Empire Justice Center

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DISABILITY LAW NEWS

Governor Cuomo Signs Law Ensuring Free Access to Medical Records

Disabled New Yorkers scored an important victory with the passage and enactment of legislation (A7842/ S6078) that will streamline the process to obtain medical records needed to support applications for government benefits free of charge. Governor Cuomo signed the bills into law on September 13, 2017.

The legislation amends New York State's Public Health Law Secs. 17 and 18 and Mental Hygiene Law Sec. 33.16. The laws now clearly state that no charge may be imposed for providing, releasing, or delivering medical records "where requested for the purpose of supporting an application, claim or appeal for any government benefit or program." Because the language is clear on its face, there was no need to include additional language restricting the application of the law to specific individuals (i.e., the patient, a representative, a parent, or other qualified person acting on the patient's behalf). Instead, as long as the purpose of requesting the medical records by any individual is to support an application, claim or appeal for any government benefit or program (including federal, state, county, or local government benefit or program), no charge may be imposed. This applies to records maintained in either electronic or paper form. We recommend that any medical records release contain language to the effect that the records are needed to support an application for government benefits.

If an attorney requests a patient's medical records on behalf of the patient for the purpose of supporting the patient's application, claim or appeal for any government benefit or program, no charge may be imposed. It is the patient that benefits from the receipt of the medical records the patient needs to support a claim for government benefits. Medical records are often requested by a patient through counsel. The expense of obtaining medical records is borne by patients; patients generally are required to reimburse their attorneys for such expenditures where, in the past, fee waivers were not granted. The attorney merely acts as an agent of the patient in requesting the records for the patient.

The same holds true if a parent, guardian, social worker or other qualified person acting on the patient's behalf requests the records on behalf of the patient to assist the patient in filing an application, claim or appeal for benefits. In fact, many patients who need government benefits require the assistance of other individuals to obtain records to support their claims because they are not capable of making the requests directly due to medical or psychiatric conditions.

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SSA Pays 2.0 Percent COLA for 2018

Monthly Social Security and Supplemental Security Income (SSI) benefits will increase 2.0 percent in 2018, a welcome change from very small cost of living adjustments (COLAs) in recent years.

The monthly SSI federal benefit rate for an individual will go up $15 to $750; the monthly rate for a couple goes up $22 to $1,125. The New York supplement will continue at $87 for individuals and $104 for couples living alone; the living with others supplements remain at $23 and $46, respectively. We will post the 2018 New York State SSI benefit chart when it is available.

With this COLA, other SSA's benchmarks also saw some increases. Substantial Gainful Activity (SGA) threshold for Non-Blind has increased to $1,180 per month. The SGA level for blind workers went to $1,970. The Trial Work Period (TWP) threshold increased to $850 per month (from $840). The quarter of coverage amount has increased to $1,320. The maximum taxable earnings for OASDI (old-age, survivors and disability insurance) purposes will go to $128,700 in 2018.

Most beneficiaries will continue to pay Medicare Part B monthly premiums of $109.00 per month in 2018. Some higher earning beneficiaries will have higher premium rates. Information about 2018 Medicare changes will be available at www.medicare.gov.

For SSA's Fact Sheet on 2018 Social Security Changes, see

https://www.ssa.gov/news/press/factsheets/colafacts2018.pdf

Free Access to Medical Records- Continued

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When disabled New Yorkers have timely access to their medical records, they can submit this evidence with their applications for government benefits such as Social Security disability or SSI. Without this critical evidence, eligible applicants are often denied benefits. With ever increasing wait times for processing appeals in Social Security cases, a denial at the initial stage means claimants go long periods of time without much needed financial assistance, often resulting in housing instability. With this change in the law, many eligible claimants can be expected to get their disability benefits more quickly.

Advocates from the Empire Justice Center, New York Legal Assistance Group (NYLAG), Queens Legal Services and the Urban Justice Center worked collaboratively to draft the new legislation, meet with Assembly sponsor Richard Gottfried and Senate sponsor David Valseky, and move the bill through the legislature.

SSR 17-4p Muddies the Waters

In recent years, the Social Security Administration (SSA) has published two sets of regulations ramping up the responsibility of claimants and their representatives to develop evidence in disability claims in a timely manner. First, SSA issued the "all evidence" rule in March 2015, requiring claimants and representatives to inform the agency about or submit "all evidence known to you that relates to your disability claim," including "all evidence received from any source in its entirety." Representatives are required to "help obtain the information or evidence" that must be submitted. SSA specifically noted this requirement includes both favorable and unfavorable evidence. These rules were summarized in the March 2015 edition of this newsletter. http://www.empirejustice.org/issue-areas/disability-benefits/rules--regulations/final-submission-of-evidence.html#.WeUnUste670.

Then, in December 2016, SSA published its "five-day" rule, mandating that any and all evidence must be submitted at least five business days before a scheduled hearing, unless the claimant can show good cause for failure to do so. In the alternative, the rule provides the claimant must inform SSA of the evidence. This rule was effective January 17, 2017, but compliance was not expected until May 2017. http://www.empirejustice.org/issue-areas/disability-benefits/rules--regulations/five-day-requirement.html#.WeUodste671.

These rules have raised a host of questions and challenges for representatives. What evidence actually relates to a claim? Must all records be submitted, even hundreds of pages documenting a hospital stay? What about duplicates? Is informing SSA of the existence of records, particularly records not especially favorable to a claim, sufficient? How are the five business days counted? Does SSA include the first and final days of the time period? Can an ALJ really exclude relevant evidence simply because it was submitted fewer than five days before a hearing, even if the claimant or representative informed the ALJ of its existence?

Rather than addressing these issues, SSA has instead issued a Social Security Ruling (SSR) that reads more like a reprimand than a clarification or elucidation. SSR 17-4p, entitled "Responsibility for Developing Written Evidence" and published on October 4, 2017, purports to clarify SSA's "responsibilities and the responsibilities of a claimant and a claimant's representative to develop evidence and other information in disability and blindness claims."

While emphasizing the obligations imposed by the new regulations, the SSR also focuses on representatives' duties under SSA's rules of conduct and standards of responsibility for representatives. See 20 C.F.R. §§ 404.1740(b)(1) & 416.1540(b)(1). Although acknowledging the agency's role in developing the record, it instead emphasizes the primary responsibility of claimants and appointed representatives to provide evidence – and to provide it in a timely and complete fashion as dictated by SSA. Per the SSR, claimants and representatives are expected "to exercise their reasonable good faith judgment about what evidence 'relates' to their disability claims." And it adds requirements and interpretations not found in the regulations themselves.

For example, in addressing the five-day rule, the SSR provides a new definition of the "inform" option:

> To satisfy the claimant's obligation under the regulations to "inform" us about written evidence, he or she must provide information specific enough to identify the evidence (source, location, and dates of treatment) and show that the evidence relates to the individual's medical condition, work activity, job history, medical treatment, or other issues relevant to whether or not the individual is disabled or blind.

If the claimant or representative does not provide specific enough information, SSA will not request the information, and may not consider the "inform" obligation met. This requirement will be particularly burdensome for pro se claimants. Plus, the SSR provides "it is only acceptable for a representative to inform us about evidence without submitting it if the representative shows that, despite good faith efforts, he or she could not obtain the evidence." This new requirement places substantial new obligations on claimants and representatives not imposed by the regulation itself.

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SSR 17-4 Muddies the Waters- Continued

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And as if the five-rule was not burdensome enough, SSR 17-4 p, relying on the representative rules of conduct, claims that five days is not really good enough. The rules of conduct require representatives to act with reasonable promptness to obtain evidence, and prohibit representatives from causing unreasonable delay in the processing of a claim without good cause. According to SSA, that requirement means representatives are expected to submit or inform SSA about written evidence as soon as they obtain it or become aware of it. Simply informing SSA of the existence of evidence without providing it, or waiting until five days to inform SSA of the evidence when it was "otherwise available" may be considered a violation of SSA's rules of conduct and could lead to sanction proceedings against the representative.

According to the SSR, any number of actions or inactions could lead to possible sanctions:

- a representative informs us about written evidence but refuses, without good cause, to make good faith efforts to obtain and timely submit the evidence;
- a representative informs us about evidence that relates to a claim instead of acting with reasonable promptness to help obtain and timely submit the evidence to us;
- the representative waits until five days before a hearing to provide or inform us of evidence when the evidence was known to the representative or available to provide to us at an earlier date;
- the clients of a particular representative have a pattern of informing us about written evidence instead of making good -faith efforts to obtain and timely submit the evidence.

The SSR goes on to limit the circumstances in which SSA will assist with developing the record. While SSA acknowledges it has a duty to make "every reasonable effort" to help claimants obtain medical evidence, the claimant or representative will first have to demonstrate that he or she was unable to obtain the evidence despite good faith efforts. Development of evidence at the Appeals Council is even more limited.

The National Organization of Social Security Claimants' Representatives (NOSSCR) has written a letter to SSA, objecting to many aspects of this SSR. https://nosscr.org/sites/default/files/ssr_17-4p_letter_to_berryhill_redacted_0.pdf Some advocates have pointed out that the SSR, while objectionable in tone and intent, does not necessarily go beyond what is already required of representatives under the rules of conduct. Others have questioned whether SSA can regulate the conduct of representative through an SSR, which does not carry the force of law like regulations do. And the ruling may conflict with the Social Security Act itself, which requires the Commissioner to develop and consider a complete medical history. See 42 U.S.C. § 423(d)(5)(B). In light of the statute, can SSA really refuse to consider relevant evidence? The SSR may thus face legal challenges depending on the extent to which SSA attempts to enforce it.

But in the meantime, how will SSR 17-4p actually affect the practices of claimants and representatives? Unfortunately, we still do not have any guidance or authority to challenge recalcitrant ALJs interpreting the definition of "five days" too narrowly. Nor do we know when we can omit submitting what appears to be extraneous or duplicative evidence. But we do know we are more than encouraged to submit evidence early and often, including submitting it as we receive it, rather than waiting to submit all the evidence together with our pre-hearing arguments. Some preliminary practice tips offered by Kevin Liebkemann from Legal Service of New Jersey:

- Inform your client in writing of the importance of informing you promptly of any new information relating to the claim.
- Meticulously document all medical sources of which your client informed you.
- Contact your client periodically while waiting for the hearing to be scheduled to see if there are any changes or new medical sources/visits/reports.

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ODAR Now OHO

There are those of us who were still getting used to the transition to ODAR (Office of Disability Adjudication and Review) from OHA (Office of Hearings and Appeals). But as of October 1, 2017, ODAR is no more. According to the Social Security Administration (SSA), ODAR has been split into two different components: The Office of Hearing Operations (OHO) and the Office of Appellate Operations (OAO). OHO will continue to be led by Deputy Commissioner Theresa Gruber in Falls Church, Virginia.

OAO, which includes the Appeals Council (AC) and its Administrative Appeals Judges, has been moved to a new Deputy Commissioner-level organization: the Office of Analytics, Review, and Oversight (OARO). Five other existing offices from different components of SSA were also incorporated into OARO. The six offices now composing OARO are: the Office of Anti-Fraud Programs; Office of Business Improvement; Office of Quality Review; Audit Liaison Staff, from the Office of Budget, Finance, Quality and Management; the Office of Appellate Operations; and the Analytics Center of Excellence, from the Office of the Commissioner.

SSA's rational for these changes?

> Integration of these organizations with complementary missions provides an opportunity to mature our anti-fraud efforts, institutionalize and foster data analysis in our programs, improve coordination to provide oversight of the disability adjudication systems, and communicate a unified message within and outside the agency. This restructuring presents an opportunity to maximize resources and better organize efforts to explore and develop the future of analyses and oversight.

Sufficient justification for all those new signs and stationary?

SSR 17-4p Muddies the Waters - continued

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- Promptly inform SSA in writing upon receipt of any new information relating to the claim (medical treatment, work activity, etc.), and save proof of delivery. Include all the details required by SSR 17-4p.
- Promptly request copies of medical records – and save copies of requests.
- Document in writing all attempts to follow up on your record requests.
- Upon receipt of the hearing notice, promptly contact the client, get updated information on medical treatment, and send out medical record requests.
- Submit all medical records received promptly to SSA.
- If there is a good reason for not being able to obtain or submit records promptly to SSA, document the reason in writing in the file, and inform SSA. Request subpoenas if necessary.
- If you are submitting evidence within five business days of the hearing, include a letter documenting the efforts you took to obtain the evidence, and any good reasons it was not submitted earlier.

Adhering to these procedures will undoubtedly be burdensome and inefficient for advocates, resulting in endless documentation and piece-meal requests for and submission of evidence while waiting for a hearing. If despite the advocates' best efforts, ALJs nonetheless exclude evidence citing SSR 17-4p, advocates should object, try to proffer the evidence, and argue due process violations on the record!

Please keep us informed of your experiences in the brave new world of SSR 17-4p.

New Social Security Ruling on Sickle Cell Disease

SSA issued Social Security Ruling (SSR) 17-3p, "Titles II and XVI: Evaluating Cases Involving Sickle Cell Disease (SCD)," effective September 15, 2017. It provides basic background information about SCD and its variants and guidance on how SSA adjudicators should consider evidence regarding this impairment in a simple Q&A format. In a footnote, SSA explains that this Ruling will be applied to new applications filed on or after September 15, as well as claims pending on or after this date.

SSR 17-3p first explains that SCD is "a type of hemolytic anemia and an inherited hematological disorder that affects the hemoglobin within a person's red blood cells (RBC)," which has different variants that can indicate the severity of complications and the resulting functional limitations caused by the disease. The Ruling lays out the most common variants of SCD, describing how each occurs and its prevalence and severity. The Ruling then clarifies that sickle cell trait, which "occurs when a person inherits one sickle hemoglobin gene from one parent and a normal gene from the other parent," is not a variant of SCD and will usually not meet the criteria for disability on its own. Since people with sickle cell trait "rarely have signs and symptoms associated with SCD and usually do not need treatment," SSR 17-3p makes clear that sickle cell trait alone is not an impairment and cannot be a basis for disability without "medical signs or laboratory findings of complications from sickle cell trait" that meet the duration requirement.

SSR 17-3p next sets forth the common complications and symptoms of SCD, explaining that symptoms vary from person to person and can change over time, and then gives details of the most prevalent complications, including pain (vaso-occlusive) crisis, anemia, pulmonary complications, strokes and silent strokes, bacterial infections, and mental disorders.

The Ruling goes on to describe how SCD is evaluated under the hematological disorders listings, by simply reiterating what each of the following listings require:

- Listings 7.05 and 107.05, Hemolytic anemias;
- Listings 7.17 and 107.17, Hematological disorders treated by bone marrow or stem cell transplantation; and
- Listing 7.18, Repeated complications of hematological disorders.

SSR 17-3p then explains how SCD is evaluated when assessing an adult's residual functional capacity, which is based on all the relevant evidence of record, including the effects of treatment. The Ruling provides two obvious examples: adults with SCD may have pain, fatigue, and shortness of breath that impact their ability to stand and walk; and persons who experience repeated acute pain crises may have difficulty maintaining concentration, completing tasks, or attending work without frequent absences.

Perhaps the most useful part of this Ruling is an explanation of how SCD is evaluated when assessing functional equivalence in child claims under each of the six domains of functioning, with specific examples of how SCD complications can impact each domain:

> ***Acquiring and using information.*** Some children with SCD may have limitations in acquiring and using information due to stroke, including silent stroke. A stroke can cause brain injury that impairs a child's ability to learn, concentrate, speak, and remember.
>
> ***Attending and completing tasks.*** Frequent pain crises can result in limitations in attending and completing tasks at school and at home. If a child does not feel well due to pain, it may be difficult for him or her to stay focused on activities long enough to complete them in an age- appropriate manner. A child with SCD who is experiencing pain may also have difficulty paying attention to details and may make mistakes on schoolwork due to an inability to concentrate.
>
> ***Interacting and relating with others.*** SCD can also cause limitations interacting and relating with others. The unpredictable nature of pain in SCD may cause anxiety and difficulty maintaining relationships. Children suffering from complications of SCD may become withdrawn, uncooperative, or unresponsive.

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SSR 16-3p Revised

Is "effective date" different than "applicable date"? Yes, according to the Office of the Federal Register. In response, the Social Security Administration (SSA) has revised Social Security Ruling (SSR) 16-3p, to reflect the change in terminology from "effective" to "applicable." SSR 16-3p had rescinded SSR 96-7p, and governs the evaluation of symptoms in disability claims. See the March 2016 edition of this newsletter for more details: http://www.empirejustice.org/issue-areas/disability-benefits/rules--regulations/ssr-16-3p-evaluates-symptoms.html#.We9z18te670.

SSA is now republishing SSR 16-3p in its entirety to clarify that adjudicators should apply SSR 16-3p when making determinations and decisions on or after March 28, 2016. U.S. District Courts should review claims using the rules that were in effect at the time the decision under review was issued. But if a court remands a claim for further proceedings after the applicable date of the ruling (March 28, 2016), SSA will apply SSR 16-3p to the entire period under review on remand.

The SSR was also "updated" to reference revised regulations issued on March 27, 2017 – the infamous changes to the treating physician regulations outlined at http://www.empirejustice.org/issue-areas/disability-benefits/rules--regulations/treating-physician-1.html#.We92pcte670.

According to SSA, the SSR is otherwise unchanged. The "revised" SSR was published in the Federal Register on October 25, 2017. https://www.federalregister.gov/documents/2017/10/25/2017-23143/social-security-ruling-16-3p-titles-ii-and-xvi-evaluation-of-symptoms-in-disability-claims.

New SSR on Sickle Cell Disease- Continued

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Moving about and manipulating objects. If SCD limits a child's ability to move and manipulate objects, we evaluate those effects in the domain of 'Moving about and manipulating objects.' For example, sickling in the hip bones, knees, and ankles due to SCD may cause joint pain and problems with walking, running, and climbing up and down stairs.

Caring for yourself. Caring for yourself involves a child's basic understanding of his or her body's normal functioning and the adequate emotional health for carrying out self-care tasks. A child with SCD may avoid taking medication or ignore complications of the disease out of frustration with the limitations of SCD.

Health and physical well-being. The ongoing effects of SCD and its treatment may affect a child's health and physical well-being. In this domain, we evaluate the effects of periodic exacerbations of pain crises due to sickle cell anemia. We consider the frequency and duration of the exacerbations as well as the extent to which they affect a child's ability to function physically.

SSR 17-3p is nothing novel: it does not make any changes in policy or otherwise, offers only easily accessible medical/diagnostic information on SCD, reiterates the hematological disorders listings criteria, and explains the well-known standard for assessing an adult's RFC. It may, however, be useful for evaluating complications of SCD under functional equivalence in child claims, as it does offer some specific guidance on that issue.

Thanks to NOSSCR for this excellent analysis of this important new Ruling.

REGULATIONS

Attorney Advisor Program Extended

SSA extended the attorney advisor program for six months, with a new sunset date of February 5, 2018. Attorney advisors are authorized to conduct certain prehearing proceedings and to issue fully favorable decisions. 82 Fed. Reg. 34400 (July 25, 2017). https://www.gpo.gov/fdsys/pkg/FR-2017-07-25/pdf/2017-15493.pdf

This program was instituted in order to decrease backlogs at ODAR on August 9, 2007, and set to expire August 10, 2009, then extended to August 10, 2011, then to August 9, 2013, and most recently to August 7, 2015. It allows fully favorable disability claim allowances at the hearing level to be made by non-ALJs in what SSA considers clear-cut cases. The rule permits "some attorney advisors to conduct certain prehearing proceedings and issue fully favorable decisions when the documentary record warrants doing so. . . .

We instituted this practice to provide more timely service to the increasing number of applicants for Social Security disability benefits and Supplemental Security Income payments based on disability."

The regulatory amendment made with this announcement is at 20 C.F.R. Sections 404.942(g) and 416.1442(g), and reads, for both programs: "Sunset provision. The provisions of this section will no longer be effective on February 5, 2018, unless we terminate them earlier or extend them beyond that date by notice of a final rule in the Federal Register."

Neurological Disorder Listings Corrected

SSA announced a minor correction to section 11.00H.4. in the preamble of the Listing on Neurological Disorders. This Listing was last amended a year ago, effective September 29, 2016. 82 Fed. Reg. 39664 (August 22, 2017). https://www.gpo.gov/fdsys/pkg/FR-2017-08-22/pdf/2017-17724.pdf

11.00.H.4. relates to defining the frequency-of-seizure criteria in Listing 11.02. The first two sentences of preamble section 11.00.H.4. initially stated, "4. Counting seizures. The period specified in 11.02A, B, or C cannot begin earlier than one month after you began prescribed treatment. The required number of seizures must occur within the period we are considering in connection with your application or continuing disability review. . . ." The correction merely changes that first sentence to add 11.02D, dyscognitive seizures occurring at least once every 2 weeks, to sections A, B and C in the list.

There is no parallel provision in the childhood disability Listing.

This change is termed a "correction" of an inadvertent error, and is effective immediately. There is no express guidance in this announcement as to how the change affects cases adjudicated under the incorrect provision; presumably, they are very few and would be controlled by SSA's customary reopening regulations.

New Compassionate Allowances Issued

On September 7, 2017, SSA announced the addition of three new Compassionate Allowance (CAL) Conditions. The conditions are:

- DI 23022.127 CACH - Vanishing White Matter Disease - Infantile and Childhood Onset Forms
- DI 23022.143 Congenital Myotonic Dystrophy
- DI 23022.207 Kleefstra Syndrome

Those conditions have now been added to the list in the POMS-

- DI 23022.080 List of Compassionate Allowance (CAL) Conditions

Available at: https://secure.ssa.gov/apps10/reference.nsf/links/09122017032539PM

Emergency Message Clarifies Third Party Can Assist with Claims Filing

SSA issued Emergency Message (EM)-17032 on October 11, 2017. The EM clarifies that a third party can help a claimant file for disability benefits by completing an iClaim for DIB or DIB/SSI.

According to EM-17032:

D. Protective filing policy for third-party iClaims

- A third party may establish a protective filing date or a claimant by initiating or submitting an iClaim.
- A third party initiates an iClaim when he or she completes the iClaim Applicant Identification screens and receives the application number.
- A third party who completes and submits an iClaim for a claimant is not a proper applicant and cannot sign the online application.

IMPORTANT: An iClaim that is completed and submitted by a third party is a protective filing. It does not become a valid application until the claimant reviews the benefit application, affirms under penalty of perjury that information provided is correct, and signs the application.

Contact Us!

Advocates can contact the DAP Support attorneys at:

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HALLEX Sections Updated

The Social Security Administration (SSA) has made some changes to and added HALLEX sections.

HALLEX I-2-5-10 & I-2-5-12 for remanding claims back to state agencies underwent minor changes. Both sections involve circumstances under which ALJs can remand claims to the prior adjudicative component before a hearing is held. HALLEX I-2-5-10 permits ALJs to send cases for "prehearing reviews" only if additional evidence is submitted or is available; there is a change in a law or regulation; or there is an error in the file or other indication that the prior determination may be revised. A prehearing review may not delay a hearing; if not completed by the time the hearing is scheduled, the state agency must return the claim to the ALJ unless all parties consent. If the state agency issues a fully favorable determination while the hearing request is still pending, the request will be dismissed. See HALLEX I-2-4-45.

HALLEX I-2-5-12, on the other hand, permits the ALJ to remand to the state agency only if there is a reasonable certainty a revised fully favorable decision will be issued on remand. Examples of possible reasons for these remands also include new and material evidence, or a change in the law. This type of remand may be at the claimant's or ALJ's request, and results in a dismissal of the hearing request. A claimant can object to a remand proposed by an ALJ within ten days of the notice to remand. Query whether these provisions will become more relevant as OHO attempts to work through its hearing backlog?

SSA has also amended HALLEX I-1-10-47 to provide instructions for addressing subsequent claims when processing a pending court case or court remand. Of significance, it provides that the Appeals Council, in considering a voluntary remand from court, will generally not stipulate to affirm a subsequent allowance. According to the HALLEX, such a stipulation would limit the Appeals Council's ability to correct other possible issues in the subsequent claim, such as unreported earnings. This could be of concern to advocates who want to protect a subsequent allowance still within the time frame for reopening by SSA.

Finally, SSA has added HALLEX I-5-3-30, entitled "Revisions to Rules Regarding the Evaluation of Medical Evidence." This section provides background on why and how SSA eliminated the "treating physician rule" with its new regulations for evaluating medical evidence. See http://www.empirejustice.org/issue-areas/disability-benefits/rules--regulations/treating-physician-1.html#.WejbActe670. In addition to outlining the new regulations, the HALLEX section provides guidance as to when the rules apply in various scenarios.

Advocates will recall that while the regulations went into effect on March 27, 2017, they will only apply to claims decided on or after that date. The old rules will continue to govern cases in the pipeline. Section F, in particular, details when and how the prior rules will be applied. It emphasizes that rescinded SSRs 96-2p, 96-5, 96-6p and 06-03p will not be applicable even in claims filed before March 27th. Rather adjudicators are to cite instead "old" regulations at 20 C.F.R. §§ 404.1527(d) & 416.927(d) and 404.1527(e) & 416.927(e), or the new SSR 17-2p on medical equivalence, and new 20 C.F.R. §§ 404.1527(f) & 416.1527(f), which incorporate some of the provisions from SSR 06-03p on evaluating evidence from non-acceptable medical sources.

NY ABLE: Open for Business

The New York State "Achieving a Better Life Experience" (NY ABLE) program began enrolling participants this past August. NY ABLE is the culmination of federal and state legislation allowing people with disabilities the opportunity to save money without losing essential benefits and services. Thomas DiNapoli, New York State Comptroller, spoke about NY ABLE, a 529A savings plan, at a recent press conference. He estimates more than 700,000 New York State residents will be eligible to participate in the program. The program has already received deposits in excess of $175,000 from New Yorkers with disabilities who want to save for their future needs.

NY ABLE is administered through the Comptroller's Office by the firm currently managing the state's 529 College Savings Plan. NY ABLE is enrolling participants on its website at www.mynyable.org. Applicants may apply by phone or submit the paper Enrollment form. The ABLE administrator handles inquiries and applications by email at clientservices@mynyable.org or by phone at (855)5NY-ABLE, or Monday – Friday, from 8 a.m. to 8 p.m.

To be eligible for NY ABLE, individuals must prove they are qualified beneficiaries and New York State residents, and they must deposit a minimum of $25.00. A qualified beneficiary is one who is currently eligible for SSI or SSD because of a disability that occurred prior to age 26. If not currently eligible for those programs, individuals may still qualify by certifying (or having a parent or guardian certify) they meet Social Security's standard of disability for children under 18. NY ABLE does not require proof of eligibility to open an account. Rather, participants are advised to maintain relevant documents such as doctors' letters or reports with diagnoses in case proof of eligibility is required at a later date. Once enrolled, a beneficiary may save $14,000 per year up to a maximum of balance of $100,000 while maintaining eligibility for benefits like Supplemental Security Income (SSI).

Prior to the ABLE Act legislation, people with disabilities could manage excess resources and maintain eligibility for benefits and services through qualified trusts. Without a trust to hold these excess resources, an individual could quickly meet or exceed a program's resource limit. SSI recipients, for example, are limited to $2000 in resources. Family members who wanted to help with expenses were unable to do so without risking an adverse effect on their loved one's benefits. NY ABLE offers an alternative to the formal structure of a trust. A NY ABLE account is opened in the beneficiary's name, and the beneficiary can access funds directly through a checking account or with a debit card. The money in the account can come from the individual or from family or friends.

Qualified beneficiaries may use their NY ABLE savings for qualified disability expenses (QDEs). The proposed IRS regulations and comments advise the definition for QDEs should be "broadly construed." *See* 26 C.F.R. 1.529A-2 (h)(1) and comments, at 80 Fed. Reg. 35602-35620 (June 22, 2015). For example, unlike the beneficiary of a trust, a qualified beneficiary of an ABLE account *may* use the money in an ABLE account for housing and avoid an SSI reduction for in-kind support and maintenance. A complete list of QDEs is found on the NY ABLE website. If a qualified beneficiary deposits personal income into an NY ABLE account, it will be counted by Social Security under the rules for income; it will not count toward the resource limits. Contributions to 529A accounts are not tax deductible and may be subject to tax and penalties if the funds are not used for QDEs.

Under these basic provisions, NY ABLE can be used by individuals with disabilities, their families, attorneys, advocates, and service providers to provide for current and future needs. Thanks to Jennifer Karr of the Empire Justice Center for this introduction to the rules of the program. Below is a list of resources that provide an in-depth look at the regulations of the program and how participation may affect an individual's eligibility for other types of benefits and services.

1) *"Achieving a Better Life Experience (ABLE) Accounts,"* by James R. Sheldon, Jr., Esq., http://www.nls.org/files/Disability%20Law%20Hotlines/National%20AT%20Advocacy/ABLE%20ACCOUNTS%20September%202017.pdf. 2) Social Security Administration, particularly POMS SI 01130.740. https://secure.ssa.gov/apps10/poms.nsf/lnx/0501130740. 3) The ABLE National Resource Center is a resource for information on the programs throughout the country. www.ablenrc.org

COURT DECISIONS

2d Circuit Remands for Consideration of SGA

When is past work relevant at Step four of SSA's Sequential Evaluation for determining disability? When it was performed within the past fifteen years, lasted long enough for the claimant to learn how to perform it, and was substantial gainful activity. 20 C.F.R. § 404.1560(b)(1). See also POMS DI 25005.000, providing guidance on the evaluation of past work. Work performed for less than substantial gainful activity (SGA) during the time in question cannot be considered relevant at Step four. SGA levels are adjusted yearly. See POMS DI 10501.015.

What if an Administrative Law Judge (ALJ) determines a claimant can return to his past relevant work without properly determining whether the work was SGA based on earnings? According to a recent decision from the Court of Appeals for the Second Circuit, the claim must be remanded for the ALJ to make explicit findings as to whether past work constituted SGA.

In *Klemens v. Berryhill*, 2017 WL 4387186, --- Fed. App'x --- (2d Cir. Oct. 3, 2017), the court faulted the ALJ for his perfunctory finding that the claimant performed past work as a cleaner with sufficient earnings "to raise the presumption of substantial gainful activity." The court noted the record was "rife" with inconsistent information regarding the claimant's earnings. The ALJ failed to question the claimant about these earnings at the hearing, and failed to provide citations to the record to support his finding of SGA. "In short, based on our review of the certified administrative record, the ALJ simply failed to acknowledge relevant evidence or explain his implicit rejection of the conflicting evidence." 2017 WL 4387186, at *2.

In remanding the claim, the court emphasized the importance of carefully appraising the claimant's past work. "Indeed, '[t]he decision as to whether the claimant retains the functional capacity to perform past work which has current relevance has far-reaching implications and *must be developed and explained fully in the disability decision*.'" 2017 WL at 4387186, at *3, n. 1 (quoting *Abbott v.* Colvin, 596 F. App'x 21, 23 (2d Cir. 2015); SSR 82–62, 1982 WL 31386, at *3) (emphasis in *Abbott*).

Congratulations to private attorney Timothy Hiller of Buffalo on this victory.

ALJ Required to Develop Record

The Second Circuit reaffirmed the ALJ's duty to develop the record, even if the claimant is represented, in *Guillen v. Berryhill*, 2017 WL 4279335, --- Fed. App'x --- (2d Cir. Sept. 27, 2017). In particular, the court found the ALJ failed to obtain a medical source statement from the plaintiff's treating physician, or encourage the plaintiff to do so herself. The Commissioner argued that a statement had twice been requested, although the court noted it was unclear from the record whether such a request was actually made. The Commissioner also asserted the record contained sufficient evidence for the ALJ to assess residual functional capacity (RFC).

But the court found to the contrary, holding the medical evidence of record did not shed light on the plaintiff's RFC, nor had a consulting doctor personally evaluated her. The record did not offer any insight into how the plaintiff's impairments affected her functional abilities. The court also disputed the ALJ's rejection of the plaintiff's lupus diagnosis, finding the ALJ's statement that the record did not contain a formal diagnosis at odds with the records of the treating physician.

The Court of Appeals remanded the claim to a different ALJ, with orders to request a medical source statement from the plaintiff's treating physician, including a functional assessment and clarification of the lupus diagnosis.

The plaintiff was ably represented on appeal by Carolyn Kubitschek of New York City, a DAP attorney in her past life.

ALJ Failed to Determine Transferability of Skills

According to the Court of Appeals for the Second Circuit, the crucial factors in any disability determination must be set forth with sufficient specificity to enable to court to determine whether the determination is based on substantial evidence. The ALJ failed to do so in regard to transferability of skills in *Clark v. Berryhill*, 2017 WL 3951758, --- Fed. App'x --- (2d Cir. Sept. 8, 2017).

The plaintiff argued the ALJ erred in concluding he was not disabled at age 50 under the Medical-Vocational Guidelines (the "grids") based on the ALJ's determination the plaintiff had acquired transferable vocational skills. Citing Social Security Ruling (SSR) 82-41, the court agreed the ALJ had not set forth specific enough findings on transferability. Ostensibly relying on the testimony of a vocational witness at the hearing, the ALJ found the plaintiff had acquired vocational skills from his past semi-skilled work that were transferrable to other jobs identified by the witness. But the ALJ failed to identify the skills the plaintiff allegedly acquired or how the skills transferred to the jobs identified. Without the required findings, the court could not determine if the decision was supported by substantial evidence. It remanded the claim for the Commissioner to make specific findings.

Peter Gorton of Endicott represented the plaintiff.

N.D.N.Y. Remands Two Claims

Mike Telfer, Senior Attorney at the Legal Aid Society of Northern New York in Albany, convinced U.S. District Court Glenn Suddaby to order remand in not just one but two appeals in the past two months.

In *Bishop o/b/o K.M.B. v. Comm'r of Soc. Sec.*, 2017 WL 4512163 (N.D.N.Y. Oct. 10, 2017), Judge Suddaby remanded for further proceedings after determining ALJ Robert Wright's findings regarding functional equivalence were not supported by substantial evidence. The ALJ did not provide an adequate explanation to allow the court to determine whether his findings regarding the domains of interacting and relating with others and caring for oneself were supported by substantial evidence.

The ALJ found the claimant had a marked limitation in the domain of interacting and relating with others. But the plaintiff argued evidence of record demonstrated an extreme limitation. Relying on a teacher questionnaire indicating very serious problems in 10 of 13 listed areas, the court noted the teacher's opinion "more appropriately would be interpreted as supporting a finding of extreme limitation overall in this domain." Judge Suddaby was unwilling to decide whether the overall evidence supports the ALJ's finding of a marked limitation "due to the ALJ's lack of explanation related to his interpretation of the opinion from K.M.B.'s teacher."

The ALJ had determined K.M.B. had less than a marked limitation in caring for self, which the plaintiff disputed given the evidence of record. Judge Suddaby found the ALJ failed to explain how his finding was supported by substantial evidence. Based on a teacher opinion rating six of ten listed areas as very serious problems and one as serious, the court noted "the regulations seem to indicate that these very serious problems would be equivalent to extreme limitations while serious problems would be equivalent to marked limitations." According to the court, the teacher questionnaire appeared to suggest a marked limitation.

Judge Suddaby faulted the ALJ for failing to explain how he arrived at his decision to the contrary, or on what contrary evidence he relied. Other than one case manager opinion, the evidence the ALJ cited substantiated fairly significant limitations and did not lead to a conclusion of a less than marked limitation. Nor did the discussion of evidence in the rest of the decision provide an explanation as to the finding of less than marked.

The ALJ also erred in blaming K.M.B.'s mother for failing to ensure her 14-year-old daughter adhered to her medication regime. The analysis should have been whether K.M.B.'s refusal to follow treatment was indicative of self-care skills below the expected standard for her age. Per Judge Suddaby, "the ALJ's focus on Plaintiff's sometimes willful non-compliance with psychiatric medications and treatment as a factor detracting from the alleged severity of her mental impairment ignores the fact that a refusal to take her medication despite knowing it helped her symptoms could reasonably support a fairly significant deficit in K.M.B.'s self-care abilities."

As with the other domain, the court held remand was necessary because the ALJ failed to reconcile the very serious limitations imposed by K.M.B.'s teacher with his finding of a less than marked limitation in this domain. This "harmful error" prevented adequate review.

In *Waldvogel v. Comm'r of Soc. Sec.*, 2017 WL 3995590 (N.D.N.Y. Sept. 11, 2017), Judge Suddaby remanded ALJ John Farrell's decision for further proceedings based on the ALJ's failure to consider whether the Medical-Vocational Guidelines should have been applied in a non-mechanical fashion due to Plaintiff's borderline age situation. The plaintiff was approximately two months from her fiftieth birthday at the date of the ALJ's February 2016 decision. The court found the ALJ's error was not harmless, "as there is a significant likelihood that non-mechanical application would have resulted in a finding of disability as of the date of the ALJ' decision."

Although Judge Suddaby had not previously faced this issue, he relied on recent cases from the W.D.N.Y. for his decision. [NOTE: Advocates will recall that the Social Security Administration (SSA)

(Continued on page 15)

N.D.N.Y. Remands Two Claims - Continued

(Continued from page 14)
recently amended its POMS pertaining to borderline age cases, allowing non-mechanical application of the grid rules only if the claimant would otherwise be denied. See http://www.empirejustice.org/issue-areas/disability-benefits/rules--regulations/borderline-age-poms-amended.html#.WfIPIMte670.]

Judge Suddaby also clarified the role of the court in reviewing the Appeals Council's decision in this case. Although it denied review, the Appeals Council issued a notice indicating it had considered the borderline age issue. In considering whether review was warranted, the Appeals Council determined "the factors in the record do not support application of the higher age category." The court held the Appeals Council's consideration of this issue without granting review was not sufficient to remedy the ALJ's failure to assess the issue.

Because the Appeals Council denied the request for review, Judge Suddaby held that the ALJ's decision was the final Agency decision, citing *Lesterhuis v. Colvin*, 805 F.3d 83, 87 (2d Cir. 2015) ("Because the Appeals Council denied review in this case, our review focuses on the ALJ's decision."). The district court distinguished cases in which the Appeals Council considers new and material evidence that had not been reviewed by the ALJ, but nonetheless denies review. Citing *Perez v. Chater*, 77 F.3d 41, 45 (2d Cir. 1996), Judge Suddaby noted that in those situations, the final decision Agency decision would necessarily include the Appeals Council's conclusion that the ALJ's decision remained correct despite the new evidence. But in this instance, where the ALJ had the opportunity to consider the specific issue of borderline age, the court found it would be inconsistent with the administrative appeals structure and definition of "final Agency decision" to consider the Appeals Council decision the final decision subject to review. Judge Suddaby thus concluded the ALJ's legal error necessitated remand.

Congratulations to Mike for these victories.

OIG Studies ALJ Productivity and Allowance Rates

Two recent reports by the Social Security Administration's (SSA) Office of the Inspector General (OIG) studied trends in ALJ productivity and allowance rates. Thanks to Keith Jensen of the Empire Justice Center for summarizing them.

OIG A-12-18-50289, published in September 2017, examined factors that have led to a decrease in administrative law judge (ALJ) productivity. In FY 2011, ODAR had 705,367 pending cases and an average processing time of 426 days. By the end of FY 2016, the number of cases pending had increased to over 1.1 million, and the average processing time has worsened to 543 days. During this time, ALJ productivity decreased by about 21 percent. ODAR measures ALJ productivity by dispositions per day per available ALJ. In FY 2011, ALJs produced an average of 2.42 dispositions per day; in FY 2016, this number decreased to 1.9 dispositions per day.

Two main factors related to decreasing ALJ productivity include decreased staffing ratios and a renewed focus on quality. By the end of April 2017, decision writer-to-ALJ ratios had decreased 22 percent from FY 2011 levels, and hearing office staff-to-ALJ ratios had decreased by 22 percent. During the same period, ALJ productivity has decreased 22 percent as well. Other factors related to decreased ALJ productivity were (a) a change in regulations that increase the medical evidence claimants must submit for their hearings and (b) an increase in the number of denied cases at the hearing level since denial decisions typically take longer to process.

(Continued on page 16)

ALJ Productivity and Allowance Rates- Continued

(Continued from page 15)

According to the OIG, SSA had used its scarce resources in recent years to continue hiring ALJs to address a growing hearings backlog. But while the number of new ALJs hired has increased, ALJ productivity has decreased. SSA developed the Compassionate and Responsive Service (CARES) plan in 2016 to address the hearings backlog, but the plan depends on funding to hire a sufficient number of support staff. The OIG recommended that SSA needs to continue balancing productivity with quality.

OIG A-12-17-50247, also published in September 2017, found that ALJs with the most experience, had, on average, higher allowance rates than ALJs with fewer years of experience

Allowance rates reflect the number of favorable Administrative Law Judge (ALJ) decisions as a percentage of the number of requests for a hearing in a given year. The ALJ decisional allowance rate had fluctuated from a high of 75.2 percent in FY 1994 to a low of 53.5 percent in FY 2015. The 53.5 percent decisional average allowance rate in FY 2015 was the lowest rate in 23 years.

In FY 2013, ODAR began calculating a quality measure on appealed ALJ denial and dismissal decisions-known as the "agree rate." The agree rate represents the extent to which the Appeals Council (AC) concludes the ALJ's decisions were supported by substantial evidence and contained no error of law or abuse of discretion justifying a remand or reversal. SSA's national goal for agree rate is 85 percent. ALJs with the most experience had, on average, lower agree rates than ALJs with fewer years of experience.

The Office of Inspector General (OIG) was not able to determine why these trends were occurring. And the Agency had no information on any pattern regarding a relationship between an ALJ's years of service and his/her quality.

Individual allowance rates ranged from 19.9 percent to 90.0 percent, and the average national decisional allowance rate was about 53.5 percent. ALJs in the most experienced group had an average allowance rate of 57.74 percent, or 4.2 percent about the average. ALJs in the least experienced group had an average allowance rate of 48.8 percent, or 4.5 percent below the average. The allowance rate of ALJs in the most experienced group was nine percent above the ALJs who had fewer than five years of experience.

ALJ agree rates ranged from 59.3 percent to 100 percent. The OIG's review showed that ALJs who had more than 14 years of service had, on average, lower agree rates than all the other groups. The most experienced ALJs had average agree rates of about 84 percent, which was six percent below the average of ALJs with fewer than five years' experience.

The OIG also reviewed ALJ training information to determine whether it could be a factor in the high allowance and low agree rate pattern as ALJs gain more experience. It could not, however, determine why these trends were occurring, nor did it find a link between the amount or type of training an ALJ received and the high allowance rate and low agree rate pattern.

When the OIG examined SSA's judicial training attendance records, it initially identified 16 ALJs who had not attended any judicial training over the last seven years. The OIG presented this information to SSA, which argued that some of these ALJs watch a taped version of judicial training. After accounting for these ALJs, the OIG found that seven of the more experienced ALJs had not received judicial training over the last seven years; and four of these seven ALJs had agree rates that were below the 85-percent national goal. SSA informed OIG that one of the seven ALJs was scheduled for this year's virtual judicial training.

ADMINISTRATIVE DECISIONS

ALJ Grants Claim Under New 12.05 Listing

Advocates should be aware by now that new mental impairment listings have been in effect since January. See http://www.empirejustice.org/issue-areas/disability-benefits/rules--regulations/new-mental-impairment-listing.html#.WeeeWcte671. Among other changes, the new listings revised the criteria for evaluating intellectual disorders.

Jenna Karr of the Rochester office of the Empire Justice Center used new Listing 12.05 to her advantage, securing a fully favorable decision from an ALJ in an Age - 18 review. Her client had been approved in 2014 based in large part on IQ testing performed by a consultative examiner when the client was only 15-years-old. The ALJ relied on those scores in the redetermination even though scores obtained at younger ages (i.e., before age 16) are generally considered less reliable. See POMS DI 24515.055. The ALJ cited the POMS, but determined the older scores were representative of the claimant's current functioning. He also noted the claimant had been sent to a consultative examiner before the hearing for a new evaluation, but the CE did not perform an intellectual evaluation despite the claimant's intellectual disability.

Jenna was thus able to argue Listing 12.05 because the claimant had a full scale score of 71-75 accompanied by verbal IQ score of 63. She also persuaded the ALJ that her client met the "B" criteria of the listing. Jenna relied on the client's special education records and testimony from the client's mother to demonstrate marked limitations in two areas of the "B" criteria: understanding, remembering, or applying information; and adapting and managing oneself. Among other limitations, the client was barely able to read and could not write a letter, nor could she prepare simple meals or shop by herself. She got lost using public transportation. These two marked limitations demonstrated significant deficits in adaptive functioning, as required by the second paragraph of the new listing.

Congratulations to Jenna for mastering this new listing and preserving her client's SSI benefits.

No, It's Not Your Imagination

If you are thinking it is getting harder to win claims, you are right. According to Social Security's 2016 Annual Statistical Report, the approval rate for claims at all levels is in a downward trend. https://www.ssa.gov/policy/docs/statcomps/di_asr/2016/index.html.

As an example, initial approval rates were 38.7% in 2008, down to 35% in 2015. At the hearing level or above, 68.3% of claims were approved in 2008. In 2015, only 48.8% were approved. Inquiring minds want to know what has changed so significantly in the intervening years???

Appeals Council Remands for IQ Test

Marty Roberts of the Geneva office of LawNY does not give up easily. Her client had been represented by Jody Davis, now retired from LawNY, who had argued equivalency to Listing 12.05C based on intellectual disabilities. Following an unfavorable decision, Jody persuaded Marty to appeal the case to United States District Court, where Marty was offered a voluntary remand. At the remanded hearing, Marty was again unable to persuade the ALJ her client met or equaled Listing 12.05. Nevertheless, she persisted.

Marty went back to the Appeals Council, and the Appeals Council listened. Not only did Marty get another remand; the remand order was based on Marty's astute arguments, something that does not happen often at the Appeals Council. Marty argued the ALJ failed to develop the record when he allegedly relied on a medical expert who testified at the hearing. The ALJ had overlooked two important points. Although the medical expert testified he did not believe the claimant's limitations met or equaled Listing 12.05C, the expert admitted it was very hard to assess the claim without a "really good psychological assessment in the record." The Appeals Council agreed with Marty that the ALJ should have obtained a new psychological assessment before deciding the claim.

The Appeals Council also agreed the ALJ erred in claiming the medical expert's opinion was based on his review of the entire medical record including the claimant's hearing testimony. As Marty pointed out, the medical expert testified before the claimant testified! The Appeals Council ordered the next ALJ to obtain a psychological consultative examination including an IQ assessment and, if warranted , additional expert testimony.

On remand, Marty will face a different ALJ, and the claim will be assessed under the revised Listing 12.05. See http://www.empirejustice.org/issue-areas/disability-benefits/rules--regulations/mental-impairment-listings.html#.WeeXGMte670. But we are confident Marty will persist—and finally prevail.

Appeals Council Reverses Based on New Evidence

Attorney Sarah Frederick of Buffalo and former DAP attorney Cate Lynch have joined the one percent. They actually persuaded the Appeals Council to reverse an ALJ decision, which happens in only one percent of claims reviewed by the Appeals Council. See SSA's 2016 "Waterfall Chart," available at http://www.empirejustice.org/issue-areas/disability-benefits/non-disability-issues/misc/ssa-fy-2016-waterfall-chart.html#.WejFg8te670.

The fully favorable decision was based largely on new and material evidence from a medical consultant to the Appeals Council, who agreed with Sarah and Cate's contentions that the claimant's visual impairments would interfere with her balance and cause other work related limitations. Sarah and Cate had also submitted new evidence from the claimant's treating ophthalmologist. The vision impairments, combined with other functional limitations, rendered the claimant unable to perform her past relevant work, and thus disabled under the Medical-Vocational Guidelines (the "Grids").

Kudos to Sarah and Cate for this impressive victory.

Communication Rescues Claim

Sometimes the long wait for a hearing can be put to good use. Jessica Woodhouse of the Bath office of LawNY used the eight months between meeting her client and his hearing to coach him on how to better communicate with his medical sources, resulting in a fully favorable decision.

When Jessica first reviewed the claim, she was prepared to reject it. The claimant's seizures did not occur frequently enough to meet the epilepsy listing, and there were repeated references in the records of his failure to take his anti-seizure medication. Nor had he pursued recommended shoulder surgery. But when Jessica met the 40-year-old claimant, she learned that many of the problems stemmed from his lack of communication with his medical providers. He had been afraid to undergo shoulder surgery because his neurologist and orthopedic surgeon had not communicated with each other about how to control his seizures post-surgery. He had stopped going to appointments, frustrated by his failed attempts to get his providers to listen to him. He also ascribed his forgotten medications to severe short-term memory problems: seizures were "rotting his brain."

Jessica encouraged her client to attend his appointments, and suggested ways in which he could articulate his concerns to his doctors so they would be reflected in the medical records. Although the orthopedic surgeon was not responsive, the neurologist became much more helpful. He started the client on new medication, which unfortunately also proved ineffective, but was well-documented. He also referred the client for an independent cognitive evaluation that revealed significant short-term memory and executive functioning deficits. Ultimately, the neurologist wrote a letter to the ALJ supporting the claim based on the claimant's breakthrough seizures.

With the updated medical evidence and testimony, including testimony by the claimant's girlfriend who had witnessed his seizures, the ALJ crafted a very limited residual functional capacity. Even though the ALJ limited the claimant to light work, he found many other exertional and non-exertional restrictions based on the claimant's shoulder problems, intermittent seizures, and cognitive deficits. The addition to the RFC of "unexpected, unanticipated and unpredictable periods of off task time 3-12 times a year which would require basic first aid level attention and a period of convalescence totaling up to 75 minutes and that would interfere with the ability of co-workers in close proximity to perform their jobs" led to a response of "no jobs" from the vocational witness.

Jessica clearly went the extra mile and beyond, resulting in a favorable decision and ultimately better medical care for her client.

District Office Homelessness Coordinators Listed

Did you know that each Social Security District Office has a specially designated homelessness coordinator? So now you know, and can find out who it is for each office, along with contact information.

The list is available as DAP # 589.

WEB NEWS

SSA Disability Insurance Chart Book Available

Social Security Disability Insurance (SSDI), an integral part of Social Security, provides modest but vital benefits to workers who can no longer support themselves due to a serious and long-lasting medical impairment. Nearly nine million people received disabled-worker benefits from Social Security. Payments also go to some of their family members: 135,000 spouses and 1.7 million children.

The following charts provide important background information about SSDI:

Why Is Social Security Disability Insurance Important?

Why Have the SSDI Rolls Grown?

Who Receives SSDI?

What Financing Issues Does SSDI Face?

https://www.cbpp.org/research/social-security/chart-book-social-security-disability-insurance

Updated Family Court Resource Translated into Seven Languages

The Empire Justice Center's "Seeking Protection from Domestic Violence in New York's Family Court" provides answers to frequently asked questions about how to obtain an order of protection and to fully access Family Court. The resource was recently updated and now translated into seven languages.

The updated brochure is now available in French, in addition to Arabic, Haitian Creole, Polish, Russian, Simplified Chinese, Spanish, and English. This 2017 version includes important recent updates in the laws and court policies impacting people with limited English or who are in immigrant communities.

http://www.empirejustice.org/publications/brochures/seeking-protection-from.html

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

Don't Just Sit There!

According to a recent *New York Times* article, sitting for long stretches might shorten your life. A study conducted by scientists from Columbia University and many other institutions relied on extensive data on tens of thousands of Caucasian and African-American men and women over 45 who were part of a stroke risk study. The participants had been screened with a variety of tests. The scientists honed in on the records of the 8,000 participants who wore accelerometers for a week to track their daily movements. They also analyzed how many hours per day each person sat, and how long each bout of sitting lasted, as well as how much time each was spent exercising. They then compared the records against mortality registers, discarding the data of any people who died within a year of testing, since they might have had an underlying illness.

The resulting data revealed strong statistical correlations between sitting and mortality. Those who sat for the most hours per day had the highest risk of early death, especially if they sat for more than 30 minutes without interruption. Risk was not affected by age, gender, race, or body mass. And most significantly, the risk was barely lowered if the people exercised regularly. But the scientists did find the risk of early death was lower if the total sitting time was in shorter intervals. Those who sat fewer than thirty minutes without interruption were less likely to have died.

The article cautions that this study was associational, meaning that it did not prove too much sitting undermines health, only that they are linked. And other variables could have affected the results. For examples, deaths could have been from causes unrelated to time spent sitting, such as automobile accidents or illnesses. The full study was published in the *Annals of Internal Medicine.* The researchers are planning further study, including exploring whether just standing rather than walking around could lessen the risks associated with sitting.

But in the meantime, if you are stuck in your chair before your computer most of the day, stand up and move around every 30 minutes. It could save your life!