Empire Justice Center

April 2017
Issue 2 2017

DISABILITY LAW NEWS

New SSRs Issued, Others Rescinded

In the past several months, the Social Security Administration (SSA) has promulgated a flurry of new regulations, ranging from new mental impairment, neurological, and HIV listings, to new rules for evaluating opinion evidence. (See the last two editions of this newsletter, available at www.empirejustice.org). SSA has now turned its attention to Social Security Rulings (SSRs).

SSR 17-1p - Reopening Based on Error on the Face of the Evidence — Effect of a Decision By the Supreme Court of the United States Finding a Law That We Applied to Be Unconstitutional

SSA issued SSR 17-1p in response to the U.S. Supreme Court's decision in *Obergefell v. Hodges*, 135 S. Ct. 2584 (2015), finding Section 3 of the Defense of Marriage Act (DOMA) unconstitutional. Prior to *Obergefell*, a claimant who was a member of a same-sex marriage could be denied Title II benefits to which he was otherwise entitled on the basis that he and his wage-earner spouse were not legally married. Under the new SSR, a claimant who was denied benefits as a member of a same-sex marriage, can now ask SSA to reopen its decision denying benefits.

SSA has "clarified" that the reopening provisions of 20 C.F.R. §§ 404.989(b) & 416.1489(b), which preclude reopening based on "change of legal interpretation or administrative ruling upon which the determination or decision was made," is not applicable if SSA issued an unfavorable decision based on a federal or state law the Supreme Court later found unconstitutional. In those situations, Title II claimants can rely on 20 C.F.R. §§ 404.988(c)(8), which allows for reopening "at any time" to correct an error that appears on the face of the evidence. Title XVI claimants will have rely on 20 C.F.R. §§ 416.1488(b) & 416.1489(a)(3), which only allows for reopening within two years of the initial decision for "error on the face" under these circumstances. Favorable or partially favorable Title II decisions based on a law later found unconstitutional can be reopened within four years under 20 C.F.R §§ 404.988(b) & 404.989(a)(3). SSR 17-1p was issued on March 1, 2017.

SSA also made corresponding changes to POMS GN 00210.030, "Same-Sex Marital Relationships - Reopening Title II and Title XVI Determinations and Decisions," effective March 1, 2017. The new POMS give instructions to reopen Titles II and XVI

(Continued on page 2)

INSIDE THIS ISSUE:

Disability Law News© is published four times per year by:

Empire Justice Center
1 West Main Street, Suite 200
Rochester, NY 14614
Phone: (585) 454-4060

The newsletter is written and edited by:
Louise M. Tarantino, Esq.
Catherine M. Callery, Esq.

April 2017 issue.

Available online at:

www.empirejustice.org

New SSRs Issued, Others Rescinded- Continued

(Continued from page 1)
determinations and decisions when DOMA or state law prohibited SSA from recognizing marital relationships that would have been recognized if not for their same-sex nature.

Justice in Aging has prepared a helpful fact sheet on the new SSR and POMS: http://www.justiceinaging.org/wp-content/uploads/2017/04/POMS-for-Same-Sex-Marriage.pdf

SSR 17-2p - Evidence Needed by Adjudicators at the Hearings and Appeals Council Levels of the Administrative Review Process to Make Findings about Medical Equivalence

This SSR was issued on March 27, 2017, in conjunction with the implementation of the new rules on evaluating opinion evidence, which went into effect on that date. It rescinds and replaces SSR 96-6p: "Titles II and XVI: Consideration of Administrative Findings of Fact by State Agency Medical and Psychological Consultants and Other Program Physicians and Psychologists at the Administrative Law Judge and Appeals Council Levels of Administrative Review; Medical Equivalence." SSR 17-2p reminds adjudicators – perhaps even more emphatically than did SSR 96-6p – that it remains their responsibility to make an equivalency determination.

While SSR 96-6p also emphasized the adjudicator's ultimate responsibility for an equivalency decision, it cited "longstanding policy requires that the judgment of a physician (or psychologist) designated by the Commissioner on the issue of equivalence on the evidence before the administrative law judge or the Appeals Council must be received into the record as expert opinion evidence and given appropriate weight." The new SSR actually requires a prior administrative medical finding from a medical consultant (MC) or psychiatric consultant (PC) from the initial or reconsideration adjudication levels supporting the medical equivalence finding; or medical expert (ME) evidence, which may include testimony or written responses to interrogatories, obtained at the hearings level supporting the medical equivalence finding; or a report from the Appeal Council's medical support staff supporting the medical equivalence finding. But those findings are not binding on the adjudicator.

Query whether the agency can have it both ways – the equivalency determination is left to the factfinder, but the factfinder cannot make an equivalency determination without an opinion from a non-examining agency consultant? And note the new regulations on evaluating opinion evidence specifically provide that statements or opinions of a claimant's own medical source as to equivalency will be inherently "non-persuasive." 20 C.F.R. §§ 404.1520b(c)(3) & 416.920b(c)(3).

If the adjudicator does find medical equivalency, s/he must "articulate" how the record establishes medical equivalency. On the other hand, if medical equivalency is not found, the adjudicator is not required to articulate specific evidence supporting his or her finding. "Generally, a statement that the individual's impairment(s) does not medically equal a listed impairment constitutes sufficient articulation for this finding." Presumably, according to the SSR, the rationale the adjudicator articulates for denying the claimant at the final steps of the sequential evaluation will provide adequate guidance to the a court reviewing the decision. This, of course, remains to be seen.

SSRs 96-2p, 96-5p, and 06-03p Rescinded

As promised in the publication of the "Revisions to Rules Regarding the Evaluation of Medical Evidence" on January 18, 2017 (82 Fed. Reg. 8543), SSA has rescinded SSRs 96-2p, 96-5p, and 06-3p. The rescission notice was published on March 27, 2017, the day the new regulations went into effect in cases filed on or after that date. 82 Fed. Reg. 15263 (March 27, 2017). According to the rescission notice, the final rules revised the policies for how adjudicators will evaluate opinions from treating sources, rendering SSR 96-2p's instructions about weighing such opinion evidence obsolete. Similarly, SSR 96-5p explained how adjudicators should consider medical source opinions on issues reserved to the Commissioner. The new rules relieve adjudicators of this obligation, as such opinions will be considered "inherently neither valuable nor persuasive."

(Continued on page 3)

New SSRs Issued, Others Rescinded-Continued

(Continued from page 2)

SSR 06-3p governed evaluation of opinions from non-acceptable medical sources and decisions by other agencies as to disability. The new regulations render the latter inherently non-persuasive. They also revise who will be considered an acceptable medical source in claims filed on or after March 27, 2017, and how their opinions will be considered. Although not spelled out in the rescission notice, 20 C.F.R. §§ 404.927(f) & 416.1527(f) have been added to the current regulations, ostensibly incorporating some of the provisions of SSR 06-03p to allow for consideration of opinions of non-acceptable medical sources in claims filed prior to March 27th.

SSR 93-2p Rescinded

On March 15, 2017, SSA rescinded SSR 93-2p: Evaluation of Human Immunodeficiency Virus Infection. 82 Fed. Reg. 13914 (March 15, 2017). The SSR provided guidance for evaluating duration in cases meeting or equaling the HIV listings, which were revised on December 2, 2016. See the January 2017 edition of this newsletter. The SSR instructed adjudicators that an individual found to meet or equal the listing would be considered to have an impairment that was permanent or expected to result in death. A separate durational finding that the impairment had lasted or was expected to last twelve months was not required. According to SSA, with advances in medical science and treatment, it is no longer proper to assume all impairments meeting or equaling the HIV listings are permanent or will result in death. Consequently, SSR 93-2p has been rescinded as obsolete.

SSR 87-6p Rescinded

On March 3, 2017, SSA formally rescinded SSR 87-6p, which provided guidance to adjudicators on the role of prescribed treatment in the evaluation of epilepsy. SSA published new listings for Neurological Disorders for adults and children (Listings 11.00 and 111.00), effective September 29, 2016. 81 Fed. Reg. 43048 (July 1, 2016). SSA indicated then that SSR 87-6 would be rescinded because relevant parts have been incorporated into the new listing.

No More Barcodes?

Advocates registered with Appointed Representative Services (ARS) know the advantages of being able to access clients' file through Electronic Records Express (EXE). They probably also know the frustration of getting bar codes from ODAR hearing offices – and labeling and uploading records. As of December 10, 2016, appointed representatives enrolled with ARS have the capability to upload documents to their client's electronic folders (eFolders) without a barcode.

SSA is touting the many benefits to using ARS to upload documents, including the following:

- Claimant and destination are populated automatically by the system, reducing the amount of time representatives spend uploading files
- Representatives simply attach their file, select the document type from a dropdown menu, and enter any document-specific information requested by the system (e.g., source, treatment dates)
- Documents are automatically routed to the correct section in the eFolder and labeled with the document-specific information

SSA has produced an ERE "User Guide of Send Individual Responses," with screen shots and a list of the document types that can be uploaded via ARS. It is available as a pdf at www.ssa.gov.

Limited SSI Applications Now On-Line

The Social Security Administration (SSA) has allowed Title II claimants to file applications for benefits on-line for several years. It has finally extended this privilege to Title XVI – or Supplemental Security Income (SSI) applications – but only in limited situations and effective March 25, 2017. https://secure.ssa.gov/apps10/reference.nsf/links/03062017061717AM

According to Emergency Message 17008, iClaim "enhancements" will include:

- A limited deferred Supplemental Security Income (SSI) application known as iSSI,
- Phasing out the Spanish iClaim, and
- Expanding the availability of iAppointment.

The iSSI will only be available to a claimant who is also applying on-line for Title II, and is:

- Age 18 through 64;
- Resides in 1 of the 50 states, the District of Columbia, or the Commonwealth of the Northern Mariana Islands;
- Alleges disability, but not blindness;
- Never married; and
- Claimant's Social Security Number (SSN) does not exists in any SSI system such as the Modernized SSI Claims System (MSSICS) and Supplemental Security Record (SSR) – in other words, hasn't filed before?

It is not clear why the Spanish iClaim is being phased out, but applicants who select a non-English language as their preferred reading language in iClaim will have the option either to schedule an interview using iAppt or to continue the online application in English.

These changes follow closely on other iAppeals described in the January edition of this newsletter, permitting individuals to file requests for reconsideration or requests for hearings for nonmedical/non-disability related issues. The website for non-medical appeals is https://secure.ssa.gov/iApplNMD/start.

Contact Us!

Advocates can contact the DAP Support attorneys at:

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

REGULATIONS

NICS Background Check Regs Rescinded

In light of the new administration's threats to claw back Obama era regulations, advocates wondered how SSA's year-end flurry of new regulations would fare. Most of the regulations issued at end of Acting Commissioner Colvin's term have survived, for better or worse. But Congress used the Congressional Review Act (CRA) to permanently halt implementation of SSA regulations that would have required SSA to report certain disability beneficiaries to a gun-control database. The rules, which implemented the National Instant Criminal Background Check System (NICS) Improvement Amendments Act of 2007, required SSA to report individuals to NICS who receive Title II or SSI benefits based on a finding the individual's impairment meets or equals listing 12.00 and requires a representative payee. Inclusion on the NICS database restricts the individual's ability to purchase firearms and certain explosives. 81 Fed. Reg. 91702 (Dec. 19, 2016). The President signed the CRA cancellation into law on February 28, 2017. NOSSCR and other advocacy groups had objected to these regulations when they were proposed, arguing the criteria were both over and under inclusive, as not determinative of an individual's propensity for violence. Under the CRA, an agency cannot engage in rulemaking "substantially the same" as the canceled regulations.

Five-Day Rule Coming Soon

The January 2017 edition of this newsletter summarized SSA's "program uniformity" rules, published on December 16, 2017. http://www.empirejustice.org/issue-areas/disability-benefits/rules--regulations/five-day-requirement.html#.WO-kJMs2y70.

The new regulations, among other things, close the hearing record five days before the hearing and require seventy-five days' notice of the hearing.

The regulations technically went into effect on January 17, 2017, but compliance was not required until May 1, 2017. SSA has been ramping up for the May 1st date, sending notices to representatives and claimants about "key changes" to the rules beginning May 1, 2017 – including in cases where hearings have already been scheduled or even held! Advocates report many claimants have been confused by these notices, so be prepared to reassure your clients who may fear they now have a hearing scheduled for May 1st.

As these regulations go into effect, be aware that representatives and claimant must either submit or let ODAR know about evidence at least five business days prior to the hearing. And requests for subpoenas must be made ten days prior to the hearing.

Please keep us informed as to how various ODARs and ALJs are enforcing these regulations.

Recent POMS Changes May Affect Vets

Several years ago, SSA made substantial revisions to POMS governing evaluation of past relevant work (PRW). See POMS DI 25005.000, *et seq.* SSA recently revised POMS DI 25005.020 - Past Relevant Work (PRW) as the Claimant Performed It. According to new section D, SSA cannot evaluate a military occupation as generally performed in the national economy; the Dictionary of Occupational Titled (DOT) does not provide information about the physical and mental demands of a military occupation. See also POMS DI 25005.025 Past Relevant Work (PRW) as Generally Performed in the National Economy, Section C. Types of work that may not have a DOT counterpart include work performed in the military.

For example, a job described as "clerk-typist" in the military should not be compared to the DOT's description of clerk-typist (203.362-010) to determine if the claimant could perform PRW "as generally done in the national economy." Thus, if the claimant cannot perform the PRW as s/he actually performed it, the evaluation should proceed to Step five of the sequential evaluation. The claimant may, however, have acquired transferrable skills from a military job that could be considered at Step five.

HALLEX Guidance on Bench Decisions Issued

In November 2017, presumably as part of the Office of Disability Adjudication and Review's (ODAR) efforts to reduce its growing hearing backlog, SSA revised HALLEX provisions governing the issuance of "bench decisions." See HALLEX I-2-8-19 - Oral Decisions on the Record (Bench Decisions). These decisions could be welcome relief for claimants who now often wait months after their hearings for decisions. But these "bench decisions" are permissible only in certain circumstances.

Current regulations allow an ALJ to enter a fully favorable oral decision on the record based on the preponderance of the evidence, "and thereafter issue a written decision that incorporates the oral decision by reference." 20 C.F.R. §§ 404.953(b) & 416.1453(b). The HALLEX provisions, however, limit bench decisions to cases that have been identified in advance as appropriate for an oral decision. And they are only appropriate in either Title II and/or Title XVI, adult disability claims; claims for disability benefits as a disabled widow, widower, or surviving divorced spouse under title II; or Title XVI claims for benefits by a child under age 18. An ALJ may not issue a bench decision in a disabled adult child claim, an age -18 redetermination, a continuing disability review (CDR), a claim involving drug addiction or alcoholism, a claim where there is reason to believe fraud was involved, or in non-disability claims. The ALJ must generate "an oral decision checklist." And the contents and style of the decision itself is highly regulated.

Check out this revised HALLEX, and let us know if you succeed in getting any bench decisions.

New Medical Evidence Regs Corrected

As noted elsewhere in this newsletter and described in detail in the January edition, SSA published new regulations regarding the evaluation of opinion evidence on January 18, 2017, effective on March 27, 2017, in claims filed on or after that date. On March 27, 2017, SSA published a list of technical corrections to the new final regulations. See https://www.federalregister.gov/documents/2017/03/27/2017-06023/revisions-to-rules-regarding-the-evaluation-of-medical-evidence-correction.

Washington Post Article Refuted

The *Washington Post* recently joined the chorus of critics of the Social Security disability program. It published an article entitled "Disabled or Desperate?" about the dilemma faced by many working-age adults in rural communities who, according to the article are foregoing work—albeit it scare—to apply for disability benefits in record numbers. http://www.washingtonpost.com/sf/local/2017/03/30/disabled-or-just-desperate/?tid=a_inl&utm_term=.f122ef8b8785.

It followed with an editorial calling for reforms to the system. https://www.washingtonpost.com/opinions/the-social-security-disability-program-needs-reform/2017/04/08/29aa6dda-1af9-11e7-9887-1a5314b56a08_story.html?utm_term=.10127d571c6c.

There have been a number of well-reasoned responses and criticisms of the article, including one by a physician who had worked reviewing disability claims and a legal services attorney who represents claimants. https://www.washingtonpost.com/opinions/disability-and-desperation-are-not-mutually-exclusive/2017/04/03/6fa8ce46-15a2-11e7-bb16-269934184168_story.html?utm_term=.094f71723baa. See also http://www.cbpp.org/blog/the-big-picture-on-disability-benefits.

Talk Poverty also responded with several pieces, including an in-depth analysis of the fundamental flaws in the statistics upon which the *Washington Post* article was based. https://talkpoverty.org/2017/04/13/washington-posts-data-social-security-disability-just-plain-wrong/.

The *Post* added a correction to the on-line version of the story, although there are still problems with the *Post's* analysis and conclusions. For example, even with the *Post*'s flawed methods, only one county—out of more than 3,100 counties nationwide—reflected the story's central claim that "as many as one-third of working-age adults are receiving monthly disability checks" holds up. Not a single other county even comes close. https://talkpoverty.org/2017/04/18/washington-post-correction-disability-story-still-wrong/.

These responses can provide ammunition to debunk the aspersions cast upon the disability program, and more significantly, the beneficiaries of the program.

COURT DECISIONS

Treating Physician Rule Still Reigns

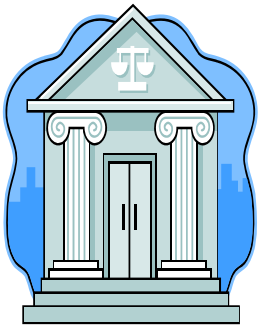
The treating physician rule was the basis for the Second Circuit's recent summary order in *Gavazzi v. Berryhill*, 2017 WL 1400456 (2d Cir. Apr. 19, 2017). The case was commenced before the treating physician regulations were decimated. See 82 Fed. Reg. 5844 -5845, discussed in the January 2017 edition of this newsletter at http://www.empirejustice.org/issue-areas/disability-benefits/rules--regulations/treating-physician-1.html#.WPjL58s2y70. The Court of Appeals reviewed the claim under the regulations then in effect, under which the treating physician's opinion should be given "controlling weight," so long as it is not inconsistent with the record.

The Administrative Law Judge (ALJ) had discounted the treating physician's opinion of limitations. In doing so, the ALJ cited only that "there is no clinical evidence to support the need to change positions," instead of citing any "contrary medical opinions." The court found this assessment was insufficient. Additionally, by discounting the treating physician's opinion without contrary medical evidence, the ALJ "arbitrarily substituted his own judgment for competent medical opinion (citations omitted)." Citing Social Security Ruling (SSR) 96-9p, the court also directed the ALJ to consider on remand the frequency of Gavassi's need to alternate between sitting and standing, and if indicated, consult a vocational resource to determine if Gavassi would be able to make an adjustment to other work.

Congratulations to Attorney Peter Gorton of Endicott on this victory.

Comparative Standard Reiterated

The Second Circuit, in the summary order *Hathaway v. Berryhill*, 2017 WL 1380549, at *1 (2d Cir. Apr. 18, 2017), discussed the Continuing Disability Review (CDR) standard under 42 U.S.C. § 421, where an individual may be determined to be no longer entitled to disability benefits. In Ms. Hathaway's case, she submitted a questionnaire outlining her ongoing problems and thus "met the "limited burden of 'introducing evidence.'" The Administrative Law Judge (ALJ) only discussed current medical reports in the decision reviewing Ms. Hathaway's disability. The ALJ also neglected to mention Ms. Hathaway's cognitive limitations, despite previous court rulings that cognitive limitations are unlikely to improve over time. The court reiterated the correct standard for determination was a "comparative standard." The Court of Appeals vacated and remanded Ms. Hathaway's case, finding ALJ's failure to compare previous medical evidence with new medical evidence reversible error. Attorney Mark Schneider of Plattsburg was responsible for this helpful decision.



Appeals Council Guilty of "Bait" and "Switch"

Timeliness of an appeal was addressed by the Court of Appeals for the Seventh Circuit in *Casey v. Berryhill*, 2017 WL 398309 (7th Cir. Jan. 30, 2017). The Social Security Administration (SSA) had denied the plaintiff's request for a waiver of an overpayment, so he requested review from the Appeals Council. Unfortunately, the request to review was untimely. Despite the untimeliness of the request, the Appeals Council seemed to allow the appeal implicitly, granting plaintiff's request that the deadline to submit evidence be extended. Notably, the letter from the Appeals Council did not refer to "good cause" or "timeliness," but merely referred to an extended time for evidence to substantiate the request for a waiver. Notwithstanding this action, nearly a year later the Appeals Council dismissed the request to review, finding "no good cause to extend the time of filing."

The Seventh Circuit held the Appeals Council has the discretion to determine what is considered to be "good cause" for a delay in filing an appeal, but it was arbitrary to first grant, and then retroactively deny the request. The court characterized the Appeals Council's action as "having the effect of an unfair administrative bait-and-switch." The Seventh Circuit found that since no final decision had been reached by the Appeals Council on the waiver, it had no jurisdiction. The case should therefore be remanded to the agency.

Court Order Remand to Different ALJ

Attorney Ruth Alexrod, of Axelrod & Gottlieb in New York City, convinced U.S. Magistrate Judge Paul Davison that Administrative Law Judge (ALJ) Seth Goldman's conduct warranted remand to a different ALJ. *DeMota v. Berryhill*, 2017 WL 1134771 (S.D.N.Y. March 24, 2017).

The Commissioner had argued for remand, acknowledging the ALJ had improperly evaluated the medical source evidence of record. In fact, the ALJ had refused to accord weight to most medical sources, stating (and underlining) "because I find the claimant to be not credible, I also do not credit the opinions of the experts who relied, at least in part, on her presentation and testimony." Although Ruth had argued for a remand for calculation of benefits, the Magistrate found the ALJ's failure to apply the treating physician rule warranted remand. Magistrate Davison agreed, however, the ALJ's conduct warranted remand to a new ALJ.

The Magistrate found the ALJ's hostility toward the claimant apparent from the record, noting the ALJ's degree of frustration was surprising given the claimant's mental impairments, which included hallucinations and early onset dementia. The ALJ made comments suggesting he relied on stereotypes about people in the Bronx instead of conducting a detached evaluation. The Magistrate also criticized the ALJ's "medical expertise." When counsel at the hearing suggested another consultative examination was not necessary since there were already three psychiatric reports confirming hallucinations, the ALJ stated "there's only one opinion that counts at the end of the day – and that's mine." The court also found the ALJ attempted to manipulate the testimony of the medical expert.

Kudos to Ruth, who argued a remand to ALJ Goldman would make a "mockery of due process."

Court Rejects Boilerplate Credibility Assessment

In a recent decision from the Western District of New York, U.S.D.C. Judge Charles Siragusa rejected the ALJ's use of the "oft-criticized" phrase that claimant's "statement concerning the intensity, persistence and limiting effects of these symptoms are not credible to the extent they are inconsistent with the above residual functional capacity assessment." According to the court, "this boilerplate language implies that ability to work is determined first and is then used to determine claimant's credibility." *Rosario v. Colvin*, 2017 WL 655268 (W.D.N.Y. Feb. 17, 2017).

Judge Siragusa went on to find the ALJ failed to assess the claimant's credibility properly. The ALJ failed to take into consideration the assistance she required from her family in her activities of daily living. Additionally, the ALJ erred in stating her pain was controlled, since the treatments used to control the symptoms had to be discontinued due to adverse side effects. [Advocates will recall that SSA no longer assesses "credibility," but rather will assess symptoms. See SSR 16-3p, discussed at http://www.empirejustice.org/issue-areas/disability-benefits/rules--regulations/ssr-16-3p-evaluates-symptoms.html#.WPFDf8s2y70.]

Judge Siragusa remanded the case for further assessment. He also found the ALJ erred in relying on a consultative examiner's opinion as a basis for the residual functional capacity without addressing the limitations imposed by the claimant's physical therapist, other doctors, and testimony.

The court also addressed the claimant's inability to speak English, holding although the ability to speak and understand English is only considered an important factor for claimants aged 45 to 49 under the Medical-Vocational Guidelines, it should be considered as an educational factor under the fifth step of the sequential analysis. But in this case, where the ALJ informed the vocational expert that the claimant was Spanish speaking, there was no legal error in the assessment of the English language ability.

Congratulations to Mollie Dapolito, formerly of the Geneva office of LawNY, and Marty Roberts, still at the Geneva office, for this victory.

ADMINISTRATIVE DECISIONS

Claimant Prevails in CDR Appeal

Advocates may be seeing in uptick in the number of claimants facing Continuing Disability Reviews (CDRs). Despite decreased funding for other essential work, Congress has continued to fund "program integrity," which includes CDRs.

Ellen Heidrick, an experienced advocate from the Bath office of LawNY, recently prevailed in an usually difficult CDR. Ellen agreed to represent her client before a Disability Hearing Officer (DHO). DHOs handle the reconsideration hearings in CDR appeals. Ellen's client had been approved in 2008 under Listing 12.05 C for mental retardation. She was 19 years old at the time. On review, the Division of Disability Determinations (DDD) determined the original allowance was incorrect, and proposed terminating benefits based on the "error on the face of the evidence" exception to the medical improvement review standard (MIRS) usually applied in CDRs.

DDD had reviewed the evidence at the comparison point date (CPD), which was when the claim was initially allowed. It included IQ scores from 2007 that were higher than 70, which was the score required by 12.05C. (Note Listing 12.05C has since been revised by the new mental impairments listings, which went into effect on Januay18, 2017. See http://www.empirejustice.org/issue-areas/disability-benefits/rules--regulations/new-mental-impairment-listing.html#.WPEYDcs2y70. But in determining whether medical improvement has occurred, the listing in effect at the CPD must be considered. POMS § DI 28015.050.)

The DDD Medical Consultant (MC) determined that new testing from 2009 revealing scores below 70 was not necessary and should not have been ordered, since the earlier scores were considered valid. The MC relied on "error on the face" to deny the claim.
Ellen argued the "error on the face" exception should not apply in this type of situation, citing POMS §§ DI 28020.350 & 28020.355. She argued the original allowance had been proper, and the MC was illegally "substituting judgment" in violation of POMS § DI 28005.007.

The DHO acknowledged Ellen's points, but agreed with the MC that the original 12.05C allowance was improper. The DHO found, however, the evidence from the CPD showed the claimant was nonetheless disabled, in that she was incapable of performing even simple tasks. The DHO went on to find that the current evidence continued to demonstrate the claimant was markedly limited, and incapable of performing even simple work in a competitive setting. Ellen may have lost the battle, but she definitely won the war!

The appeals process and the sequential evaluation process for CDRs differ from reviews in initial claims, and may present new challenges for advocates wading into this area. The Empire Justice has training materials available and can offer support for advocates in these cases.

Advocate Focuses on Human Factors to Win Claim

Jessica Woodhouse, an attorney with the Bath office of LawNY, not only won her first appeal, but won it with an "on the record" (OTR) decision. Jessica's client is a young woman with severe adaptive functioning deficits and low IQ scores, but who can appear high functioning in brief interactions. She was initially denied based on an examination by a consulting psychologist who diagnosed her as merely learning disabled.

In preparing for the hearing, Jessica contacted all of her client's providers informally to determine which ones would be the strongest allies. From these initial contacts, Jessica was able to glean much more about her client's issues and limitations than she was able from self-reports and medical reports. As a result, she made tailored requests for information from the providers. Some were able to provide concrete examples of adaptive-functioning deficits. With others, she used individual assessment forms tailored to the conversations she had with them. Through these reports and assessments, she was able to convey a portrait of a young woman who struggled with persistence and pace even in a sheltered employment setting. And she learned the extent to which the providers observed her client's inability to distinguish fantasy from reality, and their fears that she could become a victim of physical or sexual abuse if forced to work with the general public – none of which was clearly reflected in the evidence of record.

Jessica wrote a compelling pre-hearing memo seeking an OTR, in which she argued her client met Listings 12.05B, C, or D. The ALJ did not find the claimant meet a listing, based on what she described as "fluctuating" IQ scores. But she agreed the claimant's intellectual disability and psychogenic non-epileptic seizures rendered her unable to perform simple task independently, and found her disabled.

Congratulations to Jessica for her creative efforts to help the ALJ see her client as her providers saw her.

What Does It Take To Get A Decision?

Advocates and claimant know well the frustration of waiting years for hearings to be scheduled and decisions issued in disability claims. Advocates representing claimants in non-disability claims face similar frustrations – usually waiting to get a decision at all. But Jane Reinhardt, Senior Staff Attorney in the Mental Health Law Project at Nassau-Suffolk Law Services, lost patience waiting for a decision in an SSI overpayment case.

Jane attended two meetings at the SSA field office to advocate for her client. But the field office would not issue a denial or any formal response from which to file an appeal. So, in January of 2016, Jane sought a mandatory injunction against the SSA Commissioner in federal court - simply to get the field office to send its decision to ODAR. SSA took notice, and in late January 2016, the field office finally sent the case to ODAR. Jane discontinued the federal court case and appeared before an Administrative Law Judge in November 2016. The ALJ ruled in favor of the client, restoring the client's SSI and waiving the overpayment. The appeal process took three years from the date of the initial interruption of SSI. Kudos to Jane for her resourcefulness.

When Is A Couple Not A Couple?

Many individuals living together as couples are improperly categorized as "holding out as married" by SSI under 20 C.F.R. § 416.1806. As a result, some claimants are considered ineligible for benefits if the couple's combined income exceeds the statutory limit. That is what happened to a New York City claimant suffering from end-stage renal disease. Luckily for her, she found Michelle Spadafore, attorney at New York Legal Assistance Group, who represented her at a hearing on the "holding out" issue.

Michelle had to overcome a few obstacles, including the claimant's allegation that her boyfriend was her husband simply so he would be allowed to accompany her in her SSI appointment. The claimant and her partner had also registered as domestic partners with the City of New York so the boyfriend's supportive housing agency would allow her to remain in his apartment.

Michelle argued that under recent case law developments, a domestic partnership is not the same as marriage. She also refuted SSA's findings with letters from a social worker from Upper East Side Dialysis where the claimant was treated three days a week, a cab driver the couple uses on a regular basis, the employee at their local pharmacy, and a neighbor. All of these individuals interact with the couple on a regular basis and confirmed they introduce themselves to people as boyfriend and girlfriend and not as husband and wife.

The Administrative Law Judge agreed that "a majority of the evidence suggests" couple is cohabitating, as supposed to "holding out" as married status. In this case, the claimant indicated she was not married on her SSI application, denied being married on subsequent relationship questionnaires, held herself out in public as being unmarried, and had only acquired a domestic partnership certificate to obtain housing. It was also noted that the couple shared no bills, tax returns, installment contracts or mail addressed to them as a married couple. As a "majority of the evidence" suggested no martial relationship was established, the ALJ determined the couple was not "holding out" as a married couple. Therefore, the claimant's partner's income could not be included in any calculation determining SSI eligibility.

Thanks to Michelle, the claimant's application was forwarded on for a disability assessment as an expedited TERI (Terminal Illness) case.

SNT Found To Be Exempt

Michelle Spadafore of NYLAG worked her magic in another non-disability claim involving a 59 year old man with an intellectual disability who faced a termination of his SSI benefits and a substantial overpayment when SSI discovered a Special Needs Trust (SNT) in his name. Because the client could not find the trust documents, SSI refused to consider the otherwise exempt asset exempt. But the client was unable to access the funds in the SNT.

Michelle arranged for a pro bono attorney to file for temporary guardianship for property management of her client. The temporary guardian then opened a new, polled SNT for the client, and transferred the funds from the original SNT into the pooled trust. At a hearing, Michelle convinced the ALJ the money in the original SNT should have been considered exempt because the client could not access it. The money, once transferred to the pooled trust, continued to be exempt. Thanks to Michelle's creative advocacy, the client's SSI benefits have been reinstated and the $27,000 overpayment removed from his record.

SSA OIG Issues Report

Pre-Effectuation Reviews of Favorable Hearing Decisions - A-12-15-50015

The Social Security Administration's (SSA) Office of the Inspector General (OIG) issued a report in February 2017 to determine whether the Office of Disability and Adjudication and Review (ODAR) timely processed its pre-effectuation reviews (PER) of favorable hearing decisions. It also considered whether the Office of Operations appropriately terminated benefits for claimants whose cases were denied or dismissed.

For context, ODAR's Division of Quality (DQ) has conducted pre-effectuation reviews of randomly selected favorable hearing decisions before any payments are made to the claimants since Fiscal Year (FY) 2011. Pre-effectuation reviews are randomly selected and include at least 350 cases per region as well as 350 cases from National Hearing Centers. To be selected for a pre-effectuation review, a case must also be electronic. [NOTE: these reviews are different from—but similar to—from the Appeals Council's "own motion review" process, under which the Appeals Council can initiate review within sixty days of an ALJ decision. See 20 C.F.R. §§ 410.969 & 416.1469.]

As part of the pre-effectuation review process, the Division of Quality can effectuate (agree with) the favorable decision; remand it for a new decision; or reverse, modify, or dismiss it. While appeals officers effectuate cases, only administrative appeal judges can remand, reverse, or dismiss a case.

The Division of Quality agreed with about four of every five cases selected for a pre-effectuation review in FYs 2011 through 2015, and set the remaining cases aside for review. In about ninety-nine percent of the pre-effectuation review cases, the Division of Quality either agreed with the case or notified claimants within the required 60 days, per 20 C.F.R §§ 404.969 and 416.1469, although average processing times had steadily increased over the five-year period.

For cases requiring further review (about one of every five), the majority were remanded to Administrative Law Judges, with average processing times for remanded cases also increasing over this period- which Division of Quality staff attribute to a growing case load, staff and management loss, and a lack of timeliness goals.

From FYs 2011 to 2015, ODAR's Division of Quality processed 26,177 pre-effectuation reviews, which represents about 1.4 percent of the total favorable decisions issued over the five-year period. Per policy, (HALLEX) I-3-6-40, if the case is still pending in ODAR's PER process after 110 days, the Agency is required to start paying interim benefits. According to the report, if the claimant's case is denied or dismissed after the PER process, DQ sends a notice to SSA's Office of Operations to cease disability benefits to the claimant- though the Agency does not consider interim benefits already paid as overpayments. Claimants have a right to appeal the PER decision.

The report also found problems with the Agency's process for terminating benefit payments for reviews that resulted in an unfavorable decision or dismissal, although the error rate has improved in recent years.

Additionally, the report found the Agency saved about $4 to $5 on average per dollar spent on pre-effectuation reviews in FY 2011. The OIG suggests the Agency should consider increasing the number of reviews to maximize potential savings, as well as collecting and reporting on the costs and savings associated with PERs, and producing future projections of these data.

In order to improve the PER process, identify additional cases with quality issues, and increase program savings, the OIG made four additional recommendations, all of which the Agency agreed with.

https://oig.ssa.gov/audits-and-investigations/audit-reports/A-12-15-50015

(Continued on page 15)

SSA OIG Issues Report- Continued

(Continued from page 14)

Disability Applications Denied Because Of Claimant's Ability to Work - A-01-17-50222

In response to a request from the Senate Committee on the Budget, SSA's Office of the Inspector General (OIG) gathered information on claimants who were denied Disability Insurance (DI) benefits or Supplemental Security Income (SSI) payments because of their ability to work. OIG issued its report in March 2017. https://oig.ssa.gov/audits-and-investigations/audit-reports/A-01-17-50222

The OIG identified 1.1 million claimants who were denied Disability Insurance or Supplemental Security Incomes payments in 2013 at the initial claims level based on ability to work. The OIG then selected a random sample of 275 individuals for further analysis.

The results show average annual earnings for claimants in the ten year period before initial denial was $12,160. This includes 118,934 claimants who had no earnings over the ten year period. In the two year period following denial, 445,696 claimants had earnings, with average annual earnings of only $3,814. This number, however, does not include the 646,649 individuals who had no earnings throughout this two year period, presumably making the actual average income even lower. For ten years prior to initial denial, only 10.9% of individuals had no earnings. This percentage skyrockets post denial: 59.3% of individuals had no earnings.

The Senate Committee on the Budget also asked the OIG for additional information regarding individuals who were denied based on their ability to work. The results show the claimant's average age at denial was 43-years-old. The majority of denials affected individuals 60 years old and younger. Additionally, 53.3% of claimants denied were female, and 46.7% were male.

The report also identifies which body systems were listed in the claimants' initial disability application. Musculoskeletal system (39.6%), mental disorders (27.8%), and cardiovascular system (6.5%) top the list, with primary diagnosis of disorders of the back (22.7%), affective disorders (16.5%), and other and unspecified arthropathies (6.4%) following.

Additionally, the report shows 25% of claimants were denied at step 4 of SSA's Sequential Evaluation Process, and 75% of claimants denied at step 5.

Relying on its sample, OIG estimated 77.8% of claimants had appealed or filed a new claim after the initial denial and outcome, while 22.2% had not appealed or re-applied. According to OIG, most of the claimants in its sample, did have their claims approved after reapplying or on appeal.

Lastly, the report provides reasons as to *why* claimants were found ineligible to receive benefits: 25.5% of claimants had earnings indicating potential substantial gainful activity (SGA), 9.1% of claimants had a new claim or an appeal pending, 5.9% of claimants received retirement or widow's benefits, 4.8% of claimants were in prison, and 50.0% of claimants did not meet SSA's disability standards.

Thanks to Empire Justice Center paralegal Keith Jensen for summarizing these studies.

WEB NEWS

Guidance For Same Sex Couples Seeking SSA Benefits

On March 1, 2017, the Social Security Administration (SSA) announced that it would reopen its decisions to deny spousal or survivor's benefits to individuals who had been married to someone of the same sex, and whose marriage wasn't recognized because of a discriminatory state or federal ban on marriage. This ruling and policy applies not only to individuals who were denied benefits after the Supreme Court struck down federal discrimination against same-sex spouses (in *United States v. Windsor* in 2013) and state discrimination (in *Obergefell v. Hodges* in 2015), but also to individuals who applied for and did not receive benefits before these Supreme Court decisions because of the discriminatory laws in effect at the time they applied.

Justice in Aging has developed a new Fact Sheet that includes more detailed information about who is affected by the new guidance and what advocates and their clients should do to get their cases reopened.

http://www.justiceinaging.org/wp-content/uploads/2017/04/POMS-for-Same-Sex-Marriage.pdf

New Website for Veterans and Volunteer Attorneys Available

Pro Bono Net and the Veterans Consortium Pro Bono Program have collaborated to create a new website to support and engage both veterans and volunteer attorneys. The new site leverages the probono.net technology platform, which is used to support broad-based networks of legal aid, civil rights, and pro bono lawyers across the country.

The new web platform makes it easier for veterans to file federal court appeals, more efficient for attorneys to volunteer and ask for cases to represent veterans in need, and more effective for The Veterans Consortium (TVC) staff attorneys to carefully match the right client with the best volunteer. https://www.vetsprobono.org/

Benefits Checklist for Older Adults in NYS Updated

The Brookdale center has updated its ***Benefits Checklist for Older Adults***, an essential resource for anyone who advises or assists older adults in New York State – from lawyers, accountants and financial advisers to social workers, nurses, and doctors. Professionals involved in shaping elder care law and policy or overseeing services for the elderly will also find the Benefits Checklist useful. https://brookdale.org/tools-resources/benefits-checklist/

NY Attorney General Issues Tenant Rights Information

Every New Yorker who rents a home or an apartment has the legal right to live there in peace. State law prohibits landlords and their employees from harassing or threatening tenants, and these protections apply regardless of a tenant's immigration status. All tenants have rights that are protected by a variety of federal, state, and local housing laws. Attorney General Eric Schneiderman's office has set up a know-your-rights website and hotline outlining immigration based protections for NY tenants. https://ag.ny.gov/sites/default/files/immigration_tenants_rights_web.pdf

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

I'm Sorry, But...

You might say "I'm sorry" countless times a day without really thinking about it, but it is not so easy when it comes to actually apologizing. In her new book, *Why Won't You Apologize?,* author Harriet Lerner suggests the best apologies are short and don't include explanations. The "but" after "I'm sorry" might undo the apology itself. Nor should you request or expect forgiveness. The offended person might be ready to accept an apology but not yet forgive the transgression. Dr. Lerner told the *New York Times*, "It's not our place to tell anyone to forgive or not forgive."

According to Dr. Lerner, the focus of an apology should be on what you said or did. Adding "I'm sorry you feel that way" turns "I'm sorry" into "I'm really not sorry at all." Dr. Lerner acknowledges it can be hard to offer a sincere, unconditional apology. We are hard-wired to be defensive, and offering an apology leaves us vulnerable. Suppose the apology is rejected?

Apologies involving family members can be particularly challenging. Long histories can get in the way. But Dr. Lerner offers that "history can be used as an explanation, not an excuse." She urges the listener not to "interrupt, argue, refute, or correct facts, or bring up your own criticisms and complaints." And even if you are not completely at fault, apologize for your part, no matter how small you may think it was.

Dr. Lerner views apologies as critical to emotional and physical health – bestowing self-respect, integrity and maturity. According to the author, "I'm sorry" are the two most healing words in the English language.