSets/02_HO_Workload_Data.html (Fiscal Year to Date)
How many people will die while awaiting hearings?

7897 people died waiting for hearings, 9/26/15 to 9/1/16

CARES: Current Initiative Snapshot

- National Adjudication Team (NAT)
  - Increased non-ALJ dispositions by 169% since First Quarter FY 2016
- Pre-Hearing Conferences Pilot
  - Conducted over 6,000 pre-hearing conferences
- SmartMands Initiative
  - 10/2017: Expanded to 250 cases per week
  - 1/27: Expanded to 500 cases per week
- Reducing CD Burning in Hearing Offices
  - Direct Pay Representatives: By end of FY 2016, reduced the number of CDs burned by over 9%, with cost savings of over $1 Million in FY 2016
  - Medical/Vocational Expert eFolder Access: Expect to cease burning CDs for ME/VEs by end of FY 2017

Source - Gruber, Ray presentation to SSAB January 2017
**ALJ Hiring, but lack of decision writers is a problem**

### ALJ Hiring Since 2000

As of September 2016
SSA hired 204 ALJs in FY16

### 17. What’s going on at the Appeals Council & Federal Court?

<table>
<thead>
<tr>
<th></th>
<th></th>
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<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>AC Grant Review</td>
<td>25,457</td>
<td>31,019</td>
<td>35,135</td>
<td>33,458</td>
<td>26,167</td>
<td>22,912</td>
<td>20,800</td>
<td>21,442</td>
</tr>
<tr>
<td>All AC RR Dispositions</td>
<td>102,062</td>
<td>126,992</td>
<td>166,020</td>
<td>176,251</td>
<td>162,280</td>
<td>150,673</td>
<td>154,402</td>
<td>159,000</td>
</tr>
<tr>
<td>Percentage</td>
<td>24.94%</td>
<td>24.43%</td>
<td>21.16%</td>
<td>18.98%</td>
<td>16.12%</td>
<td>15.21%</td>
<td>13.47%</td>
<td>13.49%</td>
</tr>
</tbody>
</table>

"Grant review actions include when the AC either returns the hearing level decision or dismissal with a remand order for further action, or when the AC issues a new decision."

Source: https://ssagov/appeals/DataSets/AC02_AC_GrantReview_All_Dispositions.html
Court Cases

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>Court Cases Decided</th>
<th>Allowed</th>
<th>Remanded</th>
<th>Cases Awarded or Remanded</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010</td>
<td>12143</td>
<td>4%</td>
<td>47%</td>
<td>6193</td>
</tr>
<tr>
<td>2011</td>
<td>13271</td>
<td>3%</td>
<td>46%</td>
<td>6503</td>
</tr>
<tr>
<td>2012</td>
<td>14575</td>
<td>3%</td>
<td>45%</td>
<td>6996</td>
</tr>
<tr>
<td>2013</td>
<td>16029</td>
<td>2%</td>
<td>42%</td>
<td>7053</td>
</tr>
<tr>
<td>2014</td>
<td>18193</td>
<td>2%</td>
<td>43%</td>
<td>8187</td>
</tr>
<tr>
<td>2015</td>
<td>18348</td>
<td>2%</td>
<td>45%</td>
<td>8624</td>
</tr>
<tr>
<td>2016</td>
<td>18244</td>
<td></td>
<td></td>
<td>9489</td>
</tr>
</tbody>
</table>

Source: 2010-15 waterfall charts (cases awarded or remanded is an estimate calculated from data and is based on rounded percentages from the waterfall charts); 2016 https://www.osa.gov/apps/auditor/DR National New Court Cases and Remands.html

What else should I know?

- iAppeals: beware the single submission policy!
- Application and award rates (including at National Hearing Centers)

<table>
<thead>
<tr>
<th></th>
<th>Dispositions</th>
<th>% Dismissals</th>
<th>% Denials</th>
<th>% Awards</th>
<th>% of Awards that were fully favorable</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHC</td>
<td>25,004</td>
<td>21.95</td>
<td>39.87</td>
<td>38.17</td>
<td>83.05</td>
</tr>
<tr>
<td>Non-NHC</td>
<td>625,728</td>
<td>19.78</td>
<td>36.12</td>
<td>44.10</td>
<td>85.86</td>
</tr>
<tr>
<td>Total</td>
<td>650,732</td>
<td>19.86</td>
<td>36.27</td>
<td>43.87</td>
<td>85.77</td>
</tr>
</tbody>
</table>
Chapter 7
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Fewer Approvals and Applications

FY 2009-15: 4 points decrease for initial, 2 for reconsideration, and 18 for hearings

SSDI application peak: FY11
2016 Q1-3: 3% fewer applications than in 2015.

Sources: waterfall charts

What can I do about all of this?

• Tell Congress what you think!
  • Write an email or letter
  • Make a call
  • Visit DC or district offices — Hill day in June
  • Town hall meetings (some by telephone)—sign up for your members’ listserv to get details
    • See if your clients want to be involved too!
• Comment on regulations as they are proposed
• Write letters to the editor
• Share your stories with NOSSCR—and with others in your community
• Let NOSSCR help you

Sources: 2014-15 waterfall charts, 2008-13
Is there any good news?

• 75-days’ notice of hearings under program uniformity regs
  • Unclear as to start date – 1/17/17 or 5/1/17
• Appeals Council is now sending barcodes with acknowledgement letters, so you may not need to request extensions of time.
• Ability to track status of claims and appeals through mySocialSecurity began in December 2016
• iAppeals upgrade to include requests for reconsiderations or ALJ hearings for non-medical denials and other non-disability decisions (including overpayments) began 12/10/16
• FY17: scheduled launch of iSSI application and online waiver requests
• FY18: scheduled launch of attachments to online SSDI applications

Questions?

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www.nossr.org
GEORGIA MANDATORY CLE FACT SHEET

Every “active” attorney in Georgia must attend 12 “approved” CLE hours of instruction annually, with one of the CLE hours being in the area of legal ethics and one of the CLE hours being in the area of professionalism. Furthermore, any attorney who appears as sole or lead counsel in the Superior or State Courts of Georgia in any contested civil case or in the trial of a criminal case in 1990 or in any subsequent calendar year, must complete for such year a minimum of three hours of continuing legal education activity in the area of trial practice. These trial practice hours are included in, and not in addition to, the 12 hour requirement. ICLE is an “accredited” provider of “approved” CLE instruction.

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706-369-5664

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Your ICLE Staff

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