SCHEDULE

8:00  Registration and Continental Breakfast Buffet

8:20  Welcome
Presider: Judge Ollie L. Garmon
SSA Office of Disability Adjudication & Review
Atlanta, Georgia

8:30  Nuts and Bolts of Handling a SSD Case: The Top 20 Things You Need to Know
Peter J. Lemoine
Social Security Disability Practice
Cottonport, Louisiana

9:30  Ethics Issues: Fee Splitting and Permissible Referral Fees
Janet P. Cox
Cox & Reynolds LLC
Birmingham

10:00 Refreshment Break

10:10 Preparing Your Client to Testify (includes 30 minutes of Ethics)
R. Michael Booker
R. Michael Booker PC
Birmingham
John M. Pennington
Pennington Law Firm LLC
Birmingham

11:40 Lunch on your own

12:40 What Judges Are Looking For
Moderator: Judge Ollie L. Garmon
Regional Chief Administrative Law Judge
SSA Office of Disability Adjudication & Review
Atlanta, Georgia

Residual Functional Capacity (RFC)
David Stephens
Administrative Law Judge
Office of Disability Adjudication & Review
Birmingham

Assessing Credibility
William Lawson
Administrative Law Judge
Office of Disability Adjudication & Review
Birmingham

Evaluating Medical Source Statements
Cynthia W. Brown
Administrative Law Judge
SSA Office of Disability Adjudication & Review
Birmingham

2:40 Refreshment Break

2:50 Lost in Translation: How to Interpret the Earnings Record
Susan Nadell
SSA Office of Disability Adjudication & Review
Birmingham

Video Hearings: The Testimony of Medical Experts
James A. Abernathy II
Abernathy Disability Law LLC
Tuscaloosa

3:50 Adjourn
2014 Social Security Disability Seminar
The University of Alabama School of Law – Tuscaloosa
Friday, October 24, 2014

FACULTY

James A. Abernathy II, Abernathy Disability Law LLC, Tuscaloosa
Mr. Abernathy received his B.A. and his J.D. from The University of Alabama. His practice is limited nearly exclusively to the area of Social Security Disability, but occasionally he will assist other lawyers with Workers Compensation briefs and appeals. Mr. Abernathy is a member of the Tuscaloosa County Bar Association, the Alabama State Bar, the Alabama Association for Justice, and a sustaining member of the National Organization of Social Security Claimants' Representatives. From 1999 until 2012, he was a contributing author to Alabama Workers' Compensation Law and Handbook, and from 2004-2007 taught Workers' Compensation at The University of Alabama School of Law. Mr. Abernathy is a former chair of the Workers' Compensation Section of the Alabama State Bar.

R. Michael Booker, R. Michael Booker PC, Birmingham
Mr. Booker holds a B.S. from Auburn University, a J.D., cum laude, from Cumberland School of Law of Sanford University, and a Master of Laws in Taxation from The University of Alabama School of Law. He restricts his practice to Social Security disability claims before the administration and to the appeal of adverse administrative decisions to the Federal District and Federal Circuit Courts of Appeal. Mr. Booker is a member of the Alabama State Bar, the American Bar, the Association of Trial Lawyers of America, the Alabama Trial Lawyers Association, and he has been a member of the National Organization of Social Security Claimant's Representatives since its inception. He regularly practices Social Security Law before each of the four Offices of Hearing & Appeals in the state of Alabama and occasionally ventures beyond the borders of the state of Alabama to represent disability claimants as well.

Cynthia W. Brown, SSA Office of Disability Adjudication and Review, Birmingham
Judge Brown graduated from Harvard University School of Law in 1979. She received her Bachelor of Science degree, cum laude, from the University of Alabama in 1976. During her undergraduate career, she was elected a member of Alpha Lambda Delta and Beta Gamma Sigma, honorary societies. Her legal experience includes clerking for former Chief Judge U. W. Clemon, U. S. District Court for the Northern District of Alabama, and serving as assistant district attorney in the Jefferson County District Attorney’s Office. In 1984, she joined the staff of the Office of the Solicitor, U. S. Department of Labor, as a trial attorney. She was promoted to Associate Regional Solicitor in 1994. She was awarded the Secretary of Labor’s Exceptional Achievement Award and the Award for Distinguished Career Service with the Department of Labor. In October, 2001, she was appointed to the position of U. S. Administrative Law Judge for the Social Security Administration and she continues to serve in the Birmingham Office of Disability Adjudication and Review.
Janet P. Cox, *Cox & Reynolds LLC*, Birmingham

Ms. Cox received her J.D. from Cumberland School of Law and was admitted to the Alabama State Bar in 1977. From 1978 to 1982 she was a Staff Attorney for the Birmingham Office of Hearings and Appeals. Since 1982, she has been in the private practice of law concentrating in the areas of Alabama workers’ compensation and Social Security disability claims at the administrative and federal court levels. Ms. Cox is a member of the Alabama Bar Association and the Birmingham Bar Association, and is a Sustaining Member of the National Organization of Social Security Claimant’s Representatives.

Judge Ollie L. Garmon III, *Office of Disability Adjudication & Review*, Atlanta

Ollie L. (Dockie) Garmon, III has served as Regional Chief Administrative Law Judge of the Office of Disability Adjudication and Review (ODAR) for the Atlanta Region since 2003. He leads and manages a region of the Social Security Administration in the United States which is composed of over 370 U. S. Administrative Law Judges and a total staff of approximately 2200 in following 8 states: Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina and Tennessee. Judge Garmon is directly responsible for all program and administrative matters concerning the Social Security Administration’s hearings process in the region. Judge Garmon earned his Bachelor’s Degree at Mississippi State University and his J.D. Degree at the University of Mississippi.


Judge Lawson is a graduate of Virginia Tech and Cumberland School of Law, where he was a member of The American Journal of Trial Advocacy. He was a senior trial attorney with the U.S. Department of Labor in the Atlanta and Birmingham offices for over 18 years. Judge Lawson has been with the Office of Disability Adjudication and Review since 2001. He also is an adjunct instructor at Samford University, teaching in the joint degree program of Juris Doctorate/Masters in Environmental Management.

Peter J. Lemoine, *Social Security Disability Practice*, Cottonport, Louisiana

Peter J. Lemoine served as a Social Security Judge for seven years before returning to private practice in 1997. His practice is devoted entirely to Social Security Disability Law. He has appeared as a topic presenter at numerous seminars dealing with Social Security Law and has published several articles on various Social Security topics which have appeared in NOSSCR’s Social Security Forum, Louisiana Law Review and West’s Social Security Reporting Service. Mr. Lemoine has also served as an Adjunct Professor at Northwestern State University from 1995-1997. He is a member of the Baton Rouge, Avoyelles Parish, Louisiana State (Seminar Chair) and American Bar Associations as well as the National Organization of Social Security Claimant's Representatives.

Susan Nadell, *SSA Office of Disability Adjudication and Review*, Birmingham
**John M. Pennington**, *Pennington Law Firm LLC*, Birmingham

Mr. Pennington received his B.S. from the University of Alabama in Birmingham and his J.D. from Cumberland School of Law. His practice concentrates in the areas of Social Security, long term disability litigation, and ERISA. Mr. Pennington has lectured frequently on disability issues at local and national seminars. He is a member of the Alabama Bar, and is admitted to practice in the Northern and Middle Districts of Alabama, the Northern District of Florida, the Eleventh Circuit Court of Appeals, and the United States Supreme Court. He handles Social Security cases all across the State of Alabama, in Georgia, and in the Panhandle of Florida. He is a sustaining member of NOSSCR, and a member of the American Association for Justice, the Alabama Association for Justice, and the Birmingham Bar Association.

**David L. Stephens**, *SSA Office of Disability Adjudication and Review*, Birmingham

Judge Stephens received his B.A. degree from Emory University (1972) and J. D. degree from the Walter F. George School of Law, Mercer University (1975). Judge Stephens served as an Attorney-Advisor in the Office of Hearings and Appeals, Social Security Administration, Macon, Georgia (1975-1976), was a solo practitioner in Fort Valley, Georgia (1976-1980), clerked for a Superior Court Judge in Macon, Georgia (1980), served as an attorney and supervisory attorney for the Georgia Legal Services program in Dalton, Georgia (1980-1981), served as an Attorney-Advisor in the Office of Hearings and Appeals, Social Security Administration, Atlanta, Georgia (1981-1986), and served as Assistant Regional Counsel and Appellate Coordinator for the Office of General Counsel, Region IV, Department of Health and Human Services, Atlanta, Georgia (1986-1991). He has extensive experience in writing decisions in Social Security cases and in defending ALJ decisions in the U. S. District and Circuit Courts. Judge Stephens was appointed as an Administrative Law Judge for the Social Security Administration in May 1991 and served in the Birmingham, Alabama Hearing Office until September 1997. From September 1997 through February 2006, Judge Stephens served in the Macon, Georgia Hearing Office. He returned to the Birmingham, Alabama Office of Disability Adjudication and Review in February 2006. Judge Stephens has participated as an instructor for new Administrative Law Judges since April of 1994, has been involved in the training of new decision writers for the Social Security Administration, has presented Interactive Video Training nationally to Administrative Law Judges, has participated as a presenter or panel member in several CLE seminars related to Social Security Disability Practice, participated in delivering training to five Region IV Hearing Office on the Findings Integrated Templates, and recently participated in the training of the first group of Federal Reviewing Officials. He was appointed by Commissioner Barnhart as a member of the Decision Review Board in January 2007, serving through January 2008, and continues to serve as an Administrative Law Judge in the Birmingham Office of Disability Adjudication and Review.
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Social Security Disability Law

The University of Alabama School of Law
Tuscaloosa, Alabama
Friday, October 24, 2014

Handling Special Issues

Peter J. Lemoine
Attorney at Law
Cottonport, Louisiana
I. Know your good onset; that is, know what your claimant's alleged onset of disability should be. Here, give full consideration to the unsuccessful work attempt provisions of §§ 404.1574(c)/416.974(c) providing that a work attempt of up to six months, even if at the SGA level, can properly be considered an unsuccessful work attempt. Understand as well, the trial work period provisions of § 404.1592 and in connection therewith the reentitlement provisions of § 404.1592a. **Oftentimes, representatives stipulate to a closed period of disability when a trial work period could have been awarded.** Under the trial work period provisions, a claimant is allowed to work for up to nine months at any level and continue to draw Title II disability benefits.

II. Know how to properly calculate earnings:

A. Remember that unless there is a significant change in work patterns or earnings, substantial gainful activity is computed on a yearly basis by averaging earnings for each such period. See §§ 404.1574a/416.974a.

B. Remember that calculation of monthly earnings is determined by multiplying weekly earnings by 4.33 weeks - not 4 weeks.
C. Remember that for purposes of determining substantial gainful activity, compensation is
considered paid in the month earned, not received. Note also that payments of sick and/or
vacation pay are not considered earnings. See POMS DI 10505.01C.

III. Remember the rules governing subsidy. Here, you may be able to reduce gross earnings to an
amount that falls below presumptive SGA because of the substandard quality of the
claimant's work performance. See SSR 83-33 which essentially states that an employer's
statement as to the percentage of the claimant's compensation that is considered to be subsidy
as opposed to actual earnings, if substantiated by appropriate rational, must be accepted by
SSA.

IV. In dealing with a medical expert/s, I recommend the following:

A. Beware of medical experts who do not play by the rules. For example, some medical
experts will only consider what is shown by clinical signs and laboratory findings in
assessing ability to function. Some medical experts refuse to consider certain
impairments or disorders even though SSA has already recognized same such as, for
example, fibromyalgia and chronic fatigue syndrome.

B. Make sure the medical expert has the latest medical exhibits before questioning.

C. Make sure the medical expert is receiving updates to the Listing of Impairments.
D. On some occasions the ALJ chooses to question the medical expert first (usually a good sign). But if the medical expert’s testimony is not dispositive of the case, I would not agree to allow the medical expert to be released because such expert has rendered an opinion without hearing the claimant’s testimony. See here HALLEX I-2-6-70 (B) providing that the medical expert must either hear the testimony or receive a summary thereof.

E. Agree to disagree with the medical expert; that is, instead of attacking, find common ground. Talk to the medical expert about things you do agree upon and then work your way towards your theory of the case. Medical experts usually do not respond well to the tough, adversarial approach. Most seem to take it rather personally as they see it as an attack on their competence or qualifications.

F. If all else fails, ask the medical expert if additional testing is necessary or appropriate.

V. Do not forget about key non-exertionals. It is important to call the adjudicator’s attention to the following key nonexertional limitations:

A. Manipulative limitations—fine and gross.

B. Need to elevate one or both lower extremities—it is important to establish angle or height of elevation.
C. Limitations with respect to the amount of time the individual can work in the neck-flexed position as well as the amount of time the individual must straighten the head up for rest.

VI. In dealing with consultative examiners consider the following: SSA sometimes orders unnecessary consultative examinations. The regulations prescribe narrow circumstances under which a consultative examination should be ordered. Social Security Disability Advocate’s Handbook, Section 512.3 citing 20 CFR 404.1512(f)/416/912(f) indicates that “if information [SSA] need[s] is not readily available from the records of [the claimant’s] medical treatment source or [SSA is] unable to seek clarification from [the] medical source, [SSA] will ask [the claimant] to attend one or more consultative examinations at [SSA’s] expense.” 20 CFR 404.1512(f)/416.912(f) also provides that generally, SSA will not request a consultative examination until “every reasonable effort” has been made to obtain evidence from the claimant’s own medical sources.

I recommend that you be proactive when consultative examinations are ordered: First, I recommend that you exercise your right to object to certain individuals being selected to perform consultative examinations. 20 CFR 404.1519j/ 416.919j. Secondly, there is nothing that prevents you, as the attorney of record, from requesting that certain exhibits or records be forwarded to the consultative examiner. Thirdly, upon completion of the consultative examination, ask that the Judge forward to you a list of all exhibits that were submitted to the consultative examiner. Fourth, send a tip sheet to the claimant advising him/her how to prepare for the consultative examination, including how to dress as well
as to call your office immediately with any adverse or favorable impressions, including but not limited to, how thoroughly the consultative examiner examined the claimant and how long the examination lasted.

VII. Be ready to challenge findings regarding past relevant work. Remember that past relevant work is defined by §§ 404.1565(a)/416.965(a) as follows:

A. Work that is done in the last fifteen years or fifteen years prior to the date before which disability must established (DLI),

B. lasted long enough for the claimant to learn the job,

C. was performed to the substantial gainful activity level.

Remember in this regard that the best witness in evaluating the exertional and non-exertional requirements of the claimant's past relevant work is sitting right next to you. Vocational experts sometimes mischaracterize the claimant's past work in terms of skill level, exertional level, and/or provide a DOT occupational code number that does not correspond to the type work that the claimant actually performed. Of course, the greater the requirements of past work the less likely it is that it will be determined that the claimant could perform such work either as he/she performed it or generally performed in the national economy. The lower the skill level, the less likely it is that the vocational expert will be able to find transferrable skills at step five.
VIII. Be aware of the no work profiles. These are profiles that generally remove the case from the vocational expert as they provide an independent basis for a finding of disability. SSR 96-9p speaks of the sedentary, unskilled occupational base and talks about medical - vocational profiles that generally call for a finding of disability. In applying this ruling, bear in mind that it is as well applicable where the claimant may have skilled or semiskilled work but has no skills transferrable into work consistent with the claimant's RFC. See §§ 404.1565(a)/ 416.965(a).

SSR 85-15 contains no work profiles as well and in my opinion is one of the most important Social Security rulings on the books. Among other things, SSR 85-15 provides that where an individual can tolerate very little noise, dust, etc., the impact on the ability to work is considerable "because very few job environments are entirely free of irritants, pollutants, and other potentially damaging conditions." Administrative law judges often include in the hypothet/s a stipulation that the claimant must be free of irritants, pollutants or noxious fumes. SSR 85-15 further provides that a finding of disability may be appropriate where an individual's visual impairments eliminate all jobs that require very good vision (such as working with small objects or reading small print) in instances where "the claimant's vocational profile is extremely adverse, e.g., closely approaching retirement age, limited education or less, unskilled or no transferrable skills, and essentially a lifetime commitment to a field of work in which good vision is essential."
§§404.1562/416.962 provide additional bases for a finding of disability. §§404.1562(a)/416.962(a) provide for a finding of disability where the claimant:

A. has a marginal education;

B. work experience of 35 years or more of *arduous, unskilled physical labor*;

C. the claimant is not working; and

D. the claimant is no longer able to do prior work because of a severe impairment.

The term “arduous” is defined by SSR 82-63.

§§404.1562(b)/416.962(b) provide that a finding of disability is in order where the claimant:

A. has a severe medically determinable impairment;

B. is of advanced age;

C. has a limited education; and

D. has no past relevant work experience.
A third independent basis for a finding of disability, though not contained in the regulations or rulings, appears in POMS DI 22001.025 and provides that an individual will “generally” be entitled to a finding of disability if he/she:

A. has thirty years or more of work in a field that is unskilled or possesses no skills transferable into work consistent with his/her RFC;

B. can no longer perform past work because of a severe impairment;

C. is closely approaching retirement age (60 or over);

D. has no more than a limited education.

IX. Tips/tactics for examination/cross examination of the vocational expert.

A. **SSR 00-4p is SSA’s adaptation of the US Supreme Court’s decision in Daubert v. Merrell Dow Pharmaceuticals, Inc. 509 U.S. 579, 113 S. Ct. 2786 (1993).** It provides that an Administrative Law Judge must, in each case, make a specific finding that occupational evidence provided by a vocational expert is reliable before it can serve as a basis for a denial at either step four or five of sequential evaluation. SSR 00-4p places on the adjudicator an affirmative duty to inquire about any real or apparent conflict that may exist between vocational expert testimony and the Dictionary of Occupational Title (DOT) and its companion publication, the Selected Characteristics of Occupations...
defined in the revised Dictionary of Occupational Titles (SCO). If a real or apparent conflict exists, the adjudicator must obtain from the vocational expert a reasonable explanation for the conflict and must explain in the decision how the conflict was resolved. Importantly, in discussing the circumstances to which the ruling applies, SSR provides: “Evidence from VEs or VSs can include information not listed in the DOT.” Accordingly, SSR 00-4p and the attendant obligation of the Administrative Law Judge to conduct appropriate inquiry in order to determine whether vocational expert’s testimony is the product of reliable evidence applies not only when vocational expert testimony directly conflicts with the DOT/SCO but as well where vocational expert testimony speaks to work-related functions or environmental elements not profiled in the DOT/SCO. This, of course, is entirely consistent with §§404.166(d)/416.966(d) as well as the U.S. Supreme Court’s decision in Daubert.

B. Do not lose sight of the fact that at step five the burden of going forward with evidence of reliable job information rests with the Commissioner.

C. In light of the above, make use of the null hypothesis approach to examining or cross examining the vocational expert; that is, once the vocational expert has identified occupations and job numbers, ask him/her to begin with the assumption that no occupations or jobs exist and to come forward with proof by reliable evidence that this hypothesis is false. This approach is entirely consistent with the burden shifting that takes place at step five of sequential evaluation.
D. Familiarize yourself with key Social Security rulings to include SSR 82-41 (Work Skills and their Transferability as Intended by the Expanded Vocational Factors Regulations); SSR 83-10 (Determining Capability to do Other Work); SSR 83-14 (Capability to Do Other Work – the Medical-Vocational Rules as a Framework For Evaluating a Combination of Exertional and Nonexertional Impairments); SSR 85-15 (Capability to Do Other Work – the Medical-Vocational Rules as a Framework For Evaluating Solely Nonexertional Impairments); SSR 96-9p (Determining Capability to do Other Work—Implications of a Residual Functional Capacity for Less Than a Full Range of Sedentary Work); SSR 00-4p (Use of Vocational Expert and Vocational Specialist Evidence, and Other Reliable Occupational Information in Disability Decisions).

E. Be wary of undefined variables contained in the hypothet submitted to the vocational expert. These are problematic because there is no way of knowing whether the vocational expert and the administrative law judge had the same meaning in mind and thus a valid vocational expert response cannot be elicited. Examples include the use of the term “limited” as in the claimant is capable of only “limited” fine manipulation. How limited is “limited”? Standing alone it is subject to many interpretations. In order to elicit a valid vocational expert response modifying or qualifying language must accompany the term “limited”. This would include, per SSR 83-10, frequency descriptors, i.e. none, very little to one-third (occasional), one-third to two-thirds (frequent), and more than frequent.  

1. Other undefined variables often used include: (a) use of the term “simple”, without more; (b) restricting the claimant to one-two step instructions - what is a step? Does
this refer to the ability to only perform work at SVP level one or two, i.e. unskilled?; (c) use of the terms “routine” and “repetitive” (no definition provided by SSA); (d) restricting the claimant to “low stress” work activity (per SSR 85-15, stress is a function of the individual, not the job; that is to say, response to the demands of work is highly individualized); (e) use of an open ended sit/stand option (SSR 96-9p provides that a sit/stand option must stipulate how long the individual can sit and how long the individual must be allowed to stand or walk before returning to sitting.

2. Finally, remember that the restrictions contained in the hypothet cannot invade the province of the vocational expert. Examples would include the stipulation that the claimant can sit for fifteen minutes at a time and then must be allowed to stand for an equal period but with no interruption of the work processes of the job. The determination as to whether or not an individual thus restricted can continue to work depends upon the duties required by the occupation and is therefore an assessment that must be made by the vocational expert, not the administrative law judge.

Another example is the stipulation that the claimant is limited to “unskilled work”. The Appeals Council has specifically addressed this and proscribed the use of such a restriction. In an Appeals Council decision dated April 23, 2010, the Council noted that restricting the claimant to “unskilled work” is a stipulation that is “generally considered to be a vocational consideration and not a limitation found in the residual functional capacity assessment.”
F. **Request the issuance of a subpoena duces tecum prehearing pursuant to §§ 404.950(d)/416.1450(d)**, requesting the administrative law judge to order the vocational expert to produce *all* statistics, research, and other data upon which he or she intends to rely at the hearing. I have forwarded a letter requesting such evidence in hundreds of cases over the past few years and in the vast majority of cases the Administrative Law Judge does not act upon my request. **The advantage, however, of making the request is that HALLEX I-2-5-78 provides that the administrative law judge must rule upon the request and provide the reasons for his or her ruling in the decision.** This gives you at least one plausible argument to the Appeals Council in the event the decision is not favorable to your client and the Administrative Law Judge fails to comply with the aforesaid HALLEX provision.

G. **Remember again, that regional and job numbers are published by Census and SOC code number and there are almost always multiple DOT titles contained under each. Vocational expert's typically identify a singular DOT title but provide job numbers for an entire census or SOC code numbers and fail to inform the Administrative Law Judge of such. So be sure to ask the vocational expert for the Census or SOC numbers for each set of regional and national job numbers identified.** Then ask the vocational expert to provide the total number (not list each one) of DOT occupational titles contained under the Census or SOC code numbers identified. If he/she doesn’t know, you can easily access this information through electronic sources such as *Job Browser Pro*. If, for example, there are eleven DOT occupational titles under the applicable SOC code number, ask the vocational expert if he/she has checked all
eleven for consistency with the hypothet. In almost every case, if the vocational expert is being truthful, he/she will acknowledge that the singular DOT occupational title cited is the only one that the vocational expert has checked for consistency with the hypothet. If the vocational expert does, indeed, acknowledge this, the Commissioner has failed to identify the existence of any regional or national job numbers associated with those DOT occupational title/s which are identified as consistent with the hypothet and so the Commissioner’s burden of going forward with reliable evidence of job numbers has not been discharged. If the vocational expert maintains that he/she has in fact verified that all DOT occupational titles contained under the applicable Census or SOC code number/s are consistent with the hypothet, push forward with your interrogation by asking the vocational expert to list each DOT occupational title contained thereunder so that you can test the accuracy of the vocational expert’s response. Let’s say the vocational expert identifies, in response to a hypothet which includes an unskilled past work history and light RFC, the position of Feather Renovator, DOT Number 362.685-010, light, SVP-2, and states that there are 9,221 jobs regionally and 452,681 in the national economy. You then ask the vocational expert to provide the SOC code number (51-6011) for the job numbers cited as well as the remaining DOT occupational titles contained thereunder. At this point, by reference to the occupational profiles contained in the DOT/SCO, which can be quickly accessed through software products such as Job Browser Pro, you are able to determine that of the twenty-three occupational titles contained under SOC code number 51-6011, fifteen are listed as SVP-3 or above (semiskilled or above) and eleven have an exertional level of medium or above. This leaves a total of only four DOT occupational titles that are light, unskilled and therefore consistent with the hypothet. But
the regional and national job numbers are for the entire SOC code number inclusive of twenty-three occupational titles. The vocational expert’s testimony has been thusly discredited as the occupational titles that are in fact consistent with the hypothet and the job numbers provided do not match. Stated another way, the Commissioner has failed to provide reliable evidence of regional and national job numbers associated with those DOT occupational titles which are in fact consistent with hypothet. In all likelihood, once you have established the above, the vocational expert’s fallback response will be that based on his/her “experience” as a vocational expert, a percentage of the previously stated job numbers, say thirty percent, continue to fit the hypothet, with the reduction being based upon the elimination of those DOT titles revealed to be inconsistent with the hypothet. But “experience” without substance is simply not enough and so the vocational expert’s testimony will not and cannot serve as a basis for denial given the Supreme Court’s standard in Daubert as well as SSR 00-4p. Appeals Council decision making is in accord. Finally, bear in mind that the undermining of vocational expert testimony in the manner aforementioned can sometimes be both tedious and time consuming and perhaps a source of aggravation to the administrative law judge. So you’ll have to make a judgment call as to whether or not your argument is too time consuming or involved to present at the hearing. If so, ask the judge to leave the record open for submission of a post-hearing brief. This will provide you with more time to structure your arguments, and with supporting documentation. It will also give the administrative law judge more time to review and understand your theory. In any event, regardless of the approach taken, it is time for practitioners to better familiarize themselves with the mechanics of vocational expert testimony.
Until more practitioners begin to construct more intelligent effective arguments exposing the weaknesses of flawed vocational expert testimony, the unsound practices presently engaged in by many vocational experts will likely continue and even increase.

H. Utilize the work field approach described above to test the validity of vocational expert testimony on the issue of transferable work skills.

I. Beware of the vocational expert's use of the Occupational Employment Quarterly published by US Publishing, a private concern. Its methodology for breaking down job numbers into exertional/skill categories is unscientific and has been repudiated by the Appeals Council.

J. Inquire as to the recency of the data relied upon by the vocational expert. I frequently have hearings with one vocational expert who routinely relies upon the OEQ, but the latest edition in his possession is the third quarter of 2005 even though the OEQ is updated quarterly.

K. Test the vocational expert’s knowledge of the software product upon which he/she relies. If the vocational expert cannot both identify the data source of his/her electronic software and provide an adequate explanation of the methodology upon which it is based then you should object, noting that proper foundation prerequisite to its admissibility has not been established.
X. Understand the importance of SSR 83-20. SSR 83-20 is a most important ruling that, I believe, is not applied nearly enough. This ruling provides that a finding of disability can be made prior to the date of first recorded medical treatment based on lay testimony and other nonmedical evidence:

In some cases, it may be possible, based on the medical evidence to reasonably infer that the onset of a disabling impairment/s occurred sometime prior to the date of first recorded medical examination….” (emphasis added)

See also Newell v. Commissioner of Social Security, 347 F.3d 541 (3rd Cir. 2003):

Retrospective diagnosis of an impairment even if non-corroborated by contemporaneous medical records, but corroborated by lay evidence relating back to the claimed period of disability, can support a finding of past impairment….

SSR 83-20 provides that in the case of slowly progressing impairments, disability onset must be inferred where the following exists: a) no medical evidence exists, b) medical evidence exists but is inadequate. The ruling further states that where disability onset must be inferred medical expert testimony is required.
XI. Understand the evidentiary import of the claimant's receipt of unemployment compensation benefits (UCB). In a memorandum dated November 15, 2006, the Chief Administrative Law Judge, Frank Cristaudo, observed that "the receipt of [UCB] does not preclude the receipt of Social Security disability benefits." Judge Cristaudo further observes:

In addition, it is often uncertain whether we will find a person who applies for unemployment benefits ultimately to be disabled under our rules, and our decision making process can be quite lengthy.

Therefore, it is SSA's position that individuals need not choose between applying for unemployment insurance and Social Security disability benefits.

In a second memorandum dated August 9, 2010, Judge Cristaudo reaffirmed the above and noted that it is not so much the "what" of filing for UCB but he why, i.e., the circumstances prompting the individual to file for UCB benefits will often provide ample justification for doing so.

Importantly, Louisiana unemployment law allows an individual to collect both UCB and Social Security benefits. UCB benefits will be offset by any Social Security disability benefits received. UCB overpayments are collectible out of tax refunds due the claimant, although the claimant can request waiver of the overpayment. Another point to be made is that RS 23:1601 provides that in filing for unemployment benefits the individual only has to certify that he is available for suitable "work" and this considers any physical/psychiatric
impairments which may limit the type work that the individual can perform. Finally, remember as well that in some instances an individual may qualify for Social Security disability and/or SSI benefits even though capable of some level of work activity.

XII. Strategize to reduce if not eliminate the offset effect of workers' compensation or other public disability benefits. In connection herewith, consider:

A. The offset: Section 404.408(a)(2) provides that a disability insurance benefit payable to an individual (including benefits payable to auxiliaries) is reduced in accordance with a hereinafter stated formula where the individual is also for the same month concurrently entitled to a periodic benefit based on a work relationship on account of a total or partial disability pursuant to a law or plan of the United States, a State, or Political Subdivision.

B. Social security benefits not subject to offset:
   1. Retirement insurance benefits are not subject to offset;
   2. At age 62, an individual can elect to receive early retirement insurance benefits to avoid the offset;
   3. Other Title II disability benefits are not subject to the offset, e.g. disabled widow’s benefits, disabled adult child’s benefits.

C. Circumstances under which offset does not apply:
1. Offset does not apply where the law or plan under which is periodic public disability benefit is payable provides for a reduction of that benefit when an individual is entitled to Social Security Disability Insurance benefits;

2. Veteran’s Administration benefits not subject to offset;

3. Public Disability Benefit (except workers’ compensation) payable to a public employee based on employment covered by Social Security is not subject to offset;

4. Public benefits based on need are not subject to offset;

5. Wholly private pension or private insurance benefits (e.g. LTD benefits) not subject to offset.

D. The formula:

1. Add total W/C/PDB to total Social Security Disability Insurance Benefit including amounts paid to auxiliaries. Subtract 80% of average current earnings. Difference is the amount of the offset.

The offset reduces auxiliary benefits first and then the wage earner’s disability insurance benefits (PIA), if necessary.

2. Average current earnings shall be the higher of: a) average monthly wage. Note: you will never figure out how to calculate this; it is one of the formulas used to figure benefit rates; b) 1/16 of the total of the individual’s wages and earnings from self-employment for the five (5) consecutive calendar years during which employed or self-employed earnings were the highest; c) 1/12 of the total of the individual’s wages and earnings from self-employment during the period consisting of the year in which
the individual became disabled and the five (5) years immediately preceding that year.

PRACTICE TIP: SSA’s computation of the individual’s average current earnings can almost always be found on the individual’s earnings record and usually labelled “ACEH”. It will not be accurate when earnings for one or more years fall beyond the earnings base for computation of FICA tax. *Note also that where the individual’s high year of earnings falls in the year of disability or five (5) preceding years, this will always be the individual’s average current earnings. This can be easily determined by a simple review of SSA earnings reports.*

E. Practice tips-prior to workers’ compensation settlement:

1. Get workers’ compensation pay history to SSA as early as possible.

2. Once a favorable determination is received from SSA, make sure SSA has a complete and accurate pay history. Oftentimes, benefit amounts change and SSA has not been provided this information. Also, if part of the workers’ compensation indemnity benefit is being withheld for attorney’s fees, this amount is not subject to offset.

3. Beware of stipulating to later disability onset in Social Security disability cases. This could change the formula used to determine average current earnings to the detriment of the claimant.

4. Advise workers’ compensation attorneys of strategies that can be used to eliminate or reduce the offset effect in the event settlement is reached.

F. Sources of law:
1. 20 CFR 404.408.

2. Social Security rulings include SSR 97-3.

3. POMS Provisions. The POMS is an internal policy manual maintained by the Social Security Administration. But it is binding on adjudicators and practitioners at the administrative review level. You should familiarize yourself with the following POMS sections:
   a) DI 52150.060 (Prorating a Workers’ Compensation/Public Disability Benefit Lump Sum Settlement);
   b) DI 52150.065 (Complex Lump Sum Awards and Settlements);
   c) DI 52150.050 (Excludable Expenses);
   d) DI 52120.001 (Introduction to State Specific Workers’ Compensation Procedures);
   e) DI 52120.105 (Louisiana Workers’ Compensation).

G. Workers’ compensation lump sum settlement agreements:

Lump sum workers’ compensation settlements are counted in the same manner as periodic workers’ compensation indemnity benefits. Section 404.408(g) provides:

“Where public disability benefits are paid periodically but not monthly, or in a lump sum as a commutation of or a substitute for periodic benefits, such as a compromise and release settlement, the reduction under this section is made at the time or times and in the amounts that the Administration determines will approximate as
nearly as practicable the reduction required under paragraph (a) of this section.”

PRACTICE TIP: Do not advise workers’ compensation attorneys to over-allocate for future medical expenses in order to reduce the offset effect of the settlement on Social Security Disability Insurance Benefits. This only inures to the benefit of CMS (Medicare)-not the claimant. Underallocation can lead to a challenge by CMS. My advice is to fairly, realistically allocate for future medical and to provide supporting rationale in the settlement documents.

PRACTICE TIP: A more effective way to reduce the offset effect of a workers’ compensation lump sum settlement on Social Security Disability Insurance benefits is the implementation of a lifetime spread. This fictitiously prorates the lump sum settlement proceeds over the balance of the individual’s life expectancy. It should be included in the release document as well as the petition and preferably the order approving workers’ compensation settlement as well. Finally, remember that Louisiana is a reverse offset state; that is, in Louisiana the workers’ compensation carrier can reverse the offset in its favor. SSA has addressed this in POMS DI 52120.105 and enumerates the requirements that must be met in order for SSA to honor an offset reversal in favor of the comp carrier. When a reverse offset is obtained in connection with a workers’ compensation lump sum settlement, this completely removes any offset by SSA in that a claimant cannot be subject to double offset.
I have enclosed sample paragraphs that deal with both eventualities-lifetime spread and reverse offset. See Exhibits A and B.

H. Dealing with Medicare set-aside issues:

Remember again that Medicare is a secondary payer for workers’ compensation related medical expenses. 42 CFR Section 411.46 provides: “If a settlement appears to be an attempt to shift to Medicare the responsibility for payment of expenses of a work-related condition, the settlement will not be recognized.” Accordingly, if the settlement is judged by CMS to not give reasonable recognition to job related medical expenses and/or does not apportion any amount for medical expenses, CMS has the authority to reapportion the settlement agreement as between compensation for indemnity benefits versus future medical expenses.

CMS has taken a measured approach to the enforcement of these provisions. Currently, as a general rule, CMS only attempts to enforce its secondary payer status with respect to lump sum settlements in excess of $250,000 or where the claimant has already become entitled to Medicare at the time of the workers’ compensation lump sum settlement agreement. To this end, CMS has established a procedure which, practically speaking, mandates that workers’ compensation settlement agreements falling under this rubric be submitted to the CMS regional office for approval.

One of the problems that has emerged from the above is that workers’ compensation attorneys frequently seek to circumvent CMS requirements by advising the client not to
file for Social Security Disability Insurance Benefits until the workers’ compensation case is settled. This is an unfortunate and ill-advised practice because delay in filing for Social Security Disability benefits often results in irreparable loss to the claimant. Specifically, the claimant will often incur permanent loss of past due Social Security benefits as well as a delay in the individual’s Medicare entitlement date. Note: In Medicare entitlement commences 24 months from the date that the individual becomes first entitled to Social Security Disability insurance benefits.

PRACTICE TIP: Don’t circle around CMS guidelines by advising the client to delay filing for Social Security Disability Insurance Benefits until the workers’ compensation case is settled. The claimant gains nothing by the attorney’s effort to circumvent CMS’s guidelines as stated above, but, as the reader can see, often suffers a significant loss in Social Security Disability benefits and/or Medicare coverage. The Social Security claimant will often have a rude awakening when the individual eventually files a Medicare claim (once found entitled to Social Security Disability benefits) and learns from Medicare that the claim will not be paid because the expense in question is workers’ comp related.

PRACTICE TIP: Remember, POMS DI 52150.050 C provides: “For lump sum proration purposes, an MSA is an excludable expense [only] if it is not paid in a separate check.”

I. Proration of lump sum workers’ compensation settlement:
SSA guidelines establish a separate method for prorating indemnity benefits and expenses. POMS DI 52150.060 sets forth a priority base approach for determining the rate of proration of workers’ compensation lump sum settlement proceeds. The order is as follows:

- The rate specified in the lump sum award

  **Note:** Here the Social Security practitioner can suggest to the workers’ compensation attorney that a life expectancy rate be used to prorate the settlement amount. While this will usually prove to be the most beneficial rate of proration, the aforenoted POMS provision provides a safeguard in that it states that where a life expectancy rate is used, SSA must nonetheless apply the rate of proration which is most advantageous to the number holder. Again, this will usually be the life expectancy rate.

- If the settlement agreement does not specify a rate of proration, then the settlement will be prorated in accordance with the amount of periodic payments last received prior to lump sum settlement.

- If the lump sum settlement does not specify a rate of proration and no periodic payments were received prior to settlement, but the language of the settlement implies a compensation rate, the implied rate will be used.

- If none of the above apply, the settlement will be prorated according to the state’s maximum workers’ compensation rate in effect on the date of injury or illness.

J. Proration of expenses:

The rate most advantageous to the claimant must be applied.
**Method A:** Excluding expenses from the beginning of the proration period. Divide excludable expenses by the weekly compensation rate and this results in a number of weeks. Delay imposing the offset for this number of weeks beginning with the date DIB would have otherwise been offset.

**Method B:** Subtract expenses from the lump sum and divide the result by the total lump sum. This produces a fraction or percentage that is multiplied by the applicable workers’ compensation proration rate for indemnity benefits (see above) resulting in a reduced rate of proration.

**Method C:** Subtract the expenses from the lump sum and prorate only the balance at the applicable rate of proration of indemnity benefits discussed above.
EXHIBIT A

**Provision to be used in case of direct offset – where Social Security takes the offset: (no reverse offset applied)**

It is expected that the functionally limiting effects of the injuries or medical conditions upon which this settlement is based shall exist for the remainder of ______________________ (Employee) life expectancy. Accordingly, the amount paid to ________________________ pursuant to this (Employee) lump sum settlement agreement shall serve as a substitute for periodic workers compensation payments owed and/or payable for the remainder of ________________________ life (Employee) expectancy of _____ years, which computes to a specified monthly rate of $______________.

**Note:** Proration must be based on gross amount of settlement.

If need be, point out to defense counsel that while the above paragraph describes permanent disability it does not infer in any way that the claimant is totally disabled and so does not represent a stipulation of total and permanent. If counsel still objects, insert “some or all of the” before “functionally limiting effects”.

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EXHIBIT B

**Provision to be used in case of reverse offset:**

The parties hereto stipulate that __________________________ is permanently and totally disabled within the meaning of __________________________. It is further acknowledged that __________________________ have filed judicial demand for reverse offset under the provisions of LSA-R.S. 23:1225A which has been approved by order of the State of Louisiana, Department of Labor, Office of Workers’ Compensation dated _________________. The legal effect of this order, all parties agree, is to reduce __________________________ liability for periodic workers’ compensation benefits from date of judicial demand and this, in turn, results in a reduction in the amount paid to __________________________ pursuant to this lump sum settlement agreement.
Ethics Issues: Fee Splitting and Permissible Referral Fees

Janet P. Cox  
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I. Basics of attorney fees for appointed representatives.

A. 406(a) Fees for services rendered before the Social Security Administration.

Social Security has the absolute authority to regulate attorney fees for services before the Social Security Administration. These are 406(a) fees (42 U.S.C. 406(a)). See also 20 C.F.R. §404.1720-1740, §416.1520-1540.

B. Rules and regulations regarding fees are enforced.

Social Security has the authority to discipline representatives who violate the rules with regard to charging or collecting, directly or indirectly, an unauthorized fee. 20 C.F.R. §404.1740(c)(2); 404.1745; HALLEX I-1-2-81; POMS GN 03970.017.

C. A representative is required to use either a fee agreement or a fee petition.

In most cases, a representative has the option to choose between utilizing a fee agreement or filing a fee petition. If the fee agreement is not approved, then the representative must file a fee petition. (See HALLEX I-1-2-12 for conditions for approval of a fee agreement.)

D. Only fees for services rendered before the Social Security Administration are subject to SSA approval.

In Alabama, a referral fee paid to a referring attorney is not subject to approval if the referring attorney has not performed any services as representative in the case.
HALLEX I-1-2-12 C.2, states that “a fee agreement providing for sharing the authorized fee with another person who referred the case will not cause the fee agreement to be disapproved”.

**E. 406(b) fees for services rendered in Federal Court.**

Attorney fees for services performed in any proceeding in Federal Court are not subject to approval by Social Security but are approved by the Federal Court pursuant to 42 U.S.C. 406(b), 20 CFR §404.1728, §416.1528.

**F. When a single legal entity/firm has an appointed representative(s) in a case, the fee agreement will be approved when all representatives have submitted a Form 1696, all representatives and the claimant have signed a single fee agreement, and none of the representatives has waived a fee.**

Note, however, each appointed co-representative will be authorized an equal share of the fee amount. HALLEX I-1-2-18, POMS GN 03940.009 (equal shares in separate checks).

**G. A fee agreement will not be approved if the claimant appointed representatives who are not members of a single firm.**

Any representative in this situation must file a fee petition in order to be authorized to charge and receive a fee. HALLEX I-1-2-12.

**H. The exception stated above does NOT apply if the claimant and the appointed representative(s) from a single firm signed the fee agreement and any other appointed representative(s) waived charging and collecting a fee. See: HALLEX I-1-2-12 and EM -13024.**

The fee is apportioned among all appointed representatives who are in single firm or entity, in equal shares, separate checks. Emergency Message (EM)-13024.
I. Multiple appointed representatives from the same entity, all on the fee agreement, and one or more of the representatives waives the fee.

The share apportioned to any representative waiving is returned to the claimant. EM-13024.

More on Fee Sharing

II. Are referral fees excepted from the fee approval process when the referring attorney has performed services in the claim?

A. If the referral fee is being paid from fees approved for Federal Court work, it is not subject to SSA approval.

B. What about paying a referral fee from fees authorized for services performed before SSA?

If the referring attorney does not waive his or her fee, separate fee petitions must be filed.

C. What if the referring attorney waives his or her right to charge and collect a fee from the claimant and/or auxiliaries?

This topic is being reserved for discussion at the seminar. What follows are excerpts from the law and SSA policy that seem pertinent to the discussion.

1. The statutory language referencing a criminal violation of a 406(b) fee states:

   [A]ny person who .....shall knowingly charge or collect directly or indirectly any fee in excess of the maximum fee, or make any agreement directly or indirectly to charge or collect any fee in excess of the maximum fee, prescribed by the Commissioner of Social Security shall be deemed guilty of a misdemeanor…

2. 20 CFR §404.1520 (e) states:

   (e) When we do not need to authorize a fee. We do not need to authorize a fee when:
(1) An entity or a Federal, State, county, or city government agency pays from its funds the representative fees and expenses and both of the following conditions apply:

   (i) You and your auxiliary beneficiaries, if any, are not liable to pay a fee or any expenses, or any part thereof, directly or indirectly, to the representative or someone else; and

   (ii) The representative submits to us a writing in the form and manner that we prescribe waiving the right to charge and collect a fee and any expenses from you and your auxiliary beneficiaries, if any, directly or indirectly, in whole or in part; or

(2) A court authorizes a fee for your representative based on the representative's actions as your legal guardian or a court-appointed representative.


3. A law firm is an “entity”, and is repeatedly referred to as such throughout the HALLEX and POMS attorney fee provisions.

4. The POMS and HALLEX examples of attorney fee violations clearly set out hypothetical situations where the claimant paid the unauthorized fee, either directly or indirectly. In the HALLEX and POMS instructions in investigating and documenting fee violations, the focus is entirely on documenting that the claimant paid the fee, either directly or indirectly. POMS GN 03970.017.

5. If the referring attorney waives the right to collect from the claimant, and the appointed attorney receives a fee authorized by SSA, can the claimant be harmed?

6. POMS GN 03920.010 defines third-party entity as a business, firm, or other association, for-profit or nonprofit, who provides a claimant with
representation and pays the representative’s fee and expenses without passing any financial liability to the claimant or any auxiliary beneficiaries.

Where does this come from? Perhaps someone with policy history can provide insight.

III. Slightly off topic, but worth discussion, if we have time:

A. In a fee petition case, the representative must file a fee petition or intent to file within 60 days of the favorable decision. A 20 day notice will be sent prior to releasing withheld benefits.

B. Unappointed Representative.

HALLEX I-1-2-12 C (3)(b): If a representative and claimant both signed the Form SSA-1696-U4 (or equivalent statement) and the fee agreement, and a person other than the appointed representative (e.g., a paralegal working under the supervision of the appointed representative), actually attended the hearing as the claimant's sole advocate, the decision maker will assume that that person is acting as a co-representative. If that person did not sign the fee agreement, the decision maker will disapprove the fee agreement. The decision maker will do this because the representative may not delegate to an unappointed assistant the authority to undertake tasks that require making significant decisions regarding the case, such as appearing as the claimant's advocate in a hearing before an ALJ. This task requires making decisions about presenting evidence, cross-examining witnesses, arguing facts and law, and appealing any adverse ruling. Whoever performs such tasks is, by definition, a representative, and must be appointed as such.

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by the claimant. Only an individual whom the claimant has appointed, and whom SSA has
accepted as the claimant's representative, has the authority to perform such tasks.

NOTE:
If the paralegal in the above scenario had signed the fee agreement, the ALJ approved the fee
agreement and the claimant was entitled to past-due benefits, the paralegal would share the
authorized fee (but not receive direct payment). § 404.1720. Fee for a representative's services.

(a) General. A representative may charge and receive a fee for his or her services as a
representative only as provided in paragraph (b) of this section.

(b) Charging and receiving a fee. (1) The representative must file a written request with us
before he or she may charge or receive a fee for his or her services.

(2) We decide the amount of the fee, if any, a representative may charge or receive.

(3) Subject to paragraph (e) of this section, a representative must not charge or receive any fee
unless we have authorized it, and a representative must not charge or receive any fee that is more
than the amount we authorize…

(5) When we do not need to authorize a fee. We do not need to authorize a fee when:

(1) An entity or a Federal, State, county, or city government agency pays from its funds the
representative fees and expenses and both of the following conditions apply:

(i) You and your auxiliary beneficiaries, if any, are not liable to pay a fee or any expenses, or
any part thereof, directly or indirectly, to the representative or someone else; and

(ii) The representative submits to us a writing in the form and manner that we prescribe
waiving the right to charge and collect a fee and any expenses from you and your auxiliary
beneficiaries, if any, directly or indirectly, in whole or in part; or
(2) A court authorizes a fee for your representative based on the representative's actions as your legal guardian or a court-appointed representative.

End of Presentation

Reference Material

§ 404.1728. Proceedings before a State or Federal court.

(a) Representation of a party in court proceedings. We shall not consider any service the representative gave you in any proceeding before a State or Federal court to be services as a representative in dealings with us. However, if the representative also has given service to you in the same connection in any dealings with us, he or she must specify what, if any, portion of the fee he or she wants to charge is for services performed in dealings with us. If the representative charges any fee for those services, he or she must file the request and furnish all of the information required by § 404.1725.

(b) Attorney fee allowed by a Federal court. If a Federal court in any proceeding under title II of the Act makes a judgment in favor of a claimant who was represented before the court by an attorney, and the court, under section 206(b) of the Act, allows to the attorney as part of its judgment a fee not in excess of 25 percent of the total of past-due benefits to which the claimant is entitled by reason of the judgment, we may pay the attorney the amount of the fee out of, but not in addition to, the amount of the past-due benefits payable. We will not certify for direct payment any other fee your representative may request.

§ 404.1730. Payment of fees.

(a) Fees allowed by a Federal court. We will pay an attorney representative out of your past-due benefits the amount of the fee allowed by a Federal court in a proceeding under title II of the
Act. The payment we make to the attorney is subject to the limitations described in paragraph (b)(1) of this section.

(b) Fees we may authorize—(1) Attorneys and eligible non-attorneys. Except as provided in paragraph (c) of this section, if we make a determination or decision in your favor and you were represented by an attorney or an eligible non-attorney, and as a result of the determination or decision you have past-due benefits, we will pay the representative out of the past-due benefits, the smaller of the amounts in paragraph (b)(1)(i) or (ii) of this section, less the amount of the assessment described in paragraph (d) of this section.

(i) Twenty-five percent of the total of the past-due benefits; or

(ii) The amount of the fee that we set.

(2) Non-attorneys ineligible for direct payment. If the representative is a non-attorney who is ineligible to receive direct payment of his or her fee, we assume no responsibility for the payment of any fee that we authorized. We will not deduct the fee from your past-due benefits.

(c) Time limit for filing request for approval of fee to obtain direct payment. (1) To receive direct fee payment from your past-due benefits, a representative who is an attorney or an eligible non-attorney should file a request for approval of a fee, or written notice of the intent to file a request, at one of our offices, or electronically at the times and in the manner that we prescribe if we give notice that such a method is available, within 60 days of the date we mail the notice of the favorable determination or decision.

(2)(i) If no request is filed within 60 days of the date the notice of the favorable determination is mailed, we will mail a written notice to you and your representative at your last known addresses. The notice will inform you and the representative that unless the representative files, within 20 days from the date of the notice, a written request for approval of a fee under §
404.1725, or a written request for an extension of time, we will pay all the past-due benefits to you.

(ii) The representative must send you a copy of any request made to us for an extension of time. If the request is not filed within 20 days of the date of the notice, or by the last day of any extension we approved, we will pay all past-due benefits to you. We must approve any fee the representative charges after that time, but the collection of any approved fee is a matter between you and the representative.

§ 404.1740. Rules of conduct and standards of responsibility for representatives……

(c) Prohibited actions. A representative must not:

(2) Knowingly charge, collect or retain, or make any arrangement to charge, collect or retain, from any source, directly or indirectly, any fee for representational services in violation of applicable law or regulation;
Please Note: The links in this document are not functional at this time, so their content is not available. We are working to resolve technical difficulties to make this information viewable as soon as possible. We apologize for any inconvenience.

Identification Number: EM-13024

Intended Audience: All RCs/ARCs/ADs/FOs/TSCs/PSCs/OCO/OCO-CSTs/ODAR

Originating Office: ORDP OISP

Title: Distributing Fees When All Appointed Representatives Who Are Not Members of the Same Entity as Those with an Approved Fee Agreement Waive Their Fees—POMS Instructions Will Follow Shortly

Type: EM - Emergency Messages

Program: Title II (RSI); Title XVI (SSI)

Link To Reference: See References at the end of this EM.

Retention Date: July 15, 2014
Extension Retention Date: January 14, 2015

Purpose
We are modifying our appointed representative fee distribution procedure in one fee situation. This emergency message (EM) provides instructions on how technicians should distribute an authorized fee when there are appointed representatives from multiple entities; there is an approved fee agreement from one or more representative in a single entity; and all other appointed representatives waive charging and collecting a fee.

The new policy does not change the existing instructions that decision makers follow when they approve or disapprove a fee agreement (GN 03940.003B).

A. Background
Currently, to determine the individual fees in a multiple representative situation, we divide the total fee amount under the approved fee agreement by the total number of representatives, including those representatives who waive their fees. We then allow an equal share of the fee to each representative who did not waive a fee and allocate the remaining “waived share(s)” to the claimant. (GN 03940.009A). We are modifying this procedure, as explained in this EM.
B. New fee distribution procedure

1. Apply the new fee distribution procedure when the situation meets all of the following conditions:

   • The claimant appoints representatives from more than one entity;
   • We have an approved fee agreement from a representative or multiple representatives in a single entity;
   • All other representatives waive charging and collecting a fee, either from any source (i.e., worked pro bono) OR from the claimant and any auxiliary beneficiary or eligible spouse because a third-party entity or government agency pays the fee from its funds, as described in GN 03920.010; AND
   • The decision maker approves the fee agreement because it meets all of our requirements. See GN 03940.002 and GN 03940.003.

2. Under the new procedure, distribute the authorized fees based upon an approved fee agreement in the following manner:

   a. Divide the total authorized fee amount by the number of appointed representatives who are members of the same entity as those representatives who signed onto the fee agreement, including those representatives from the same entity who waived charging and collecting a fee.

   **NOTE:** Do not consider the appointed representatives from any other entity when dividing the total authorized fee amount.

   b. Allocate the apportioned amount to each appointed representative signing onto the fee agreement, but only directly pay the apportioned amount to those who qualify.

   **NOTE:** In a situation where appointed representatives from the same entity waive their fees, allocate to the claimant any remaining portion of the authorized fee.

If the representative meets all of the conditions, follow this new procedure regardless of whether the representatives who waived their fees:

   • withdrew from the case,
   • had their appointments revoked, or
   • remain appointed.
I-1-2-4. **Representative's Fees Subject to SSA's Authorization**

**Last Update: 2/25/05 (Transmittal I-1-48)**

A representative, attorney or non-attorney, must obtain the Social Security Administration's (SSA's) authorization to charge and collect a fee for services provided in proceedings before SSA regardless of whether among other things:

- the services result in an allowance, reinstatement or disallowance action by SSA;
- the individual was ever recognized by SSA as a claimant's representative, or the individual did not deal directly with or actually contact SSA;
- the fee is charged to or collected from the claimant or a third party (e.g., an insurance company), unless Social Security Ruling SSR 85-3 applies (see I-1-2-5 (A.)); or
- the claimant's title II and/or title XVI past-due benefits have been withheld to pay the fee.

SSA considers any claim or asserted right under titles II, XVI or XVIII of the Social Security Act which results in the following to be a proceeding before SSA for fee purposes:

- an initial, revised or reconsidered determination or action by a field office (FO) or processing center (PC); or
- a decision or action by an Administrative Law Judge or an Administrative Appeals Judge.

Proceedings that require SSA's fee authorization include, but are not limited to, services in connection with:

- an application for social security monthly benefits, supplemental security income (SSI) payment or a lump-sum death payment;
- an application for hospital insurance benefits or supplemental medical insurance benefits;
- a request to establish or continue a period of disability;
- a request to modify the amount of benefits;
- a request to reinstate benefits;
- a request to waive recovery of an overpayment, or an appeal of an overpayment denial determination; and
- a request to revise an earnings record.
I-1-2-12. Fee Agreements — Evaluation Policy

A. Statutory Conditions for Approval

The following statutory conditions must be met for the representative to obtain the Social Security Administration's (SSA's) approval to charge and collect a fee under this process:

1. The representative or the claimant files the agreement with SSA before the date we make a favorable decision on the claim. This condition is met if the representative or claimant files the agreement with SSA before the date SSA makes the first favorable decision the representative worked toward achieving.

2. The representative and the claimant both signed the fee agreement.
   - Representatives may use stamped or photocopied signatures in lieu of their actual signatures on a fee agreement, and may submit a photocopy (or fax) of the original fee agreement. A fee agreement stamped only with a representative's firm's name is not acceptable.
   - If the representative's signature is illegible and the Administrative Law Judge (ALJ) or Administrative Appeals Judge (AAJ) has a question about the representative's identify, the ALJ/AAJ may contact the representative for clarification.
   - If, at the time the ALJ or AAJ is prepared to issue a favorable decision, he/she realizes that the claimant or representative failed to sign the agreement, the ALJ or AAJ must disapprove the agreement because both did not sign it.
   - SSA recognizes the appointment of individuals, not firms, corporations or other entities, as representatives. If a claimant attempts to appoint a firm or other entity, and a representative accepts the appointment on behalf of the firm (e.g., by signing an SSA-1696-U4 (Appointment of Representative) or a fee agreement that contains an appointment provision), SSA recognizes that representative in his/her individual capacity as the claimant's appointed representative.
   - If the individual who signs the fee agreement, on behalf of the firm or corporation, is the appointed representative or if the claimant appoints one representative and submits a fee agreement signed by that individual and others in the same firm, the decision maker must approve the fee agreement if all other conditions for approval are met and none of the exceptions in B. below apply.
   - If someone other than the appointed representative signs the fee agreement on behalf of the firm or corporation, the decision maker must disapprove the fee agreement because the appointed representative did not sign the fee agreement.

3. The fee specified in the agreement does not exceed, whichever is less:
   - 25 percent of the claimant's past-due benefits
• or
  - $4,000 if the fee agreement was approved before February 1, 2002.
  - $5,300 if the fee agreement was approved on or after February 1, 2002, but before June 22, 2009.
  - $6,000 if the fee agreement was approved on or after June 22, 2009.

NOTE 1: Pub. L. 101-508 established a limit of $4,000 in the fee agreement process and also gave the Commissioner of Social Security the authority to increase the limit, from time to time, provided that an increase does not at any time exceed the rate of increase in the primary insurance amounts since January 1, 1991. On January 17, 2002, the Commissioner announced an increase in the limit to $5,300, applicable to fee agreements approved on and after February 1, 2002. On February 4, 2009, the Commissioner announced a further increase in the dollar limit to $6,000, applicable to fee agreements approved on or after June 22, 2009. The increased limit is effective based on the date the decision maker acts on the fee agreement, not on the date the fee agreement was signed or filed or the date of the determination/decision on the claim for benefits.

NOTE 2: In concurrent claims, the 25 percent includes the combined past-due benefits of both titles, and the $6,000 figure is the combined maximum SSA will approve for both titles under the fee agreement process. SSA will approve the lesser of the two (i.e., 25 percent of the total past-due benefits or $6,000).

NOTE 3: Agreements that specify a minimum fee do not meet the statutory conditions for approval under the fee agreement process.

Example: An agreement specifies that the representative's fee will be 25 percent of past-due benefits or $6,000, whichever is less, except that if 25 percent of past-due benefits does not exceed $1,500, the representative's fee will be $1,500. This constitutes an agreement that the least the claimant will owe is $1,500. Such an agreement is not consistent with the statutory provisions for approval.

4. Our decision is favorable to the claimant.
5. The claim results in past-due benefits.

NOTE: The decision maker's approval or disapproval of a fee agreement is limited to whether the agreement meets the statutory conditions and is not otherwise excepted. Approval of the agreement is contingent on whether the claim results in past-due benefits.

B. Exceptions
The agreement is excepted from the fee agreement process in the following situations:
1. The claimant appointed more than one representative associated in a firm, partnership or legal corporation and all did not sign a single fee agreement.

**NOTE:** This exception does not apply if the representative(s) who did not sign the fee agreement waived charging and collecting a fee.

2. The claimant appointed representatives who are not members of a single firm, partnership or legal corporation.

**NOTE:** This exception does not apply if the claimant and the appointed representative(s) from a single firm, partnership or legal corporation signed the fee agreement and any other appointed representative(s) waived charging and collecting a fee.

**Example:**
The claimant appointed attorneys Brown and Smith of the law firm Brown and Smith PC as her representatives. Subsequently, the claimant also appoints attorney Jones of the law firm Black and Jones PC. The claimant and attorneys Brown and Smith enter into a fee agreement that they submitted to SSA. Attorney Jones waived charging and collecting a fee. The decision maker in this situation would approve the fee agreement. However, if attorneys Brown and Jones had submitted the fee agreement and attorney Smith had waived charging and collecting a fee, the decision maker would have to disapprove the fee agreement because the representatives who signed the fee agreement were not members of a single firm, partnership or legal corporation.

3. The claimant discharged a representative or a representative withdrew from the case before SSA favorably decided the claim.

**NOTE:** If the claimant appointed another representative after discharging the former representative or after the former representative withdrew, this exception does not apply if the former representative waived charging and collecting a fee.

4. The representative died before SSA issued the favorable decision. When the representative dies before SSA issues a favorable decision and the claimant or representative submitted an otherwise valid fee agreement, the decision maker will:
   - disapprove the fee agreement, and
   - notify the parties, including the deceased's estate, that the agreement is excepted from the fee agreement process, but that the estate of the deceased representative may request SSA's authorization to charge and collect a fee by filing a fee petition.

5. A State court declared the claimant legally incompetent and the claimant's legal guardian did not sign the fee agreement.

**NOTE:** If SSA determined that the claimant is mentally incapable of managing his/her funds or is in the process of evaluating the claimant's mental capability, the effectuating component will defer sending notice regarding the amount of the fee under the fee agreement until SSA has selected a representative payee.
Considerations Related to the Statutory Conditions for Approval and the Exceptions

1. Multiple Fee Agreements in File From Same Representative(s)
   The decision maker will act on the most recently negotiated and signed fee agreement SSA received before the date of the favorable decision.

2. Agreement Provisions That Will Not Cause SSA to Disapprove a Fee Agreement
   The decision maker will not disapprove a fee agreement solely because it contains a provision stating that:
   - The representative has the right to seek review of the amount that otherwise would be the maximum fee under § 206(a)(2)(A) of the Social Security Act.
   - The representative may request administrative review (under § 206(a) (3)(A) of the Social Security Act) of the amount of the fee if the past-due benefits do not exceed a certain amount.
   - The authorized fee does not include any out-of-pocket expenses (e.g., costs involved in obtaining copies of medical reports or state sales tax, etc).
   - A named third party will pay the representative a fee equal to the lesser of 25 percent of the past-due benefits or $6,000, and the claimant will have no financial liability for paying the authorized fee.
   - The representative will charge interest on the unpaid balance of the authorized fee.
   - The representative will share the authorized fee with another person who referred the case.

3. Provisions/Situations That Will Cause SSA to Disapprove a Fee Agreement

   a. Fee Amount
      The following are examples of agreement provisions that are inconsistent with the statutory condition that the fee specified in the agreement does not exceed the lesser of 25 percent of the past-due benefits or $6,000. SSA will disapprove a fee agreement containing a provision that:
      - The claimant will pay a minimum fee (e.g., the fee agreement calls for a fee equal to 25 percent of the past-due benefits or $6,000, or at least $1,500). (See example in I-1-2-12A.3. NOTE 3.)
      - If 25 percent of the past-due benefits exceeds $6,000, the representative will receive a fee of $6,000 and retains the right to petition for an additional fee.
NOTE: Do not confuse "petition" with "request administrative review." Whereas a representative retains the right to request administrative review under the fee agreement process, he/she may not substitute the fee petition process for the fee agreement process after SSA issues a favorable decision.

b. Unappointed Representative
If a representative and claimant both signed the Form SSA-1696-U4 (or equivalent statement) and the fee agreement, and a person other than the appointed representative (e.g., a paralegal working under the supervision of the appointed representative), actually attended the hearing as the claimant's sole advocate, the decision maker will assume that that person is acting as a co-representative. If that person did not sign the fee agreement, the decision maker will disapprove the fee agreement. The decision maker will do this because the representative may not delegate to an unappointed assistant the authority to undertake tasks that require making significant decisions regarding the case, such as appearing as the claimant's advocate in a hearing before an ALJ. This task requires making decisions about presenting evidence, cross-examining witnesses, arguing facts and law, and appealing any adverse ruling. Whoever performs such tasks is, by definition, a representative, and must be appointed as such by the claimant. Only an individual whom the claimant has appointed, and whom SSA has accepted as the claimant's representative, has the authority to perform such tasks.

NOTE: If the paralegal in the above scenario had signed the fee agreement, the ALJ approved the fee agreement and the claimant was entitled to past-due benefits, the paralegal would share the authorized fee (but not receive direct payment).

4. Factors Not to Consider

a. Representative's Hours and Services
The number of hours the representative spends on a claim and the representative's specific services are not conditions for approval of a fee agreement. Therefore, the ALJ or AAJ may not request this information when making the initial determination on the fee agreement.

b. Death of Claimant Before Decision Issued
If a represented claimant dies before the ALJ or AAJ completes action in the matter the claimant engaged the representative to handle, the ALJ or AAJ will presume, absent evidence to the contrary, that the representative's authority continues. Therefore, if a claimant or representative submitted a fee agreement before the claimant's death, and the ALJ or AAJ issues a favorable decision
after the claimant's death, the ALJ or AAJ will approve the fee agreement, assuming it meets all statutory requirements for approval and is not otherwise excepted from the fee agreement process.

c. Death of Claimant or Representative After Decision Issued
When a claimant or representative submitted a valid fee agreement and either party dies after an ALJ or the Appeals Council issues a favorable decision, the decision maker will approve the fee agreement if he/she did not do so at the time of the favorable decision. The ALJ or AAJ will notify the parties, including the survivors or deceased's estate, of the fee agreement approval.

D. Actions for Which SSA Cannot Approve a Fee Agreement
Section 206(a)(2)(A) of the Social Security Act provides that the fee agreement process applies in a claim of entitlement to past-due benefits. Actions such as changes in workers' compensation offset and other similar actions are adjustments of benefit amounts to which entitlement has already been established. Consequently, the fee agreement process does not apply to this category of actions.
GN 03920.010 Representative's Fees Not Subject to Social Security Administration's (SSA) Authorization

A. Definitions

1. Nonprofit organization

A nonprofit organization is one that is exempt from income tax under section 501 or 521 of the Internal Revenue Code, as discussed in RS 01901.540.
Generally, most nonprofit organizations considered within the scope of this section are those, which perform, or arrange for the performance of, representative services on behalf of claimants and assume responsibility for the payment of these services at no cost to the claimants.

2. Government agency

Government agency is used in the common sense of the term (i.e., a Federal, State, county, or city agency).

3. Third-party entity

A third-party entity is a business, firm, or other association, including but not limited to partnerships, corporations, for-profit or nonprofit organizations, or a government agency. As used in this section, a third-party entity provides a claimant with representation and pays the representative’s fee and expenses without passing any financial liability to the claimant or any auxiliary beneficiaries.

4. Out-of-pocket expenses

Out-of-pocket expenses are expenses incurred by the representative for which the representative has been paid or expects to be paid. Out-of-pocket expenses include, but are not limited to, the cost of obtaining copies of doctor or hospital reports, birth or death certificates, postage, and photocopying. They do not include paralegal or secretarial services, in-house experts, review of fees, or any share of the representative's overhead or utility costs.

5. Waiver statement

A waiver statement is a written statement a representative submits to document that the representative does not wish for us to withhold past-due benefits for direct fee payment or does not wish to charge or collect a fee. We accept three types of waiver statements:

a. Waiver of direct payment – the representative waives the right to receive direct payment of his or her fees. We will authorize the fee the representative will charge, but
we will not withhold any amount from the claimant’s past-due benefits or pay that fee. The representative must collect his or her fee directly from the claimant (see GN 03920.020B.2).

b. **Waiver of payment of the fee from a claimant and any auxiliary beneficiaries** – the representative relieves the claimant and any auxiliary beneficiary from all liability to pay a fee and any expenses, but may charge and collect the fee from another source. We may not have to authorize this fee if certain specific criteria are met (see GN 03920.010B).

c. **Waiver of all fees** – the representative will not charge or collect a fee from any source (i.e., the claimant or a third party) for services the representative provided in representing the claimant before us or before a court. This relieves the claimant of all liability to pay a fee and expenses for those services (see GN 03920.020 for waiver procedures).

**B. Policy for payment of fee by a third-party entity**

1. **General provisions of authorization of fees for representatives**

A primary purpose of SSA’s statutory authority to authorize fees for representation is to protect claimants against unreasonable fees. However, when a third-party entity pays for the representative’s services, the risk of claimants’ liability for unreasonable fees is eliminated. Therefore, when a third-party entity pays the representative’s fees and certain conditions are met, we do not need to authorize the representative’s fee.

2. **When we do not need to authorize a fee**

Our regulations at 20 C.F.R. §§ 404.1720 and 416.1520 do not require fee authorization by SSA under the following conditions:

- The claimant and any auxiliary beneficiaries are free of direct or indirect financial liability to pay a fee or expenses, either in whole or in part, to a representative or to someone else; and
- A third-party entity, or a government agency from its own funds, pays the fee and expenses incurred, if any, on behalf of the claimant or any auxiliary beneficiaries; and
- The representative submits to SSA a form SSA-1696-U4 (or a written statement) waiving the right to charge and collect a fee and expenses from the claimant and any auxiliary beneficiaries as specified in GN 03920.020B.3.b.
Preparing Your Client for the Hearing

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FAR MORE THAN 10 QUESTIONS YOU WANT
YOUR SOCIAL SECURITY CLIENT TO ANSWER CORRECTLY

Three Questions You Do Not Want Your Social Security Disability Client to Have to Answer

1. Lawyer walks into the Office of Disability Adjudication and Review waiting room and asks “Ms. Wilson, who is Mrs. Wilson?”

   If the first time you meet your client is the morning of the hearing, you are doing your client a disservice (read malpractice) and you are doing yourself a disservice (read no $$$). The value of a disability claim is approximately $250,000 taking into account back pay, monthly benefits and Medicare payments. The attorney should give the Social Security Disability case the respect it deserves. This is especially true when fair consideration is given to attorney’s fees. There is a significant dollar amount of attorney’s fees paid when you think of it in terms of an hourly rate for services rendered.

2. Ms. Wilson, now what medical problems do you say would keep you from working?

   The attorney should be in control from the beginning meaning that the attorney, not the client or claimant, should initiate the conversation regarding the medical basis and symptomatology that would render the claimant disabled within the meaning of the Social Security Act.

3. To Ms. Wilson – “Do you have any idea where the bathroom is?”

I. PREPARATION H (HEARING)

   Preparation of your client to testify appropriately at the Social Security evidentiary hearing is not the be-all/do-all answer to establishing disability under the Social Security Act. But, if the client is not prepared to testify, a good, meritorious case can go down the tubes in a heartbeat. These areas of questioning are common in most all disability hearings, and contrary to the Title of this presentation, represents far more than 10 questions.
II. THE BASICS

a. Age – not much to say except in Medical/Vocational Guidelines cases, age guidelines are not to be mechanically applied in a borderline situation. **20 CFR §404.1563(b).**

b. Education – usually grade level suffices but:

i. Special Education – Most claimants know whether or not they have been placed in special education. Most of your clients will know whether they received a regular diploma, an occupational diploma or a certificate. Most of your clients will also know how they performed in the special education classes. Ask them.

ii. Literacy – Marginal/Limited or Illiterate. **20 CFR §404.1564.** Can your client really make change or does he/she simply rely on the clerk to give them the correct amount of change? Did the claimant actually read the Notice of Hearing (8th grade level) or did the claimant have his sister read it?

iii. Ninth Grade Education but Significant Absenteeism in the 7th, 8th and 9th grades. Have the vocational expert testify about the true education level which in this instance is probably 6th grade or marginal since that is the highest level the claimant completed without the excessive absenteeism from school.

c. Past Relevant Work – **20 CFR §404.1565.** Past relevant work is considered by the Social Security Administration to be what work was performed within the last 15 years and was considered by the Social Security Administration to be substantial gainful work activity. **20 CFR §404.1565.**

i. Fast Food Manager – what did your client actually manage? Did they have the authority to hire, fire or to grant vacations? Did the fast food manager have to clean the restaurant, unload the trucks or fill in as needed when another employee was absent?

ii. Cook – Describe duties. Is it really SVP7?

ii. Store Manager – Or Department Manager – makes a difference in the transferable skills


v. Completion of forms/reports/wife completed log book for truck driving husband.
vi. Composite Jobs – Past relevant work – load and unload trucks but spent two hours a day doing “paper work” – emphasize labor part of the job not the administrative portion.

vii. Is it past work or past relevant work? Last 15 years/work long enough to learn the job and substantial gainful work activity. Past relevant work -- not substantial gainful work activity -- then it is not really past relevant work.

Lately, many Administrative Law Judges in my area have been having the vocational expert describe all past work not just past relevant work. This seems to be a labor that is unnecessary since only past relevant work can be used in the overall disability equation.

III. A DAY IN THE LIFE

a. Why Does the ALJ want to know? Equates a day in the life with the ability to engage in substantial gainful work activity.

b. Prepare Claimant to “Quantify” Routine Daily Activities – cook, clean, do laundry, grocery shop, etc. How often are these chores performed, how long are they performed at a time, how long are they performed in total adding up the 10 minutes here and the 15 minutes there that the chores are actually performed. Prepare your client so that the client does not say “well it takes me all day to do the chores around the house”.

c. Drive? How often, how long and how far: Did you have to stop? How often? For what? Are you going to drive to the hearing? Don’t if you can avoid it. Some short sighted Administrative Law Judges equate the ability to drive to the ability to work.

d. Sleep Habits – Trouble falling asleep, staying asleep, wake tired?

e. TV – How long at a time? Any trouble with focus and concentration while watching TV? Some clients respond to this question about concentration and focus by stating that most days the TV watches them rather than them watching the TV.

f. Computer – Does your client have a Facebook page? If so, does the claimant regularly use it? Then, ask the pay-off question to your client – “Is there anything on your Facebook page that would indicate that you are anything other than totally and permanently disabled? In other words, did your client brag on their Facebook page that they went white-water rafting, parasailing or horseback riding in the immediate past?

g. Sports/Activities – Not necessary for a disability claimant to be helpless, bedfast or at death’s door to be disabled within the meaning of the Social Security Act. However, if the claimant regularly goes fishing, hunting, plays softball or basketball, there needs to be a clear
explanation for the Administrative Law Judge to be in a position to rule favorably in the case. Side bar – one of my clients many years ago was asked by a conservative Administrative Law Judge how much weight they could lift at one time. The claimant responded to the Judge’s delight – “380 lbs.” We were able to turn that situation in favor of an approval of the claim when it was brought out that the claimant was a power lifter but suffered brittle diabetes that caused exacerbations followed by remissions and during the remissions, the claimant performed his function as a power lifter.

h. Frequency/Duration. Ask your client if they can wear their Sunday shoes o.k. or are their feet so swollen that you can’t get them on?

IV. BAD HABITS

If your client has them, admit them and quantify them realistically; note: the ALJ already knows.

a. Smoke – One pack per day – when I smoked many years ago I would say that I smoked one pack per day when in reality it was two packs per day. So my rule of thumb is to double the amount my clients tell me for the correct answer – but, emphysema is non-reversible so there is still a basis of disability even if the claimant were to stop smoking. The problem in the smoking arena is that many administrative law judges will ask your client why don’t they quit smoking and use the money saved to buy medication or seek medical treatment. There is not a very good answer to that inquiry by the ALJ.

b. Drink – Six packs per day? Again, double it. And again, liver disease still present even if you cease alcohol.

c. Criminal History – Is it relevant to the disability determination? Admit to the criminal activity and explain that time has been served or otherwise the debt has been paid. Some ALJ’s, especially those with a prosecutorial background, want to use the fact that an individual has been convicted of a crime as a part of the credibility assessment. It is my understanding that certain administrative law judges in my jurisdiction have been admonished not to do that anymore. But even if they do, just have your client admit to the offense and claim the debt has been paid.

d. Substance Addiction Disorder - The claimant should know that the use or abuse of illegal substances will find its way all through the medical evidence of record. While the claimant may want to hide substance abuse from the ALJ, he or she certainly will be unable to do that. It is true that substance addiction disorder is relevant to a disability determination – thumbs up or thumbs down – but substance use is not – otherwise at least two recent presidents and many members of congress would not be eligible for disability benefits should they file.

V. MEDICAL PROBLEMS
a. Symptoms are what you seek through testimony from your client. So, know the symptoms of the illnesses they suffer and question your client accordingly.

b. Specifics – establish that your client can work some – say 30 minutes but then must rest for 10 minutes and repeat this throughout the day. Resting approximately 10 to 15 minutes per hour equates to the claimant being off task for as much as 20% of the work day.

i. Unscheduled work breaks more than two times per day of more than 15 to 20 minute duration equals the claimant cannot sustain an 8-hour work day, 5 day work week.

ii. 15% off task-20% off task.

c. Specifics – peripheral edema with claimant being able to sit o.k. but must elevate one leg or both legs for some period of time during the day:

i. 6 inches

ii. 12 inches

iii. 18 inches

iv. hip level – sofa

v. above the heart – recliner

vi. headstand

d. Specifics – heart disease – chest pain (description, frequency and whether or not the chest pain is relieved by nitroglycerin), shortness of breath and easy fatigability.

e. Mild mental retardation/intellectual disability

i. Special Education in school? All grades?

ii. Literate or?

iii. Ever lived independently?

iv. Paid bills, used credit or debit card, used a check book, bought insurance; if not, how are these functions done in your family when the claimant was, in fact, working?
v. Driver’s license? Written or oral test? Did you pass the first time or did it take you several times to complete?

   i. Dominant hand injury – explains grasp/handle/finger and feel and just like everything else establishes frequency and duration of use.
   ii. Less than occasionally, occasionally, frequently (what about rarely?)
   iii. If you say it enough, it becomes fact.

g. Pain (non-headache pain)
   i. Describe frequency, intensity and duration in realistic terms – no 24/7 and no 10/10.
   ii. Explain VAS – visual analog scale as used by ALJs:
      a. 0-4, mild pain – no big deal. No medications of any sort necessary.
      b. 5-6, moderate pain – sinus headache, 30 minute duration relieved by over the counter medications usually.
      c. 7-8, moderately severe pain -- difficult to deal with, requires strong prescription pain medicine and over the counter medication as well.
      d. 9 -- in the car getting ready to go to emergency room
      e. 10 – at the emergency room with medicine that has "contin" in the name.
   iii. No 10/10 at the hearing. The Administrative Law Judge will not believe it and neither will I.
   iv. Realistic duration – not 24/7/365 – more like a parabolic pain curve – begin severe with medication and lying down becomes less severe then becomes severe again when the
pain medications wear off and the claimant begins to stir around again.

v. Sneaky ALJ – uses scale of zero-five instead of zero-ten. Yes, clients have answered that the pain level is 7/8 even though the ALJ’s pain scale ended at five.

vi. Ask claimant pain questions like this: “If you take your pain medications as they are prescribed for you, lie down, use heat, ice, TENS, etc., what is the LOWEST level to which your pain can be reduced?” Hopefully, this will fall somewhere in the 3 to 5 range on the VAS scale. Then ask, with normal activity, would their pain level go up? Presuming the answer is yes, the question would be “how high?” It is likely this last question would be answered somewhere 7 or above unless the scale is zero to five.

vii. Medication side effects – can be as bad and disabling as the underlying pain. Go over the medication regimen with your client. When do you take your first dose of medication? Is it common for you to lie down for a period of time after the medication begins its effect on you? How long after you take the medication does the medication begin to wear off? When are you allowed to take another dose of the same medication or a different medication for pain, inflammation, muscle spasm, etc.?

h. Headache Pain.

i. Only discuss the “severe” headaches. Many claimants will respond concerning frequency of headaches that they have a headache every day. While they might have a headache every day, it may not be vocationally relevant in terms of frequency, severity and duration. Stick to the “severe” headaches only. Much more believable than, “I have a headache every day.”

ii. Warning? Does the claimant have a warning before the onset of a severe migraine type headache? Describe the symptoms of each headache. Most importantly, have a clear understanding through your client’s testimony as to the duration of the severe headaches, the activity of the claimant during the pendency of the headache, and the frequency of the severe headaches over the period of disability claimed. Most migraine type headaches are severe and debilitating for at least one day and possibly as long as three days. The proper development of the headaches symptomatology and associated limitations will
allow questioning of the vocational expert concerning tolerable absenteeism in the type of work for which the claimant might otherwise be qualified to perform.

iii. Medication regimen for migraine headache pain – again, the medication for migraine type headaches could result in significant limitation of function even to the point that the medication alone could preclude the claimant from engaging in and sustaining substantial gainful activity even if the underlying headache pain is controlled to some extent.

i. Specifics – Psychiatric Illness

i. Ask your client what they consider to be the primary psychological problem that they experience and then compare that testimony to the medical records so developed.

ii. Group/Individual therapy. The frequency that the claimant sees the therapist or psychiatrist and the frequency they do participate in group and/or individual therapy.

iii. Concentration, Persistence, Pace

iv. Interact appropriately with supervisors, co-workers and the general public.

v. Understand, remember and carry out simple work instructions

vi. All of a sudden, the Administrative Law Judges began using “occasional” as it relates to interacting with supervisors, co-workers and the general public and “occasional” as to the ability to understand, remember and carry out simple instructions instead of the previously used rating terms of mild, moderate, marked and extreme. Where did this come from anyway? I am careful to point out to Administrative Law Judges that “occasional” refers to frequency while “mild, moderate, marked and extreme” refer to severity.

VI. MISCELLANEOUS PROBLEMS THAT SHOULD BE RESOLVED PRIOR TO HEARING

a. Unemployment Compensation
Were you lying when you filed for unemployment compensation or were you lying when you filed for Social Security disability?

Neither. You can have the ability to work full time and still be disabled within the meaning of the Social Security definition of disability – even to the point of having a residual functional capacity for medium work. See, 20 CFR §404.1569, Appendix 1, Rule 203.01 and 203.02.

b. Workmen’s Compensation

i. Alabama. Settlement documents key to any offset on disability insurance benefits.

ii. Off the subject – administrative law judge asks for workmen’s compensation documents including the functional capacity evaluation. What do you do? Do you obtain it and present it to the Administrative Law Judge or do you tell the ALJ that if he wants the documents he can get them himself. In Alabama, our code of professional responsibility has spoken directly to the issue. If you have documents that would be helpful to the Court in making the disability determination although harmful or potentially harmful to your client’s disability case, those documents must be provided to the Court. Presumably, if you do not have the documents in your possession you do not have to conduct a house-to-house search to find the documents and then intentionally poison your client’s case.

c. LTD/STD – not relevant to disability claim unless the ALJ believes that the claimant has sufficient income already. There are some ALJs that fall within that category.

d. Earned Income Tax Credit. What to do when $11,000 or $12,000 in self employment income magically appears on your client’s earning record when the client has stated and alleged subject to a penalty of perjury that he has not worked since 2010.

i. The claimant denies he worked at any time since the alleged onset date of disability but there it is – claimed self employment income of approximately $11,000 in the two years since the alleged onset date of disability.

ii. Upon further questioning, the claimant fesses up, an unscrupulous tax preparer made me do it. It just so happens that
the earned income tax credit will result in significant payments to
the client last and to the tax preparer.

iii. But there is still the matter of the disability claim. Of
course, a disability claim cannot be approved if the
claimant has worked at substantial gainful work activity
levels over a significant period of time. The $11,000 or
$12,000 in earnings in the years after the alleged onset date of
disability tend to indicate that the claimant has engaged in
substantial gainful work activity and that, as a result, would not be
considered to be disabled within the meaning of the Social
Security law.

iv. What to do – what to do? One suggestion is to amend
away the tax problem by amending the tax returns
claiming that the claimant actually had no earned income
during the two years in which the claimant earned $11 or $12,000.
The claimant deals directly with the Internal Revenue Service
about the repayment of the tax credit. The Internal Revenue
Service in my area has shown a propensity of allowing this course
of action so long as the disability claimant points the finger at the
unscrupulous tax preparer.

v. Amend the disability claim to reflect an alleged onset date
of disability AFTER the period when the earned income tax
credit was claimed.

There is no substitute for preparing your client to testify appropriately at the evidentiary hearing.
This testimony, when it is consistent with the underlying medical and vocational evidence of
record results in a fully favorable decision being issued on your client’s disability claim.

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Social Security Disability Law

The University of Alabama School of Law
Tuscaloosa, Alabama
Friday, October 24, 2014

Preparing Your Client for the Hearing

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PREPARING YOUR CLIENT FOR THE HEARING

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I. Are the medical records the most important part of a Social Security case?

Medical evidence clearly is important, but I have had more than a few cases over the years where we had great medical evidence, and the claim ended up being denied chiefly because the claimant’s testimony was bad and/or the ALJ got the impression my client was exaggerating.

II. Can you prevent this from happening in every case?

No, but with good client preparation, you hopefully can reduce the incidence.

III. When should you start preparing your client for the hearing?

As early as possible. I take cases where the client has not yet applied or has just applied, in addition to claims that have already been denied DDS. If you are involved while the claim still is at DDS, you need to help your client with the Adult Function Report, Daily Activities questionnaires, etc. Most of our clients are going to have conditions that vary from day to day, or even from hour to hour. The
forms completed by your client need to accurately reflect that. Do not let your client answer all the questions in the questionnaires based on their worst day. If activities vary from day to day, say so. If your client bases his or her answers on their worst day, it will sound as though the client is exaggerating, when that was not their intent at all.

IV. How do you prep your client for the hearing itself?

There probably are as many ways to do this as there are people in attendance at this seminar. The way in which I prep my clients for hearing has evolved somewhat over the years, but I now give just about the same spiel in every case. I call it the “prehearing conference.”

V. When in relation to the hearing should you have your prehearing conference?

I actually have tried this a lot of different ways - days before the hearing, the day before the hearing, and right before the hearing at the hearing office. In my experience, it works best doing it the day of the hearing because the client better remembers what you talked about. Unfortunately, that is not always possible. As many of you who practice in the Birmingham ODAR know, until very recently, there were no conference rooms available for the attorney meet with his or her client privately. If there are no conference rooms, you basically are forced to talk with your client in the waiting room. Because of this, I started meeting with my
VI. **How long should you spend with your client in a prehearing conference?**

There is no one correct answer to this question. I have found that I can get my client fairly well prepared in about one hour.

VII. **What should you cover in your prehearing conference?**

Different firms have different business models, but in my firm, I am involved in the development of the case/evidence from the very start. As a result, I usually am aware of the “issues” with the evidence fairly early on. However, in almost every case when I do the final review of the exhibit file (right before the prehearing conference), I will discover some things which I need to clarify with the client. For example, you may have questions about some of the claimant’s past relevant work, or you may have questions about the claimant’s alleged onset date, or you might have questions about what appear to be conflicting statements made by the claimant to treating sources. In most cases, I am able to spend fifteen minutes or less sorting out these potential issues. Once I have clarified whatever needs to be clarified, I then give my spiel, which normally takes about forty-five minutes, and includes the following:

(a) I usually start with the purpose of the hearing. In my view, the main purpose is to gather as much information from the claimant as possible relative to
the test Social Security has to apply, so that the most informed, and hopefully
correct decision can be made. I also contrast the decision made by DDS with the
decision made by ALJs. In my opinion, Social Security asks DDS to make “a
decision,” as opposed to the “correct decision.” I am sure all of you have seen
cases where it was denied by DDS because they had trouble getting medical
evidence. Those insufficient evidence denials have nothing to do with a person’s
abilities. On the other hand, the ALJs are charged with making the correct
decision, and that includes making sure they have as much information as possible
so that they can make the most informed decision.

(b) I have also spend a couple of minutes explaining the hearing itself,
stressing the fact that the hearing will not be like going to court. Most of our
clients certainly will have seen court on television, or they may even have been in
court as a participant or a juror. From this, they know that court proceedings can be
very intimidating. I explain to my clients that court is often intimidating because
of the nature of the proceeding in court. In court, you almost always have an
adversarial situation, meaning there are one or more parties fighting about
something. That requires that judges in court be very strict - follow strict rules of
procedure and evidence. In contrast, Social Security hearings are non-adversarial,
and I explain to my client that this means there will not be anyone at the hearing
from Social Security trying to keep them from getting their benefits. Although not
technically correct, I tell my clients that ALJs are separate and independent from Social Security, and therefore, the Judges are not on the other side of the case. In other words, the Judge is our friend, not our enemy. Accordingly, since we are not fighting with anyone at the hearing, it allows us to be very informal compared to court, and the strict rules of evidence and procedure do not apply. I do explain that there are some formalities including having to promise to tell the truth, and also the fact that an audio recording will be made, which means that your client has to answer out loud.

(c) I next briefly explain the other people who will be in attendance at the hearing - the hearing reporter, the vocational expert, possibly a medical expert - and all of their respective roles in the hearing.

(d) I next explain the test for disability. I think it is important to do this for several reasons, but the most important is that it lets your client participate better in the hearing. They don’t constantly have to think to themselves during the hearing “why is he asking me this?” You also must get across to your client that the inability of your client to do their past work, in most cases, is not enough to qualify them for benefits. As far as the test for disability is concerned, I explain that it involves five steps that we take in the same order in every case. I explain that you start at step one, and if you pass step one you get to go to step two, and so on, until you pass step five, and qualify for benefits. I explain that if you fail one
of the tests along the way, you go home. (I realize this is not true for step three, but if we are talking about meeting a listing, the client’s testimony probably doesn’t matter much anyway). I then explain to the client that by the time we get to the hearing we usually have successfully dealt with steps one through three, and that in the hearings, we usually are focused in on steps four and five of the process.

I explain that under step four the question is whether the claimant can return to his or her past relevant work. I explain that the test doesn’t just look at the person’s most recent job, but instead looks back as much as fifteen years, and at all the jobs the person held within that period. I explain that if a claimant has the ability to do one of their past jobs, then they cannot get disability benefits. I find it helps them to give an example. For instance, say you get a call from a potential client who says they applied for Social Security but got denied, and want your help appealing. My first question to most people who call for my help is “what medical problems are you having that are interfering with your ability to work?” In this particular telephone call, the potential client states that he was working construction, hurt his back, has now had two back surgeries, and his doctor now will not let him lift more than fifteen pounds. I can tell from that one statement that the potential client is not going to return to the last job he had. However, I explain that I cannot stop there with my questioning, and must ask if the client if
they have done in any other kind of work. The potential client then states that he worked for the construction company for about five years, but for two years prior to that, worked in a convenience store. I then ask the potential client what his job was at the convenience store. To this, the potential client replies that he “basically just took people’s money.” I then ask if the potential client had to do the other things that convenience store workers normally do like stock the cooler, stock the shelves, mop the floor, empty the trash, etc. To this question, the potential client answers “no, I didn’t do any of that stuff. I just sat back there and took people’s money.” I then ask “did you just say you sat back there and took people’s money?” To this the potential client answers “yeah, I had a stool back there, I could do whatever I wanted.” Then I have to ask the dreaded question “could you do that job today,” to which my potential client states “yeah, I’m sure I could, but I know they’ve hired somebody else by now.”

As everyone in attendance at the seminar probably knows, under step four, the test is not whether your former job is open and available for you. Instead, the test is whether the claimant has the ability to do their past work (as actually performed or as generally performed in the economy). Because this potential client has admitted to me that he can do his past work, I cannot help this person.

I next tell my clients that for the purposes of our discussion at the prehearing conference, I am going to assume that they can’t do any of their past work. But,
that is not the end of the story. We still have step five to deal with, and step five is the most difficult test. What that step says is that even if can’t do your past work, if there is any work that a person with their restrictions and limitations can do, and there is still a good number of jobs that they can do, then they cannot get disability benefits. This is basically a fancy way of saying that in order to qualify for Social Security, you have to be disabled from all work.

I next explain how we show a person is disabled from “all work.” I explain that there are several ways, but that we almost always do it just one way, and that is to show that the person lacks the ability to do what we call “sustain” employment. I explain that I have had literally thousands of clients over the years, and that when I think back through all the people that I have represented over the years, I have a very difficult time coming up with a former client who I thought was completely unable to do a single day’s work anyway at anything. (You might get some push-back from a few clients on this issue, but you need to stick to your guns). I explain that most people, if they’re having a good day, can go tough out an eight-hour shift at some easy job. I explain that getting through a shift is not the biggest problem for most people with serious disabilities - instead, the biggest problem is the inability of the person to go to work day after day, on a regular and continuing basis. They might make it through a shift, or two, or even longer depending on the nature of their impairment, but eventually whatever is wrong with them will sort of
jump up and bite them, and make them miss a lot of work, or keep them from doing the job the way that it is supposed to be done. I next explain that a person’s ability to sustain employment is critical to what the Judge will be deciding; and, that in fact, most vocational experts will say that missing more than two days of work a month will not be tolerated. I explain that we have literally thousands of rules and regulations that potentially govern what we do in hearings, but in most cases, the issue at the hearing is rather simple, and comes down to this - in the United States economy, which includes all the thousands of occupations and jobs that exist, of all of those thousands of jobs, there are about ten which for lack of a better way of saying it, are the easiest. These jobs are the easiest because they require the least of a person physically and least of a person mentally during the work day. Basically the person could sit almost all day, they could alternate between sitting and standing if that was better, they would not have to lift much more than a clipboard, and these jobs can be done by someone who does not have a high school education, and who actually has trouble reading and writing. So what we are doing in the hearing is we are going to look at these ten or so so-called easy jobs, and what a person would have to do during the course of a work day to perform these jobs, then we look at you (the claimant), and basically see if you have left what it takes to do one or more of these so-called easy jobs. If you have that ability, then you won’t be able to get Social Security, because these jobs do
exist in significant numbers in the economy. Maybe not in your home town, and you may not have heard of any of these jobs, but they are out there.

Now that I have scared them to death, I next explain that even though these jobs are the easiest, they all are in something that we call a “competitive work environment.” This means, first, that they are full time - eight hours per day, five days per week. In addition, when a person is performing one of these so-called easy jobs, they always will be working for a business. And, that business always will be in competition with other businesses which are doing the same thing. For instance, if you are working for Home Depot, you will be competing with Lowe’s. If you are working for Walmart, you will be competing with Target. If you are working for McDonald’s, you will be competing with Burger King. The way that these businesses compete effectively with one another is their employees come to work every day, and they get the business’s product or service out for people to buy. I like to give an example of this - say you are the cook at McDonald’s, and you are supposed to be there 5 days per week. But, you have some chronic health problem where you are only showing up for work 4 days per week. I explain that in that situation it will not take the burger buyers of this world very long to figure out they are getting lousy service at that restaurant, and that their response to lousy service is simply to drive a quarter mile down the road to another fast food restaurant. And, this particular McDonald’s will not last very long, unless they
make a change - they have to get rid of the cook that is not coming to work. Therefore, it is critical that a person be able to work every day. And, in addition to going to work every day, the claimant also has to have the ability to do the job like they are expected to do it for a full eight hours every day. I explain that sometimes I have clients that might could go stay at the work place for eight hours, but that for a significant part of the day, say an hour or more of the day, they are unable to do the job like their boss expects them to do it. Basically, they are sitting there like a lump on log. That does not help your boss only to have you there, if you are not doing the work. So not only do you have to go every day, you also have to do the job like they expect you to do it for the full eight hours every day. And that is the way that we normally demonstrate that a person is disabled from all work, including the so-called easy jobs - either a person is going to have trouble going to work regularly, they are going to have trouble doing the job like they are supposed to do it for the full eight hours, or some combination of those two things.

(e) In the next portion of my prehearing conference, I deal with actual testimony. I explain that there will be some background questions regarding age, education, past work, etc., but that the majority of the hearing will be spent talking with the client about what is wrong with them. I explain that we have their medical records showing their diagnoses, but what we need to hear from them are the symptoms that they experience. In other words, how does it make them feel? I
explain that what we are trying to get a feel for is whether the symptoms the person is experiencing are significant enough to interfere with the ability to do work activities. And when I say work activities, I mean not only what the person had to do in their prior work, but also what the people would have to do in the so-called easy jobs. What we would like to demonstrate to the Judge is that the client’s symptoms are significant enough to interfere even with their ability to do these so-called easy jobs.

I then explain that there are two parts to all work, and that they are equally important. You have the physical side of work, and you also have the nonphysical, or nonexertional requirements for work. These two parts are equally important in the sense that you have to do each of them satisfactorily if you were to keep your job.

I next explain that if some of the physical requirements of the job are going to “get” one of my clients, it’s usually the fact that these jobs are eight hours a day, and that during those eight hours, the worker must maintain acceptable work postures - sit, stand, and walk. If a person has to lie down on an unpredictable basis in order to control their symptoms, there will be almost no tolerance for this in the competitive work place.

I also talk with my clients about the nonexertional requirements for work which in a nutshell are the ability to concentrate, to be persistent, and to keep pace
- they need to go at the rate the boss says, so the work gets finished by the end of the work day. If you have something wrong with you that significantly interferes with your ability to do these things, then it is just as bad as not being able to meet the physical demands of the job. I then explain that there are lots of things that can interfere with your ability to do the nonexertional requirements for work, but that the most common thing that we see in Social Security cases is pain. I explain that there are many people in this country who go to work everyday who have chronic pain. These people who do work successfully with chronic pain might be aware that they are experiencing some pain during the course of the work day, but their pain is not at a level which interferes with their ability to do the job. However, pain can get to the point where it does interfere. Pain can get to the point where it starts to preoccupy your thoughts, when your pain gets to that point, you aren’t thinking about what your boss is asking you to do, but instead about your pain and what you need to do to relieve it. Most people at that point start engaging in pain avoiding behaviors which might vary depending on the source of the pain. It would be taking more pain pills, it could be lying down, it could be getting on heating pad, etc. Therefore, we certainly will want to know whether the person’s pain ever gets to the point where it could be expected to interfere, the types of things that cause their pain to get to that point, and what the person basically has to do to deal with their pain.
At this point in the prehearing conference I usually go into the visual analog scale for pain - rating your pain on a scale of one to ten. I think it is important to explain to the client what the Judge’s perspective on a scale of one to ten is, and why many of the Judges ask the claimants to rate their pain. I briefly explain that doctors ask that question so that they can properly assess and treat the patient. On the other hand, Judges ask claimants to rate their pain on a scale of one to ten because of what vocational experts tell us about the significance of pain in the work place. I explain that most vocational experts will testify that there are many people who go to work every day in this country who have chronic pain. These people who work successfully likely are experiencing only mild pain to moderate pain. However, if that person’s pain gets over the moderate level, into the moderately severe and severe levels of pain, that is the type of pain that is significant in the work place. When a person’s pain gets to be moderately severe, they are seriously distracted from their job tasks, and begin to fail to complete their job tasks in a timely manner. People with severe pain abandon their job task altogether.

I then explain that on a scale of one to ten, nine and ten is considered severe, and seven and eight is considered moderately severe pain. Therefore, if a person’s pain gets up into a seven or more range often enough during the work day or work week, that person will not keep their job very long. I then explain that from a
Judge’s perspective, if your pain was nine or ten you would not come to the hearing. That is emergency room pain or in-the-bed pain. I also explain that I rarely have clients that come to hearings whose pain is at level seven or eight. I explain that in most of my cases, my clients have had chronic pain for some time, and have figured out the things that aggravate it. And, if they avoid those things that aggravate their pain, they usually can keep their pain under that seven to eight level. It is usually when my clients start doing those things they know they should not, and unfortunately a lot of the things that we associate with work, that their pain gets up into that moderately severe or severe level. At this point, I always stress that it is not necessary for a person to have pain that is seven or more twenty-four hours a day, seven days a week, in order to qualify for Social Security. I explain that the vocational expert will testify that a person who chronically experiences pain at greater than the moderate level for an hour or more of the work day will not be able to hold down a job.

(f) The final part of my prehearing conference deals with some of the actual questions that will be asked regarding the client’s ability to do work-related activities such as sitting, standing, or walking. In my view, it is critical that you get across to your client that if a judge perceives that the client is exaggerating, the case will be denied. Unfortunately, some clients can give the impression that they are exaggerating, when they really are not. I believe this happens most often as a
result of a natural tendency on people’s parts to come to their hearing and answer most, if not all, the questions based on their worst day. Of all the clients that I’ve have over the years, I can only recall one for whom every day was the same. That client was blind. When you’re blind, your days are pretty much the same. The overwhelming majority of my clients are not the same every day. Their condition is more like a roller coaster, and their ability to function may depend in large part on what is going on with them on a particular day. In other words, on their good days, they function better than on their bad days. I stress to my clients it is critical that you not fall in to the trap of answering questions about things like your ability to sit, stand, or walk based only upon your worst days. In my view, you cannot stress with your client enough the importance of contrasting their abilities on their good and bad days. Most of my clients have identified certain activities that they will not try any more. Then there are some activities which they are able to do depending on what kind of day they are having. Finally, there is the category of things that they can do almost all the time. (e.g., care for their personal needs). Lastly, most of my clients have never put a stopwatch on their ability to sit, stand, or walk. Some do a pretty good job of estimating, but others do not. I think it is helpful for a client to give real world examples of their limitations. For instance, when a hearing judge asks a client “how long can sit at one time,” probably the true answer to that question is “it depends on the day.” Then give examples. For
instance, I had a client testify in response to this line of questioning that the length of time he could sit depended on the amount of pain that he was having on a particular day. He gave the example of having tried to go to church the previous Sunday, which happened to be Easter, and having to leave church after only ten minutes to go lie down in his truck. He then told the Judge that it was not always that way - that was an example of how it was when he’s at his worst. He then gave an example of having a very good day, and he and his wife attending a movie, during which, he would only have to stand up one or two times. Real examples like that, in my view, are the best evidence you can give. However, if your client is unable to come up with examples, explain that it is fine for them to give a range of time - for example I can sit for about X number of minutes on a bad day before I have to change position, and probably Y number of minutes on a good day.

That’s my story, and I am sticking to it!
What Judges Are Looking For: Residual Functional Capacity

Judge David Stephens
Office of Disability Adjudication & Review
Birmingham
**BASICS:**

*State the most the individual can do in the RFC*

20 CFR Sections 404.1545 and 416.945 defines RFC: “Your residual functional capacity is the most you can still do despite your limitations.” 20 CFR Sections 404.1546(c) and 416.946(c) state that at the administrative law judge hearing level the administrative law judge “is responsible for assessing your residual functional capacity.”

The RFC is not a general conclusion about the claimant’s ability to work. Instead, it must be an evidence-based statement of the claimant’s physical and mental functional limitations.

**GUIDE FOR A SUFFICIENT RFC:**

1. **Comprehensive** - The Regulations and Social Security Ruling (SSR) 96-8p provide the RFC must be derived from all the relevant medical and other evidence.
   a. RFC must be a function-by-function assessment of the claimant’s ability to perform work related activity;
   b. The decision must show the connection between the evidence and the RFC.
   c. Other helpful SSRs
      - SSR 83-12 addresses alternate sitting and standing and the loss of upper extremity functions
      - SSR 85-15 gives examples of how certain non-exertional impairments affect the occupational base at step 5
      - SSR 85-16 deals with RFC assessments for mental impairments
      - SSR 96-5p explains the difference between the RFC assessment, which is a decision reserved to the Commissioner, and other statements including medical source statements, and
      - SSR 96-9p, discusses the implications of an RFC for less than the full range of sedentary work
2. **Clear** - A clear RFC distinguishes impairments and symptoms from the true component of the RFC assessment – capacities and limitations.
   a. You must assess the RFC on a function-by-function basis.
   b. Make the link between the impairment – herniated discs; the symptom – pain; and the RFC – the ability to stand, walk and reach – all in a positive statement of what the claimant is capable of doing function-by-function on a regular and continuing basis.

3. **Consistent** - The RFC and the VE hypothetical must be the same, and they must be consistent with the decision rationale.
   a. The FIT decisional template helps by stating the RFC only once in the decision.
   b. ALJs, make sure the RFC in the decision matches the hypothetical you ask the vocational expert.
   c. Attorneys and paralegals, don’t repeat the RFC in the draft. Say it once in the RFC finding paragraph.
COMMON PROBLEMS IN RFC ARTICULATION:

The claimant is limited to less than sedentary work

1. It does not articulate a residual functional capacity as a statement of the MOST an individual can do.
2. “Less than sedentary” does not equal disabled under the regulations or SSR 96-9p. It depends primarily on the nature and extent of the functional limitations or restrictions.
3. Some clarifying examples:
   a) Instead of saying “alternate sitting and standing at will,” the RFC should state: how frequently the claimant must alternate sitting and standing; how long the claimant can sit before needing to stand; and how long the claimant must stand before sitting again?
   b) Instead of using the term “extended periods,” the RFC should say how often and how long the person must recline, and whether a normal break and lunch schedule could accommodate these periods.
   c) If the only impairments are mental and there is no evidence they cause physical limitations, the correct RFC should state the claimant can perform the full range of work at all exertional levels and then describe the limitations associated with the mental health impairments. For example, the claimant can do the full range of work at all exertional levels but must work primarily alone, with only occasional supervisory contact.
4. Section 201.00(h) of the Medical-Vocational Rules does NOT direct a finding of disabled if the individual is limited to less than sedentary work. It depends on the nature and extent of the additional limitations.

The claimant is unable to sustain work on a full-time basis

1. “Unable to sustain work” is NEVER a proper RFC.
2. It does not state the most the claimant can do despite limitations. It does not identify or quantify the claimant’s functional limitations.
3. The “unable to sustain work” RFC short-circuits the sequential evaluation process. In effect, it skips
RFC and steps four and five and jumps right to the conclusion – that the claimant is disabled.

CAUTIONS:

Use care with RFC terms such as: the claimant will be “off task 20% of the workday” or “miss four or more days of work per month.”

The claimant will be off task 20 percent of the workday
1. Either phrase may be used in an RFC, but the record must support the finding.
2. Look to medical records for corroborating evidence; Complaints to doctor/therapist about loss of concentration/focus; reduced ADLs; medication/side effects; and change of prescriptions.
3. SSR 06-3p says you must consider 3rd party statements. Testimony of the claimant may also support your finding.
4. Tie your finding directly to the evidence.
5. The AC or Court cannot supply the rationale for you.
6. Whatever the cause, corroborating evidence must support the RFC finding.
7. Off task 20% should not be used as a shortcut for finding disability when the evidence does not support it.
8. Moderate limitations in social functioning and moderate limitations in concentration, persistence, or pace may be inconsistent with finding of claimant off task 20% of the time.

The claimant is likely to miss 2 or more days of work per month
1. It’s another way of saying the claimant cannot attend to work tasks for a certain period of time.
2. The evidence must support this finding.
3. MSS with a check box indicating how many days per month the claimant would be expected to miss work must be considered and evaluated as any other opinion.
4. Compare the allegation to the reported activities of daily living, what the claimant reported to medical providers, whether symptoms reported to the doctor as severe as alleged in testimony, what diagnostic tests show, and what treatment is prescribed.

TIPS
**Avoid the terms “moderate,” ”sit/stand option,” or “low stress work” in an RFC**

**Trap 1**: Using the term “**moderate**” to describe a functional limitation.
1. Only one exception - describing noise level because the DOT defines a moderate noise level. Otherwise, the term “moderate” should not be used in an RFC.
2. Moderate is not specific. It may mean different things to different people. Instead, use clear, defined terms, for example, those defined in the DOT such as “never,” “occasional,” or “frequent.”
3. An RFC that says the claimant has moderate limitations in concentration is never correct.

**Tip 1**: Other than in noise environments, never use the term “**moderate**” to describe a functional limitation.

**Trap 2** - Using the term “**low stress**” to describe the work environment.
1. There is no definition of a low stress environment in the DOT. What’s stressful to one may not be stressful to another.
2. Tailor the RFC to the cause of stress, as supported by the evidence.
3. Common stress inducing work situations include:
   a. Working with supervisors
   b. Working with coworkers
   c. Dealing with the public
   d. Making decisions
   e. Using judgment
   f. Working at a production rate pace
   g. Working at unprotected heights

**Tip 2**: Tailor the RFC to the work activity causing stress.

**Trap 3** – Using the “**sit/stand option**”
1. The phrase is too vague.
2. **SSRs 96-9p and 83-12** says an individual may need to alternate sitting of sedentary work by standing periodically. When this cannot be accommodated by scheduled breaks and a lunch period, the occupational base for sedentary, unskilled work is eroded. The extent of erosion depends on how
frequently the individual must alternate positions and the length of time needed to stand.

3. The phrase “sit/stand option” in an RFC is a red flag on appeal.

Tip 3: If the claimant must alternate between sitting and standing, state the frequency and length of time in the RFC.

KEY RULINGS:

SSR 96-5p – Explains the difference between the RFC assessment, which is a decision reserved to the Commissioner, and other statements, including medical source statements.

SSR 96-8p – 1. An RFC must be a function-by-function assessment of the claimant’s ability to perform work related activity. 2. The decision must show the connection between the evidence and the RFC.

SSR 83-12 – Addresses the effect of special limitations such as alternate sitting and standing and the loss of upper extremity function.

SSR 85-15 – Has examples of how certain non-exertional impairments affect the occupational base at step 5 of the sequential evaluation process.

SSR 85-16 – Stresses the importance of RFC assessments for mental impairments.

SSR 96-9p – Discusses the implications of an RFC for less than the full range of sedentary work.
CLE Alabama

Social Security Disability Law

The University of Alabama School of Law
Tuscaloosa, Alabama
Friday, October 24, 2014

Assessing Credibility

William Lawson
Administrative Law Judge
Office of Disability Adjudication & Review
Birmingham
ASSESSING CREDIBILITY

William Lawson
Administrative Law Judge, ODAR
Birmingham, Alabama

General Overview

The Administrative Law Judge is required under the Social Security Act to evaluate the subjective complaints and credibility of the claimant’s allegations at a Social Security Hearing. This requires knowledge of the assessment criteria outlined in the Social Security Regulations and Rulings and experience in conducting credibility questioning.

In addition, other forms of evidence may be the subject of credibility determinations. How does the agency define “evidence”?

20 CFR 404.1512(b): “Evidence is anything you or anyone else submits to us or that we obtain that relates to your claim.”

Where does the term “credibility” appear in the regulations?
20 CFR 404.1528(a) and 416.928(a) or
20 CFR 404.1529 and 416.929???

Credibility is assessed by considering and assessing the claimant’s symptoms. The foregoing regulations define symptoms and provide factors for evaluating the same. In addition, SSR 96-7p specifically addresses the evaluation of symptoms and “Assessing the Credibility of an Individual’s Statements.”

Is the ALJ’s discussion of the evidence regarding pain and fatigue “suspended over air”?
Does the ALJ’s finding that claimant could return to her PRW “amount to a bad joke”?
On appeal, do the attorneys have to “milk the record” for other evidence to support the denial? Martinez v. Astrue, 630 F.3d 693, 7th Circuit (2011)(No surprise—Judge Richard Posner)

404.1528(a) + 404.1529 + 96-7p = DEFERENCE

Sources of Credibility Assessment:

The credibility of a claimant’s statements about pain or other symptoms and their functional effects is the degree to which the statements can be believed and accepted as true (SSR 96-7p).
The ALJ must consider the entire case record and give specific reasons for the weight given to the claimant’s statements.

The ALJ need not accept or reject the claimant’s statements, in toto. “Falsus in unum, falsus in omnibus”

Because symptoms, such as pain, sometimes suggest a greater severity of impairment than can be shown by objective medical evidence alone, the claimant’s statements about symptoms must be carefully considered in light of all the evidence in deciding credibility. A credibility determination, of course, is not dispositive on the issue of disability. A “non-credible” claimant can be disabled just as an entirely truthful and credible claimant may not meet our definition of disability.

A conclusory statement in a decision that the claimant is or is not credible is not sufficient. The decision must contain specific reasons supported by evidence in the record.

Post-hoc rationalizations do not comply with SSR 96-7p and generally will not be accepted by the Federal Courts. “What matters are the reasons articulated by the ALJ, not the reasons advanced by the government on appeal.”

**Evaluation of Credibility**

The regulations identify seven factors to be used in evaluating symptoms, including pain (20 CFR 404.1529(c) and 416.929(c); SSR 96-7p).

1. Activities of daily living
   “One does not have to be utterly incapacitated in order to be disabled.”
2. Symptom location, duration, frequency, intensity
3. Precipitating or aggravating factors
4. Type, dosage, effectiveness, side effects of medications
5. Treatment other than medications for relief
6. Any measure to relieve symptoms
7. Other factors concerning functional limits or restrictions due to symptoms

The credibility of a claimant’s statements about pain, symptoms, and the ability to function must be based on a consideration of all evidence of record. This includes:

- Medical signs and laboratory findings
- Diagnosis, prognosis, and medical opinions from medical sources
- The longitudinal medical treatment history
- Statements and reports from others about the claimant’s medical history, treatment, and response. SSR 06-3p requires us to identify and evaluate such statements with weight accorded along with rationale.
Observations of SSA employees and adjudicators during interviews
. Consistency, both internally and with other information in the case record (Hallmark of credibility)
. Observations of the claimant
. The claimant’s prior work record

**Receipt of Other Governmental Benefits**

Claimants occasionally apply for unemployment benefits for the same period they are claiming disability. In the application for unemployment benefits the claimant states he or she is ready, willing and able to work. This obviously conflicts with the claim for disability benefits.

An application for unemployment insurance benefits may be considered on the issue of credibility, but should not be the sole ground for finding the claimant not credible. Do not overlook the receipt of unemployment benefits—it is NOT a disqualification.

Possible areas of inquiry:
Did claimant fill out any job applications?
Did claimant travel to job interviews/personally report to unemployment office/ do it online?
Did claimant maintain record of job searches/provide information to state agency?
How many hours/days spend looking for work?
Look to the activities associated with the receipt of benefits, not the receipt alone.
Remember, one that is ready, willing and able to work may still be found disabled under our medical vocational guidelines.

Likewise, the claimant may have applied for work during the period of claimed disability. Again, the claimant should be asked to explain this apparent inconsistency.

A claimant may receive a decision by another governmental or nongovernmental agency about whether the claimant is disabled or blind. Such a decision by another agency is not binding on the Social Security Administration (20 CFR 404.1504; 416.904); however, evidence of a disability decision by another agency cannot be ignored and must be considered by an ALJ (SSR 06-3p).

**Traditional Means to Assess Credibility**

Traditional means for judging credibility may be applied in hearing cases. In particular, the ALJ may utilize prior inconsistent statements, inconsistencies with the remainder of the credible record and demeanor evidence in conjunction with the special SSA rules.
Activities of Daily Living

Frequently, one of the best sources for judging credibility is the information related to the claimant’s activities of daily living. ADL information may be found in:

. the Disability Report
. Daily Activity Forms completed by the claimant
. The “History” portion of a consultative examination
. Hospital and emergency room records documenting the reason for the visit and patient history
. Medical reports from treating and examining sources
. Statements and testimony from other witnesses

It is important to consider the longitudinal history when reviewing these reports. For example, a note that the claimant was able to fish once this year may not be significant but if other records show the claimant has fished regularly, it may be significant.

Gaps in Treatment or Medication

The file should contain medical records from at least one year prior to the alleged onset date of disability. Are there gaps in treatment? If so, ask the claimant to explain this. Such gaps in treatment may reflect a diminution of symptoms or the claimant may have been unable to afford treatment and not had access to free or low cost medical services.

Information about medication and other treatment used to relieve symptoms should be in the medical records and claimant statements. Are there periods of time when the claimant has not required prescription medication or treatment for symptoms? Ask the claimant to explain these gaps.

Consistency of Testimony

Look for both internal consistency and consistency with the record as a whole. For example:

. Does the claimant give contradictory testimony in the hearing?
. Does the claimant who alleges blackouts and seizures continue to drive?
. Does the claimant who alleges poor concentration attend college or vocational training?
. Does the claimant who alleges hand problems wash dishes, button clothes, prepare meals, or hold a book or newspaper to read?
. Does the claimant who has taken prescribed pain medication for years claim it provides no relief or that it causes intolerable side effects?

Evidence of Demeanor

The claimant’s demeanor at the hearing is a legitimate tool for assessing credibility but the courts have precluded the use of the “sit and squirm” test as a measure for credibility. Demeanor evidence is generally not the best evidence for assessing credibility and should never be the sole
grounds for assessing credibility. If an ALJ is going to use demeanor as evidence, it should be made a part of the record. Examples of demeanor evidence:

. Does the claimant who alleges an inability to sit more than 20 minutes, sit through an hour long hearing in no apparent discomfort?
. Does the claimant who alleges depression smile and react appropriately to questions at the hearing?
. Does the claimant who alleges poor concentration or memory have any difficulty answering questions or recalling events?
. If the claimant alleges a disabling memory loss, the ALJ might ask a number of questions requiring detailed recall of dates, events and names before turning the questioning over to the representative.
. If a claimant alleges a hearing loss, make a note on the record of the ability to hear questions in the hearing room

**Claimant Witnesses**

An ALJ does not need to prepare a complete credibility evaluation for each non-claimant witness; however, the degree of analysis may depend on whether the witness is an acceptable medical source, medical source that is not an acceptable medical source, non-medical source who has seen the claimant in a professional capacity, or non-medical source who has not seen the claimant in a professional capacity. Although one might assume that a friend or relative will testify favorably toward the claimant, this alone is not grounds for accepting or rejecting the testimony. An ALJ should assess the witness’s credibility using the same general tools for assessing claimant credibility in light of the record as a whole, and for non-medical sources factors for consideration would include the nature and extent of the relationship, qualifications of the source, supportability (how well explained, relevance), consistency with other evidence, specialization, and any other factors (SSR 06-3p).

**Social Media--Administrative Message-12053**

. Applies at all administrative levels
. Adjudicators must not use uncorroborated information
. Adjudicators should not instigate an independent investigation
. If a potential fraud situation arises, the suspected fraud should be reported
. If evidence suggests allowance, yet fraud is being investigated, decision must be delayed
. If the Cooperative Disability Investigations Unit completes an investigation and prepares a Report of Investigation, adjudicators must use the corroborated evidence to assess potential fraud and similar fault. All evidence must be considered before determining whether to disregard specific evidence.
CLE Alabama

Social Security Disability Law

The University of Alabama School of Law
Tuscaloosa, Alabama
Friday, October 24, 2014

Assessing Medical Evidence

Cynthia Brown
Administrative Law Judge
Office of Disability Adjudication & Review
Birmingham
Assessing Medical Evidence

Cynthia Brown

Administrative Law Judge

SSA/ODAR

Birmingham AL ODAR
ASSESSING MEDICAL EVIDENCE

It is the responsibility of the judge to hear and decide cases in accordance with agency policy. Once the record has been sufficiently developed, a judge must review all of the evidence in the file and make the appropriate findings in accordance with 5 U.S.C. § 223(d)(5) and 1614(a)(3)(H). Further, a judge must articulate the reasons for their findings in their decision. A judge may not simply “rubberstamp” a third party’s assessment.

When assessing the evidence provided by the claimant, the source and nature of the information must be identified. 20 C.F.R. §§ 404.1527(a)(1) and 416.927(a)(1). Evidence from acceptable medical sources, as defined by 20 C.F.R. §§ 404.1513 and 416.913, may establish the existence of a medically determinable impairment (20 C.F.R. §§ 404.1513(a) and 416.913(a)), and may form the basis of a medical opinion (20 C.F.R. §§ 404.1527(a)(2) and 416.927(a)(2)). The medical opinion of a treating source may be entitled to controlling weight on the issue(s) of the nature and severity of the claimant’s impairment(s), but only if it is well-supported by medically acceptable clinical and laboratory diagnostic techniques and is not inconsistent with the other substantial evidence in the claimant’s record. See 20 C.F.R. §§ 404.1527(c)(2) and 416.927(c)(2). SSR 96-2p should be referred to for guidance in addition to the regulations on assessing treating source medical opinions, including deciding that a treating medical source statement is not entitled to controlling weight.

Evidence from sources other than “acceptable medical sources” also must be handled in accordance with agency policy. Information from these “other
sources” cannot establish the existence of a medically determinable impairment. There must be evidence from an “acceptable medical source” for this purpose. However, information from such “other sources” may be based on special knowledge of the individual and may provide insight into the severity of the impairment(s) and how it affects the individual's ability to function. In addition to the regulations, SSRs 96-5p, 96-6p and 06-3p should be referred to for guidance on assessing opinions and evidence from sources other than “acceptable medical sources.”

Properly assessing evidence from the various sources is particularly important when determining residual functional capacity (RFC). Making a proper RFC assessment does not include a blind acceptance of a third party’s assessment. It also does not include weighing the various medical source statements in the file and determining which one most “closely” matches the claimant’s abilities. The RFC is determined by considering all the evidence of record, and if the evidence is questioned, the appropriate steps must be taken to resolve any issues.

For example, if the ALJ believes that an opinion or other evidence received from a medical source is insufficient or inconsistent, the ALJ may contact that source to clarify the evidence or seek additional information, including whether the medical source completed or reviewed the statement submitted on behalf of the claimant. 20 C.F.R. §§ 404.1520b(c) and 416.920b(c). The ALJ may also determine that the medical source’s testimony is needed to inquire fully into the matters at issue. If so, the ALJ should follow the procedures in HALLEX I-2-5-18.
FOUR KEYS TO MEDICAL SOURCE STATEMENTS

A MEDICAL SOURCE STATEMENT (MSS) IS GIVEN “CONTROLLING WEIGHT” ONLY UNDER LIMITED CIRCUMSTANCES

Controlling weight should be given to an MSS only if it is:

1. A treating source opinion, AND
2. Well supported by medically accepted clinical and diagnostic techniques, AND
3. Not inconsistent with other substantial evidence

If the opinion is not given controlling weight, it must still be evaluated by applying the factors listed in 20 CFR 404.1527(d) and 416.927(d)

AN MSS MAY BE ACCEPTED IN PART; IT IS NOT REQUIRED TO ACCEPT EVERY PART OF THE OPINION

An MSS may comprise separate medical opinions regarding diverse physical and mental functions. Great weight may be given to some elements and little weight to other elements of an MSS, but the decision should cite the evidence for the weight given to the elements adopted or rejected.

SUPPORT THE WEIGHT GIVEN AN OPINION BY CITING TO THE SUPPORTING EVIDENCE. DO NOT USE STOCK PHRASES ALONE TO SUPPORT YOUR CONCLUSION

Show how the evidence supports the conclusion. A few sentences focused and tied to the evidence will often suffice.

A CASE MAY BE DECIDED WITHOUT AN MSS

- An MSS is not required to determine whether a claimant meets a listing or in determining RFC
- Order a CE and request an MSS only if necessary for a full development of the impairment(s)
- A Medical Source Statement of Ability to Do Work Related Activities Form should be sent with all requests for medical records
- A Single Decision Maker (SDM) assessment is not opinion evidence and should not be assessed as such in a decision
MEDICAL SOURCE OPINION DESK GUIDE

Applicable Rulings

96-2p – Giving controlling weight to treating source medical opinions.

96-5p - Medical source opinions on issues reserved to the Commissioner.

96-6p - Consideration of administrative findings of fact by DDS medical and psychological consultants at ALJ and AC levels.

Acceptable Medical Sources

1- licensed physicians
2- licensed osteopaths
3- licensed or certified psychologists including school psychologists for mental retardation and learning disabilities in child cases
4- licensed optometrists for measurement of visual acuity and visual fields
5- licensed podiatrists for impairments of the foot or foot and ankle
6- qualified speech/language pathologists for speech and language impairments in allowances only
7- persons authorized to send us a copy or summary of the medical records of a hospital, clinic, sanatorium, medical institution or health care facility.

Reg. 404.1513(a) and 416.913(a)
POMS DI 22505.003B.1., DI T25205.007

Other Sources

These are not acceptable medical sources, but their opinions must be considered in the overall evaluation:

1. Teachers
2. Chiropractors
3. Audiologists
4. Licensed or certified counselors
5. Vocational rehab counselors
6. Physical therapists
7. Other persons, such as friends, employers, relatives, etc.

Reg. 404.1513(e), 416.913 (e)
POMS DI 22505.003B.2.

Three kinds of medical sources

1. treating source
2. examining source
3. non-examining source

References: POMS DI 22505.001B.1 22505.003B.1.
22505.004
24515.006A.
24515.007A.
25205.007

What is a medical opinion?

A statement from an acceptable medical source about the nature and severity of an individual’s impairment(s), including symptoms, diagnosis, prognosis, what the claimant can still do despite the impairment(s), and mental and physical restrictions.

Reg. 404.1527(a)(2) & (b)
416.927 (a)(2) & (b)
SSR 96-2p
POMS DI 24515.002B.2., 24515.003A.1.

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Controlling Weight
When a judge gives an opinion controlling weight, it means that the judge adopts that opinion. Controlling weight may be given only if the opinion is:

1. from a treating source
2. a medical opinion
3. well-supported by medically acceptable clinical and laboratory diagnostic techniques
4. not inconsistent with the other substantial medical and non-medical evidence in the case.

Regs. 404.1527(d)(2), 416.927 (d)(2)
POMS DI 24515.003A.2.,
DI 24515.004

Opinion Non-Controlling
Factors to consider for weighing noncontrolling treating source medical opinions and opinions from nontreating and nonexamining sources:

1. treatment relationship
2. examining relationship
3. supportability
4. consistency
5. specialization
6. other factors
POMS DI 24515.003A.3. & 4.
24515.005B.4. & 5.

Issues reserved to the Commissioner
1. Whether an impairment meets or equals the Listings.
2. Assessment of RFC
3. Application of vocational factors, such as age, education and work experience
4. Whether the individual is disabled, blind or unable to work
Regs. 404.1527(e), 416.927(e)
SSR 96-5p
POMS DI 24510.010, DI 24515.009

Evaluating inconsistencies in medical opinions
There may be inconsistencies:

1. between two different reports
2. internal inconsistencies within a particular medical report
3. between a medical report and a third party report

Resolving inconsistencies
Additional development may not be necessary if:

1. other evidence outweighs the inconsistent evidence
2. the inconsistency is not material to the determination
3. there is an apparent inconsistency but not actual inconsistency in the evidence
POMS DI 24515.001B.

Recontacting the medical source
Recontact with the medical source is necessary when the evidence ODAR receives from the medical source is inadequate for us to determine whether the individual is disabled and the medical report:

1. contains an inconsistency or ambiguity that must be resolved
2. does not contain all the necessary information
3. appears not to be based on medically acceptable clinical and laboratory diagnostic techniques.
POMS DI 22505.008B
24515.001B.3.b.
§ 404.1513. Medical and other evidence of your impairment(s).

(a) Sources who can provide evidence to establish an impairment. We need evidence from acceptable medical sources to establish whether you have a medically determinable impairment(s). See § 404.1508. Acceptable medical sources are—

(1) Licensed physicians (medical or osteopathic doctors);

(2) Licensed or certified psychologists. Included are school psychologists, or other licensed or certified individuals with other titles who perform the same function as a school psychologist in a school setting, for purposes of establishing intellectual disability, learning disabilities, and borderline intellectual functioning only;

(3) Licensed optometrists, for purposes of establishing visual disorders only (except, in the U.S. Virgin Islands, licensed optometrists, for the measurement of visual acuity and visual fields only);

(4) Licensed podiatrists, for purposes of establishing impairments of the foot, or foot and ankle only, depending on whether the State in which the podiatrist practices permits the practice of podiatry on the foot only, or the foot and ankle; and

(5) Qualified speech-language pathologists, for purposes of establishing speech or language impairments only. For this source, “qualified” means that the speech-language pathologist must be licensed by the State professional licensing agency, or be fully certified by the State education agency in the State in which he or she practices, or hold a Certificate of Clinical Competence from the American Speech-Language-Hearing Association.

(b) Medical reports. Medical reports should include—

(1) Medical history;

(2) Clinical findings (such as the results of physical or mental status examinations);

(3) Laboratory findings (such as blood pressure, x-rays);
(4) Diagnosis (statement of disease or injury based on its signs and symptoms);

(5) Treatment prescribed with response, and prognosis; and

(6) A statement about what you can still do despite your impairment(s) based on the acceptable medical source's findings on the factors under paragraphs (b)(1) through (b)(5) of this section (except in statutory blindness claims). Although we will request a medical source statement about what you can still do despite your impairment(s), the lack of the medical source statement will not make the report incomplete. See § 404.1527.

(c) Statements about what you can still do. At the administrative law judge and Appeals Council levels, we will consider residual functional capacity assessments made by State agency medical and psychological consultants, and other program physicians and psychologists to be “statements about what you can still do” made by nonexamining physicians and psychologists based on their review of the evidence in the case record. Statements about what you can still do (based on the acceptable medical source's findings on the factors under paragraphs (b)(1) through (b)(5) of this section) should describe, but are not limited to, the kinds of physical and mental capabilities listed as follows (See §§ 404.1527 and 404.1545(c)):

(1) The acceptable medical source's opinion about your ability, despite your impairment(s), to do work-related activities such as sitting, standing, walking, lifting, carrying, handling objects, hearing, speaking, and traveling; and

(2) In cases of mental impairment(s), the acceptable medical source's opinion about your ability to understand, to carry out and remember instructions, and to respond appropriately to supervision, coworkers, and work pressures in a work setting.

(d) Other sources. In addition to evidence from the acceptable medical sources listed in paragraph (a) of this section, we may also use evidence from other sources to show the severity of your impairment(s) and how it affects your ability to work. Other sources include, but are not limited to—
(1) Medical sources not listed in paragraph (a) of this section (for example, nurse-practitioners, physicians' assistants, naturopaths, chiropractors, audiologists, and therapists);

(2) Educational personnel (for example, school teachers, counselors, early intervention team members, developmental center workers, and daycare center workers);

(3) Public and private social welfare agency personnel; and

(4) Other non-medical sources (for example, spouses, parents and other caregivers, siblings, other relatives, friends, neighbors, and clergy).

(e) Completeness. The evidence in your case record, including the medical evidence from acceptable medical sources (containing the clinical and laboratory findings) and other medical sources not listed in paragraph (a) of this section, information you give us about your medical condition(s) and how it affects you, and other evidence from other sources, must be complete and detailed enough to allow us to make a determination or decision about whether you are disabled or blind. It must allow us to determine—

(1) The nature and severity of your impairment(s) for any period in question;

(2) Whether the duration requirement described in § 404.1509 is met; and

(3) Your residual functional capacity to do work-related physical and mental activities, when the evaluation steps described in § 404.1520(e) or (f)(1) apply.

§ 404.1527. Evaluating opinion evidence.

(a) General. (1) You can only be found disabled if you are unable to do any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months. See § 404.1505. Your impairment must result from anatomical, physiological, or psychological abnormalities which are demonstrable by medically acceptable clinical and laboratory diagnostic techniques. See § 404.1508.

(2) Evidence that you submit or that we obtain may contain medical opinions. Medical opinions are statements from physicians and psychologists or other acceptable medical sources that reflect judgments about the nature and severity of your impairment(s), including your symptoms, diagnosis and prognosis, what you can still do despite impairment(s), and your physical or mental restrictions.

(b) How we consider medical opinions. In determining whether you are disabled, we will always consider the medical opinions in your case record together with the rest of the relevant evidence we receive. See § 404.1520b.

(c) How we weigh medical opinions. Regardless of its source, we will evaluate every medical opinion we receive. Unless we give a treating source's opinion controlling weight under paragraph (c)(2) of this section, we consider all of the following factors in deciding the weight we give to any medical opinion.

(1) Examining relationship. Generally, we give more weight to the opinion of a source who has examined you than to the opinion of a source who has not examined you.

(2) Treatment relationship. Generally, we give more weight to opinions from your treating sources, since these sources are likely to be the medical professionals most able to provide a detailed, longitudinal picture of your medical impairment(s) and may bring a unique perspective to the medical evidence that cannot be obtained from the objective medical findings alone or from reports of individual examinations, such as consultative examinations or brief
hospitalizations. If we find that a treating source’s opinion on the issue(s) of the nature and severity of your impairment(s) is well-supported by medically acceptable clinical and laboratory diagnostic techniques and is not inconsistent with the other substantial evidence in your case record, we will give it controlling weight. When we do not give the treating source’s opinion controlling weight, we apply the factors listed in paragraphs (c)(2)(i) and (c)(2)(ii) of this section, as well as the factors in paragraphs (c)(3) through (c)(6) of this section in determining the weight to give the opinion. We will always give good reasons in our notice of determination or decision for the weight we give your treating source’s opinion.

(i) Length of the treatment relationship and the frequency of examination. Generally, the longer a treating source has treated you and the more times you have been seen by a treating source, the more weight we will give to the source’s medical opinion. When the treating source has seen you a number of times and long enough to have obtained a longitudinal picture of your impairment, we will give the source’s opinion more weight than we would give it if it were from a nontreating source.

(ii) Nature and extent of the treatment relationship. Generally, the more knowledge a treating source has about your impairment(s) the more weight we will give to the source’s medical opinion. We will look at the treatment the source has provided and at the kinds and extent of examinations and testing the source has performed or ordered from specialists and independent laboratories. For example, if your ophthalmologist notices that you have complained of neck pain during your eye examinations, we will consider his or her opinion with respect to your neck pain, but we will give it less weight than that of another physician who has treated you for the neck pain. When the treating source has reasonable knowledge of your impairment(s), we will give the source’s opinion more weight than we would give it if it were from a nontreating source.

(3) Supportability. The more a medical source presents relevant evidence to support an opinion, particularly medical signs and laboratory findings, the more weight we will give that opinion. The better an explanation a source provides for
an opinion, the more weight we will give that opinion. Furthermore, because nonexamining sources have no examining or treating relationship with you, the weight we will give their opinions will depend on the degree to which they provide supporting explanations for their opinions. We will evaluate the degree to which these opinions consider all of the pertinent evidence in your claim, including opinions of treating and other examining sources.

(4) Consistency. Generally, the more consistent an opinion is with the record as a whole, the more weight we will give to that opinion.

(5) Specialization. We generally give more weight to the opinion of a specialist about medical issues related to his or her area of specialty than to the opinion of a source who is not a specialist.

(6) Other factors. When we consider how much weight to give to a medical opinion, we will also consider any factors you or others bring to our attention, or of which we are aware, which tend to support or contradict the opinion. For example, the amount of understanding of our disability programs and their evidentiary requirements that an acceptable medical source has, regardless of the source of that understanding, and the extent to which an acceptable medical source is familiar with the other information in your case record are relevant factors that we will consider in deciding the weight to give to a medical opinion.

(d) Medical source opinions on issues reserved to the Commissioner. Opinions on some issues, such as the examples that follow, are not medical opinions, as described in paragraph (a)(2) of this section, but are, instead, opinions on issues reserved to the Commissioner because they are administrative findings that are dispositive of a case; i.e., that would direct the determination or decision of disability.

(1) Opinions that you are disabled. We are responsible for making the determination or decision about whether you meet the statutory definition of disability. In so doing, we review all of the medical findings and other evidence that support a medical source's statement that you are disabled. A statement by a medical source that you are “disabled” or “unable to work” does not mean that we will determine that you are disabled.
(2) Other opinions on issues reserved to the Commissioner. We use medical sources, including your treating source, to provide evidence, including opinions, on the nature and severity of your impairment(s). Although we consider opinions from medical sources on issues such as whether your impairment(s) meets or equals the requirements of any impairment(s) in the Listing of Impairments in appendix 1 to this subpart, your residual functional capacity (see §§ 404.1545 and 404.1546), or the application of vocational factors, the final responsibility for deciding these issues is reserved to the Commissioner.

(3) We will not give any special significance to the source of an opinion on issues reserved to the Commissioner described in paragraphs (d)(1) and (d)(2) of this section.

(e) Opinions of nonexamining sources. We consider all evidence from nonexamining sources to be opinion evidence. When we consider the opinions of nonexamining sources, we apply the rules in paragraphs (a) through (d) of this section. In addition, the following rules apply to State agency medical and psychological consultants, other program physicians and psychologists, and medical experts we consult in connection with administrative law judge hearings and Appeals Council review:

(1) In claims adjudicated by the State agency, a State agency medical or psychological consultant may make the determination of disability together with a State agency disability examiner or provide one or more medical opinions to a State agency disability examiner when the disability examiner makes the initial or reconsideration determination alone (see § 404.1615(c) of this part). The following rules apply:

(i) When a State agency medical or psychological consultant makes the determination together with a State agency disability examiner at the initial or reconsideration level of the administrative review process as provided in § 404.1615(c)(1), he or she will consider the evidence in your case record and make findings of fact about the medical issues, including, but not limited to, the existence and severity of your impairment(s), the existence and severity of your symptoms, whether your impairment(s) meets or medically equals the
requirements for any impairment listed in appendix 1 to this subpart, and your residual functional capacity. These administrative findings of fact are based on the evidence in your case but are not in themselves evidence at the level of the administrative review process at which they are made.

(ii) When a State agency disability examiner makes the initial determination alone as provided in § 404.1615(c)(3), he or she may obtain the opinion of a State agency medical or psychological consultant about one or more of the medical issues listed in paragraph (e)(1)(i) of this section. In these cases, the State agency disability examiner will consider the opinion of the State agency medical or psychological consultant as opinion evidence and weigh this evidence using the relevant factors in paragraphs (a) through (e) of this section.

(iii) When a State agency disability examiner makes a reconsideration determination alone as provided in § 404.1615(c)(3), he or she will consider findings made by a State agency medical or psychological consultant at the initial level of the administrative review process and any opinions provided by such consultants at the initial and reconsideration levels as opinion evidence and weigh this evidence using the relevant factors in paragraphs (a) through (e) of this section.

(2) Administrative law judges are responsible for reviewing the evidence and making findings of fact and conclusions of law. They will consider opinions of State agency medical or psychological consultants, other program physicians and psychologists, and medical experts as follows:

(i) Administrative law judges are not bound by any findings made by State agency medical or psychological consultants, or other program physicians or psychologists. State agency medical and psychological consultants and other program physicians, psychologists, and other medical specialists are highly qualified physicians, psychologists, and other medical specialists who are also experts in Social Security disability evaluation. Therefore, administrative law judges must consider findings and other opinions of State agency medical and psychological consultants and other program physicians, psychologists, and
other medical specialists as opinion evidence, except for the ultimate
determination about whether you are disabled (see § 404.1512(b)(8)).

(ii) When an administrative law judge considers findings of a State agency
medical or psychological consultant or other program physician, psychologist, or
other medical specialist, the administrative law judge will evaluate the findings
using the relevant factors in paragraphs (a) through (d) of this section, such as
the consultant's medical specialty and expertise in our rules, the supporting
evidence in the case record, supporting explanations the medical or
psychological consultant provides, and any other factors relevant to the weighing
of the opinions. Unless a treating source's opinion is given controlling weight, the
administrative law judge must explain in the decision the weight given to the
opinions of a State agency medical or psychological consultant or other program
physician, psychologist, or other medical specialist, as the administrative law
judge must do for any opinions from treating sources, nontreating sources, and
other nonexamining sources who do not work for us.

(iii) Administrative law judges may also ask for and consider opinions from
medical experts on the nature and severity of your impairment(s) and on
whether your impairment(s) equals the requirements of any impairment listed in
appendix 1 to this subpart. When administrative law judges consider these
opinions, they will evaluate them using the rules in paragraphs (a) through (d) of
this section.

(3) When the Appeals Council makes a decision, it will follow the same rules
for considering opinion evidence as administrative law judges follow.

11877, Mar. 7, 2000; 71 FR 16445, Mar. 31, 2006; 75 FR 62681, Oct. 13, 2010; 76 FR
Lost in Translation: How to Interpret the Earnings Record

Susan Nadell
Office of Disability Adjudication & Review
Birmingham
Handout Not Available at Time of Printing
Video Hearings:
The Testimony of Medical Experts

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VIDEO HEARINGS: THE TESTIMONY OF MEDICAL EXPERTS

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After many months of waiting, you receive a Notice of Hearing informing you that your client, Mr. Jones, has a hearing date. You quickly review the notice to confirm the date, time and location of the hearing, check to see if the ALJ will be appearing by video or in-person, and confirm the identity of the experts. You notice that the ALJ plans to take testimony from both a vocational expert and a medical expert. You prepare your case, complete with a plan for cross-examining the experts, and finally, the day of the hearing arrives. While the judge is introducing the witnesses, you are informed, for the first time, that the medical expert is to testify via telephone. What do you do?

A. Exercise professional judgment

While there may not be time for ponderous consideration, there is still a need for the hearing representative to exercise professional, experience-based judgment at the moment the representative is first informed that an ALJ intends to use telephonic expert testimony. Not every breach of proper procedure calls for an objection, even when the legal breach is clear. For example, if the ALJ is calling the expert for the purpose of supporting a Fully Favorable Decision, then the representative would be wise to heed the advice of Napoleon Bonaparte, “Never interrupt your enemy when he is making a mistake.” However, care should be taken before deciding to remain silent. Failure to

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1 Of course, the quotation’s application to the “nonadversarial” disability claims process is of limited value, and an ALJ who intends to issue a Fully Favorable Decision is hardly an “enemy.” The point remains—if the client is winning, the representative should not interfere.
make a timely objection at the hearing level can result in a waiver of the issue on a later appeal.

B. **Object at the earliest opportunity and reiterate the objection as appropriate**

On June 25, 2014, SSA issued new final regulations governing the use of video and telephonic hearings. Changes to Scheduling and Appearing at Hearings, 79 Fed. Reg. 35926 (June 25, 2014). There are new time frames for objecting to video and telephonic hearings. Initially, the ALJ will send a notice if a video hearing is intended to be used. As the new regulations state, “Prior to scheduling your hearing, we will notify you that we may schedule you to appear by video teleconferencing. If you object to appearing by video teleconferencing, you must notify us in writing within 30 days after the date you receive the notice.” Changes to Scheduling and Appearing at Hearings, 79 Fed. Reg. 35926, 35931, 35933, 35934 (June 25, 2014) (amending 20 CFR § 404.936(d), 20 CFR § 405.317(a), and 20 CFR § 416.1436(d)). Provided that a timely objection is made and provided that the claimant has not changed residences during the pendency of the appeal, then the new regulations require that the hearing be conducted in person. *Id.* However, if the claimant has changed residences while the hearing request has been pending, then the ALJ retains discretion to hold the hearing by video despite the claimant’s timely objection. *Id.*

If an ALJ intends to call a witness to the hearing, the new regulations require that the Notice of Hearing specify whether that testimony is to be presented by video or by telephone. Changes to Scheduling and Appearing at Hearings, 79 Fed. Reg. 35926, 35932, 35933, 35935 (June 25, 2014) (amending 20 CFR § 404.938(b), § 405.316(b)(5), and § 416.1438(b) Lack of notice that the ALJ intends to call an expert by telephone is, by itself, objectionable. How is the claimant harmed by the ALJ’s failure to include this information in the Notice of Hearing? If the representative had been able to object earlier, the ALJ may have been more likely to sustain the objection and either made arrangements for the medical expert to testify live or by video teleconference on the originally
scheduled hearing date or else reschedules the hearing for a time when the medical expert could appear live or by video teleconference or else arrange for a different medical expert to appear live or by teleconference. Had the ALJ sustained the objection and made arrangements for an in-person or video teleconference appearance of the medical expert, the representative’s cross-examination may have been more effective or the ALJ may have found the medical expert’s testimony less persuasive.

In the event that the ALJ includes notice of telephonic testimony in the Notice of Hearing or otherwise provide notice of the intention to call the medical expert via telephone, the representative should lodge a timely objection as a matter of course. The new regulations require that an objection to the time and place of the hearing be made in writing not later than 5 days before the hearing or 30 after receipt of the Notice of Hearing, whichever is earlier. Changes to Scheduling and Appearing at Hearings, 79 Fed. Reg. 35926, 35931 (June 25, 2014). In the event that the representative receives actual notice of the telephonic testimony before the hearing, and fails to make a timely objection, the representative may waive an otherwise meritorious issue on appeal. Compare Rice v. Astrue, No. 5:09CV00093 JTR, 2010 WL 3417803, at *7 n.7 (E.D. Ark. Aug. 26, 2010) with Edwards v. Astrue, No. 3:10CV1017 MRK (D. Conn. Aug. 10, 2011).

C. Articulate reasons why live cross-examination is needed

The Administrative Procedures Act provides that parties are entitled to conduct cross-examination “as may be required for a full and true disclosure of the facts.” See 5 U.S.C. § 556(d). The representative should be ready to articulate reasons why telephonic testimony does not meet this standard. Among such reasons may be:

-- Cross-examination is not nearly as effective when the questioner cannot adjust the questions based on the appearance, demeanor and nonverbal cues of the witness.
Requiring experts to appear in-person at the hearing helps ensure that the expert is not distracted by day-to-day business matters or interrupted by other office personnel.

“Telephonic testimony conveys the impression that the hearing is perfunctory and not an important stage in the Social Security disability process.” Comments of the Association of Administrative Law Judges Regarding Social Security Administrative Notice of Proposed Rulemaking, as quoted in Edwards v. Astrue, No. 3:10CV1017 MRK (D. Conn. Aug. 10, 2011).

In-person testimony helps to ensure the identity of the witness.

In-person testimony makes apparent when the witness is referring to documents to aid the testimony, so that any such documents may be identified as appropriate subjects of inquiry.

Especially in videoconference hearings, the likelihood of communication disruptions during the hearing and an inaudible hearing recording is increased with telephonic testimony.

D. Make a record during the hearing of any difficulties in communication via telephone

In the event that hearing and understanding the witness on the telephone is difficult, the hearing representative should make note of that fact on the record. The more occurrences of communication difficulties due to the telephonic testimony, the stronger the appeal. But, the record on appeal may not reflect those difficulties if no one mentions them on the record as they occur. Begin making a record at the first instance of a problem, rather than waiting to see if the problems
CONCLUSION

Provided that the representative lodges a timely objection and is able to articulate sound reasons why telephonic testimony is inadequate for a “full and true disclosure of the facts,” an ALJ should not proceed with expert witness testimony via telephone over the claimant’s objection. If the ALJ ignores or overrules the claimant’s objection in this regard, the hearing representative should make a solid record for an appeal by ensuring that timely and repeated objections are noted on the record, any difficulties with communication are made part of the record, and appropriate legal arguments are made as soon as practicable after the representative learns of the ALJ’s intention to receive testimony by telephone.
Commission on the date specified in the scheduling notice. A prehearing brief shall be signed and shall include a table of contents. A prehearing brief shall be filed electronically, and nine (9) true paper copies shall be submitted (on paper measuring 8.5 x 11 inches and single-sided) on the same business day. The prehearing brief should present a party’s case concisely and shall, to the extent possible, refer to the record and include information and arguments which the party believes relevant to the subject matter of the Commission’s determination.

16. Amend § 207.67 by revising paragraph (a) to read as follows:

§ 207.67 Posthearing briefs and statements.
(a) Briefs from parties. Any party to a five-year review may file with the Secretary a posthearing brief concerning the information adduced at or after the hearing within a time specified in the scheduling notice or by the presiding official at the hearing. A posthearing brief shall be filed electronically, and nine (9) true paper copies shall be submitted on the same business day. No such posthearing brief shall exceed fifteen (15) pages of textual material, double spaced and single-sided, when printed out on paper measuring 8.5 x 11 inches and single-sided. In addition, the presiding official may permit persons to file answers to questions or requests made by the Commission at the hearing within a specified time. The Secretary shall not accept for filing posthearing briefs or answers which do not comply with this section.

17. Amend § 207.68 by revising paragraph (b) to read as follows:

§ 207.68 Final comments on information.
(b) The parties shall have an opportunity to file comments on any information disclosed to them after they have filed their posthearing brief pursuant to § 207.67. Comments shall be filed electronically, and nine (9) true paper copies shall be submitted on the same business day. Comments shall only concern such information, and shall not exceed 15 pages of textual material, double spaced and single-sided, when printed out on paper measuring 8.5 x 11 inches and single-sided. A comment may address the accuracy, reliability, or probative value of such information by reference to information elsewhere in the record, in which case the comment shall identify where in the record such information is found. Comments containing new factual information shall be disregarded.

The date on which such comments must be filed will be specified by the Commission when it specifies the time that information will be disclosed pursuant to paragraph (a) of this section. The record shall close on the date such comments are due, except with respect to changes in bracketing of business proprietary information in the comments permitted by § 207.3(c).

By order of the Commission.
Issued: June 19, 2014.
Lisa R. Barton,
Secretary to the Commission.

SOCIAL SECURITY ADMINISTRATION
20 CFR Parts 404, 405, and 416
[Docket No. 2011–0056]
RIN 0960–AH37
Changes to Scheduling and Appearing at Hearings
AGENCY: Social Security Administration.
ACTION: Final rules.
SUMMARY: These final rules explain how a claimant may object to appearing at a hearing via video teleconferencing, or to the time and place of a hearing. These final rules adopt, with further clarification regarding our good cause exception, the notice of proposed rulemaking (NPRM) that we published in the Federal Register on June 27, 2013. We expect that these final rules will have a minimal impact on the public, help ensure the integrity of our programs, and allow us to administer our programs more efficiently.
DATES: These final rules are effective July 25, 2014.
FOR FURTHER INFORMATION CONTACT:
Maren Weight, Social Security Administration, 5107 Leesburg Pike, Falls Church, VA 22041–3260, (703) 605–7100 for information about this notice. For information on eligibility or filing for benefits, call our national toll-free number, 1–800–772–1213 or TTY 1–800–325–0778, or visit our Internet site, Social Security Online, at http://www.socialsecurity.gov.
SUPPLEMENTARY INFORMATION:
Background
We are making final, with further clarification regarding our good cause exception, the proposed NPRM that we published in the Federal Register on June 27, 2013. As we discussed in the preamble to the NPRM, our workloads at the administrative law judge (ALJ) hearing level continue to grow, and we are implementing final rules that will help us provide better service by allowing us to conduct hearings and issue decisions more expeditiously.

Objecting to Appearing by Video Teleconferencing
As we explained in the NPRM, we have conducted hearings by video teleconferencing since 2003. Over the last decade, we found that hearings held by video teleconferencing help reduce our average processing time, reduce travel expenses, and allow us to better serve the public. Therefore, we have continued to improve our video teleconferencing capabilities, added five National Hearing Centers that hold hearings exclusively by video teleconferencing, and increased the number of ALJs in traditional hearing offices who hold hearings by video teleconferencing.
However, we reiterate in these final rules that while we have taken significant strides in increasing our video teleconferencing capacity, we remain concerned that some individuals are manipulating our rules in order to obtain a hearing with an ALJ with a higher allowance rate. As we previously noted, this may be an unintended consequence of our commitment to transparency as we make more information, such as an ALJ’s allowance rates, available to claimants and their representatives. Until the effective date of this final rule, these types of efforts to undermine the random assignment of ALJs have generally been successful. Our business process has been to reschedule a hearing if the claimant, or a representative on a claimant’s behalf, objected to appearing by video teleconferencing at a time before or at the hearing, or to transfer a case if a claimant indicated he or she moved closer to another hearing office.
Our continued concerns about efforts to undermine our rules are not merely anecdotal. At the time of this final rule, we brought and pursued sanction actions against an appointed representative for misrepresenting facts in order to have cases transferred to a hearing office with a higher allowance rate. We have observed some individuals decline hearings by video teleconferencing after learning that the claimant is scheduled to appear before an ALJ with a lower allowance rate. We have observed other questionable conduct that, while not necessarily constituting misconduct often delays the processing of cases and prevents the use of video teleconferencing.

technology in certain offices. We continue to receive declinations less than 20 days before the date the hearing, resulting in the loss of the hearing slot that we could have used to hold a hearing for another claimant. Finally, when we receive a declination for a hearing by video teleconferencing after the hearing has been scheduled, we must use additional administrative resources to reschedule a hearing at a time and place amenable to all hearing participants. For these types of reasons, a change to our current process was necessary.

In this final rule, before we assign an ALJ to the case or before we schedule a hearing, we will notify a claimant that he or she has the right to object to appearing at the hearing by video teleconferencing. If the claimant objects to appearing at the hearing by video teleconferencing, the claimant must tell us in writing within 30 days after the date he or she receives the notice, unless he or she shows good cause for missing the deadline. If we receive a timely objection, or we find there was good cause for missing the deadline, we will schedule the claimant for an in-person hearing, with one limited exception. If a claimant moves to a different residence while his or her request for a hearing is pending, we will determine whether the claimant will appear in person or by video teleconferencing, even if the claimant previously objected to appearing by video teleconferencing. In addition, in order for us to consider a change in residence when scheduling a hearing, the claimant must submit evidence verifying a new residence. After we receive evidence regarding the claimant’s new residence, we will decide how the claimant’s appearance will be made. This limited exception to the rule allows us to protect the integrity of our programs while providing us with the flexibility to transfer cases when there is a legitimate change in residence and we can process the case more efficiently.

**Time Period for Objecting to a Hearing**

In these final rules, we also specified the time period for objecting to the time and place of a hearing. To ensure that we have adequate time to prepare for the hearing, we require that a claimant notify us of an objection in writing at the earliest possible opportunity, but not later than 5 days before the date set for the hearing or, if earlier, 30 days after receiving notice of the hearing. If the claimant objects to the time and place of the hearing outside of the specified time period and fails to attend the hearing, the ALJ will follow existing sub-regulatory authority to develop good cause for failure to appear. We also adopted other minor revisions in the final rules to clarify when we will reschedule a hearing for good cause. For instance, we removed the example that a claimant might offer living closer to another hearing site as a good cause reason to object to the time and place of the hearing.

**Appearing at the Hearing by Telephone**

To further reduce the need to reschedule hearings and to improve our efficiency, we provide that the ALJ may determine that extraordinary circumstances exist to schedule the claimant, or any other party to the hearing, to appear at the hearing by telephone. For example, an ALJ will direct a claimant or other party to the hearing to appear by telephone when the person’s appearance in person is not possible, such as when the person is incarcerated, the correctional facility will not allow a hearing to be held at the facility, and video teleconferencing is not available. The flexibility in the final rule allows us to continue the practice of scheduling a hearing by telephone when the claimant specifically requests a hearing in this manner, and the ALJ determines that extraordinary circumstances prevent the claimant or other party who makes the request from appearing at the hearing in person or by video teleconferencing.

As we noted in the NPRM, we spend a significant administrative resources arranging in person hearings with officials of correctional facilities. It also reduces our productivity when an ALJ travels to a confinement facility to hold one or two hearings rather than conducting a full hearing docket. These final rules will save administrative resources and allow us to provide more timely hearings to all claimants because the ALJ will be present in the hearing office to conduct a full hearing docket.

**Part 405**

In the final rule, we adopted several changes to Part 405 for consistency with the rules in Parts 404 and 416. We adopted changes relating to video teleconferencing and hearings by telephone in extraordinary circumstances, as described above. For consistency with our pilot program in all regions except Boston, we also adopted changes allowing the agency, rather than the ALJ, to set the time and place for hearing.

**Public Comments on the NPRM**

In the NPRM, we provided a 60-day comment period, which ended on August 26, 2013. We carefully considered the 13 public comments we received. Because some of the comments were lengthy, we summarize them below. We present the commenters’ concerns and suggestions and respond to the significant issues relevant to this rulemaking. We do not respond to comments, or portions of comments, that are outside the scope of this rulemaking proceeding.

**Comment:** One commenter indicated that ALJs will not be able to adequately see and observe claimants if they were scheduled to appear via video teleconferencing. Another commenter argued that it is unfair if claimants have to wait longer for in-person hearings. Both commenters essentially argued that hearings held by video teleconferencing violate claimants’ due process rights.

**Response:** We disagree with the concerns raised in these comments. First, it is important to reiterate that under these final rules claimants will generally continue to have the right to appear in person at a scheduled hearing if they timely object to appearing via video teleconferencing. Furthermore, our regulations have allowed claimants to appear via video teleconferencing at our hearings since 2003. In our experience holding hearings by video teleconferencing, we have found that ALJs are able to observe a claimant adequately. As our resources permit, we continue to improve our video teleconferencing equipment for hearings, and we manage cases as effectively as possible to provide claimants hearings in the timeliest method available.

We also disagree with the commenters’ concerns that a hearing held by video teleconferencing can adversely affect a claimant’s right to due process. A number of Federal courts have held that hearings conducted via video teleconferencing are adequate to protect a claimant’s due process rights.

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2Our regulations require that we provide notice of a hearing 20 days in advance. See 20 CFR 404.938 and 416.1438. Late declinations are even more problematic in the Boston Region where we are required to give notice 75 days in advance. See 20 CFR 405.316.

3See 20 CFR 404.936(a) and (b), and 416.1436(a) and (b).

468 FR 5210 and 68 FR 69003.

Thus, claimants who appear at the hearing by video teleconferencing receive due process, regardless of the wait time for an in-person hearing or the use of video teleconferencing equipment.  

Comment: Two commenters recommended that the first option should be to schedule in person hearings. If the claimant cannot attend the scheduled hearing, then the commenters suggested that, rather than opting out, the claimant should be able to request to appear via telephone or video teleconferencing. One commenter noted this was a concern for claimants who are homeless.  

Response: As discussed above, under these final rules claimants will continue to have the right to appear in person at a scheduled hearing if they timely object to appearing via video teleconferencing, unless an exception exists. Since our agency began using the video teleconferencing process for hearings, claimants have been required to opt out of appearing at a hearing via video teleconferencing, and this process has operated efficiently for us over the last 10 years. Requiring claimants to opt into appearing at a hearing via video teleconferencing could potentially delay scheduled hearings, create additional staff work, and cost us valuable resources. This would likely result in diminished overall public service, especially to claimants who have critical cases, including homeless claimants. Furthermore, we anticipate holding a small number of hearings via telephone because our final rules provide that we will schedule a claimant to appear via telephone only when the claimant’s appearance in person is not possible, or if the ALJ determines that extraordinary circumstances prevent the claimant or another party from appearing at the hearing in person or by video teleconferencing. Therefore, these final rules continue to give the claimant the option to appear in person, except in limited circumstances, while balancing our needs for administrative efficiency.  

Comment: Several commenters raised a concern about the limited exception to the right to decline a hearing by video teleconferencing. Under the proposed rules, we retained the right to schedule claimants to appear at the hearing via video teleconferencing if they change residence while the case is pending, even if they have timely objected to appearing by video teleconferencing. The commenters noted that many claimants have legitimate reasons to move, often involving financial hardships, and the reason a claimant requests an in-person hearing does not change when they move.  

Response: We agree that most claimants have legitimate reasons for changing residences; however, as noted in the preamble of the NPRM (78 FR at 38611), and reiterated in this final rule, we are concerned that some claimants or their appointed representatives may be misusing our procedures regarding a change in residence to undermine the random assignment of cases to our ALJs. We are aware of situations in which a representative instructed claimants to report a change of address, which was not a change of residence, so that cases would be reassigned to a different hearing office with higher allowance rates. As a result of such practices, we must have a means to ensure the integrity of our program.  

We anticipate that we will apply this exception infrequently. For example, one of the commenters expressed concern that we should not apply the exception if a claimant moves within the same servicing area after an in-person hearing is scheduled. These final rules give us discretion to address this concern. Since the claimant would not be trying to gain an advantage by changing residence address, and the same hearing office would process the case, we would not expect the ALJ assigned to the case to apply the exception. In another example, if a claimant changes residences to a different servicing area, there is no additional delay to schedule the claimant to appear in person at the hearing, and we have no indication that the claimant is attempting to manipulate the assignment of the case to another ALJ, then we would use our discretion to schedule the hearing in person, in accordance with the claimant’s initial objection. Therefore, we have not deleted the exception we proposed, as some of the commenters requested. Under these final rules, we continue to include a limited exception that would allow us to schedule claimants to appear at the hearing via video teleconferencing if they change residence while the case is pending, even if they have timely objected to appearing by video teleconferencing. }
Response: We considered the comment and the work the commenter put into creating the guide. Once these final rules are published, we will update our sub-regulatory authority and business processes to be consistent with the rules, and we will consider whether any other resource for the public may be necessary.

Comment: One commenter questioned whether the specific hearing office would be listed on the notice sent to claimants indicating that they have 30 days to object to a hearing held via video teleconferencing. The commenter, who was a representative, indicated concern about practicing before unfamiliar hearing offices.

Response: We considered this concern, and we may or may not include specific hearing office addresses on notices to claimants about their right to request an in-person hearing within the required time period. Regardless of whether hearing office addresses are included, we operate a nationwide program at the hearing level, and all hearing offices follow the same regulations, policies, and procedures. Therefore, representatives can effectively represent claimants at any hearing office. We note that ALJs have some limited variances in how they manage their cases, including requesting pre-hearing briefs. Under this process, we will continue to provide representatives with prior notice of the name of the ALJ assigned to a hearing and will continue to provide in advance any specific instructions from the ALJ that may affect how a representative prepares his or her case. We note that this same potential for minor variances among ALJs currently exists in individual hearing offices. Thus, the final rules do not significantly affect how representatives practice before us.

Comment: Multiple commenters raised the concern that there was no “good cause” exception for extending the 30-day time period to object to appearing at the hearing via video teleconferencing or to object to the time and place of the hearing.

Response: We agree with these commenters. There may be legitimate instances when a claimant may not be able to object to appearing at a hearing via video teleconferencing or to the time or place of hearing within the stated time period, including, but not limited to, serious illness or death in the family. Consistent with our other regulations that provide a good cause exception to filing deadlines, we revised the final rules to allow the ALJ to determine whether the claimant had good cause to file an objection outside the time period specified to object to appearing at a hearing via video teleconferencing or to the time and place of a hearing. The final rules state that ALJs will use the standard for good cause set forth in our current regulations at 20 CFR 404.911, 405.20, and 416.1411 to evaluate these late filings.

Comment: One commenter suggested that the proposed regulation allowing for a 5-day time period for objecting to the time and place of the hearing was too short. The commenter suggested the period should be longer.

Response: We considered this comment, but we disagree with it. The final rules provide that claimants must notify us in writing that they object to the time and place of the hearing at the earliest possible opportunity, but not later than 5 days before the date set for the hearing or 30 days after receiving notice of the hearing, whichever is earlier. In fiscal year 2012, we averaged scheduling nationwide at least 60 days in advance. With this advance scheduling, most claimants will be required to object 30 days after receiving notice of the hearing, which allows us sufficient time to reschedule the hearing. In the limited circumstances where we schedule claimants’ hearing between 20 to 35 days prior to the hearing, we need to allow claimants adequate time to consider whether they will object to the time and place of the hearing that may cause the hearing to be rescheduled at a later time. The final rules address both scenarios and give claimants adequate time to decide if they are going to object to the time and place of the hearing.

Comment: Several commenters recommended that we should retain living closer to another hearing site as a reason for to find good cause to change the time and place of a hearing. The commenters noted that it might be more difficult for a claimant to travel to another office that is further away from him or her residence.

Response: We disagree with the concerns raised in these comments. As noted previously, we are concerned that claimants or their appointed representatives may be misusing our procedures regarding a change in residence to undermine the random assignment of cases to our ALJs. We need to protect the integrity of our program and ensure that ALJs only reschedule a hearing for good cause. It may be appropriate, in some instances, for ALJs to determine that good cause exists to change the time and place of a hearing based on the claimant’s residence. However, removing this reason makes the final rules more consistent and protects the integrity of our programs.

Comment: Multiple commenters noted that more limits were necessary on the use of telephone hearings. Specifically, commenters recommended that claimants should be able to object to appearing by telephone. They raised concerns about claimants or representatives who have hearing impairments and whether we will make reasonable accommodations in these situations.

Response: We considered these concerns. However, the final rules make clear that an ALJ will direct a claimant’s appearance by telephone under two limited circumstances. First, an ALJ will direct a claimant to appear by telephone when the claimant’s appearance in person is not possible, such as if the claimant is incarcerated, the facility will not allow a hearing to be held at the facility, and video teleconferencing is not available. Second, an ALJ will direct a claimant to appear by telephone if the ALJ determines, either on his or her own initiative, or at the request of the claimant or another party, that extraordinary circumstances prevent the claimant from appearing in person or by video teleconferencing.

Since an ALJ will direct a claimant’s appearance by telephone only under certain limited circumstances, we do not believe it is necessary or appropriate to provide the claimant with an opportunity to object to the mode of this appearance. However, we will use this provision on a limited basis, and its goal is to promote efficiency of hearings. We believe the policy is consistent with our goal of making the hearing process more efficient for claimants because appearing by telephone will allow claimants to have their hearings before an ALJ in the shortest possible time period.

Claimants who are scheduled to appear by telephone will receive the same due process rights currently available to all claimants. This includes the right to object to the time or place of hearing under 20 CFR 404.936(d), 405.317, and 416.1436(d), which have been revised accordingly. Regardless of the mode of appearance, we will also continue to make reasonable accommodations for all claimants and representatives. Therefore, we will adequately protect a claimants’ rights without placing additional limitations on our ability to schedule a claimant’s appearance at a hearing by telephone.

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6 We note that regulations that apply only in the Boston Region allow for some variances in hearing office practices. 20 CFR 405.1 through 405.901.
Social Security Administration, OLCA, Office of Management and Budget, Attn: OIRA Desk Officer for SSA, Fax Number: 202–395–6974, Email address: OIRA_Submission@omb.eop.gov.

Social Security Administration, OLCA, Attn: Reports Clearance Director, 3100 West High Rise, 6401 Security Blvd., Baltimore, MD 21235, Fax: 410–966–2830, Email address: OR.Reports.Clearance@ssa.gov.

You can submit comments until July 25, 2014, which is 30 days after the publication of this rule. To receive a copy of the OMB clearance package, contact the SSA Reports Clearance Officer using any of the above contact methods. We prefer to receive comments by email or fax.

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

List of Subjects

20 CFR Part 405
Administrative practice and procedure, Blind, Disability benefits, Old-Age, Survivors, and Disability Insurance, Public assistance programs, Reporting and recordkeeping requirements, Social Security, Supplemental Security Income (SSI).

20 CFR Part 416
Administrative practice and procedure, Aged, Blind, Disability benefits, Public assistance programs, Reporting and recordkeeping requirements, Supplemental Security Income (SSI).


Carolyn W. Colvin,
Acting Commissioner of Social Security.

For the reasons set out in the preamble, we are amending 20 CFR

SSA submitted an Information Collection Request for clearance to OMB. We are soliciting comments on the burden estimate; the need for the information; its practical utility; ways to enhance its quality, utility, and clarity; and ways to minimize the burden on respondents, including the use of automated techniques or other forms of information technology. If you would like to submit comments, please send them to the following locations:

Office of Management and Budget, Attn: Desk Officer for SSA, Fax Number: 202–395–6974, Email address: OIRA_Submission@omb.eop.gov.

Social Security Administration, OLCA, Attn: Reports Clearance Director, 3100 West High Rise, 6401 Security Blvd., Baltimore, MD 21235, Fax: 410–966–2830, Email address: OR.Reports.Clearance@ssa.gov.

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20 CFR Part 405
Administrative practice and procedure, Blind, Disability benefits, Old-Age, Survivors, and Disability Insurance, Public assistance programs, Reporting and recordkeeping requirements, Social Security, Supplemental Security Income (SSI).

20 CFR Part 416
Administrative practice and procedure, Aged, Blind, Disability benefits, Public assistance programs, Reporting and recordkeeping requirements, Supplemental Security Income (SSI).


Carolyn W. Colvin,
Acting Commissioner of Social Security.

For the reasons set out in the preamble, we are amending 20 CFR
PART 404—FEDERAL OLD-AGE, SURVIVORS AND DISABILITY INSURANCE (1950— )

Subpart J—Determinations, Administrative Review Process, and Reopening of Determinations and Decisions

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

Authority: Secs. 201(i), 204(f), 205(a)–(b), (d)–(h), and (j), 221, 223(i), 225, and 702(a)(5) of the Social Security Act (42 U.S.C. 401(i), 404(f), 405(a)–(b), (d)–(h), and (j), 421, 423(i), 425, and 902(a)(5)); sec. 5, Pub. L. 97–455, 96 Stat. 2500 (42 U.S.C. 405 note); secs. 5, 6(c)–(e), and 15, Pub. L. 98–460, 98 Stat. 1802 (42 U.S.C. 421 note); sec. 202, Pub. L. 100–203, 118 Stat. 509 (42 U.S.C. 902 note).

2. Revise § 404.929 to read as follows:

§ 404.929 Time and place for a hearing before an administrative law judge—general.

If you are dissatisfied with one of the determinations or decisions listed in § 404.930, you may request a hearing. The Deputy Commissioner for Disability Adjudication and Review, or his or her delegate, will appoint an administrative law judge to conduct the hearing. If circumstances warrant, the Deputy Commissioner, or his or her delegate, may assign your case to another administrative law judge. At the hearing, you may appear in person, by video teleconferencing, or, under certain extraordinary circumstances, by telephone. You may submit new evidence, examine the evidence used in making the determination or decision under review, and present and question witnesses. The administrative law judge who conducts the hearing may ask you questions. He or she will issue a decision based on the preponderance of the evidence in the hearing record. If you waive your right to appear at the hearing, in person, by video teleconferencing, or by telephone, the administrative law judge will make a decision based on the preponderance of the evidence that is in the file and any new evidence that may have been submitted for consideration.

3. In § 404.936, revise paragraphs (b) and (c)(1), redesignate paragraphs (d) through (h) as paragraphs (e) through (i), add a new paragraph (d), and revise redesignated paragraphs (e) and (f), to read as follows:

§ 404.936 Time and place for a hearing before an administrative law judge.

(b) Where we hold hearings. We hold hearings in the 50 States, the District of Columbia, American Samoa, Guam, the Northern Mariana Islands, the Commonwealth of Puerto Rico, and the United States Virgin Islands. The “place” of the hearing is the hearing office or other site(s) at which you and any other parties to the hearing are located when you make your appearance(s) before the administrative law judge, whether in person, by video teleconferencing, or by telephone.

* * * *

(1) We will consult with the administrative law judge to determine the status of case preparation and to determine whether your appearance, or the appearance of any other party to the hearing, will be made in person, by video teleconferencing or, by telephone. The administrative law judge will determine that your appearance, or the appearance of any other party to the hearing, be conducted by video teleconferencing if video teleconferencing equipment is available to conduct the appearance, use of video teleconferencing to conduct the appearance would be more efficient than conducting the appearance in person, and the administrative law judge determines that there is no circumstance in the particular case that prevents the use of video teleconferencing to conduct the appearance. The administrative law judge will direct you or another party to the hearing to appear by telephone when:

(i) An appearance in person is not possible, such as if you are incarcerated, the facility will not allow a hearing to be held at the facility, and video teleconferencing is not available; or

(ii) The administrative law judge determines, either on his or her own, or at your request or at the request of any other party to the hearing, that extraordinary circumstances prevent you or another party to the hearing from appearing at the hearing in person or by video teleconferencing.

* * * *

(d) Objecting to appearing by video teleconferencing. Prior to scheduling your hearing, we will notify you that we may schedule you to appear by video teleconferencing. If you object to appearing by video teleconferencing, you must notify us in writing within 30 days after the date you receive the notice. If you notify us within that time period and your residence does not change while your request for hearing is pending, we will set your hearing for a time and place at which you may make your appearance before the administrative law judge in person.

* * * *

(1) Notwithstanding any objections you may have to appearing by video teleconferencing, if you change your residence while your request for hearing is pending, we may determine how you will appear, including by video teleconferencing, as provided in paragraph (c)(1) of this section. For us to consider your change of residence when we schedule your hearing, you must submit evidence verifying your new residence.

(2) If you notify us that you object to appearing by video teleconferencing more than 30 days after the date you receive our notice, we will extend the time period if you show you had good cause for missing the deadline. To determine whether good cause exists for extending the deadline, we use the standards explained in § 404.911.

(e) Objecting to the time or place of the hearing. If you object to the time or place of the hearing, you must:

(1) Notify us in writing at the earliest possible opportunity, but not later than 5 days before the date set for the hearing or 30 days after receiving notice of the hearing, whichever is earlier (or within the extended time period if we extend the time as provided in paragraph (e)(3) of this section); and

(2) State the reason(s) for your objection and state the time and place you want the hearing to be held. We will change the time or place of the hearing if the administrative law judge finds you have good cause, as determined under paragraph (f) of this section. Section 404.938 provides procedures we will follow when you do not respond to a notice of hearing.

(3) If you notify us that you object to the time or place of the hearing less than 5 days before the date set for the hearing or, if earlier, more than 30 days after receiving notice of the hearing, we will extend the time period if you show you had good cause for missing the deadline. To determine whether good cause exists for extending the deadline, we use the standards explained in § 404.911.

(f) Good cause for changing the time or place. The administrative law judge will determine whether good cause exists for changing the time or place of your scheduled hearing. However, a finding that good cause exists to reschedule the time or place of your hearing will not change the assignment of the administrative law judge for your case, unless we determine reassignment will promote more efficient administration of the hearing process.

(1) We will reschedule your hearing, if your reason is one of the following circumstances and is supported by the evidence:
PART 405—ADMINISTRATIVE REVIEW PROCESS FOR ADJUDICATING INITIAL DISABILITY CLAIMS

§ 405.351 Time and place for a hearing before an administrative law judge.

(a) General. We may set the time and place for the hearing. We may change the time and place, if it is necessary. If we change the time and place of the hearing, we will send you reasonable notice of the change. We will notify you of the time and place of the hearing at least 75 days before the date of the hearing, unless you agree to a shorter notice period.

(b) Where we hold hearings. We hold hearings in the 50 States, the District of Columbia, American Samoa, Guam, the Northern Mariana Islands, the Commonwealth of Puerto Rico, and the United States Virgin Islands. The “place” of the hearing is the hearing office or other site(s) at which you and any other parties to the hearing are located when you make your appearance(s) before the administrative law judge, whether in person, by video teleconferencing, or by telephone.

(c) * * * *

(d) Consultation procedures. Before we exercise the authority to set the time and place for an administrative law judge’s hearings, we will consult with the appropriate hearing office chief administrative law judge to determine if there are any reasons why we should not set the time and place of the administrative law judge’s hearings. If the hearing office chief administrative law judge does not state a reason that we believe justifies the limited number of hearings scheduled by the administrative law judge, we will then consult with the administrative law judge before deciding whether to begin to exercise our authority to set the time and place for the administrative law judge’s hearings. If the hearing office chief administrative law judge states a reason that we believe justifies the limited number of hearings scheduled by the administrative law judge, we will not exercise our authority to set the time and place for the administrative law judge’s hearings. We will not work with the hearing office chief administrative law judge to identify those circumstances where we can assist the administrative law judge and address any impediment that may affect the scheduling of hearings.

(e) Pilot program. The provisions in the first three sentences of paragraph (a), the first sentence of paragraph (c)(1), and paragraph (d) of this section are a
pilot program. These provisions will no longer be effective on August 9, 2014, unless we terminate them earlier or extend them beyond that date by notice of a final rule in the Federal Register.

7. In § 405.316, revise paragraphs (a) and (b)(5), to read as follows:

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

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

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

8. Revise § 405.317 to read as follows:

§ 405.317 Objections.

(a) Objecting to appearing by video teleconferencing. Prior to scheduling your hearing, we will notify you that we may schedule you to appear by video teleconferencing. If you object to appearing by video teleconferencing, you must notify us in writing within 30 days after the date you receive the notice. If you notify us within that time period and your residence does not change while your request for hearing is pending, we will set your hearing for a time and place at which you may make your appearance before the administrative law judge in person.

(1) Notwithstanding any objections you may have to appearing by video teleconferencing, if you change your residence while your request for hearing is pending, we may determine how you will appear, including by video teleconferencing, as provided in § 405.315(c). For us to consider your change of residence when we schedule your hearing, you must submit evidence verifying your new residence.

(2) If you notify us that you object to appearing by video teleconferencing more than 30 days after the date you receive our notice, we will extend the time period if you show you had good cause for missing the deadline. To determine whether good cause exists for extending the deadline, we use the standards explained in § 405.20.

(b) Objecting to the time and place of the hearing. If you object to the time or place of your hearing, you must:

(1) Notify us in writing at the earliest possible opportunity before the date set for the hearing, but not later than 30 days after receiving notice of the hearing. If you notify us that you object to the time or place of hearing more than 30 days after receiving notice of the hearing, we will extend the time period if you show you had good cause for missing the deadline. To determine whether good cause exists for extending the deadline, we use the standards explained in § 405.20; and

(2) State the reason(s) for your objection and state the time and place you want the hearing to be held. The administrative law judge will consider your reason(s) for requesting the change, the facts supporting it, and the impact of the proposed change on the efficient administration of the hearing process. Factors affecting the impact of the change include, but are not limited to, the effect on the processing of other scheduled hearings, delays that might occur in rescheduling your hearing, and whether we previously granted you any changes in the time or place of your hearing. However, an objection to the time or place of your hearing will not change the assignment of the administrative law judge for your case, unless we determine reassignment will promote more efficient administration of the hearing process.

(c) Issues. If you believe that the issues contained in the hearing notice are incorrect, you should notify the administrative law judge in writing at the earliest possible opportunity, but you must notify him or her no later than 5 business days before the date set for the hearing. You must state the reason(s) for your objection. The administrative law judge will make a decision on your objection either at the hearing or in writing before the hearing.

9. In § 405.350, revise the first sentence of paragraph (a) to read as follows:

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

(a) * * * You have a right to appear before the administrative law judge, either in person or, when the administrative law judge determines that the conditions in § 405.315(c) exist, by video teleconferencing or telephone, to present evidence and to state your position. * * *

(b) Where we hold hearings. We hold hearings in the 50 States, the District of Columbia, American Samoa, Guam, the Northern Mariana Islands, the Commonwealth of Puerto Rico, and the United States Virgin Islands. The “place” of the hearing is the hearing...
office or other site(s) at which you and any other parties to the hearing are located when you make your appearance(s) before the administrative law judge, whether in person, by video teleconferencing, or by telephone.

(c) * * *

(1) We will consult with the administrative law judge to determine the status of case preparation and to determine whether your appearance, or the appearance of any other party to the hearing, will be made in person, by video teleconferencing or, under extraordinary circumstances, by telephone. The administrative law judge will determine that your appearance, or the appearance of any other party to the hearing, be conducted by video teleconferencing if video teleconferencing equipment is available to conduct the appearance, use of video teleconferencing to conduct the appearance would be more efficient than conducting the appearance in person, and the administrative law judge determines there is no circumstance in the particular case that prevents the use of video teleconferencing to conduct the appearance. The administrative law judge will direct you or another party to the hearing to appear by telephone when:

(i) An appearance in person is not possible, such as if you are incarcerated, the facility will not allow a hearing to be held at the facility, and video teleconferencing is not available; or

(ii) The administrative law judge determines, either on his or her own, or at your request or at the request of any other party to the hearing, that extraordinary circumstances prevent you or another party to the hearing from appearing at the hearing in person or by video teleconferencing.

(d) Objecting to appearing by video teleconferencing. Prior to scheduling your hearing, we will notify you that we may schedule you to appear by video teleconferencing. If you object to appearing by video teleconferencing, you must notify us in writing within 30 days after the date you receive the notice. If you notify us within that time period and your residence does not change while your request for hearing is pending, we will set your hearing for a time and place at which you may make your appearance before the administrative law judge in person.

(1) Notwithstanding any objections you may have to appearing by video teleconferencing, if you change your residence while your request for hearing is pending, we may determine how you

will appear, including by video teleconferencing, as provided in paragraph (c)(1) of this section. For us to consider your change of residence when we schedule your hearing, you must submit evidence verifying your new residence.

(2) If you notify us that you object to appearing by video teleconferencing more than 30 days after the date you receive our notice, we will extend the time period if you show you had good cause for missing the deadline. To determine whether good cause exists for extending the deadline, we use the standards explained in §416.1411.

(e) Objecting to the time or place of the hearing. If you object to the time or place of your hearing, you must:

(1) Notify us in writing at the earliest possible opportunity, but not later than 5 days before the date set for the hearing or 30 days after receiving notice of the hearing, whichever is earlier (or within the extended time period if we extend the time as provided in paragraph (e)(3) of this section); and

(2) State the reason(s) for your objection and state the time and place you want the hearing to be held. We will change the time or place of the hearing if the administrative law judge finds you have good cause, as determined under paragraph (f)(1) of this section. Section 416.1438 provides procedures we will follow when you do not respond to a notice of hearing.

(3) If you notify us that you object to the time or place of hearing less than 5 days before the date set for the hearing or, if earlier, more than 30 days after receiving notice of the hearing, we will extend the time period if you show you had good cause for missing the deadline. To determine whether good cause exists for extending the deadline, we use the standards explained in §416.1411.

(f) Good cause for changing the time or place. The administrative law judge will determine whether good cause exists for changing the time or place of your scheduled hearing. However, a finding that good cause exists to reschedule the time or place of your hearing will not change the assignment of the administrative law judge for your case, unless we determine reassignment will promote more efficient administration of the hearing process.

(1) We will reschedule your hearing, if your reason is one of the following circumstances and is supported by the evidence:

(i) A serious physical or mental condition or incapacitating injury makes it impossible for you or your representative to travel to the hearing, or a death in the family occurs; or

(ii) Severe weather conditions make it impossible for you or your representative to travel to the hearing.

(2) In determining whether good cause exists in circumstances other than those set out in paragraph (f)(1) of this section, the administrative law judge will consider your reason(s) for requesting the change, the facts supporting it, and the impact of the proposed change on the efficient administration of the hearing process. Factors affecting the impact of the change include, but are not limited to, the effect on the processing of other scheduled hearings, delays that might occur in rescheduling your hearing, and whether we previously granted you any changes in the time or place of your hearing. Examples of such other circumstances that you might give for requesting a change in the time or place of the hearing include, but are not limited to, the following:

(i) You unsuccessfully attempted to obtain a representative and need additional time to secure representation;

(ii) Your representative was appointed within 30 days of the scheduled hearing and needs additional time to prepare for the hearing;

(iii) Your representative has a prior commitment to be in court or at another administrative law judge hearing on the date scheduled for the hearing;

(iv) A witness who will testify to facts material to your case would be unavailable to attend the scheduled hearing and the evidence cannot be otherwise obtained;

(v) Transportation is not readily available for you to travel to the hearing; or

(vi) You are unrepresented, and you are unable to respond to the notice of hearing because of any physical, mental, educational, or linguistic limitations (including any lack of facility with the English language) which you may have.

* * * * * * * * * * * * * * * * *

13. In §416.1438, revise paragraph (b) to read as follows:

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

(b) Notice information. The notice of hearing will contain a statement of the specific issues to be decided and tell you that you may designate a person to represent you during the proceedings. The notice will also contain an explanation of the procedures for requesting a change in the time or place of your hearing, a reminder that if you fail to appear at your scheduled hearing without good cause the administrative law judge may dismiss your hearing request, and other information about the
scheduling and conduct of your hearing. You will also be told if your appearance or that of any other party or witness is scheduled to be made in person, by video teleconferencing, or by telephone. If we have scheduled you to appear at the hearing by video teleconferencing, the notice of hearing will tell you that the scheduled place for the hearing is a video teleconferencing site and explain what it means to appear at your hearing by video teleconferencing.

* * * *

[FR Doc. 2014–14793 Filed 6–24–14; 8:45 am]
BILLING CODE 4191–02–P

DEPARTMENT OF STATE

22 CFR Part 9

[Public Notice 8776]

RIN 1400–AC75

National Security Information Regulations

AGENCY: Department of State.

ACTION: Final rule.

SUMMARY: The Department of State revises its regulations governing the classification of national security information that is under the control of the Department in order to reflect the provisions of a new executive order on national security information, E.O. 13526 and its implementing directive in Information Security Oversight Office regulations. This revision also reflects consequent changes in the Department’s procedures since the last revision of the Department’s regulations on this subject in 2004. These changes include some changes in the classification categories, in the rules governing the sharing of other-agency classified information, and in granting access to classified information to certain former government personnel. This regulation does not apply to information classified as Restricted Data (RD) or Formerly Restricted Data (FRD). Requirements for classifying and declassifying RD and FRD can be found in Department of Energy regulations on Nuclear Classification and Declassification, or in a Department of State regulation or internal order implementing those regulations.

DATES: This final rule is effective on June 25, 2014.

FOR FURTHER INFORMATION CONTACT: Alice Kottmyer, Attorney-Adviser, Department of State (L/M), 2201 C Street NW., Washington, DC 20520, or kottmyeram@state.gov.

SUPPLEMENTARY INFORMATION: The executive order governing classification of national security information, E.O. 12958, has been superseded by E.O. 13526, effective December 29, 2009. In Section 1.4, the new order makes some minor changes in classification categories, such as eliminating reference to transnational terrorism and adding a qualifier to the term “weapons of mass destruction.” That section also requires that the damage to national security be identifiable and describable. These changes are reflected in Section 9.4 of the rule.

While the basis for classification and the classification levels in E.O. 13526 are basically the same as those in predecessor orders, the new executive order contains several provisions not present in its immediate predecessors, such as the training of classifiers, particularly derivative classifiers (not covered in this rule); and, in Section 4.1(i)(1), the sharing with another agency, with certain U.S. entities, or with foreign governments of classified information that was originated by another agency after the effective date of the executive order (covered in Section 9.12 of the rule). Section 4.4 of the new executive order changes a limitation in E.O. 12958 on access to classified information by former government personnel but adds a limitation that the positions that they held be senior government positions. These changes are included in Section 9.13 of this rule. This section is among several from 22 CFR Part 171 pertaining to declassification that have been transferred to Part 9 and revised.

Regulatory Analysis

Administrative Procedure Act. The Department of State is publishing this rulemaking as a final rule. 5 U.S.C. 553(b)(B) provides that a “general notice of proposed rulemaking” need not be published in the Federal Register “when the agency for good cause finds (and incorporates the finding and a brief statement of reasons therefor in the rules issued) that notice and public procedure thereon are impracticable, unnecessary, or contrary to the public interest.” The Department of State finds good cause to issue this rule without advance notice and public comment because it has determined such procedures are unnecessary. As we note above, this rulemaking incorporates into existing Department regulations the provisions of Executive Order 13526. The Executive Order is a directive that must be implemented throughout the executive branch without significant modification; otherwise, there could be significant confusion among the public, when different agencies adopt different classification standards. Because of this, the Department determined that soliciting public comment was unnecessary.

In addition, this rulemaking involves matters of internal Department management and organization; specifically, the internal procedures for the classification and handling of classified national security information; therefore, the Department has determined that this rulemaking is exempt from notice-and-comment requirements under 5 U.S.C. 553(a)(2). Finally, the Department has determined that this final rule should be effective immediately pursuant to 5 U.S.C. 553(d)(3). The Department finds “good cause” in the need to immediately align the Department’s national security regulations with those of the White House and other agencies, thus eliminating the confusion that might be caused by conflicting regulations in such a sensitive area.

Regulatory Flexibility Act. Since the Department is not required to publish a general notice of proposed rulemaking for this rulemaking, a Regulatory Flexibility Analysis is not required.

Unfunded Mandates Act of 1995. This rule will not result in the expenditure by State, local, and tribal governments, in the aggregate, or by the private sector, of $100 million or more in any year and it will not significantly or uniquely affect small governments. Therefore, no actions were deemed necessary under the provisions of the Unfunded Mandates Reform Act of 1995.


Congressional Review Act. This rule is not a major rule as defined by the Congressional Review Act, 5 U.S.C. 804. This rule will not result in an annual effect on the economy of $100 million or more; a major increase in costs or prices; or significant adverse effects on competition, employment, investment, productivity, innovation, or on the ability of United States-based companies to compete with foreign based companies in domestic and import markets. The rule is being submitted to both Houses of Congress and the Comptroller General. Since it is not a major rule, the proposed effective date is the date of publication.

Executive Orders 12866 and 13563. Executive Order 12866 directs agencies to assess the costs and benefits of available regulatory alternatives and, if