Empire Justice Center

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DISABILITY LAW NEWS

Federal Courts Implement Changes for Handling Social Security Cases

Remember back to law school days and learning in Civil Procedure class the essential elements for commencing a civil action, including filing and serving a complaint? Now forget most of those rules if you practice Social Security law in federal court. In addition to changes in the Federal Rules of Civil Procedure, some of New York's District Courts have also implemented changes in how they process Social Security cases.

Rule 4 of the Federal Rules of Civil Procedure has changed regarding the time limit for service. The Rule now provides that a defendant must be served within **90 days** after filing the complaint, as opposed to 120 days in the original Rule.

N.D.N.Y.

The United States District Court for the Northern District of New York (N.D.N.Y.) has implemented sweeping changes to Social Security practice, embodied in new General Order 18. http://www.nynd.uscourts.gov/sites/nynd/files/general-ordes/GO18_PILOT.pdf

These new rules took effect on February 1, 2016. Cases are initially assigned to Magistrate Judges instead of District Judges. After filing, the Clerk will send a Notice of Social Security Case Assignment to each party, which notifies the plaintiff of his or her right to consent to Magistrate Judge jurisdiction. If the plaintiff timely consents within 21 days by completing a consent form, the case is assigned to that Magistrate. Under 28 U.S.C. § 636(c), if the plaintiff consents, the Magistrate's decision is final and appealable to the Court of Appeals for the Second Circuit.

If the plaintiff does not timely consent (or if the government withdraws consent), the case will be reassigned to a District Judge, and the District Judge will subsequently refer the case to that same Magistrate for a report and recommendation. Under 28 U.S.C. § 636 (b)(1), objections to the Report & Recommendation may be filed to the District Court Judge within 14 days.

The new rules also establish a Pilot Program that began on February 1, 2016, and will stay in effect indefinitely. Under the Pilot Program, service is electronic instead of by certified mail. The CM/ECF will generate a Notice of Electronic Filing upon case assignment and case opening. This notice will be sent electronically to the U.S. Attorney and to the Regional Counsel for the Social Security Administration in lieu of service by the plaintiff. The plaintiff must also file a Social Security Identification Form, available at http://www.nynd.uscourts.gov/sites/nynd/files/forms/SSA_ID_form_FILLABLE.pdf

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Federal Courts Implement Changes—Continued

(Continued from page 1)

There have also been changes regarding the timing and filing of briefs. After service of the complaint and the Social Security Identification Form, the defendant Commissioner of Social Security has 90 days to file the certified transcript of the administrative proceedings, which constitutes the defendant's answer (or the defendant can file a motion to dismiss within 90 days). After the defendant files the certified transcript, the plaintiff has 45 days to serve and file a brief. After service of the plaintiff's brief, the defendant has 45 days to serve and file a responsive brief. If the plaintiff requests a remand based on "new and material evidence," the plaintiff must file a formal motion for remand.

E.D.N.Y.

The Eastern District of New York (E.D.N.Y.) has also made several changes regarding the filing of Social Security cases, contained in Admin Order 2015-05, effective June 2015. https://img.nyed.uscourts.gov/files/general-ordes/AdmOrder2015.pdf. The defendant has 90 days after service of the complaint to file and serve the administrative record, which constitutes the defendant's answer.

If the plaintiff is represented by counsel, the plaintiff must file and serve a motion for judgment on the pleadings within 60 days of the defendant's filing the administrative record. The defendant has 60 days after service to respond. The plaintiff then has 21 days to file reply papers, if any.

However, if the plaintiff is *pro se*, the defendant must file and serve a motion for judgment on the pleadings first, and the motion must be served within 60 days of the filing of the administrative record. The plaintiff then has 60 days after service to file a response, and the defendant has 21 days after that to file a response, if any.

W.D.N.Y.

The Western District of New York (W.D.N.Y.) made several changes regarding the filing of Social Security cases in 2013, and those changes have been incorporated into Rule 5.5 of the court's Local Rules. http://www.nywd.uscourts.gov/sites/default/files/2016_civil.pdf.

Also see http://www.nywd.uscourts.gov/sites/default/files/Social%20Security%20Standing%20Order.pdf. The defendant has 90 days after service of the complaint to file the certified copy of the administrative proceedings, which constitutes the defendant's answer.

If the plaintiff is represented by counsel, the plaintiff must move first, and has to file and serve a motion within 60 days of the filing of the defendant's answer. The defendant then has 60 days after service to respond (as long as the court does not set briefing deadlines by order). The plaintiff then has 21 days to file and serve reply papers, if any.

If the plaintiff is *pro se*, all dispositive motions must be filed and served within 60 days of the defendant filing an answer. The parties have 60 days after service to respond to these motions (as long as the court does not otherwise set a briefing deadline by order). The parties then have 21 days after service to file and serve reply papers, if any. Finally, memoranda in support of or in opposition to a motion must not exceed 30 pages, and reply memoranda must not exceed 10 pages.

S.D.N.Y.

Apparently in the Southern District of New York (S.D.N.Y.), each District Court Judge or Magistrate Judge has individual rules on procedures to be followed in Social Security cases. Please be sure to acquaint yourself with those rules if you practice in this District.

Thanks to Albany Law School intern Richard White for compiling the various Social Security case rules from each District Court for this article.

Long Time DAP Advocate Moves On

Long-time DAP Advocate Alan Block

On February 5th, the Western New York DAP Task Force celebrated Alan Block. Alan began his career in legal services at North Country Legal Services. He has been with Neighborhood Legal Services (NLS) in Buffalo since DAP's inception in 1984. But, alas, February 29th was Alan's last day at NLS. Although technically not retiring, Alan will be moving on to other adventures. We will miss Alan's dedication to his clients. ALJs over the years undoubtedly came to recognize that Alan would generally not take "no" for an answer, when "no" was the wrong answer. Alan was always ready to appeal, and appeal again if need be. He won numerous victories for clients at all levels, including U.S. District Court. And while zealously representing his individual clients, Alan never lost sight of the big picture. We will miss his insights and warnings on what he saw coming down the pike. In short, we will miss Alan and wish him well.

Pictured left to right: Kate Callery, Alan Block, Jody Davis, Joanne Lewandowski, Louise Tarantino

Contact Us!

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2016 Partnership Conference Planning Underway

We are happy to announce that the New York State Bar Association will sponsor the ***2016 Partnership Conference,*** which will take place ***Wednesday September 14 through Friday September 16 at the Marriott Hotel*** in Albany.

Planning is getting underway, so please save these dates. We plan to host a Statewide DAP Task Force meeting and four substantive DAP training sessions. Please let Louise or Kate know of any training topics you would like to see, or if you are interested in serving as a trainer. CLE credits will be available.

GAO Makes CDR Recommendations

The Government Accountability Office (GAO) has released a report detailing how the Social Security Administration (SSA) could increase savings by refining its selection of cases for continuing disability reviews (CDRs). GAO 16-250 was requested by several House of Representatives committees. It can be found at http://www.gao.gov/assets/680/675168.pdf.

According to the GAO, SSA has had difficulty conducting timely CDRs in recent years, resulting in a backlog of 900,000 claims in fiscal year 2014. SSA had conducted 670,000 reviews in 2003, down to 190,000 in 2007, and back up to 429,000 in 2013. Given the potential government savings realized with CDRs, Congress asked the GAO to study SSA's ability to conduct and manage timely, high-quality reviews.

The GAO found that SSA does not necessarily select cases for review in a manner that maximizes savings. SSA's first priorities for review are those statutorily mandated, including age 18 reviews and reviews of low birth weight (LBW) children. It then uses statistical models to select other cases for review. SSA policies, such as cases identified as "medical improvement expected," are taken into consideration. But the GAO notes that SSA's statistical models have not been updated since 2007. They should be updated every seven years to account for, *inter alia*, variables such as advances in medical science and treatment.

Although some of SSA's priorities aligned with potential cost savings, such as LBW children and age 18 reviews, the GAO faulted SSA for not identifying and targeting other categories of beneficiaries whose reviews were likely to result in terminations. For example, the GAO notes that in prior studies, certain subgroups of SSI children beneficiaries such as those with language and speech disorders demonstrated higher rates of initial cessation than other SSI children beneficiaries. The GAO also suggested targeting younger individuals and beneficiaries with higher monthly benefits as ways of generating higher overall program savings.

The GAO also criticized SSA's quality review, although SSA disagreed with the GAO's suggestion that it needs to track date errors and modify its approach to sampling.

Bottom line? Expect to see more CDRs coming your way soon.

REGULATIONS

Two New Fraud SSRs Published

On March 14, 2016, the Social Security Administration (SSA) issued two Social Security Rulings (SSRs). SSR 16-1p: Fraud and Similar Fault Redeterminations, provides guidance on redeterminations of entitlement to and eligibility for benefits if there is reason to believe fraud or similar fault was involved in an application for benefits. It sets forth the procedures used for redeterminations. According to the SSR, if fraud or similar fault was involved in providing evidence, that evidence must be disregarded when redetermining entitlement or eligibility. A beneficiary may appeal a determination that the individual was not eligible at the time of original allowance. And a beneficiary who believes he or she is currently disabled may file a new application for benefits while the appeal is pending. https://www.federalregister.gov/articles/2016/03/14/2016-05661/titles-ii-and-xvi-fraud-and-similar-fault-redeterminations-under-sections-205u-and-1631e7-of-the

SSR 16-2p: Evaluation of Claims Involving Similar Fault in the Providing of Evidence, supersedes and replaces SSR 00-2p. It governs the evaluation and adjudication of claims when there is reason to believe similar fault was involved in providing evidence in support of the claim. https://www.federalregister.gov/articles/2016/03/14/2016-05660/social-security-ruling-ssr-16-2p-titles-ii-and-xvi-evaluation-of-claims-involving-similar-fault-in

Both SSRs "clarify" that SSA may find any individual *or entity* has committed fraud or similar fault, and that it may disregard evidence submitted by any individual or entity that has been found to have committed fraud or similar fault. Examples of the new term "individual or entity" include a claimant, beneficiary, auxiliary, recipient, spouse, representative, medical source, translator, interpreter, and representative payee. Both add a definition of fault, which includes intent to defraud, as compared to "similar fault": (A) an incorrect or incomplete statement that is material to the determination is knowingly made; or (B) information that is material to the determination is knowingly concealed."

SSR 16-1p states that in some circumstances, SSA may disregard evidence provided by someone who has not committed fraud or similar fault, but whose evidence relies on other evidence involving fraud or similar fault. It sets forth an example of disregarding parts of a physician's report that relies on evidence from another source that has been disregarded. It also will consider evidence relied on in a different claim to determine fraud or similar fault in another claim.

Both SSRs allow for the termination of benefits after a determination of entitlement to or redetermination of eligibility for benefits, if SSA determines that without the disregarded evidence, the evidence does not support entitlement or eligibility. Benefits paid on such evidence will be considered overpayments.

SSR 16-2p emphasizes that a "finding of similar fault does not constitute complete adjudicative action in any claim. A person may still be found entitled to, or eligible for, monthly benefits despite the fact that some evidence in the case record has been disregarded based on similar fault." But a finding of similar fault may constitute evidence to be considered in determining whether similar fault was involved with respect to other evidence provided by the same source. Under SSR 16-1p, SSA will consider evidence provided absent fraud or similar fault during the redetermination, even if not presented previously. But if the evidence does not support eligibility, benefits may be terminated and payments made may be treated as overpayments.

Finally, the new SSRs "refine" the definition of the preponderance of evidence that must be applied in determinations of similar fault: such relevant evidence that as a whole shows that the existence of a fact to be proven is more likely than not.

Both SSRs became effective on March 14, 2016.

SSR 16-3p Evaluates Symptoms, Not Credibility

On March 16, 2016, the Social Security Administration (SSA) published SSR 16-3p – Evaluation of Symptoms in Disability Claims. The new SSR supersedes SSR 96-7p – Evaluation of Symptoms in Disability Claims: Assessing the Credibility of an Individuals' Statements. https://www.federalregister.gov/articles/2016/03/16/2016-05916/social-security-ruling-16-3p-titles-ii-and-xvi-evaluation-of-symptoms-in-disability-claims.

In rescinding SSR 96-7p, SSA is proactively "eliminating" the use of the term credibility, and "clarifying" that "subjective symptom evaluation is not an examination of an individual's character." SSA instructs its adjudicators to consider all the evidence when evaluating the intensity and persistence of symptoms—once they have found a medical determinable impairment that could produce those symptoms.

The SSR generally tracks the regulatory language of 20 C.F.R. §§ 404.1529 & 416.929, including setting forth the two-step process for evaluating symptoms: whether the individual has a medically determinable impairment that could reasonably be expected to produce the alleged symptoms; and the extent to which, given the intensity and persistence of symptoms such as pain, the symptoms limit an individual's ability to perform work-related activities for an adult, or function for a child.

The SSR lists the various sources that should be considered when evaluating symptoms, including the individual's own statement, medical sources, and non-medical sources. It also spells out the factors in 20 C.F.R. §§ 404.1529(c)(3) & 416.929(c)(3), which include the seven factors previously delineated in SSR 96-7p, such as daily activities; location, duration, frequency, and intensity of pain or other symptoms; etc.

Adjudicators are to look for consistency of symptoms with objective medical evidence, including the consistency of the claimant's own statements. The SSR acknowledges that inconsistencies in a claimant's statements may not mean they are inaccurate. Because symptoms may vary, an individual's statements describing them may vary. Whether an individual seeks and/or follows medical treatment should also be taken into consideration. The SSR notes that persistent attempts to obtain relief, such as changing or increasing doses of medication, trying different treatment, seeing specialists or changing treatment sources, may support a claimant's allegations. At the same time, less frequent or intense treatment, or failure to follow treatment may be a basis for a finding of inconsistency. But adjudicators must consider the reasons why the claimant did not comply with or seek treatment. The SSR provides a list of possible reasons that could prove helpful to advocates, including the inability to afford treatment; the inability to recognize the need for treatment due to mental or language limitations; or accommodations made by the individual, such as avoiding physical activities or mental stressors, to minimize symptoms.

Per SSR 16-3p, it is not sufficient for an adjudicator to make a single, conclusory statement that "the individual's statements about his or her symptoms have been considered," or that "the statements about the individual's symptoms are (or are not) supported or consistent." Adjudicators must base their findings on evidence in the case record, and are prohibited from soliciting non-medical evidence outside of the record. They also must limit their evaluation to the individual's statements and the evidence of record. They must not assess "an individual's overall character or truthfulness in the manner typically used for an adversarial court litigation."

Time will tell whether this new SSR will be used for or against claimants. SSA undoubtedly would like this SSR to generate better reasoned, more defensible decisions. But at first blush, there may be helpful nuggets for advocates to grab and run with—at least for now…

SSR 16-3 will be effective on March 28, 2016.

Borderline Age POMS Amended

The Social Security Administration (SSA) has announced new POMS regarding the application of the Medical-Vocational Guidelines (the "grid") in cases where the claimant is within six months of a new age category. See DI 25015 TN 06, available at https://secure.ssa.gov/apps10/reference.nsf/links/02012016034439PM.

The revisions, which become effective March 26, 2016, govern those borderline situations where the grid should not be "mechanically applied" if an unfavorable decision would result. SSA claims its "new borderline age policy instructions are more concise and should lead to greater consistency throughout the agency when adjudicating claims involving borderline age situations."

The instructions on Borderline Age currently contained in POMS DI 25015.005 (Age as a Vocational Factor) have been revised and moved to a new section, DI 25016.006 (Borderline Age). The new POMS will no longer permit adjudicators to consider an earlier onset date for claims that are partially favorable allowances under the medical-vocational guidelines. Nor will adjudicators be able to establish a more advantageous established onset date (EOD) in borderline age claims; they will be limited to the latest possible EOD that still results in an allowance. In other words, borderline age can be invoked only if the claimant would otherwise be denied.

A borderline age situation exists if the claimant reached or will reach the next higher age category within a few days to a few months after the date of adjudication, date last insured (DLI), end of disabled widow(er)'s (DWB) prescribed period, end of childhood disability benefit (CDB) reentitlement period , or cessation of disability; AND using the claimant's chronological age would result in a "not disabled" determination while using the next higher age category would result in a "disabled" determination. The meaning of "a few days to a few months" has been clarified as a period usually not to exceed six months.

According to the revised POMS, SSA will no longer consider additional vocational adversities in borderline age determinations. It will, however, continue to require an evaluation of all the factors – not just age – before deciding to use a higher age category. The factors include age, education, past work experience and residual functional capacity (RFC).

Adjudicators are admonished not to "double weigh" any factors that were already taken into account. For example, illiteracy or unable to communicate in English is already considered under the Medical-Vocational Rules. A claimant with a sedentary RFC who is illiterate and is 44 years and nine months old, who would not be found disabled under Rule 201.23 cannot be found disabled under the more favorable Rule 201.17. There must be a factor other than illiteracy to justify a "non-mechanical application" of the rules. The new POMS provides other examples of educational factors that may impact cases identified as borderline age.

Similarly, if in determining RFC, the adjudicator has found a substantial erosion of the occupational base, RFC limitations will not justify a borderline age analysis. For example, if a claimant who is 49 years and seven months of age has been given a light RFC because his four-hour limitation in standing/walking significantly erodes the occupational base of light work, those same limitations cannot be used to justify application of the borderline age provisions. The POMS identify that situation as double weighing. But a 54 years, 11 month old claimant limited to light work with restricted overhead reaching may be able to take advantage of the next age category. Since the overhead reaching limitation does not significantly erode the light occupational base, it can be used as a factor to justify an allowance under the next age category.

SSA plans to publish new borderline age instructions in the Hearings, Appeals, and Litigation Law (HALLEX) manual (I-2-2-42 for the hearing level and I-3-3-25 for the Appeals Council level). HALLEX II-5-3-2, containing the old borderline age instructions, will be removed.

HALLEX Provisions Added

The Social Security Administration (SSA) has added new instructions to the Hearings, Appeals, and Litigation Law (HALLEX) manual (I-2-2-22 for the hearing level and I-3-1-30 for the Appeals Council level) governing the escalation of claims.

Section I-2-2-22 provides instructions for escalating and consolidating claims before an Administration Law Judge (ALJ). The instructions provide for circumstances under which an ALJ will not accept an escalated claim pending at a lower level, including objection by the claimant. It also instructs ALJs that it may be appropriate in some cases to notify the claimant of a proposed joining of claims prior to issuing the notice of hearing.

Under Section I-3-1-30, the Appeals Council should reject most requests to escalate and consolidate claims pending at another administrative level. The Appeals Council generally cannot accept escalated claims because of the claimant's right to have a hearing on each claim. The Appeals Council is reminded to handle subsequent claims under the provisions of HALLEX I-1-10, which incorporates the provisions of Social Security Ruling (SSR) 11-1p. SSR 11-1p precludes the filing and processing of a subsequent application in most cases when a prior application is pending at the Appeals Council.

Of note, the revisions to HALLEX I-3-1-30 "clarify" that the Appeals Council considers the entire ALJ decision on review, not just the portions with which the claimant disagrees.

Ticket to Work Rules May Face Revision

In a recent Federal Register announcement, SSA is "soliciting public input on whether and how we might revise the current Ticket to Work program rules. The Ticket to Work and Work Incentives Improvement Act of 1999 established the Ticket to Work program to allow individuals with disabilities to seek services to obtain and retain employment in order to reduce dependency on cash benefit programs. We want to explore improving our Ticket to Work program as part of our ongoing effort to help our beneficiaries find and maintain employment that leads to increased independence and enhanced productivity." 81 Fed. Reg. 7041 (Feb. 10. 2016). https://www.gpo.gov/fdsys/pkg/FR-2016-02-10/pdf/2016-02657.pdf

"The purpose of this ANPRM is to solicit ideas for improving the Ticket to Work program. We are considering whether and how we might update the Ticket to Work program rules to help both our beneficiaries and the providers that serve our beneficiaries in the program."

Any comments must be received by April 11, 2016.

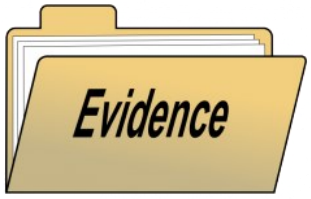
SSA To Waive SSI Same-Sex Overpayments

In previous editions of this newsletter, we have reported on the conundrum created by the Social Security Administration's (SSA's) continuing to issue Supplemental Security Income (SSI) benefits to members of same-sex couples as if they were single even after the Supreme Court struck down the Defense of Marriage Act in *United States v. Windsor*, — U.S. —, 133 S. Ct. 2675, 2695, 186 L.Ed.2d 808 (2013). In May 2015, SSA issued Emergency Message (EM) 15016, providing that future SSI can be reduced or terminated based on the income or resources of a same-sex spouse, but not prior months. But it prohibited new overpayment notices being issued to SSI recipients married to persons of the same sex, and advised adjudicators to hold the many outstanding overpayment notices issued during the interim.

On March 16, 2016, SSA issued EM 16013 – Processing SSI Overpayment Resulting from Same-Sex Marriage. It tells adjudicators to process the overpayments previously put on hold, consider them as "presumed waiver requests," and grant waivers as against equity and good conscience.

This appears to be great news for couples facing large overpayments. It is thanks in large part to the advocacy efforts of Jerry McIntyre of Justice in Aging and others.

Appeals Council Will Not Return Evidence



On February 5, 2016, the Social Security Administration (SSA) adopted a final rule that was published as a notice of proposed rulemaking (NPRM). See the October 2015 issue of the *Disability Law News*. This final rule revises SSA's rules at 20 C.F.R. §§ 404.976 & 416.1476 regarding returning evidence at the Appeals Council (AC) level. Under this final rule, the AC will no longer return additional evidence it receives when the AC determines the additional evidence does not relate to the period on or before the date of the administrative law judge (ALJ) decision.

As explanation for the change, SSA noted it now uses many electronic services that make the practice of returning evidence unnecessary. For example, the agency scans most of the medical evidence into the electronic claim(s) file or appointed representatives submit it through the Electronic Records Express system. This technology immediately uploads records into a claimant's electronic folder, making the records available for review in real time. As a result, SSA decided it was neither administratively efficient nor cost effective for it to print out documents that have been submitted electronically by a claimant or appointed representative in order to return them to the claimant.

This final rule was effective February 5, 2016. 81 Fed. Reg. 6170 (Feb. 5, 2016). https://www.gpo.gov/fdsys/pkg/FR-2016-02-05/pdf/2016-02267.pdf

Service Animals Eligible for Treats

We all know that a monthly Supplemental Security Income (SSI) grant does not go very far these days. And pets can be expensive, especially on a limited budget. But did you know the NYS Office of Temporary and Disability Assistance (OTDA) is supposed to help SSI recipients with food for guide, hearing or service dogs?

NY Social Services Law § 303-a provides for grants of assistance of up to $35 a month "to a person with a disability using a guide dog, hearing dog or service dog who has been determined to be eligible for or is receiving federal supplemental security income benefits and/or additional state payments, for the purchase of food for such dog."

Information about the program and an application is available on the OTDA website and http://onlineresources.wnylc.net/pb/showquestion.asp?fldAuto=391.

COURT DECISIONS

Second Circuit Remands for Severity Finding

In the case of *Ornelas-Sanchez v. Colvin*, 2016 WL 374042 (2d Cir. Feb. 1, 2016), the Second Circuit vacated the judgment of the district court and remanded for the Commissioner to determine if the plaintiff's intellectual disability constituted a severe impairment .

The Administrative Law Judge (ALJ) merely made a conclusory statement that the plaintiff's intellectual impairments caused more than minimal functional limitations and interfered with her ability to perform some basic work activities, but did not consider whether these impairments were severe. The Circuit noted that although the ALJ did give a more thorough analysis at step four when determining the plaintiff's residual functional capacity (RFC), this analysis must be done at step two because it is possible plaintiff may meet a listed impairment at step three if the ALJ had properly completed the severity step.

Congratulations to Buffalo attorney Timothy Hiller for a successful outcome at the Circuit.

Eighth Circuit Rules on Somatoform Disorder

These days, we often lament we do not practice within the Seventh Circuit, in order to take advantage of Judge Posner's series of decisions excoriating the Social Security Administration (SSA). Now we may have to consider relocating to the Eighth Circuit. In *Nowling v. Colvin*, --- F.3d ---, 2016 WL 690821 (8th Cir. Feb. 22, 2016), the court remanded the claim for a number of reasons, including the Administrative Law Judge's (ALJ's) failure to consider the testimony of a lay witness, improperly discounting the opinion of the treating physician, and improperly discounting the opinion of the claimant's licensed clinical social worker/therapist. While the court's review of each of these issues is elucidating, it is the court's discussion of the claimant's somatoform disorder vis a vis the ALJ's credibility determination that is most noteworthy.

The plaintiff suffered from a conversion disorder, manifesting itself as somatoform, non-epileptic "pseudo-seizures." The court cited other cases with references to medical literature in emphasizing that allegedly "exaggerated" symptoms of pseudo-seizures may not amount to malingering. The court acknowledged the plaintiff may actually believe she is experiencing symptoms at a level of severity greater than the clinical evidence can support. Recognizing the difficulty inherent in evaluating credibility in somatoform cases, the court held the ALJ should set forth his credibility determination in detail. It also emphasized the importance of lay witnesses in these types of cases. In Ms. Nowling's case, her sister had witnessed the seizures. The court found the ALJ erred in disregarding her testimony.

The plaintiff in *Nowling* had the advantage of an actual diagnosis of somatoform disorder that was supported in the medical records, something we don't see all that often. But the court's discussion of credibility may still be helpful when preparing testimony in cases in which you may suspect an underlying somatoform disorder. Although bear in mind that credibility determinations will now be characterized as evaluations of symptoms, per SSR 16-3P, outlined on page 6 of this newsletter.

Treating Physician Rules Require Remand

Congratulations to Chris Cadin of Legal Services of Central New York on a recent federal court decision. He obtained a recommendation for remand from Magistrate Judge Carter in *Ganoe v. Commissioner of Social Security*, 2015 WL 9267442 (N.D.N.Y. Nov. 23, 2015), which was fully adopted by Chief Judge Suddaby in *Ganoe v. Colvin*, 2015 WL 9274999 (N.D.N.Y. Dec. 18, 2015).

In *Ganoe*, the court held the Administrative Law Judge (ALJ) did not give proper weight to the opinion of the claimant's treating physician. The ALJ concluded the physician's opinion was not supported by the treatment evidence or by the claimant's testimony. The Court held the ALJ merely made this conclusory finding without providing further analysis or citing to any medical evidence in the record. When determining how much weight to give a treating physician's opinion, the ALJ is supposed to rely on factors laid out in 20 C.F.R. §§ 404.1527(c)(2), 416.927(c)(2), but here, the ALJ's reasons only "skimmed the surface of the factors."

The ALJ relied on the claimant's conservative treatment in weighing the physician's opinion. The court held that while the ALJ can take conservative treatment into consideration in his overall determination, the ALJ cannot rely on this treatment plan to undermine a treating physician's opinion. Moreover, the ALJ failed to explain how the conservative treatment was inconsistent with the treating physician's opinion.

The court further held it was improper for the ALJ to discredit the treating physician's opinion based on the claimant's activities of daily living. The ALJ found the claimant could exercise two to three times a week at the YMCA. However, the record indicated the claimant was active at the YMCA, but not on a regular basis, and that he was only able to bike for a few minutes before needing to rest. The court held the ALJ is required to consider all the evidence, but in this case he "selectively chose evidence which supported his conclusion."

The ALJ also selectively chose evidence regarding the opinion of the claimant's pain management specialist. The ALJ focused on the portion of the specialist's treatment notes that indicated the claimant had significant improvement, which seemed contrary to the claimant's testimony that the pain relief was only temporary. However, the specialist elsewhere noted the claimant's pain relief only lasted for three weeks, which was consistent with the claimant's testimony. The court found "the ALJ highlighted evidence in the record which supported his conclusion, while overlooking evidence that did not."

Since the ALJ did not properly consider the factors, but instead selectively chose to only consider the evidence that supported his conclusion, the court remanded for a proper evaluation of both treating physicians' medical opinions. Chris did a great job on this case and earned this decision. Thanks to Albany Law School intern Richard White for carefully reading the decision and preparing this summary.

Send Us Your Decisions!

Have you had a recent ALJ or court decision that you would like to see reported in an upcoming issue of the *Disability Law News?*

We would love to hear from you!

Contact Kate Callery, kcallery@empirejustice.org and /or Louise Tarantino, ltarantino@empirejustice.org

Court Remands for Proper Weighing of Medical Evidence

Social Security regulations set out specific requirements for considering and weighing medical evidence. These include giving more weight to treating sources, and considering all medical evidence, even that from other than acceptable medical sources. An Administrative Law Judge (ALJ) who fails to properly follow the rules does so at his or her peril, particularly if the adverse decision ends up in District Court before Judge Hurd. *Sanjurjo v. Colvin*, 1:14-CV-85, 2015 WL 7738046 (N.D.N.Y., Dec. 1, 2015), is just such a case.

In *Sanjurjo*, the claimant suffered from back impairments, respiratory impairments, and diabetes mellitus. The ALJ concluded he was not disabled since there were jobs existing in significant numbers in the national economy he could perform. The claimant argued the ALJ improperly weighed or failed to discuss certain medical opinions in the record. Specifically, the claimant argued the ALJ completely failed to consider the medical opinions of three medical sources: (1) a physician's assistant ("PA") who treated the claimant for several years and found the claimant was moderately limited in walking and very limited in sitting and lifting; (2) a doctor who treated the claimant for several months and found he was moderately limited in walking and standing; and (3) a doctor who treated the claimant at least three times and found the claimant could not bend or lift heavy objects.

The District Court agreed with the claimant that the ALJ completely failed to consider the opinions of these medical sources. The defendant contended the ALJ did not need to address each piece of evidence specifically, but the court held that completely rejecting the medical opinions of the two physicians and the PA was reversible error.

The defendant made several other arguments to no avail. The defendant argued the ALJ did not have to consider one of the doctor's opinions because it was non-specific so as to preclude a meaningful evaluation. The court concluded that if this was the case, the ALJ should have re-contacted the source for clarification. The defendant further argued the ALJ did not need to consider the PA's opinion because the PA was not an acceptable medical source. However, the court concluded the ALJ still had a duty to discuss his opinion.

The court remanded the case so that the ALJ could consider and weigh all of the relevant medical evidence, including the three medical sources whose opinions the ALJ neglected.

Congratulations to Michael J. Telfer and Shubh Nigam McTague of the Legal Aid Society of Northeastern New York on this victory. And more thanks to Albany Law School intern Richard White for his analysis of this case.

Improper Evaluation of Fibromyalgia Leads to Remand

Fibromyalgia is a difficult disease to diagnose. In our Social Security disability claims, many Administrative Law Judges (ALJs) look skeptically on complaints of this disease, particularly since there is often little objective medical evidence to support the claim. In a recent decision from the N.D.N.Y., the court found an ALJ's failure to assess fibromyalgia properly required remand. Report and Recommendation from Magistrate Judge Carter in *Wiley v. Commissioner of Social Security*, 2015 WL 9684924 (N.D.N.Y., Dec. 7, 2015), which was adopted in its entirety by Chief Judge Suddaby in *Wiley v. Commissioner of Social Security*, 2016 WL 109993 (N.D.N.Y., Jan. 8, 2015).

In *Wiley*, the claimant met with her physician several times in May of 2011 regarding joint pain in her hands, wrists, and ankles. Her physician found that, while she had a full range of motion in her spine and extremities, she also had degenerative disc disease in several discs. Later that year, her physician found that she suffered from rheumatoid arthritis, osteoarthritis, and fibromyalgia. Her physician concluded she was very limited in her ability to walk, sit, and function in a work setting at a consistent pace.

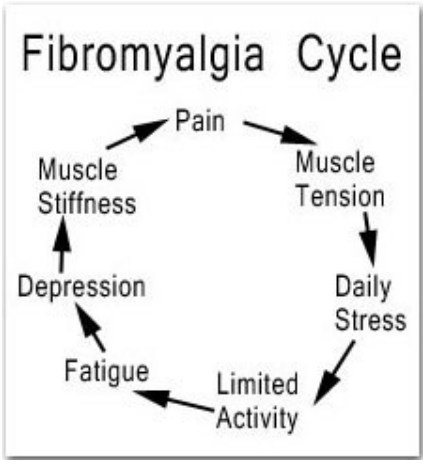
The ALJ afforded limited weight to the physician's opinion. He reasoned the physician based her opinion in part on information from the plaintiff herself, and in his view, this information was not supported by the plaintiff's physical examinations. The court held the ALJ erred in this determination because he did not cite to any physical examinations in the record as support, nor did he point to any exam results that were inconsistent with the physician's findings.

The ALJ further discredited the physician's opinion because, in his view, the limitations the claimant purported to have were unsupported by diagnostic testing. However, the ALJ failed to acknowledge the physician's belief that the claimant's limitations were based on her rheumatoid arthritis, osteoarthritis, and fibromyalgia. Moreover, another physician who treated the claimant found that while there were no objective signs of rheumatoid arthritis, her fibromyalgia may have caused the symptoms. The ALJ overlooked this evidence, and also failed to acknowledge there are no objective tests to conclusively confirm fibromyalgia. *See Green-Younger v. Barnhart*, 335 F.3d 99, 108 (2d Cir. 2003).

In sum, the ALJ did not give sufficient reasons for giving limited weight to the physician's opinion. The ALJ did not provide any medical evidence that was inconsistent with the treating physician's opinion. Moreover, the ALJ did not properly weigh the factors in 20 C.F.R. §§ 404.1527(c)(2), 416.927(c)(2).

The court also found that the ALJ did not properly evaluate the claimant's fibromyalgia under Social Security Ruling (SSR) 12-2p. The claimant argued the ALJ failed to consider how the symptoms of her fibromyalgia contributed to her ability to perform work. The court held that while the ALJ discussed the claimant's pain and symptomology, the ALJ improperly discredited those complaints based on objective medical imaging, citing SSR 12-2p. The court remanded for a proper evaluation of the claimant's symptoms in light of her fibromyalgia.

Congratulations to Adam Defayette of the Legal Aid Society of Northeastern New York. This will be a helpful decision for other advocates with fibromyalgia cases. Thanks also to Albany Law School intern Richard White for this article.



District Court Remands Kid's Case

Mike Hampden of the Partnership for Children's Rights in New York City has scored yet another victory in a children's SSI cases. He recently prevailed before Judge Matsumoto in the Eastern District of New York. *Abrams o/b/o J.T.A. v. Commissioner of Soc. Sec.*, 13-CV-5568 (KAM) (Feb. 16, 2016).

Mike's client had been *pro se* until Mike appeared in District Court. The claimant had two Administrative Law Judge (ALJ) hearings. The Appeals Council remanded the claim after the first hearing because of the ALJ's failure to advise the claimant of his right to representation and to develop the record fully, particularly in regard to missing pages of a teacher's questionnaire. On remand, the second ALJ again improperly relied on the incomplete teacher questionnaire, which did not include information about several domains. The court found that although the second ALJ made attempts to obtain the missing pages, they did not alleviate his duty to develop the educational record further. The ALJ could and should have asked the teacher to complete another evaluation or seek input on the original questionnaire even if the missing parts could not be located. The ALJ also failed to request evaluations from J.T.A.'s teachers in subsequent years, or obtain test results and psychological evaluations.

As Mike notes, the decision adds to the growing number of decisions in which district courts are holding that the ALJ's "heightened duty" to develop the record adequately in *pro se* cases is "particularly acute" in *pro se* children's cases. The decision includes a strong discussion of the duty to develop the educational records of a child and emphasizes that an ALJ decision based on inadequate development is not supported by substantial evidence.

The court also found the ALJ erred in failing to explain the weight given to opinion of an agency medical reviewer, when there was no treating physician opinion evidence in the record. The review physician had found a marked impairment in one domain, which the ALJ did not consider. The court rejected the Commissioner's claim that it was harmless error, since the outcome would have been the same if the ALJ had adopted the state agency findings. It considered the ALJ's failure to weigh the review physician's opinion in conjunction with his other errors.

Finally, the court held remand was also required because the ALJ failed to explain what level of severity he assigned J.T.A.'s alleged speech impairment. He should have specified whether it constitutes a "severe" impairment, or meets or equals a listing, especially given the extent to which the allegations were supported by documentary evidence in the record.

Congratulations to Mike for his tenacious litigation.

ADMINISTRATIVE DECISIONS

Sickle Cell Listing Argument Prevails

According to the Centers for Disease Control and Prevention, the mortality rate for young African-American children with sickle cell disease has steadily decreased since 2000, when a vaccine for invasive pneumococcal disease was introduced. http://www.cdc.gov/ncbddd/sicklecell/data.html. While the new vaccine may be saving lives, young children with the disease still need hospitalization or treatment when high fevers, respiratory illness, or pain symptoms persist. Children who have access to a comprehensive sickle cell treatment center may often receive this specialized care for complications right at the treatment center, eliminating the need for a disruptive and expensive hospital stay.

Jennifer (Jenna) Karr, a DAP attorney at the Empire Justice Center, recently encountered such a case. She represented a child in an SSI appeal who was diagnosed with sickle cell when she was a few months old. At the time of the hearing, records showed she had been hospitalized six times over a two year period. The mother of the child applied for SSI when the hospital stays, follow up appointments, and routine doctor appointments made it impossible for her to continue working full-time.

Jenna's client, hospitalized repeatedly with high fevers and respiratory illnesses, followed the same pattern each time. She received IV antibiotics for several hours, with constant blood work, followed by a period of rest. Approximately twelve hours later, she received a second dose of antibiotics and blood work; she was discharged when her counts were normal. Jenna argued her client met the Childhood Hemolytic Anemia Listing 107.05B, which requires three hospitalizations lasting forty-eight hours, at least thirty days apart, over a twelve month period. 20 C.F.R. § Pt. 404, Subpt. P, App. 1. The hours spent in an ED or sickle cell disease center immediately before hospitalization may count toward the forty-eight hour threshold.

The records showed the first two hospitalizations clearly fit within the language of the listing. During the third hospitalization, however, the child's aunt asked to be discharged after the first course of antibiotics was administered and the child's blood counts were stable. She wanted to leave the hospital so the child could sleep at home, and promised to return for the second round of antibiotics at the treatment center the following morning. The records showed the child returned within twelve hours to the hospital and completed treatment in the hematology department, a few floors above the unit where her initial dose was administered.

While the final listing language allowed counting treatment *before* hospitalization, Jenna found references in the Federal Register suggesting this antecedent requirement was not intended, and included this in a memo to the judge. Revised Medical Criteria for Evaluating Hematological Disorders, 80 Fed. Reg. 21159-02 (April 17, 2015). The ALJ granted the case, stating the "close follow up" and identical treatments in the sickle cell treatment center satisfy the listing.

Kudos to Jenna for going down the "rabbit hole" of research, and coming out with a carrot!

Extra Research Pays Off

What do you do when your client presents with an unusual medical impairment that you have never confronted before? If you are veteran DAP advocate David Ralph of the Elmira office of LawNY, you do lots of research and help the Administrative Law Judge (ALJ) understand the condition. David's client was diagnosed with polyostotic fibrous dysplasia, a condition that resulted in multiple lesions in her spine, fractures of her thoracic vertebrae at T-7 and 8, and unremitting pain. The state agency consulting physician, however, found she would be to perform sedentary work. He determined her condition was a "benign process" and "may not progress to cause spinal cord compression to T-7 and 8 levels."

David provided the ALJ with several medical articles corroborating the claimant's testimony of bone pain. According to the medical experts, pain associated with fibrous dysplasia of the bone could be unrelated to pressure on a nerve root or the spinal cord itself. The bones themselves are innervated and the nerves undergo pathological changes with the disease.

The ALJ issued a short and to the point fully favorable decision in record time after receiving David's post hearing memo. David cautions advocates to question cases where the state agency analyst, or ALJ for that matter, superimposes a requirement of nerve root impingement on a back pain case where Listing 1.04 is not in issue. His questioning certainly paid off for his client.

Evidence From Prior Claim Saves the Day

In another David Ralph victory, he again proved hard work and perseverance can pay off. David's client had been approved for benefits, thanks also to David's hard work, back in 2003. Sometime thereafter, for non-medical reasons that remain unclear, the client lost his benefits, had to reapply, and was denied. He showed up in David's office, looking for help with an upcoming hearing.

Knowing the value of the psychiatric evidence from the prior claim, David pushed ODAR to obtain the prior evidence files, to no avail. Undeterred, David convinced the District Office to search out the old paper files. He copied them himself and inundated the ALJ with hundreds of pages of medical evidence, corroborating his client could not work outside of a supported environment. He also secured updated evidence of his client's declining medical condition and supportive statements from the treating sources.

Considering all the evidence, including the older documents, the ALJ found the claimant disabled, and restored his benefits. It was clear from his decision that he took into account the longitudinal picture provided by the older evidence.

Advocates should be aware that it is not all that unusual for clients to have been on benefits previously, and have lost them for non-medical reasons, such as incarceration or work activity, for example. Evidence from the prior claims should be relevant to and considered in the current appeal, but SSA often fails to retrieve the evidence or make it available to claimants and representatives. As David's victory demonstrates, SSA needs to be pushed on this issue. See the December 2013 edition of this newsletter, available at http://www.empirejustice.org/issue-areas/disability-benefits/ssi-ssd/ssa-issues/is-ssa-obligated-to-obtain.html#.VuB5wMvSm70, for more details on SSA's obligation to obtain prior files. See also https://www.nosscr.org/workshop-materials for an updated version.

Kudos to David for his doggedness in this and other cases. And remember to check with your clients to find out if they have been on benefits before. You never know what you might find in those old files!

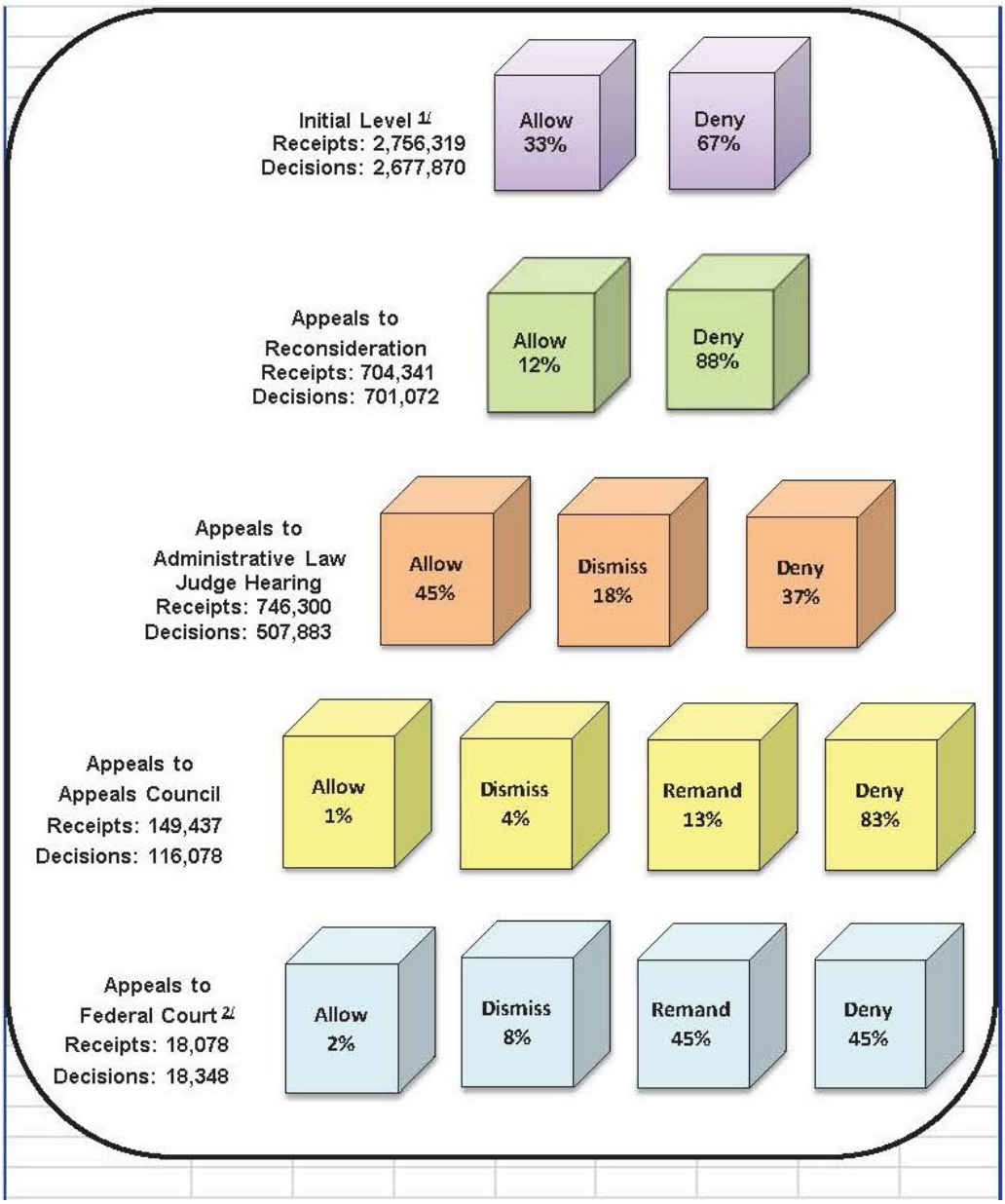
SSA Annual Waterfall Chart Available

Once again, the Social Security Administration (SSA) has confirmed our suspicions that approval rates are not going up. The annual "waterfall chart," or Fiscal Year (FY) 2015 Workload Data Disability Appeals, was included in SSA's FY 2017 Budget Justification document, available at https://www.ssa.gov/budget/

Compared to FY 2014, Administrative Law Judge (ALJ) allowances have remained steady at a paltry 45%. Dismissals remain at a high of 18%. But Appeals Council denials have inched up from 81% to 83%. Good news? District Court remands increased from 43% to 45%, while affirmances remain at 45% and allowances at 2%.

See the September 2015 edition of this newsletter for an analysis of the workload data between FY 2013 and 2014. The waterfall charts for those years are available as DAP #572. The complete 2015 waterfall chart is available as DAP #580.

Table 3.34—FY 2015 Workload Data Disability Appeals*

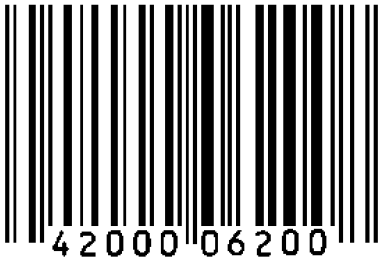


Is the Appeals Council Sending Bar Codes?

According to the Appeals Council "Best Practices Guide" for representatives, the best method to submit a Request for Review suggests requesting a twenty-five day extension in order to obtain the bar codes necessary to submit new evidence. The guidelines emphasize that bar codes obtained at the hearing level cannot be used at the Appeals Council. http://www.ssa.gov/appeals/best_practices.html#a0=3.

Rumor has it the Appeals Council has begun a new practice of manually issuing acknowledgement notices when Requests for Review (Forms HA-520) are filed. Bar codes are automatically included with the acknowledgment notice. If you do not receive a notice and bar codes within 45 days of filing an appeal, you should contact Teresa Jensen (fax 1-703-605-8691), or contact the Congressional & Public Affairs number at 1-877-670-2722.

Keep us informed as to whether you are—or are not—getting these acknowledgement notices.



Don't Be Fooled by ODAR Texts

Sue Bosworth-Quinlan of the Cortland office of the Legal Aid Society of Mid-New York has alerted us to yet another scam involving companies trolling for clients. Sue's client received a text message telling her to call right away about her application, or her hearing could be delayed. Sue contacted the Syracuse Office of Disability Adjudication and Review (ODAR), and was assured the text was not sent by ODAR. Sleuth that she is, Sue delved deeper and found a press release by the Social Security Administration (SSA) warning claimants about a text phishing scheme targeting disability claimants. http://oig.ssa.gov/newsroom/news-releases/nov3-advisory.

SSA has reiterated that it will never send unsolicited text messages to claimants. The press release warns claimants not to respond to these phishing texts or to provide any personal identification, such as social security numbers, bank account numbers, etc. The agency suggests verifying the identity of anyone who calls, texts, or emails claiming to be from SSA and requesting personal information. It also encourages reporting suspicious activity to the Social Security Fraud Hotline at http://oig.ssa.gov/report or by phone at 1-800-269-0271.

Thanks to Sue B-Q for this warning. Please pass it on to clients.

NY Court of Appeal Rules on WEP

Supplemental Security Income (SSI) claimants who received safety net assistance (SNA) while their SSI applications were pending may have their retroactive awards reduced as reimbursement to the local Department of Social Services (DSS) for the "interim assistance" paid. See 42 U.S.C. § 1383(g). But what if a claimant participated in a work experience program (WEP) during the retroactive time period? Under a recent decision by the New York Court of Appeals, the claimant may be entitled to credit for the work performed. *See In the Matter of Walter Carver v. State of New York,* 26 N.Y. 3d 272 (2015).

When Walter Carver was a recipient of public assistance, he had a WEP assignment for five years, cleaning the Staten Island Ferry Terminal. Seven years after he stopped receiving public assistance, he won the lottery - $10,000. The State of New York intercepted his lottery prize and took half to pay itself back for the public assistance paid Mr. Carver those many years before. Mr. Carver objected, arguing he had already paid his debt by working off his grant sweeping, spreading salt in the winter, and hauling trash at the Staten Island Ferry Terminal. Mr. Carver's case took years to make it to the state's highest court. But on November 19, 2015, the New York State Court of Appeals held that the provisions of the federal Fair Labor Standards Act (FLSA) applied to Mr. Carver, and that he was entitled to the minimum wage for his work. It directed the State of New York to return Mr. Carver's money. 26 N.Y. 3d at 284.

The Court of Appeals applied the "economic realities test" to determine that Mr. Carver was an employee. It relied on *Tony & Susan Alamo Foundation v. Secretary of Labor*, 471 U.S. 290, 297 (1985), a United States Supreme Court case where a religious foundation argued that it did not have to pay the people that worked for them because their employees were "volunteers." In particular, the Court concluded Mr. Carver's duties were no different than the janitorial services performed by other city employees; his benefits were compensation he received in exchange for his work; and he was entirely dependent on these benefits for years. 26 N.Y. 3d at 281.

What does *Carver* mean for people who receive public assistance while their SSI cases are pending, who participate in workfare while on assistance, and who then receive retroactive SSI awards? Will they receive credit against their interim assistance for the value of the workfare that they perform? The New York State Office of Temporary and Disability Assistance (OTDA) has not indicated whether it will apply the holding of *Carver* beyond this particular case. So long as individuals are engaged in activities that can meet the economic realities test, however, it is hard to imagine courts will not direct OTDA to follow the holding of the Court of Appeals in *Carver*. See 26 N.Y. 3d at 282 ("Had Carver spent most of his hours receiving training or education in how to obtain employment outside of the WEP program, we might have reached a different conclusion.").

Until welfare reform in 1997, it was the practice of OTDA's predecessor agency, the New York State Department of Social Services (NYSDSS) to deduct the value of workfare from interim assistance debt. The *Carver* decision may herald a return to the holdings of the pre-1997 decisions. But in the meantime, claimants who engaged in WEP during the period of interim assistance and have recently received retroactive SSI awards may need to request fair hearings with OTDA. Or they can proceed directly to U.S. District Court under the Fair Labor Standards Act. For more information, see related fair hearing decisions and federal court cases in the Benefits Law Database on the Online Resource Center at http://onlineresources.wnylc.net/welcome.asp?index=Welcome

Please feel free to contact Susan Antos at santos@empirejustice.org or Peter Dellinger at pdellinger@empirejustice.org for information or assistance.

WEB NEWS

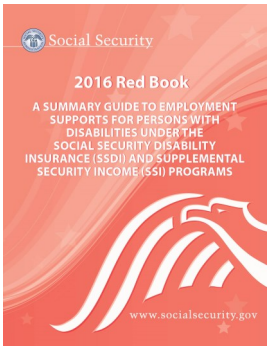
EAJA Rates Available

Thanks to the efforts of Gene Doyle, advocate extraordinaire from P.O.O.R., we are able to provide EAJA rates from March 1996 through February 2016. These rates are located on the Empire Justice Center website, and are based on Consumer Price Index (CPI) data for the relevant periods for:

- N.Y. - Northern N.J. - Long Island, NY-NJ-CT
- Northeast Urban, and
- U.S. City Average.

http://www.empirejustice.org/issue-areas/disability-benefits/non-disability-issues/benefits-level-charts/federal-eaja-hourly-rates.html

Get Your SSA Redbook



The Social Security Administration's 2016 Red Book is now available. The Red Book is SSA's free guide to employment supports for people who receive Social Security disability benefits, Supplemental Security Income, or both. It explains work incentives, how working can affect benefits, where to find local services, and more.

https://www.ssa.gov/redbook/

ABA Right to Counsel Resource

The American Bar Association's Standing Committee on Legal Aid and Indigent Defendants announced a new resource detailing the existing rights to counsel and discretionary judicial powers to appoint counsel in civil cases, in each state and the District of Columbia.

This resource provides a comprehensive guide to the myriad, and sometimes obscure, sources of authority that require or permit the appointment of counsel for poor people in civil proceedings involving such basic human needs as securing or retaining custody of children, maintaining safe and habitable housing, obtaining protection from abusive relationships, securing access to critical health care, and receiving disability payments.

The ABA Directory of Law Governing Appointment of Counsel in State Civil Proceedings can be found on the ABA website at:

www.ambar.org/civilrighttocounsel

BULLETIN BOARD

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

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

SUPREME COURT DECISIONS

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

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

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

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

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

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

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

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

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

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

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

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

SECOND CIRCUIT DECISIONS

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

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

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

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

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

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

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

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

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

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

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

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

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

END NOTE

Manage Your Energy Instead of Your Time

What happens when your work seems to expand beyond the hours in your day? All too often, many of us forego other things like sleep, exercise, or fun, to try to cram in more work hours. But according to an article in the *Harvard Business Review*, "the core problem with working longer hours is that time is a finite resource. Energy is a different story."

Tony Schwartz and Catherine McCarthy of the Energy Project took a group of employees at Watchovia Bank through a pilot energy management program and then measured their performance to prove their point. The participants outperformed a control group on a number of performance measures, and also reported substantial improvement in customer relations, engagement, and personal satisfaction.

How did these employees learn to manage energy? The Energy Group introduced the employees to a curriculum of four modules focusing on strategies for strengthening what they define as the four main dimensions of energy: the body (physical energy), emotions (quality of energy), the mind (focus of energy), and the human spirit (energy of meaning and purpose).

The participants began by focusing on physical energy, learning to develop rituals for building and renewing physical energy. The rituals might be as simple as getting enough sleep, eating breakfast, and making time for exercise. Or they could include brief but regular breaks during the day to accommodate our "ulradian rhythms," or the 90-to-120 minute cycles during which our bodies move from high-energy to a psychological trough.

Quality of energy can be improved by taking control of our emotions. One simple ritual involved "buying time" with deep, abdominal breathing. Another might be expressing appreciation to others. Finally, the participants were encouraged to change the stories they tell themselves about their own lives by viewing them different lenses.

Focusing energy may be the most obvious but most ignored. The participants designed rituals to concentrate better, such as moving away from phones and e-mails to work on a project, or checking e-mail only once or twice a day. Others planned to tackle their biggest and most important projects first thing in the day.

In terms of the human spirit, the participants learned they performed best when working on what they valued most and what gave them a sense of meaning. That might require clarifying priorities and establishing conscious rituals allocating time and energy to areas of their lives they deem most important.

So don't let a crisis mentality drain you of energy. Renew your energy - maybe you'll become more productive in less time.