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DISABILITY LAW NEWS

Second Circuit Rules on DAA Issues

The Court of Appeals, following the lead of a number of other circuit courts, has held that the burden of proving that drug or alcohol addiction is not material to a disability claim rests with the claimant. It also affirmed the ALJ's finding that the claimant would not be disabled absent drug addiction or alcoholism ("DAA") was supported by substantial evidence even though there was no medical opinion specifically addressing materiality. *Cage v. Commissioner of Social Security*, --- F.3d ---, 2012 WL 3538264 (2d Cir., August 17, 2012).

Congress imposed the materiality standard on DAA determinations with the enactment of the 1996 Contract with America Advancement Act ("CAAA"). The CAAA provides that a claimant will not be found disabled if DAA would be a contributing factor to the finding of disability. The Court of Appeals acknowledged that the Act did not specify which side bears the burden of proof as to materiality. It held, however, that assigning the burden to the claimant is in accord with the claimant's general burden of proving disability under the Social Security Act. It also opined that claimants would be better positioned to offer proof of the relevance of DAA as the relevant facts would be in their possession. And the Court found that holding claimants to the burden was in accord with the legislative history of the CAAA, which indicated that Congress was seeking to discourage alcohol and drug abuse, or at least not to encourage it with a public subsidy. According to the Court, placing the burden on the Commissioner would give the claimant who presents inconclusive evidence of materiality no incentive to stop abusing, since abstinence could resolve his limitations.

The Court rejected the plaintiff's argument that SSA's Teletype EM-96200 (Aug. 30, 1996), assigns the burden of proving materiality to the Commissioner. The Teletype is often cited by advocates in arguing that the "tie" should go to the claimant in cases where it is difficult or impossible to predict what limitations would remain if the claimant stopped using drugs or alcohol. It is available at: https://secure.ssa.gov.apps10/public/reference.nsf/links/0492003041931PM. The Court acknowledged that the Teletype could be read to endorse a presumption in favor of the claimant. It refused, however, to accord it deference, as it is an "unpromulgated internal agency guideline."

The Second Circuit panel went on to find that a "predictive medical opinion" addressing the issue of materiali-

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Second Circuit Rules on DA&A—Continued

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ty was not necessary generally - or in Cage's case in particular. The Court found that the ALJ's finding of materiality - notwithstanding the lack of a consultive opinion predicting her impairments in the absence of abuse - was supported by substantial evidence. Among other things, the ALJ cited positive evaluations of Cage conducted during impatient admissions when she was not using drugs or alcohol. He also referenced an addiction therapist's report that Cage's substance abuse made her medical and emotional issues worse.

Ironically, the same ALJ whose 2008 denial was the subject of this appeal found Ms. Cage disabled in 2009 based on an application filed several months after the denial. He relied, *inter alia*, on evidence that she had stopped abusing alcohol and drugs in 2008. The Court of Appeals, however, found that the favorable ruling was based on evidence not in the record on the original application, and related in part to different impairments. Additionally, the Court noted that the ALJ had specifically refused to reopen the earlier denial. It held that the 2009 favorable decision did not bolster Cage's claim that the 2008 decision was not supported by substantial evidence.

What does *Cage* mean for DAA claims within the Second Circuit? In terms of burden of proof, probably very little at the hearing level, as advocates will presumably continue to do all they can to develop evidence to counter a materiality determination. The decision does put an even greater burden on claimants and their representatives to seek opinions as to materiality from treating sources, since the ALJ will not be obligated to do so. While ALJs may be emboldened under *Cage* to make materiality findings in the absence of such opinions, they would still be obligated under the treating physician regulations to - at the very least - consider the opinions of treating sources who predict that their patients would continue to be disabled even if sober.

Is there continued viability in relying on the Teletype's "tie-breaker" in those situations where it is impossible to predict if the claimant's limitations would continue in the absence of drug or alcohol abuse? That obviously remains to be seen, but it is important to note that the Court did not rule on that aspect of the Teletype; it only addressed the Teletype in the context of the burden of proof issue. And following a much harsher attack on the Teletype in *Parra v. Astrue*, 481 F.3d 742, 748 (9th Cir. 2007), *cert. denied*, 552 U.S. 1141 (2008), the Commissioner continued to acknowledge the Teletype as a "reasonable implementation" of the DAA regulations and statute. *See, e.g.*, http://www.usdoj.gov/osg/briefs/2007/0responses/2007-0408.resp.pdf.

Rumor has it that a new Social Security Ruling (SSR) on DAA is in the works. In fact, in January 2010, SSA published a "Request for Comments: Drug Addiction and Alcoholism" in the *Federal Register*, asking for comments on the procedures the agency follows when evaluating drug addiction or alcoholism, and seeking suggestions as to how the evaluation process should be changed. 75 Fed. Reg. 4900 (Jan. 29, 2010); Docket No. SSA-2009-0081. See also the March 2010 edition of the *Disability Law News*, available at www.empirejustice.org. Empire Justice Center's comments are available as DAP #549. So stay tuned to these pages for further developments. And keep us informed of changes that you see in how DAA claims are adjudicated post *Cage.*

Plaintiff Cage was represented at the circuit level by *pro bono* attorneys Timothy Hoover and Peter C. Obersheimer of Phillips Lytle in Buffalo, who were appointed by the Court of Appeals. They were specifically asked to brief the Court on the issue of burden of proof and whether the ALJ could make a finding of materiality in the absence of a medical opinion specifically addressing the issue. Thanks to these *pro bono* attorneys for their hard work on this case.

GAO Issues Report On Kids' SSI

The children's SSI program - particularly in terms of children with mental impairments - has come under both criticism and scrutiny in recent years. Following a series of scathing articles in the *Boston Globe* in 2010, members of Congress asked the Government Accountability Office (GAO) to assess the extent to which SSA is properly monitoring the initial determination and continued eligibility of children with mental impairments. The GAO's preliminary findings were reported in the December 2011 issue of this newsletter. The GAO's final report, GAO -12-497, was published in June.

The GAO was asked to assess (1) trends in the rate of children receiving SSI benefits due to mental impairments over the past decade; (2) the role that medical and nonmedical information, such as medication and school records, play in the initial determination of a child's eligibility; and (3) steps SSA has taken to monitor the continued medical eligibility of these children.

Notable findings from the GAO's study include:

- While the number of children applying for and receiving SSI benefits increased by 60% from 2000-2010, the percentage of children receiving benefits based on mental impairments remained stable at 65%.
- The three most prevalent mental impairments for children found eligible in 2011 were ADHD, speech disorders, and autism. Allowances for autism show the largest percentage increases from 2000 to 2011, while those for intellectual disability decreased.
- A majority of children are denied SSI benefits. In fiscal years 2000 to 2011, the average initial determination denial rates for children with physical and mental impairments were about 63% and 54%, respectively; allowance rates have remained relatively stable over time for both groups of children.
- The number of children applying for and receiving SSI has increased due to several factors, including increased child poverty, increased awareness and improved diagnosis of many mental impairments, and increased numbers of children obtaining healthcare coverage, as well as increased awareness of the SSI program.
- Over half of children found eligible for SSI in 2010 had more than one impairment. The overwhelming majority (94%) of those secondary impairments were mental. Of kids with severe ADHD found eligible for SSI, 74% had a secondary impairment.
- Disability examiners rely on an array of sources to assess eligibility for benefits - such as medical records, school records, teacher and parent assessments, and prescribed treatment and medications. Examiners generally cited 4-5 sources as support for their decisions in 2010, most frequently the opinion of a treating medical provider.
- Despite media reports to the contrary, medication is not a key to obtaining benefits. In fact, applicants were more likely to be denied when medication was reported. It was cited as a basis for denying benefits in more than half of cases the GAO reviewed (if the medication improved the child's functioning). In cases where a child had been prescribed psychotropic medications, 68% were denied and just 32% approved.
- SSA faces challenges in conducting Continuing Disability Reviews (CDRs) due to insufficient administrative funding from Congress. CDRs are projected to save as much as $10 for every $1 spent on a CDR. Eliminating the CDR backlog and keeping up with CDR obligations timely is projected to save hundreds of millions in benefits.

The GAO recommended that SSA take steps to ensure needed information, such as secondary impairment data and school records, is consistently collected; and conduct additional childhood CDRs. SSA objected to the last recommendation, citing resource constraints. The full report is available at http://www.gao.gov/assets/600/591872.pdf.

Fibromyalgia SSR Issued

On July 25, 2012, the Social Security Administration (SSA) issued Social Security Ruling (SSR) 12-2p: Titles II and XVI: Evaluation of Fibromyalgia. 77 Fed. Reg. 43640 (July 25, 2012). The new SSR became effective immediately. It provides guidance on how to develop evidence to establish that a claimant has fibromyalgia (FM), and how it is evaluated in disability claims and continuing disability reviews.

FM is characterized by widespread pain in the joints, muscles, tendons, or nearby soft tissues that persists for at least three months. To find a medically determinable impairment (MDI) of FM, the ruling requires there be sufficient objective evidence to support a finding that the person's impairment(s) so limit the person's functional abilities that it precludes him or her from performing any substantial gainful activity. Such evidence can be provided, generally, from an acceptable medical source, i.e., a licensed physician (a medical or osteopathic doctor). A physician's diagnosis alone, however, is not sufficient. The evidence must show that the physician reviewed the person's medical history and conducted a physical exam. The treatment notes must be consistent with a diagnosis of FM, and must track the 1990 American College of Rheumatology (ACR) Criteria for the Classification of Fibromyalgia, or the 2010 ACR Preliminary Diagnostic Criteria.

Under the 1990 criteria, there are three elements for a diagnosis for FM, all of which must be met. First, there must be a history of widespread pain in all four quadrants of the body (right, left, above waist, below waist) for at least three months. Second, the individual must have at least 11 tender points (out of 18 located on each side of the body). To test the tender points, the physician must apply an amount of force that would "blanch the thumbnail." If the person experiences any pain, it qualifies as a positive tender point. Finally, evidence that other disorders that could cause the symptoms or signs must be excluded.

Under the 2010 criteria, there are also three elements, all of which must be met. First, there must be a history of widespread pain (same as 1990 criteria). Second, there must be repeated manifestations of six or more FM symptoms, signs, or co-occurring conditions, with special consideration given to fatigue, cognitive or memory problems, waking unrefreshed, depression, anxiety disorder, or irritable bowel syndrome. The "signs" may be found in Table No. 4 in the 2010 report, and include those listed, among others such as vomiting, ulcers, seizures, dry eyes, etc. Finally, evidence of other disorders that could explain the symptoms must be excluded.

With respect to appropriate documentation, the ruling states that longitudinal records reflecting ongoing medical evaluation and treatment from acceptable medical sources are especially helpful. Evidence for the 12-month period before the date of application is generally required. Evidence from "other" acceptable medical sources may be requested, as well as evidence from medical sources that are not "acceptable medical sources." Evidence from non-medical sources is also helpful (e.g., statements from neighbors, friends, or relatives regarding the individual's ability to function day-to-day and over time).

If evidence is insufficient, SSA will try to resolve the problem, either by re-contacting the treating or other sources for the missing information, requesting additional existing records, asking the person or others for more information, or by making a decision with the information it already has.

A consultative examination (CE) may also be purchased by the SSA to determine if a person has an MDI of FM (or to assess the severity and functional effects of an MDI of FM or other impairment), but not solely to determine if a person has FM in addition to another MDI that could account for his or her symptoms. SSA may rely on this report even if the examiner did not have access to longitudinal evidence if it is determined that the CE is the most probative evidence of record. The SSR notes, however, the importance of longitudinal information given the variability of symptoms over time. It acknowledges that signs and symptoms may vary and "may even be absent on some days."

To assess a person's statements about her symptoms and functional limitations, a two-step process is used.

(Continued on page 5)

OTDA Changes Protect Exempt Benefits

The Office of Temporary and Disability Assistance (OTDA) has altered its Property Execution (PEX) system to prevent the seizure of bank accounts when the respondent is a recipient of Title II or Title XIV benefits. The changes were effective on July 15, 2012. They are a result of complaints that financial institutions restrained accounts and paid over exempt benefits deposited either by the support obligor or through electronic deposit. Federal law prohibits attachment of such benefits under 42 USC §407(a). And federal regulations specify that Title XVI/SSI benefits are not subject to garnishment for child support. 5 C.F.R. §581.104(j).

The revised procedures and notices now include a claim form that recipients may use if their funds are restrained. Specific language was added to the notice and execution to direct the financial institutions not to restrain or execute on exempt funds.

Now, when data matches with SSA show support obligors are receiving exempt Social Security benefits, system edits will prevent OTDA from building a property execution record. The system will automatically terminate the property execution.

The process is also being modified to prevent a new restraining notice from being issued until one year has passed since the previous notice was issued.

OTDA's "Dear Commissioner" letter disseminating these instructions is available as DAP #550. The letter is a bit confusing as to whether both Title II and Title XVI/SSI benefits are protected under this new directive. Kevin Boyle, the author of the letter and head of the NYS Child Support Enforcement Bureau, has confirmed that the language on page two, which refers to both Title II and Title XVI, is controlling. Thanks to Susan Antos of the Empire Justice Center for her help in obtaining this clarification.

Fibromyalgia SSR Issued—Continued

First, there must be medical signs and findings that show the person has an MDI that could be expected to produce the pain or other symptoms alleged. Second, SSA will evaluate the intensity and persistence of the person's pain or any other symptoms and determine the extent to which the symptoms limit the person's capacity for work. If the evidence does not substantiate the statements, SSA will consider all of the evidence in the case record.

Finally, SSA will find a person disabled based on an MDI of FM by using the five-step sequential evaluation process (i.e., is the person doing substantial gainful activity? Is the MDI severe? Does the impairment meet or equal a listing? Is the person capable of doing any past relevant work? Does any other work exist in significant numbers in the national economy?). The SSR reminds adjudicators that widespread pain and other symptoms associated with FM may result in both exertional and nonexertional limitations, and refers to SSR 85-15 regarding using the Medical-Vocational Guidelines at Step five of the sequential evaluation as a framework.

SSR 12-2p should prove helpful to claimants, if for no other reason than it recognizes FM as a legitimate basis for disability - something that not all ALJs have been willing to accept to date, despite reminders otherwise from the federal courts. *See, e.g., Green-Younger v. Barnhart,* 335 F3. 3d 99 (2d Cir. 2003). Prior to the issuance of this ruling, the only guidance SSA had provided was in a footnote to SSR 99-2p on Chronic Fatigue Syndrome.

Many thanks to Roman Griffith, an attorney intern at the Empire Justice Center, for his summary of SSR 12-2p.

To date, by the way, there is no SSR 12-1p!

REGULATIONS

Final Regulation Allows Skipping Step Four

The September 2011 edition of the *Disability Law News* reported on a proposed regulation that would allow adjudicators to by-pass Step four of the sequential evaluation, relieving them of the obligation to develop evidence of the claimant's "past relevant work" (PRW) in certain cases. The proposed "Expedited Vocational Assessment" rule was finalized in record time, and became effective on August 24, 2012. 77 Fed. Reg. 43492 (July 25, 2012). http://www.gpo.gov/fdsys/pkg/FR-2012-07-25/pdf/2012-17934.pdf.

In equally record time, SSA has made permanent its previous temporary instruction at POMS DI 25005.005 - Expedited Vocational Assessment at Steps 4 and 5. The new instructions apply at the hearing and Appeals Council levels, as well as at DDS. https://secure.ssa.gov/apps10/public/reference.nsf/links/08312012111555AM.

SSA "expect[s] that this new expedited process will not disadvantage any claimant or change the ultimate conclusion about whether a claimant is disabled, but it will promote administrative efficiency and help us make more timely disability determinations and decisions…" SSA claims that the process of gathering work history is "time-consuming," "labor-intensive," leads to delays, and requires adjudicators to divert limited resources. Under the new regulation, if the claimant would be found not disabled at Step 5 of the sequential evaluation based solely on age, education, and residual functional capacity (the "grids"), the adjudicator has the discretion to skip over Step four.

On the other hand, if the claimant is unable to adjust to other work, the adjudicator must return to Step four and develop PRW and make a full determination. The adjudicator must also consider SSA's "special medical-vocational profiles" that show an inability to adjust to other work. The profiles include claimants with no more than marginal educations who did only arduous, unskilled labor for 35 years or more; or claimants at least 55 years old, with no more than limited education and no PRW. 20 C.F.R. §§404.1562 & 416.962.

Comments to the proposed regulations expressed concern that the expedited process might give adjudicators too much discretion, and might lead to records that are not fully developed. Advocates should be on the look out to make sure this is not happening under the new regulation.

Application Signature no Longer Required

Effective July 13, 2012, POMS §§ GN 03103.010, SI 04040.020, and GN 03104.100 were revised to eliminate the requirement for "wet" signatures when requesting ALJ hearings and Appeals Council review. According to SSA, "The regulations require a person who wishes to appeal our determination or decision to submit a written request for appeal. The regulations do not require a person to sign the appeal request, but our instructions require a signature on the request. To align the instructions with the regulations, we revised the instructions by removing the signature requirement information."

This change is presumably prompted by SSA's increasing reliance on electronic filings. The requirement for a "wet" signature would make such filings cumbersome. Note that POMS § GN 03103.010 regarding hearing requests only covers Title II entitlement cases. The POMS governing SSI cases were not changed, presumably because online requests for ALJ hearings in SSI cases are still not permitted.

New Notary Rule Proposed

In an effort to prevent notaries advertising in foreign languages from misidentifying themselves as attorneys or immigration professionals, the New York State Department of State has announced a new rule requiring disclaimers. The notary's advertisement must state: "I am not an attorney licensed to practice law and may not give legal advice about immigration or any other legal matter or accept fees for legal advice."

According to NY Secretary of State Cesar A. Perales, "These new regulations will ensure that individuals will not misidentify themselves by clearly stating they are not authorized to practice law or give legal advice. Furthermore, anyone who is not playing by the rules will be stripped of their licenses and fined accordingly."

The most recent Notary Public Licensing Law is available on the Department of State's website at www.dos.ny.gov.

Hearing Audio Now Available Online

Want to dazzle your colleagues with your brilliant cross-examination of the vocational expert at your latest hearing? Or to confirm that he actually said what you think he said? Or just want to avoid waiting interminably for the Appeals Council to respond to your request for a copy of the hearing CD? As of August 25, 2012, appointed representatives enrolled with ARS (Appointed Representative Services) have the capability to download and listen to audio hearings in their client's claims via the new Multimedia File of the Electronic Folder. This feature is only available for cases at the Hearings and Appeals levels that are pending, reactivated, or closed within the past 90 days. According to SSA, the recordings should be available within 48 hours after the ALJ hearing.

To accommodate the addition of the hearing recording, the Electronic Records Express Access to Electronic Folder page will now include a tab for "Multimedia Files." You will be able to download the selected multimedia file. As with obtaining access to exhibits and documents, you will receive an email within 48 hours that the files requested are ready. Once the file is downloaded, you need to unzip and then listen to the audio through the FTR player (same as presently used for the CDs).

The revised and updated "User Guide for Access to the Electronic Folder" (August 2012 edition) includes instructions for downloading the multimedia file. A link for "User Instructions" is at the top right hand side of the main menu page. If you experience any problems viewing the electronic folder, try refreshing the page using Ctrl+F5 on Windows machines and Cmd+F5 on Macintosh machines. If the issue remains, clear the browser cache/history and log back into the system.

Online availability of the hearing recording should have a big impact on Appeals Council workloads, as representatives with online access will no longer need to request a CD recording of the hearing. But how this will impact the Appeals Council Request for Review process? You still need to file a Request for Review, and ask for a 25 day extension to submit legal argument or new evidence and, of course, a new bar code! When you receive the letter with the barcode, there should be a notation that recording is available on ARS. The 25-day extension begins as of the date of the letter. If for some reason, the recording cannot be downloaded, send a detailed request for an additional extension to the appropriate branch both with the barcode and via fax.

If you do not yet have online access and would like to register, contact your hearing office and request an invitation to enroll.

COURT DECISIONS

Court of Appeals Upholds VE Testimony

The Court of Appeals for the Second Circuit dealt a blow to challenges to the accuracy and reliability of vocational expert (VE) testimony in *Brault v. Social Sec. Admin. Com'r,* 683 F.3d 443 (2d Cir. 2012). The Court ruled that an ALJ is not required to state expressly his reasons for accepting challenged vocational testimony, nor is the ALJ required to grant the claimant an opportunity to inspect and challenge the VE's evidence.

The claimant, through his representative, had objected to the VE's testimony as unreliable. In essence, the claimant mounted a *Daubert* challenge, which holds that "general acceptance" of scientific evidence is not a precondition to admissibility under Federal Rule of Evidence 702; rather, a court must find that the expert's testimony rests on a reliable foundation and is relevant. *Daubert v. Merrell Dow Pharmaceuticals, Inc.*, 509 U.S. 579, 113 S.Ct. 2786, 125 L.Ed.2d 469 (1993). The claimant had challenged what many advocates view as the less than scientific methods most VEs use to "extrapolate" from data to arrive at the numbers of available jobs in the economy. He was relying on a line of cases, mostly from the Seventh Circuit, holding that although the Federal Rules of Evidence do not apply in Social Security claims, the "spirit" of Rule 702 should. *See, e.g., Donahue v. Barnhart,* 279 F.3d 441, 446 (7th Cir. 2002).

From the outset, in what it acknowledged was a case of first impression, the Second Circuit made clear that *Daubert* is not applicable in administrative proceedings. The Court reviewed the claimant's challenges to the VE's numbers, under which he had argued that the VE had no scientific basis to break down the various DOT (Dictionary of Occupational Titles) jobs and match, or "cross-walk," them to the SOC (Standard Occupational Classification) codes. Claimant's counsel cross-examined the VE on this "data aggregation" issue, and submitted a post-hearing brief as well. The ALJ, however, never addressed these arguments, instead issuing a ruling relying on the VE's testimony.

Brault argued that once the VE testimony was challenged, the ALJ was required to allow the claimant to inspect and challenge the proferred evidence, and if the ALJ relied on the challenged evidence, explain why the challenge was rejected. The Court rejected both arguments, refusing to extend to the Second Circuit the *Daubert* type rule adopted in the Seventh. It cited its own non-precedential decision in *Galiotti v. Astrue*, 266 Fed.Appx. 66 (2d Cir.2008), which upheld the ALJ's reliance on VE testimony even though the VE was unable to explain fully how he arrived at the numbers of jobs to which he testified. The Court noted that absence of any applicable regulation or decision requiring a VE to identify with greater specificity the source of his figures.

The Court conceded, however, that "the extent to which an ALJ *must* test a VE's testimony is best left for another day and a closer case." It specifically noted that it was not holding that an ALJ need never question reliability, and agreed with the Seventh Circuit that evidence cannot be "conjured out of whole cloth." Rather, it found that in this case, the ALJ - although not ruling on them - had obviously considered Brault's challenges and found them unavailing.

We await that other day and closer case in which a VE's conjured numbers can be challenged in a meaningful way.

District Court Remands for MSS

U.S. District Court Judge Michael A. Telesca ordered a remand for development of a Medical Source Statement (MSS) - or RFC (Residual Functional Capacity) assessment - from the treating physician in *Ubiles v. Astrue,* 2012 WL 2572772 (W.D.N.Y., July 2, 2012). The court faulted the ALJ for making an RFC determination without the benefit of a function-by-function assessment of the plaintiff's limitations from an acceptable medical source.

Plaintiff Ubiles was a forty-two-year-old woman who suffered from low back pain. The court's recitation of the facts – underscoring that there was little or no objective evidence corroborating the back pain, and that the complaints of pain waxed and waned – would give the impression that an affirmance was in the works. Instead, the judge focused on plaintiff's argument that the ALJ did not properly develop the record by obtaining medical records from all of her providers. Of note, the plaintiff's attorney had told the ALJ at the hearing that he was trying to obtain a MSS from the treating physician, for which the record was left open. The assessment was apparently never submitted, but the ALJ did not refer to it in his decision, nor did the Appeals Council.

Judge Telesca stated that although the claimant has the general burden of proof, the ALJ nonetheless has an obligation to help develop the record in these non-adversarial proceedings. He emphasized that the obligation was particularly important in regard to treating source evidence, citing the Commissioner's statutory obligation to make every reasonable effort to obtain evidence from the treating source prior to evaluating the medical evidence. And here, where there was no function-by-function assessment by the treating source, there was a clear gap in the record. The ALJ's decision did not indicate whether the ALJ had tried to fulfill his duty. The court thus found that the ALJ's failure to develop the record represented a violation of the treating physician rule.

The ALJ had instead rejected two references in the treating physician's office notes that plaintiff was "presently disabled" as "vague and non-specific." While the court acknowledged that these notes failed to indicate function-by-function limitations, it found that it would be unreasonable to expect a physician, on his own accord, to make such an assessment in the course of treatment. It was up to the ALJ to request a more detailed assessment. Lacking the proper assessment from the treating source, the ALJ compounded his errors by relying on the opinion of the consultative examiner (CE). The court found that the CE's vaguely stated limitations were not consistent with the ALJ's RFC finding of sedentary work.

The ALJ also erred in failing to develop the record with regard to plaintiff's other medical providers. The record referenced multiple emergency visits and visits to specialists, yet their records were not obtained. Instead, the ALJ penalized the plaintiff for their absence, finding that there were no corroborating opinions by specialists or consultants. As a result, the court found that the failure to develop the record in this regard could not be considered harmless error, as the ALJ relied on these perceived gaps to find the plaintiff not disabled. The court dismissed the Commissioner's defense that the claimant had failed to mention these other treating sources in the paperwork she completed, as it was apparent from the face of the record that this information was missing.

Ultimately, Judge Telesca found that the ALJ's RFC determination was not supported by substantial evidence because he has not performed a function-by-function analysis based on medical evidence. Instead, he had erroneously substituted his own opinion in the absence of a medical opinion. Although the court held that it already had sufficient basis for remanding the claim, it also addressed plaintiff's credibility argument, holding that was erroneous for the ALJ to find the claimant's statements not fully credible simply because they are inconsistent with his own RFC finding – a piece of boilerplate that we see all too often in ALJ decisions. See the June 2012 edition of this newsletter for a discussion of this issue.

Of note, Judge Telesca was the district court judge who upheld that ALJ's decision in the *Cage* case discussed on page one of this newsletter. In *Cage,* both Judge Telesca and the Court of Appeals held that the ALJ was not obligated to seek an opinion regarding DAA materiality from the claimant's treating source.

DOMA Found Unconstitutional - Again

The U.S. District Court for the District of Connecticut has joined the growing ranks of courts that have found parts of the 1996 Defense of Marriage Act (DOMA) unconstitutional. On July 31, 2011, Judge Vanessa Bryant ruled that Section 3 of DOMA, which defines marriage as a legal union between one man and one woman, violates the 14th Amendment right to equal protection. *Pedersen v. Office of Personnel Management, et al.*, 3:10-cv-1750(VLB).

The named plaintiffs in *Pedersen* included six same-sex married couples who sued after being denied various types of federal benefits, including Social Security death benefits (lump sum payments). Although DOMA does not formally invalidate same-sex marriages recognized in various states, it prevents couples of these marriages from enjoying the panoply of federal benefits available to heterosexual couples, including Social Security auxiliary and survivors' benefits. The judge held that DOMA improperly excluded a certain category of marriages from federal recognition, and granted summary judgment to the plaintiffs. Judge Bryant denied a motion to dismiss filed by BLAG - the Bipartisan Legal Advocacy Group of the U.S. House of Representatives, which had moved to intervene after the U.S. Justice Department refused to defend Section 3 of DOMA. See the March 2011 edition of the *Disability Law News.*

The *Pedersen* decision closely followed *Windsor v. United States*, 833 F.Supp. 2d 394 (S.D.N.Y. 2012), in which the surviving spouse in a same-sex marriage had sued seeking refund of federal estate taxes, claiming the Section 3 of DOMA violated the Equal Protection Clause. U.S. District Judge Barbara S. Jones held that DOMA was unconstitutional under a rational basis standard of review.

Both cases are expected to be appealed to the Second Circuit Court of Appeals. The Court of Appeals for the First Circuit has already ruled on Section 3 of DOMA, finding it unconstitutional. Petitions for *certiorari* have been filed in *Massachusetts v. U.S. Department of Health and Human Services*, 682 F.3d 1 (1st Cir. 2012).

Social Security Court Cases Increasing

Readers may not be surprised to learn that the number of lawsuits filed by claimants against the Social Security Administration has risen in recent years. According to statistics compiled by TRAC (Transactional Records Clearinghouse at Syracuse University), there were 19.4% more SSDI/SSI appeals filed in 2012 than in the same period the previous year. According to TRAC's data, the 2012 filings were up 62.6% from levels reported in June 2007.

The largest number of filings was in the Middle District of Florida (Tampa), followed by the Central District of California (Los Angeles). TRAC reported great variation among filings in each of the ninety federal judicial districts, with the Wyoming recording no filings. TRAC ranked the ten districts with the most lawsuits and the ten districts with the fewest. New York courts did not appear in either list.

The full report is available at http://trac.syr.edu/whatsnew/email.120727.html.

ADMINISTRATIVE DECISIONS

David Conquers Goliath?

A recent victory by paralegal Gabrielle Quinn of Nassau-Suffolk Law Services proves that the underdog can sometimes win - especially with zealous advocacy on his side. Gabrielle's client had been notified by SSA that he had allegedly been overpaid approximately $113,000 in Social Security Disability (SSD) benefit payments over the course of 10 years. The gist of the SSA's contention was that the recipient's SSD should have ceased in 2000 because of his earnings.

Mr. D's problems began a number of years ago, when he called SSA to report a change of address. The SSA representative reviewed his file and questioned whether Mr. D was still eligible for disability payments. Mr. D was informed that SSA would investigate his case and contact him following its investigation. Mr. D did not hear back from SSA, so assumed he was still eligible. A year later, Mr. D received a notice from SSA requesting additional information about his earnings. Mr. D complied with this request, and continued to receive his benefits until 2008.

In 2010, almost ten years after the initial contact, Mr. D received a notice that he was overpaid because he had been ineligible since 1999. It was then that Mr. D found Gabrielle Quinn, who determined that Mr. D had consistently notified SSA of his work activities by calling the designated 800 number. Not surprisingly, SSA denied receiving any work activity reports.

Gabrielle filed a request for a waiver of the overpayment, arguing that Mr. D meet the two prong standard for waiver: that the client does not have financial means to repay the overpayment amount in question; and that the client has not, either directly or indirectly, been at fault for the overpayment made by the government.

In August of 2011, Gabrielle appeared with Mr. D before an Administrative Law Judge. The ALJ was persuaded by Gabrielle's arguments and granted a full waiver of the overpayment. The ALJ took a particularly dim view of SSA's handling of the matter, finding that SSA had more than ample time and multiple opportunities to identify and correct the overpayment problem. The ALJ found that to seek payments from Mr. D would be unduly harsh in light of the SSA's continuing course of payments over the ten-year period.

This case is yet another outstanding example of how hard work and dedication can help the claimants overcome the maze of Social Security overpayments. Great work by Gabrielle Quinn - and thanks to Philip Brookmeyer, Pro Bono Attorney, for sharing her story.

Do I Have to Submit That Report?

Disability advocates can debate endlessly the pros, cons, and ethical quandaries of what evidence must be submitted to SSA. Suffice it to say, other interpretations and state bar rules aside for the moment, there is currently some wiggle room. For example, Chief Administrative Law Judge Debra Bice has apparently announced at various CLE events that representatives do not have to submit "all" evidence. They do not need to submit adverse evidence - with two exceptions: representatives cannot redact medical records, nor can representatives refuse to submit an identified report. For example, if a claimant testifies that her treating physician prepared a report, the representative must submit it upon request.

Appeals Council Amends Onset Date

An Appeals Council victory by Attorney David Ralph of the Elmira office of LawNY underscores the value of submitting new evidence to the Appeals Council. David's client has a bipolar disorder and a long-standing history of psychiatric problems. He also suffered a traumatic brain injury (TBI) in 2007. He received a partially favorable decision from an ALJ, granting an onset coinciding with the TBI.

David objected to the onset, arguing that his client was disabled at least as early as 2005. David marshaled a great deal of new evidence for the Appeals Council, including reports from treating sources, and family and friends corroborating his many limitations and suicidal tendencies. An Appeals Council staff member actually contacted David, and commented on the amount of evidence that pointed to pervasive and long held suicidal thoughts and the futility of the various treatments tried over the years. The Appeals Council cited to that evidence in reversing the ALJ's finding and granting the earlier onset date that David requested.

David notes the value of sending the ALJ's decision to the treating psychiatrist, who then commented specifically on the ALJ's findings. Her statement that the claimant had been consistently disabled since she began treating him in 1994 was quoted by the Appeals Council. The Council was also persuaded by a neurological/psychological evaluation performed at Syracuse University, in which the examiner specifically opined that the claimant's current impairments began when the claimant was young, well before the TBI. The Appeals Council also noted that the third party statements submitted by David were consistent with the medical opinions of record. The Appeals Council also relied on the opinion of its own medical consultant, who found that the claimant's bipolar disorder meets Listing 12.04.

Congratulations to David, whose powers of persuasion are more than evident - not only in his arguments to the Appeals Council but also in his ability to convince the treating and third party sources to provide such compelling evidence. The amended onset vindicated both the claimant and his physician. And the additional Title II benefits will undoubtedly make the client's life a little bit easier.

ALJ Approves JRA Claim

Advocacy on the part of Buffalo Bruce Caulfield of Neighborhood Legal Services also underscores the importance of following up with treating sources. Bruce represented a young woman in a concurrent claim who had been diagnosed with Juvenile Rheumatoid Arthritis (JRA) when she was only two years old. Her condition waxed and waned over the years, but had started to flare up again in November 2010, when she was diagnosed with pauciarticular JRA. By January of 2012, she complained of low back pain, wrist pain, and swollen knees that needed aspiration. She was also suffering from side effects of Methotrexate.

Bruce obtained a medical source statement from the claimant's treating rheumatologist that limited his client to less than a full range of sedentary work. The ALJ was apparently persuaded by the doctor's statement. He expressed concern, however, that the laboratory evidence did not show any positive rheumatoid factor or ANA findings, which would be expected in cases of rheumatoid arthritis. At Bruce's request, the rheumatologist provided a statement explaining that JRA usually manifests itself as monoarthritis of large joints, such as the knee, or pauciarticular arthritis of several joints, as opposed to widespread polyarthritis of large and small joints typical of adult rheumatoid arthritis. Positive rheumatoid factors are associated with widespread polyarthritis. JRA - with less joint involvement - is typically RF (rheumatoid factor) negative.

The ALJ included the rheumatologist's statement in his decision, which was fully favorable. Kudos to Bruce for taking the extra effort to get the evidence needed to convince the ALJ.

Does Dire Need Matter at the Appeals Council?

How can you get the Appeals Council to consider the dire needs of your client and move the process along more quickly? Sue Bosworth-Quinlan of Legal Services of Central New York, recommends faxing a request to the "Critical Care Unit" at 703-605-8021. If that is unsuccessful, Linda Landry of the Disability Law Center in Boston, recommends contacting the Congressional Public Affairs Branch at 877-670-2722, and as a last resort, Terri Jensen, the Appeals Council Ombudsperson at 703-605-869 (faxes only).

According to the Appeals Council, a "dire need situation exists when a person has insufficient income or resources to meet an immediate threat to health or safety, such as the lack of food, clothing, shelter, or medical care." Critical Case Procedures are set forth in the HALLEX at https://www.socialsecurity.gov/OP_Home/hallex/I-03/I-3-1-51.html.

Critical situations also arise if the claimant's illness is identified as terminal; the claim is for any military service personnel injured October 1, 2001 or later; the claim has been identified as a "Compassionate Allowance (CAL)" case; the claimant is suicidal, homicidal, or potentially violent; or the case has been delayed an "inordinate" amount of time and "there is a public, congressional, or other high priority inquiry."

Note that some critical situations may intersect with SSR 11-1p, which prohibits the filing of a new application while an appeal is pending - with limited exceptions. [See the September 2011 and June 2012 editions of the *Disability Law News* at www.empirejustice.org for more on SSR 11-1p.] One of those exceptions involves evidence of a new critical or disabling condition, the submission of which will trigger immediate Appeals Council review - even if it does not justify a new application. According to Patricia A. Jonas, the Executive Director of the Appeals Council, the Appeals Council has been screening this type of new evidence in less than ten days from receipt.

Some dire need and critical case situations arise in situations where the claimant is waiting what might be described as an "inordinate" time simply to have an appeal of a dismissal reviewed. Ms. Jonas anticipates that in the near future, the Appeals Council will assign all dismissals to designated staff for expedited processing.

But remember that in the meantime, a request for dire need review and/or permission to file a new application can be made where the appeal involves a dismissal as well as an appeal on the merits.

Are More SSI Recipients Entitled to CDB Benefits?

A recent study by SSA's Office of the Inspector General (OIG) finds that a number of SSI recipients who were potentially eligible for Title II benefits as disabled child beneficiaries were not receiving those benefits. OIG estimates that there are approximately 2,160 such potential beneficiaries, due underpayments totaling approximately $9.6 million.

"Adult children" may be eligible for these Title II benefits - now known as Childhood Disability Benefits (CDB) - when certain criteria are met, such as being dependent on the parent; being age 18 or older and disabled before reaching age 22; and having a parent who is entitled to Disability or Retirement Insurance benefits or was insured at the time of death. A number of such "adult children" may be found eligible for SSI benefits under their own Social Security numbers without consideration of their eligibility for CDB. In some situations, the CDB benefits would serve to offset the SSI payments; in others, they could replace the SSI benefits. This is significant to SSA, as SSI is supposed to a program of "last resort." And of course, it can be very significant to the potential beneficiaries.

OIG identified a number of glitches that caused these errors. SSA has taken action to identify and prevent future missed entitlements, such a reminding staff and providing refresher training. A word to wise, however. Make sure you help identify your own clients who might be eligible for additional benefits and bring them to the attention of SSA.

Anonymous ALJ Policy Questioned

Advocates are trying to adapt to SSA's new anonymous ALJ policy. See the December edition of the *Disability Law News*, available at www.empirejustice.org. Some members of Congress, however, are questioning the viability of the policy. At a June 27, 2012 hearing before the House Ways and Means Social Security Subcommittee, Commissioner Astrue was grilled about it. He testified that he had not realized how much the system was being manipulated by representatives, but refused to give details of the manipulation so as not to provide a "roadmap" for others. He expressed concern that this manipulation by representatives relegated the fifteen percent of unrepresented claimants to the "stingiest ALJs." He claimed he devised the "secret" ALJ policy as a "stop gap," and announced that a workgroup looking at the problem would develop a plan by early August.

Although the August deadline was apparently not met, the Commissioner has been directed by the Senate Committee on Appropriations to come up with a report by November 1st. The policy was discussed in this excerpt from the Committee Report:

> Administrative Law Judge Disclosure Policy.--The Committee is concerned about SSA's new policy to not disclose the name of the ALJ who will preside over a disability appeal until the day of the hearing. The Committee notes SSA's concern with the possibility of claimant representatives abusing the process, specifically as it relates to declining a video hearing or postponing other hearings simply to search for judges they believe are more likely to allow a case. This abuse challenges the integrity of the process and can cause administrative delays. However, such a broad policy change could have unintended consequences. The Committee strongly encourages SSA to consider policies more targeted at suspected abuse, such as sanctions against individual representatives or changes to regulations to prevent representatives from canceling a video hearing close to the hearing date without due cause. The Committee directs SSA to submit a report to the Committee on Appropriations of the Senate no later than November 1, 2012, detailing the type and scope of abuse under the previous policy and alternative policies that were considered or could otherwise be used to address the issue.

http://thomas.loc.gov/cgi-bin/cpquery/?&sid=cp1121aqa2&r_n=sr176.112&dbname=cp112&sel=DOC&

2012 Partnership Conference

The New York Bar Association sponsored Partnership Conference will be held in Albany on September 12-14, 2012. The conference schedule and registration form is available at http://www.nysba.org/AM/Template.cfm?Section=Home&Template=/Conference/ConferenceDescByRegClass.cfm&ConferenceID=5723

Several Social Security training sessions are planned, as well as a statewide DAP Task Force Meeting. Registrations are due on September 7th! Hope to see you there!

OIG Issues Reports Related to Hearing Backlogs

SSA's Office of the Inspector General (OIG) has issued several reports related to reducing the hearings backlog and preventing its reoccurrence.

Office of Disability Adjudication and Review's Process for Scheduling Hearings When Cases are in "Ready to Schedule" Status – A-08-12-21293

The OIG's objective was to identify trends regarding case that were ready to schedule (RTS) at selected ODARs and obstacles that impacted scheduling. Guess what the ODARs and the OIG identified as one of the major obstacles? Maybe it should not come as surprise that claimant representative availability ranked high on the list of ODAR staff. The OIG cites HALLEX I-2-3-10 for ODAR's obligation to schedule hearings quickly and to ascertain the representative's availability. It also cites Model Rules of Professional Conduct R. 3.2 for the representative's obligation to expedite cases. But it goes on to report anecdotes of representatives who refuse to do hearings on Mondays or Fridays, or request multiple postponements. Interestingly enough, in terms of ALJ availability, there was the same issue of Monday/Friday availability - but it was justified as days used to prepare for hearings or write decisions. ALJ Flexiplace, which allows ALJs to work at home, also impacted availability, as did ODAR's policy of allowing ALJs to request reassignment after 90 days. The availability of expert witnesses and rooms were also obstacles.

The OIG acknowledged the difficulties ODARs face in accommodating the schedules and preferences of multiple hearing participants. It recommended, however, that representatives should not have such a strong influence in the scheduling process - although many of us may not agree that we have had much influence! It also encouraged ODAR to analyze ALJ performance data to determine it should take additional steps to address obstacles presented by ALJ schedules and preferences.

Availability and Use of Vocational Experts - A-12-11-11124

The OIG found that the use of vocational expert (VE) services varied widely. For example, VEs were used in approximately 76% of cases nationally in 2010, but in only 35% of cases in New York region. It found variability in the rotation policies at hearing offices, and in the tracking of VE contracts, making it difficult to identify potential availability problems at hearing offices. It also found that while the VE contract rates have increased since 2009, SSA has no process to ensure that the rates are set at a level to avoid potential shortages and ensure quality. The OIG recommended that SSA modify its regulations to allow VE telephone testimony (which is already happening), improve its advertising for VE services, and review its payments procedures.

Congressional Response Report: Current and Expanded Use of Video Hearings - A-05-12-21287

The OIG cited prior reports finding that video teleconferencing (VTC) has given SSA increased flexibility in reducing its backlog. In this report, however, it criticized SSA for failing to monitor VTC costs effectively. For example, SSA is unable to distinguish the time and costs of ALJ traveling to remote hearing sites from those related to training. Nor could it distinguish reimbursement to claimants and representatives to determine what portion could be reduced by more video hearings.

The OIG noted that some ALJs and claimants had objections to video hearings. It emphasized the claimant's right to refuse a video hearing as a source of delay and increased ALJ travel. It reiterated its earlier recommendation that SSA modify it regulations to prevent claimants from refusing video hearings. Although SSA has agreed with OIG's recommendation, to date, it has not proposed amending the regulation. OIG also recommend the expansion of "Desk Video Units."

To see these reports and a full listing of all the OIG reports, go to http://oig.ssa.gov/audits-and-investigations/audit-reports/all?field_audit_issue_tid=18&=Apply.

WEB NEWS

Getting Treating Source Evidence Made Easier

Advocates from Legal Services of New Jersey have developed a website entitled "Physician's Guide to Documenting Disability in Adult Social Security Claims" with links to forms for treating sources to use in preparing reports for their patients (our clients). http://www.lsnjlaw.org/english/disability/documenting/adultssclaims/index.cfm

Materials Available to Help Advocates Communicate Better

Many of the clients served by legal aid and pro bono advocates have limited English proficiency or literacy skills. Roughly 50% of native English-speaking Americans are unable to read at the 8th grade level; another 20% are only functionally literate. Limited English speakers find it particularly difficult to navigate legal texts that contain strange words and describe unfamiliar procedures. A new website offers a plain language library of legal education materials and forms, as well as an online tool to help users spot language that could be improved to be more clear. www.writeclearly.org

Guidebook for Veterans with Disabilities Published

The Institute for Veterans and Military Families ("IVMF") at Syracuse University in collaboration with Griffin-Hammis Associates LLC has released "Navigating Government Benefits & Employment: A Guidebook for Veterans with Disabilities." The guide, intended for veterans and their families, is not just about Veterans Administration (VA) benefits, but also covers TriCare, Medicare, Social Security, employment services and other benefits as well. The guide may be a valuable go-to reference for advocates with clients having questions in this topic area. http://vets.syr.edu/pdfs/benefits-guidebook.pdf

Discover a How-To for Rating Depression

A form for clients to use to self-rate their symptoms of depression is available. This form may help advocates to get specific evidence in the file that may not otherwise be covered in medical evidence, in other SSA documents, or in testimony. http://healthnet.umassmed.edu/mhealth/ZungSelfRatedDepressionScale.pdf

New Resources for Advising Senior Citizens with Disabilities Issued

Two useful resources on managed long term supports and services (LTSS) for older adults and people with disabilities LTSS are now available:

- AARP released a new analysis of existing managed LTSS programs in various states, *Keeping Watch: Building State Capacity to Oversee Medicaid Managed Long-Term Services and Supports*. This report identifies trends and variations in program design as well as best practices in areas like quality control and oversight.
- MMCO announced a new website, www.medicaid.gov/mltss/, to serve as a general resource on different features of managed LTSS program design.

WHAT IS...

What Is...Transverse Myelitis

Transverse Myelitis (hereinafter "TM") is a neurological disorder caused by inflammation across both sides of one segment of the spinal cord. TM is a rare disorder described as a "softening of the spinal cord." Myelitis means inflammation of myelin, which is the fatty insulating substance that covers nerve cell fibers. The term "transverse" is used, because patients report a band-like horizontal area of altered sensation on the neck or torso. Below this band-like area, sensation is either entirely absent or dramatically altered, but above the area, sensations were normal. The attacks of inflammation across spinal cord segments can damage or destroy myelin, and this damage can cause nervous system scars that interrupt communications between the nerves in the spinal cord and the rest of the body.

There are four major symptoms of TM: 1) weakness of the legs and arms; 2) pain; 3) sensory symptoms such as numbness or tingling; and 4) bowel and bladder dysfunction. The primary symptom, however, is pain, with up to 50% of patients reporting pain as the first presenting symptom of TM. Additionally, progression of TM can lead to full paralysis of the legs.

There is no cure for TM. However, TM is typically a monophasic illness, meaning that it only occurs one time. About one-third of all persons diagnosed with TM will experience a full recovery, usually beings within two to 12 weeks of the onset of symptoms, which may continue for up to two years. However, approximately one-third of people affected show no recovery at all, remaining wheelchair-bound or bedridden. Treatment for TM includes anti-inflammatory drugs and medications, and rehabilitative therapy.

With respect to the Social Security Administration's sequential evaluation process for determining disability, the question arises whether TM possibly medically equals any Listing, the step three inquiry. Listing 14.00 Immune System Disorders, is worth looking at since TM occurs when the immune system becomes abnormally activated and attacks and injures the nervous system. Additionally, it is estimated that 40% of all TM cases are associated with autoimmune disorders such as Multiple Sclerosis and Sjorgen's Syndrome. (See the June 2012 *Disability Law News* for a discussion of Sjorgen's Syndrome).

For more information on Transverse Myelitis, see the following links:

1. *Transverse Myelitis Association:* www.myelitis.org

2. *National Institute of Neurological Disorders and Stroke:* www.ninds.nih.gov/disorders/transversemyelitis/detail_transversemyelitis.htm

3. *Mayo Clinic:* www.mayoclinic.com/health/transverse-myelitis/DS00854

4. *John Hopkins:* www.hopkinsmedicine.org/neurology_neurosurgery/specialty_areas/transverse_myelitis/about-tm/what-is-transverse-myelitis.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

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.

Lawrence v. Chater, 116 S. Ct. 604 (1996)

The Court remanded a case after SSA changed its litigation position on appeal. SSA had actually prevailed in the Fourth Circuit having persuaded that court that the constitutionality of state intestacy law need not be determined before SSA applies such law to decide "paternity" and survivor's benefits claims. Based on SSA's new interpretation of the Social Security Act with respect to the establishment of paternity under state law, the Supreme Court granted certiorari, vacatur and remand.

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

***Vincent v. Astrue,* 651 F.3d 299 (2d Cir. 2011)**

In a case involving EAJA (Equal Access to Justice Act) attorney fees, the Second Circuit held that counsel representing Social Security claimants cannot be penalized on fee petitions "for failing to address issues collateral to the disability determination as to which counsel had no notice." The district court had found that although the ALJ had failed to develop the record, counsel should have should have addressed the underdeveloped issues as part of "his ethical obligation to act with reasonable diligence." The Court of Appeals found that the district court "demanded too much of counsel." Counsel should not have "to anticipate and refute all conceivable credibility issues…." His perceived failure to anticipate what were essentially collateral issues to the finding of disability were not "special circumstances" justifying a reduction in his EAJA award. The responsibility for the gaps in the records fell exclusively on the ALJ.

***Genier v. Astrue,* 606 F.3d 46 (2d Cir. 2010)**

Court of Appeals remanded for further proceedings where the ALJ's decision was based on a serious misunderstanding of the claimant's testimony. The claimant's testimony relating to his ability to perform household chores at the time of the hearing did not pertain to the time when he completed the questionnaire or to any time prior to his bariatric surgery. Since the ALJ's adverse credibility finding, crucial to the rejection of the claim, was based on a misreading of the evidence, the court held that it did not comply with the ALJ's obligation to consider all relevant medical and other evidence, citing 20 C.F.R §404.1545(a)(3).

***Zabala v. Astrue,* 595 F.3d 402 (2d Cir. 2010)**

Commissioner's decision upheld where ALJ's failure to consider a report from plaintiff's psychiatrist because it was "incomplete and unsigned," while incorrect, did not necessitate remand since the correct application of the treating physician would still lead to the conclusion that the plaintiff could return to her past relevant work. Case involved a "closed period" of disability, based on an agreement by counsel at the hearing to amend the time-period in issue to the period before the plaintiff allegedly began performing substantial gainful activity (SGA). The Court rejected the plaintiff's arguments on appeal that the ALJ should have done more to develop the record regarding the actual work activity. It also held the plaintiff's attorney had the authority to amend the period under review.

***Encarnacion ex rel. George v. Astrue*, 568 F.3d 72 (2d Cir. 2009) ("Encarnacion II"), cert. denied 130 S.Ct. 2342, 176 L.Ed.2d 576 (U.S. 2010).**

The Court rejected plaintiffs' challenge to SSA's policy preventing adjudicators from adding together less than marked limitations from separate domains and prohibiting SSA from adjusting the level of limitation in one domain to reflect the impact of limitations in other domains. The Court deferred to the Commissioner's interpretation of focusing on combined impairments within each domain rather than across domains. It held that the Commissioner's interpretation satisfies the test that each of a claimant's impairments be given at least some effect during each step of the disability determination process because SSA considers all impairments within each domain.

***Poupore v. Astrue*, 566 F.3d 303 (2d Cir. 2009)**

The Court agreed the opinion of the treating orthopedist that the claimant could perform "sedentary, light-duty" supported the ALJ's finding that the claimant had the residual functional capacity (RFC) for light work. It found that the need to get up and move around from time to time does not preclude an ability to perform sedentary work. It also upheld the ALJ's credibility finding, observing that the ALJ correctly noted the claimant's level of daily activities, including caring for his one-year old child. Finally, the Second Circuit adopted the Commissioner's argument that 20 C.F.R. §404.1560(c)(2)(2003) abrogated Curry v. Apfel, 209 F.3d 117 (2d Cir. 2000), clarifying that the Commissioner need not provide additional evidence of RFC at Step five of the sequential evaluation. Plaintiff's argument that the regulations should not be applied retroactively was deemed waived since it was not raised in the district court.

***Kohler v. Astrue,* 546 F.3d 260 (2d Cir. 2008)**

In a mental impairment case, the Second Circuit held that the ALJ's failure to adhere to the regulations requiring the application of a "special technique" at Steps two and five of the sequential evaluation constituted grounds for remand. The court agreed with several other circuits in finding remand appropriate where the ALJ's noncompliance with 20 C.F.R. §404.1520a(e)(2) resulted in an inadequately developed record in terms of the four functional areas: activities of daily living; social functioning; concentration, persistence, or pace; and episodes of compensation. The court also criticized the ALJ for focusing in isolation on the treating source's use of the word "stable," and for failing to consider the opinion of the nurse practitioner, where she was the only medical professional available the very rural 'North Country' of New York State.

GAO Finalizes Modernization Study

In the March 2012 edition of the *Disability Law News*, we reported on the preliminary findings made by the GAO (Government Accountability Office) on SSA's Modernization Programs. The final report, GAO-12-420 (June 2012), is entitled "MODERNIZING SSA DISABILITY PROGRAMS - Progress Made, but Key Efforts Warrant More Management Focus," and is available at www.gao.gov.

As in the preliminary report, the GAO criticized SSA's inability to update its listings in a timely manner. It emphasized how outdated several of the listings are, noting that they are no longer relied upon regularly for determinations. It observed that in earlier years, 90% of claims were decided under the listing; currently, only 47% are. It recommended that SSA identify the resources needed to achieve its five-year time frame for updating the medical listings.

The GAO also reiterated its earlier criticism of SSA's attempt to develop a new occupational information system to replace the DOT (Dictionary of Occupational Titles). It found that SSA had not followed best practices in its cost estimate, schedule, and risk assessment for its proposed occupational information system (OIS). It recommended that SSA consider "feasible alternatives" that could reduce the risks, including leveraging O*NET, now used by the Department of Labor, but rejected by SSA as not sufficiently detailed for its purposes. It also suggested adjusting the scope of the OIS, limiting data collection, and leveraging resources from other agencies.

SSA agreed with the GAO's recommendations in terms of the listings and OIS, but took issue with the third recommendation: modernizing the disability criteria by looking beyond the claimant's medical condition and placing more emphasis on his or her functional capacity. The GAO references an on going research effort with the National Institutes of Health (NIH) to develop "a computer-based tool to rapidly and reliably assess the functional abilities of individual claimants considering their medical conditions," which SSA hopes to pilot by 2016. The GAO found this promising but in the preliminary stages, as are some of SSA's other efforts to incorporate its use of functional criteria throughout the disability determination process.

SSA's major objection was to the GAO's recommendation to incorporate assistive devices and workplace accommodations into the disability process. SSA argued that the Americans with Disabilities Act of 1990 (ADA) addresses requirements for workplace accommodations. It referred to a 1999 Supreme Court case that acknowledged the complexity of SSA involvement in determining the availability of reasonable accommodations. It noted that ADA determinations are separate from disability determinations under the Social Security Act, citing *Cleveland v. Policy Management Systems Corporation* to point out that assessing reasonable accommodations may turn on highly disputed workplace-specific matters; an SSA misjudgment about that detailed matter could deprive a disabled person of the financial support the statute provides. The GAO reiterated that SSA should nonetheless continue to research the availability of selected devices and accommodations and the impact of their inclusion on disability determinations.

END NOTE

Is Honesty the Best Policy?

According to a recent study, honesty may not only be the best policy, but may also be good for your health. Anita Kelly, a psychology professor at the University of Notre Dame in Indiana, conducted an "honesty experiment," the results of which she reported at the American Psychological Association's annual convention. Professor Kelly wanted to find out if living more honestly could lead to better health.

The study, conducted over ten weeks, involved 110 participants who reported weekly to complete health and relationship measures. They also took polygraphs tests to assess the number of major and "white lies" they told during the week. Half of the participants were told to stop telling lies for the ten weeks. They were allowed to omit truths, refuse to answer questions, and keep secrets - but not tell any lies for any reason. The other half received no instructions about truth telling. Americans on average, by the way, supposedly tell about eleven lies per week according to Professor Kelly.

During the ten-week period, the researchers observed a strong link between less lying and better health. When the participants in the "no-lie" group told fewer than three white lies per week, they experienced about four fewer mental health complaints and three fewer physical complaints. Members of the control group who told three fewer white lies only experienced two fewer mental health complaints, and one fewer physical. The pattern was similar for "major" lies. When participants in both groups lied less in a given week, they reported significantly better mental and physical health. And those in the more truthful group reported that their social interactions had gone more smoothly in the weeks that they told fewer lies.

In the end, participants realized that it was not so hard to stop lying in day-to-day interactions. Some learned they could just tell the truth about their accomplishments rather than exaggerating. Others stopped making false excuses for being late or missing a deadline. And some learned to avoid lying by learning how to avoid answering the question!

For more on Professor's Kelly research, see http://newsinfo.nd.edu/news/32424-study-telling-fewer-lies-linked-to-better-health-relationships/