Social Security Disability Claims

by

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TABLE OF CONTENTS

I. Introduction and Definition of Disability

This chapter is intended to serve as a guide for lawyers in representing Social Security Disability Claimants, a map of the basic process and statements of guiding principles with sources for acquiring more in-depth information. As a practitioner who has represented claimants before the Social Security Administration for over thirty years, I have the greatest respect for the agency and the disability programs despite having had an adversarial relationship with Uncle Sam for decades. I hope that future events in our great nation will foster the continuation and refinement of the disability programs which have helped and continue to help so many unfortunate claimants.

A. The Social Security Administration Web Site

The most important source for information is the Social Security Administration web site at www.ssa.gov. Go to "Attorneys and Representatives" and click on "Resources, Fact Sheets and Guides". In the pull-down list will be "Social Security Law, Regulations, and Rules". This site provides free printable acquisition of the most current provisions of Social Security administrative law and detailed information on just about any relevant topic concerning the disability programs, the administrative processes used to determine disability, the structure of the agency, and a Freedom of Information Act [FOIA] portal for requesting information not found on the site. The West Virginia State Bar's Fastcase service is also available to West Virginia attorneys at no charge for federal court decisions: www.wvbar.org/members/fastcase. The federal SSA cases are also available through Google and the usual search engines.

B. Title II and Title XVI of the Social Security Act.

There are two types of Social Security disability claims described in the Social Security Act which the practitioner will encounter most frequently - those which relate to claims of disabled persons who have contributed to the program through FICA taxes while employed and are "insured" for benefits, and claims filed by disabled indigents. Wage-Earner claims for Title II Disability Insurance Benefits and a Period of Disability are "regular" Social Security disability claims [SSDI].**42 U.S.C. §§ 423**. Indigent disability claims

are for Title XVI Supplemental Security Income [SSI]. **42 U.S.C. §§1381, 1381a.** The regulations which pertain to wage-earner claims are found in **20 C.F.R. Part 404 "OLD-AGE, SURVIVORS, DISABILITY INSURANCE"**. The regulations which pertain to SSI claims are found in **20 C.F.R. Part 416 "SUPPLEMENTAL SECURITY INCOME FOR THE AGED, BLIND, AND DISABLED"**. For our purposes, only the sections which apply to the disability programs are relevant.

C. Insured, Eligible, Disabled, Entitled.

The two types of claims are similar in some ways. The first consideration in either claim is "eligibility" for benefits. The wage-earner claimants must demonstrate payment by the wage-earner of sufficient FICA taxes for sufficient quarters of years of employment to be "insured" for disability insurance benefits and "eligible" for potential "entitlement" to benefits. SSI claimants must demonstrate that they meet the income and resource guidelines in order to be "eligible" for potential "entitlement" to SSI benefits. The issue of eligibility for either type of claim is determined by the agency initially when the claims are first filed. Findings with regard to eligibility are subject to appeal throughout the administrative appeals process and judicial review by the federal courts. The issue of "disability" is not addressed by the agency unless the claimant is first found "eligible" for potential benefits under the program requirements.

The second consideration is "disability". The basic definition of disability and the sequential disability determination process are the same for disabled adults in both Title II Disability Insurance Benefits Wage- earner-related claims and adult SSI disability claims. ***Craig v. Chater*, 76 F. 3d 585, 589 n.1 (4th Cir. 1996)**. Under the Social Security Act, disability means:

> **" inability to engage in 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." 42 U.S.C. 423(d)(1)(A)**.**

The Commissioner's regulations defining disability are found at **20 C.F.R. 404.1505** for Title II Disability Insurance Benefits and **20 CFR 416.905** for

SSI**.** These sections explain that in order to meet the definition an individual must have:

> **"...a severe impairment(s) that makes you unable to do your past relevant work (see 404.1560(b)) or any other substantial gainful work that exists in the national economy....If your severe impairment(s) does not meet or medically equal a listing in Appendix 1, we will assess your residual functional capacity as provided in §§ 404.1520(e) and 404.1545...We will use this residual functional capacity assessment to determine if you can do your past relevant work. If we find that you cannot do your past relevant work we will use the same residual functional capacity assessment and your vocational factors of age, education, and work experience to determine if you can do other work...."**

Section 1520 describes the five step "sequential analysis" which SSA adjudicators must follow in a set order to determine the issue of disability. The SSI sections describing the same sequential steps for the determination of disability are found in **20 C.F.R. 416.920** and **416.945.**
The adult "listings" are found in **Appendix 1 to Subpart P of 20 C.F.R. Part 404** following section **20 C.F.R. 404.1599**. Appendix 2, the "MEDICAL-VOCATIONAL GUIDELINES", referred to by practitioners as "the Grids", is found following Appendix 1. **Appendix 2 to Subpart P of 20 C.F.R. Part 404**. These listings and "grids" are used for both Wage-earner related disability claims and SSI disability claims.

D. Disabled Children

There are different definitions of disability for Child SSI claimants [**20 C.F.R. 416.924-416,924b**] and Blind persons [**20 C.F.R. 404.1581-1587, 416.981-987**]. The disability definition for a child claimant for SSI is as follows:

> **" If you are under age 18, we will consider you disabled if you have a medically determinable physical or mental impairment or combination of impairments that causes marked and severe functional limitations, and that can be expected to cause death or that has lasted or can be expected to last for a continuous period**

of not less than 12 months." **20 C.F.R. 416.906.**

The child must not be engaging in substantial gainful activity.

There is a different sequential analysis for children claiming SSI disability:

> **" Your impairment(s) must meet, medically equal, or functionally equal the listings. An impairment(s) causes marked and severe functional limitations if it meets or medically equals the severity of a set of criteria for an impairment in the listings, or it it functionally equals the listings." 20 C.F.R. 416.924(d).**

The Childhood Listings are found in Part B of Appendix 1 of Subpart P of **20 C.F.R. Part 404**. Appendix 1 follows **20 C.F.R. 404.1599.** The rules for "meeting a listing" are found in **20 C.F.R. 416.925.** The rules for "medically equaling a listing" are found in **20 C.F.R. 416.926.** The rules for "functionally equaling a listing" are found in **20 C.F.R. 416.926a.**

E. Drugs and Alcohol

There is also an expanded sequential analysis that must be performed for both children and adults when alcoholism and/or drug abuse [DAA] are involved in the claim. Social Security Ruling **SSR 13-2p** describes SSA's expanded sequential analysis of all claims involving alcoholism or drug abuse.

F. Title II Benefits

Title II benefits are paid from the Social Security Trust Fund. The monthly amount of disability insurance benefits payable to a given disabled wage-earner is based upon that individual's employment and FICA tax payment record. **20 C.F.R. 404.204-404.288, 404.317.** Retroactive disability benefits up to one year prior to the filing date of the claim may be obtained by claimants for disability insurance benefits depending upon the "onset date" of disability as determined by the agency. There is always a five month "waiting period" after the onset date of disability during which no Title II benefits are payable. Therefore, in order to receive the maximum full year of retroactive

benefits, claimant's onset date must be determined to have been seventeen months prior to the filing date of the claim. **20 C.F.R. 404.315(a)(4)**. The amount of monthly benefits is stable during the calendar year except for potential annual cost of living adjustment which pertains to all beneficiaries and is determined annually. Benefits may also be payable to various classes of dependents depending upon the wage- earner's payment record and "eligibility" of the dependents. A Title II disabled claimant is entitled to Medicare benefits twenty-four months after the date of entitlement to monthly disability benefits. There are no medical benefits for dependents. **42 U.S.C. § 426(b)(2)(A)**. The Affordable Care Act did not change this Medicare entitlement, but did increase Medicare coverage for certain preventive services and drugs. Visit www.medicare.gov for specific information.

G. SSI Benefits

On the other hand, payment to SSI recipients is made from general tax revenue and is a form of federal "welfare" for aged or disabled indigents. **42 U.S.C. § 1381a.** The amount of SSI disability benefits continually fluctuates based upon the disabled individual's changing financial and household circumstances which must be regularly reported to the agency. **42 U.S.C. § 1382**. No retroactive benefits prior to the filing date may be obtained by SSI claimants. SSI benefits are due only to the disabled individual and not to the individual's dependents. SSI recipients in West Virginia automatically receive Medicaid without filing Medicaid applications or renewals. www.wvdhhr.org/bcf/family_assistance/medicaid.asp

H. Concurrent Claims

Many claimants for Title II Disability Insurance Benefits based upon work history and FICA taxes paid will also be eligible to file Supplemental Security Income claims based upon low income and assets at the time of filing. The SSA claims representative is responsible for assisting the claimant to apply for any benefits for which the applicant is potentially eligible. When found eligible to file for benefits from both programs, the disability issue for both claims is determined concurrently but separate decisional notices are issued. **POMS DI 11055.055**. In the event that a claimant is found "disabled" as to both programs, the Title II benefits are primary and paid from the Social Security Trust Fund. If the payment

amount of Title II benefits would not disqualify the claimant from SSI on the basis of increased income or assets the individual may be entitled to an additional monthly amount from SSI. Normally the SSI is paid out first and the Title II benefits are reduced by a "windfall offset" computation to avoid overpayment and paid later. See **POMS GN 02510.018.**

I. Prior Claims

When a claimant fails to file an appeal of SSA's unfavorable determinations and decisions on the claim[s] the principles of "administrative finality" come into play. SSA regulations provide that decisions which have otherwise become final may be re-opened under certain circumstances. The Commissioner's rules for reopening are found at **20 CFR 404.987-404.989** , **20 CFR 416.1487-416.1489**. The earlier
decision may be reopened for any reason if the request to reopen is filed within two years for Title II claims and one year for SSI claims. Claims may also be reopened for "good cause" such as when "new and material evidence" exists pertaining to the time period prior to the determination or decision which suggests that the finding of disability might have been different if the new evidence had been considered. Reopening for good cause may occur if the request is made within four years for Title II and two years for SSI claims. **HALLEX I-2-9-20** provides guidance on computing the time periods for reopening.

J. Subsequent claims.

Sometimes a claim has been denied and while the claim is still pending at the Appeals Council, the claimant wishes to file a new claim which addresses a subsequent time period and would be expected to continue if the current claim is ultimately denied. SSA's **HALLEX I-5-3-17** provides instructions to the agency for processing subsequent claims.

In addition, SSA's Acquiescence Ruling **AR 00-1(4)** provides instructions to ALJs for considering final decisions by an ALJ in a prior claim to be considered evidence in a subsequent claim.

II. Sources of Law

All of the following may be viewed and pertinent sections copied free of charge on the Social Security Administration web site, www.ssa.gov as noted above. Publications may also be ordered through the web site.

A. The Social Security Act

Title 42 of the U.S. Code, Subchapter II - Federal Old-Age, Survivors, and Disability Insurance Benefits is found in **Sections 401-434.** Subchapter XVI - Supplemental Security Income [SSI] for Aged, Blind, and Disabled is found in **Sections §§1381-1385.**

B. The Regulations

Pursuant to the Act, the Commissioner of Social Security has promulgated Regulations for Disability Insurance Benefits and SSI, which are found in the **Code of Federal Regulations** in Title 20. Part 404 pertains to Federal Old-Age, Survivors, and Disability Insurance, and Part 416 pertains to Supplemental Security Income for the Aged, Blind, and Disabled.

20 C.F.R. 404.1- 20 C.F.R. 404.2127 including **Listing of Impairments, Appendix 1 Medical Listings to Subpart P of Part 404 and Medical-Vocational Guidelines, Appendix 2 to Subpart P of part 404 of the regulations** pertains to Title II; and **20 C.F.R. 416.101-20 C.F.R. 416. 2176** pertains to Title XVI SSI.

C. Rulings.

Rulings promulgated by the Commissioner of Social Security are binding at all levels of the agency and have been published since 1960. These set out the Commissioner's policy and contain the agency's own interpretation of the regulations. These rulings are identified by the year in which they were promulgated, some now rescinded or superceded. A current list may be obtained from the Social Security web site. Particularly important rulings known as the "Process Unification Rulings" were promulgated in 1996, **SSR 96-1p** through **SSR 96-9p**. Familiarity with these nine rulings is basic to the representation of Social Security disability claimants. There are rulings on almost every aspect of disability claims and are extremely valuable to the attorney. The Rulings may be located on the SSA website www.ssa.gov and may be found by sequential listing by year or by topic.

D. Acquiescence Rulings.

Social Security Ruling **SSR 96-1p** acknowledges the Commissioner's duty to acquiesce in the decisions of the federal courts which conduct judicial review of agency decisions pursuant to the Social Security Act. **42 U.S.C. 405(g).** Whenever the Commissioner opines that a court decision within a federal circuit conflicts with the Agency's national policy interpretation of the Social Security Act or regulations, an Acquiescence Ruling is to be issued explaining how SSA will apply such a holding within that Circuit. Unless and until an Acquiescence Ruling is issued, SSA decision-makers are bound by SSA's nationwide policies in adjudicating claims within that circuit, notwithstanding the impact of the court decision at the court level. An Acquiescence ruling identifies and discusses the court's holding of the particular case, identifies the applicable circuit, and gives very specific instructions to SSA adjudicators within that circuit. However, the Commissioner rarely promulgates Acquiescence rulings.

Some important Fourth Circuit Acquiescence Rulings are:

AR 90-4(4) Culbertson v. Secretary of HHS, 859 F. 2d 319 (4th Cir. 1988) and Young v. Bowen, 858 F. 2d 951(4th Cir.____) suspends the rules of administrative finality of prior decisions in cases of certain mentally retarded/ mentally impaired individuals, enabling a claimant to re-open and recover benefits relating to prior claims that would otherwise be outside the time period for re-opening. The maximum time period for re-opening of Title II Disability Insurance claims would otherwise be within four years of the date of "initial determination" of the prior claim. For SSI the maximum time period for re-opening would otherwise be within two years of the "initial determination" of the prior claim. The regulations define as an initial determination "Initial determinations are the determinations we make that are subject to administrative and judicial review." **HALLEX I-3-9-4** provides that the re-opening is of the determination or decision in the prior claim which is "otherwise final".

AR 92-3(4) Branham v. Heckler, 775 F. 2d 1271 What Constitutes a Significant Work-Related limitation of Function, for the purpose of satisfying the second prong of Listing12.05C, a mental retardation listing.
The court found that when a mentally retarded claimant has demonstrated that he cannot perform past relevant work, then he has established a

significant work-related limitation of function for the purpose of the listing.

AR 00-1(4) Albright v. Commissioner, 174 F. 3d 473 (4th Circ. 1999) interpreting Lively v. Secretary of HHS, 820 F. 2d 1391 (4th Cir. 1987), explaining the effect of an ALJ or Appeals Council decision in a prior claim upon the adjudication of a subsequent disability claim within the Fourth Circuit. This ruling provides that the subsequent judge must treat the prior decision as evidence and give it appropriate weight. In determining the weight to be given the prior finding, an adjudicator will consider such factors as (1) whether the fact on which the prior finding was based is su bject to change with the passing of time, such as severity of a medical condition, (2) the likelihood of such a change considering the length of time that has elapsed since the prior decision, and (3) the extent that evidence not considered in the prior claim provides a change for making a different finding. The ruling provides that only findings made at a step in the sequential evaluation are affected by the ruling, and not "subsidiary findings" such as on credibility. See Note 5. This ruling is important to practitioners as many ALJs do not comply with the requirements of the ruling, which is fertile ground for appeal at the Appeals Council level, possibly at the court level.

E. HALLEX.

HALLEX is an acronym for **Hearings and Appeals Litigation Law Manual**, an internal handbook publication from Social Security's Office of Disability Adjudication and Review [ODAR] which office administers hearings and appeals. ALJ's and the Appeals Council are bound by SSA's procedural rules. While HALLEX contains policy statements and substantive material, its primary focus is procedural. There are specific instructions for administrative law judges regarding such matters as required language in notices to be provided to claimants, the contents of the administrative record, admission of evidence and enumeration of exhibits, the conduct of the hearing, the issues before the ALJ, witnesses, and the form and language of decisions. The Table of Contents is not "user-friendly" but has a search feature on the SSA website. Administrative law judges and hearing office staff are not always familiar with the HALLEX rules governing specific procedures; hearing procedures established in a given ODAR do not always conform to HALLEX requirements. The Appeals Council will often vacate and remand ALJ decisions based upon prejudicial violations of these rules. These are not binding at the court level, except as a possible example of abuse of discretion

by the Social Security Commissioner vy reason of a prejudicial failure to abide by the Commissioner's own procedural rules.

F. POMS.

POMS is an acronym for **Program Operations Manual System**, a primary source of information and instruction for agency employees to use in processing claims prior to reaching the hearing office level. Social Security has included a disclaimer that POMS is an internal document "and may not be relied upon to create any rights enforceable at law by any party in a civil or criminal action." However, this volume is quite useful as evidence of SSA policy and actual instructions given to employees. The public version of this manual is contained on the SSA website, but has been edited to exclude what Social Security considers "sensitive" internal data. Even the edited version is voluminous with extremely specific information regarding every imaginable aspect of the processing of Social Security claims at the lower decisional levels.

G. Administrative Procedures Act.

The **Administrative Procedures Act** is found In **5 U.S.C. §§ 511-599**, and governs the processes by which government agencies create the rules and regulations necessary to implement and enforce major legislative acts such as the Social Security Act. Much of the context in which Social Security hearing offices operate was established by the 1946 Administrative Procedures Act which created the position of administrative law judge as well as granting to judges a number of protections to insure their independence. ALJ's are appointed for life, may be removed only for cause, and may not be approached by anyone including the employing agency regarding the facts at issue except on the record. ALJ's are to be assigned to cases on a rotational basis. The Administrative Procedures Act outlines the notice and comment procedures by which Social Security rule- making occurs. **5 U.S.C. §553**. The proposed and final rules are published in the **Federal Register**. The Social Security Office of Disability Adjudication and Review administers the nationwide program by which claimants may administratively appeal adverse agency determinations in accordance with both the Administrative Procedures Act and the Social Security Act. Generally, the APA governs in the absence of a specific statutory provision in the Social Security Act.

H. Freedom of Information Act.

The **FOIA** is found in **5 U.S.C. § 552** and **§552a** and contains provisions regarding the specific types of information which a federal agency is required to make available to the public and the methods by which information may be obtained. It outlines the types of information which are exempt . **§ 552a** pertains to records of individuals. The Social Security Administration has promulgated detailed regulations pursuant to the Freedom of Information Act describing how to make a FOIA request, who can release records, how much time to make a determination regarding release, what fees are charged, what records may be inspected by the public, and the right to appeal if SSA refuses to release records. These regulations are found in the Code of Federal Regulations, **20 CFR §§402.5-402.205.** There is a FOIA section of the www.ssa.gov website through which a massive amount of data is accessible.

I. Equal Access to Justice Act.

The **EAJA** is found in **5 U.S.C. §504** and **28 U.S.C. §2412.** The purpose of the EAJA is to encourage private litigants to seek review of unreasonable government conduct. The EAJA was enacted to deter unreasonable behavior by the U.S. government and its agencies and to require these to follow the law. **28 U.S.C. 2412 (d)(1)(A)** provides:

> **"Except as otherwise specifically provided by statue, a court shall award to a prevailing party other than the United States fees and other expenses...incurred by that party in any civil action...including proceedings for judicial review of agency action...unless the court finds that the position of the United States was substantially justified."**

§2412(d)(1)(B) provides that the party shall submit to the court within 30 days of final judgment an application for fees and other expenses which shows that the party is a prevailing party....and shall also allege that the position of the United States was not substantially justified. As to be expected, "substantially justified" is a term of art giving rise to much litigation. The U.S. Supreme Court in **Pierce v. Underwood, 487 U.S. 552, 565, 108 S.Ct. 2541, 2550 (1988)** found that the term was " not 'justified to a high degree' but rather 'justified in substance or in the main' - that is,

justified to a degree that would satisfy a reasonable person. That is no different from the 'reasonable basis both in law and fact' formulation adopted by the Ninth Circuit and the vast majority of other Courts of Appeals that have addressed this issue." The Commissioner has the burden of showing substantial justification. See **Evans v. Sullivan, 928 F. 2d 109, 110 (4th Cir. 1991)**.

In the event that an unfavorable decision of the Social Security administration is before a federal court for judicial review, agency non-acquiescence to an established court precedent is fertile ground for argument by claimant's counsel. If plaintiff prevails in court this will normally result in the plaintiff's ability to recover attorney fees under the Equal Access to Justice Act. **5 USC § 504, 28USC §2412**. See, for instance, **Thompson v. Sullivan, 980 F. 2d 280 (4th Cir. 1992),** recently cited in **United States v. 515 Granby, LLC, et als. Fourth Circuit Court of Appeals, November 20, 2013, No. 12-2161.**

Recent cases have addressed whether the EAJA check should be issued by the government to the Plaintiff or to Plaintiff's attorney. Currently attorneys in the Fourth Circuit are advised to obtain an assignment from the plaintiff of any potential EAJA award and to file the assignment document with the court when the Complaint is filed.

III. Types of Disability Claims.

A. Wage-Earner Disability Claims.

Generally, in order to be "insured" for disability benefits, a disabled worker must have been employed and paid FICA taxes sufficient to earn 20 quarters out of the last 40 quarters, or for 5 out of the last 10 years. **20 C.F.R. 404.110-404.146**. A person employed full-time at minimum wage for the five years immediately prior to stopping work would be "insured" for 20 more quarters (five years) afterwards and would have the opportunity to file a claim and demonstrate that he or she became "disabled" by the Social Security definition prior to the expiration of the insured period. On the other hand, a person who has worked sporadically for low wages, or a person who has not worked at all for more than five years, may not be "insured" at the time of the onset of disability. Even though a person may not still be "insured" at the time of filing a disability claim, it may be possible to demonstrate that the claimant

became disabled prior to the expiration of insured status. Payment would still be limited to one year prior to the filing of the claim though the onset of disability may have occurred much earlier.

A record of the worker's earnings is maintained by the agency and is available to the worker on the agency website. More lenient rules for insured status pertain to young workers.

B. Dependents' claims.

When an insured wage-earner is found disabled and entitled to disability insurance benefits, his family members are potentially also entitled to receive benefits based at different times upon the wage-earner's work record. Potential dependents are - spouse, divorced spouse, child, and survivors - widow or widower, divorced spouse, child and parent. **20 C.F.R. 404.301**. spouses and divorced spouses, **20 C.F.R. 404.330-349**; widows and widowers, **20 C.F.R. 404.335-338**; children, step-children, adopted children, grandchildren; **20 C.F.R. 404.350-369**; adult children disabled before age 22, **20 C.F.R. 404.351,** parents, **20 C.F.R. 404.370-374**. These qualifying rules determining the eligibility of various classes of dependents are quite detailed and specific.

C. Ancillary Disability Claims.

An adult disabled before the age of 22 may be eligible for child's benefits if a parent is deceased or receiving retirement or disability benefits. The adult child, including an adopted child and in some cases a stepchild, grandchild, or stepgrandchild, must be unmarried, age 18 or older, and have a disability that began before age 22. The normal disability rules for establishing disability in adults are used to determine the disability of the wage-earner's adult child. **20 C.F.R. 404.351, 404.1511.**

A disabled widow, widower or surviving divorced spouse of a disabled wage-earner beneficiary who becomes disabled after reaching the age of 50 and within 7 years of the death of the wage-earner may apply for benefits based upon the wage-earner's work record. The normal rules for establishing disability in adults are used to determine the disability of the wage-earner's widow, widower or surviving divorced spouse. **20 C.F.R. 404.355-404.358, 404.1511.**

D. Purpose of the Supplemental Security Income [SSI] Program

The purpose of the program is to assure a minimum level of income for persons who are age 65 or older, or who are blind or disabled and who do not have sufficient income and resources to maintain a standard of living at the established Federal minimum income level. The eligibility requirements and the Federal minimum income level are identical throughout the nation. Payments are financed from the general funds of the U.S. Treasury. Payments are made to persons who have income and resources below specified amounts. **20 C.F.R. 416.110.** When an application for SSI is filed, the agency will require information and documentation regarding assets and income. The DO will determine whether the applicant is financially eligible to receive SSI benefits, and if found entitled to SSI by reason of disability. Redeterminations of SSI financial eligibility are made at scheduled intervals. **20 C.F.R. 416.203–204**. The rules for determining income are found at **20 C.F.R. 416.1100-1171.** Income may include in-kind support and maintenance, and income may be "deemed" to the applicant from family or household members. The rules for determining "resources" and exclusions are found at **20 C.F.R. 416.1266.** These financial eligibility rules for West Virginia applicants are the same as the eligibility rules for Medicaid, and West Virginia has elected to have the Social Security Administration determine Medicaid eligibility under the state's program for recipients of SSI. **20 C.F.R. 416.110, 416.2101-416.2176**. If found entitled to receive SSI due to disability, a West Virginia recipient is also entitled to receive Medicaid. The SSI monthly benefit amount fluctuates according to changes in the beneficiaries financial circumstances.

In SSI claims for disability, SSA determines the issue of financial eligibility first. If not found to be financially eligible for SSI, a denial notice is issued on that basis, which is considered an initial determination. **20 C.F.R. 416.1402.** The agency's determination as to financial eligibility is subject to the same administrative appeals process as disability determinations; reconsideration **20 C.F.R. 416.1407, 416.1421;** hearing **20 C.F.R. 416.1421, 416.1429**, Appeals Council **20 C.F.R. 416.1455**, and Judicial Review by the United States District Court and beyond **20 C.F.R. 416.1455**.

IV. The Administrative Review process.

There are four levels of decision within the Social Security Administration when a claim for benefits is filed. **20 C.F.R. 404.900**, **20416.1400.** The Initial Determination and Reconsidered Determination are both made by claims examiners at the Disability Determination Section [DDS] of the State Agency. The Administrative Law Judge Decision is made by a judge [ALJ] of the Office of Disability Adjudication and Review [ODAR]. The Appeals Council of the Office of Disability Adjudication and Review reviews ALJ decisions and is the highest decisional level within SSA. Judicial Review of final decisions of the Commissioner of SSA is available by filing a civil action in a federal district court.

SSA provides that the administrative process is to be conducted in an informal, nonadversarial manner. In the event that a claimant is dissatisfied with a decision made at any step in the review process but does not take the next step to appeal the decision within the 60 day period in which to appeal, the right to further administrative review and judicial review is lost, unless good cause for failure to make the timely requests for review is shown. **20 C.F.R. 404.900(b)** and **20 C.F.R. 416.1400(b)**.

A. Filing a claim.

An application for Title II disability insurance benefits may be filed on-line immediately without waiting for an appointment by using the SSA webpage. Go to www.ssa.gov to the FAQ Home page and search "How do I apply for disability benefits". There is also a "Benefit Eligibility Screening Tool" [BEST] which can be used to determine whether a person may be eligible for other benefits. www.benefits.gov/ssa/questionnaire.

There is no on-line application for SSI benefits due to the complexity of the financial eligibility rules. However a Disability Report can be completed on-line and a contact made with the agency to finish the application process by calling 1-800-772-1213 (TTY 1-800-325-0778). Normally an appointment is made for a claims representative to call the applicant back at a specific date and time. The completion of the Disability Report first will shorten the application process. The date of the contact/inquiry will be used as the application date, providing that the applicant timely completes the process as instructed after making the contact. Because no SSI benefits are payable retroactive to the filing date, it

is important to establish a "protective filing date" as early as possible.

An application may also be filed by applying in person at the closest local District Office of SSA. Street addresses and telephone numbers can be located through the website: www.ssofficelocations.net/West-Virginia. Presently there are offices in Beckley, Bluefield, Charleston, Clarksburg, Elkins, Fairmont, Huntington, Logan, Martinsburg, Morgantown, Parkersburg, Petersburg, St. Albans, Welch, Wheeling, and Williamson.

An application may also be filed by calling the SSA toll-free number: 1-800-772-1213 (TTY 1-800-325-0778) between 7:00 a.m. and 7:00 p.m. Monday through Friday. It is necessary to make an appointment using the toll-free number for a claims representative to call back at a certain date and time to take an application over the telephone. Additional documents needed to complete the claims process are mailed to the applicant.

The regulations regarding Title II Disability Insurance Applications are located at **20 C.F.R. 404.610-641**. The regulations regarding SSI applications are located at **20 C.F.R. 416.301-360.**

B. The Disability Determination Section - Initial Determination.

In West Virginia, the Disability Determination Section [DDS], a part of the West Virginia Division of Rehabilitation Services of the West Virginia Departments of Education and the Arts, by agreement with SSA determines medical eligibility for Social Security Disability [SSDI] and SSI claims. Although administered in West Virginia by the state, DDS is federally regulated and funded by SSA. West Virginia claims are generally processed in West Virginia. The offices of West Virginia DDS are located in Charleston and Clarksburg.

C. The Role of the DDS Disability Examiner

The Claims Representatives from the District Office who initiate the claim applications refer the claims to the DDS offices for medical determination by Disability Examiners. The claimant is ultimately responsible for providing evidence to show that he or she is disabled. However, DDS prepares the medical aspect of the claims. Although it is the

claimant's ultimate responsibility to produce proof of disability, SSA is responsible for developing the complete medical history including arranging consultative examination[s] and making "every reasonable effort" to help the claimant acquire reports from claimant's own medical sources. "Complete medical history" generally includes development of the history for the year prior to the onset date of disabiity alleged by the claimant through the present. **20 CFR 404.1512(d)**, **20 CFR 416.912(d)**.

1. Medical records, Bar code

The examiner attempts to acquire records from the claimant's treatment sources first and requests records from the sources identified by the claimant on the Disability Form accompanying the application. If the evidence is unavailable or felt insufficient to make a determination, DDS will arrange for a consultative physical and/or psychological examination [CE]. The claimant's treating physician is the preferred source for the CE. Usually a form called a "Routine Abstract" is sent to the claimant's physician to complete. However, in the author's experience, DDS rarely obtains the CE from the claimant's own doctor, but schedules a CE with a contract physician. Even when the claimant's physician agrees to perform the consultative examination, DDS may also obtain an examination from a DDS consulting physician or psychologist. **20 CFR 404.1512(e)**, **404.1517-404.1518**, **20 CFR 416.912(e)**, **416-917-918**.

The DDS examiner will provide to the attorney by request a claimant-specific bar code for use in efiling or efaxing evidence into the electronic claims folder.

2. Consultative Examinations

The report of the physical examination is prepared by the DDS consulting examiner using an agency template which results in a lengthy, professional-looking report not always corresponding with the quality of the actual examination performed. Examiners and ALJs tend to rely heavily on these reports. The regulations pertaining to consultative examiners, report content, and the types of evidence purchased by SSA are found at **20 CFR 404.1512-404.1519t**, **20 CFR 416.912-416.919t**. CE reports usually begin by reciting the allegations of the claimant, and always contain basic helpful examination data regarding the claimant's age, height without shoes, weight,

blood pressure, and audio and visual screening. They also usually note obvious anomalies or deformities, examination of the joints for tenderness and swelling, detailed range of motion measurements, sensation, grip and extremity strength, manipulative ability and claimant's ability to perform such motor functions as arising from a chair, standing on one leg, heel/toe and tandem walking, squatting and arising, and the ability to communicate with the examiner. The doctor or psychologist will list diagnostic impressions and a short summary of the examination findings. DDS does not ask the examining physician to assess the claimant's functional limitations.

3. DDS Functional Assessments

After receipt of sufficient evidence that the DDS examiner deems adequate for decisional purposes, the examiner obtains a signed Physical Residual Functional Capacity Form [RFC] from a non-examining State Agency contract physician and/or, when applicable, a Psychiatric Review Technique Form [PRTF] and Mental Residual Functional Capacity Assessment form from a DDS non-examining state agency physician and/or psychologist. A written document of Disability Determination Explanation is prepared by the examiner setting forth the sequential evaluation performed by the examiner and the evidence relied upon, with the conclusion that the individual is or is not disabled. The Examiner completes a Disability Determination and Transmittal form citing the DDS RFC and PRTF forms, and a Notice is prepared.

4. Notice of Initial Determination

The Notice of Initial Determination is a form letter generated by the claims examiner with applicable paragraphs selected and sent to the claimant by mail. The notice informs the claimant that his or her claim has been awarded or denied. The notice lists the evidence which was relied upon, in very general terms gives a general reason[s] why the claim was awarded or denied. It informs the claimant of the right to request reconsideration of an unfavorable decision within 60 days. Instructions for appeal are included. A notice is issued for each claim which is pending and being concurrently adjudicated, such as a Title II Wage-Earner claim for disability insurance

benefits and a claim for SSI. The Appeal form **SSA- 561** is entitled "Request for Reconsideration". It may be filed on-line or printed and mailed to the local Social Security Office. Form **SSA-3441** Disability Report-Appeal and Form **SSA-827** Authorization to Disclose Information to SSA must also be submitted.

D. The Reconsideration Determination.

The Reconsideration Determination is made at the same DDS office by a different examiner. If the DDS examiner updates the medical information and considers that there is sufficient evidence in the file for purposes of a decision, the medical evidence including any new evidence is considered by a different DDS non-examining contract physician and/or psychologist, and a second RFC and/or PRTF and Mental RFC forms are executed. The Notice of Reconsideration Determination is a form letter generated by the DDS examiner, which will again inform the claimant of the decision, generally the basis of the decision, and in the event of an unfavorable decision the right to request a hearing by an administrative law judge within 60 days. Information on how to appeal is included.

The appeal form **SSA HA-501** is entitled Request for Hearing. It may be filed on-line or the form printed and sent to the address on the Notice of Reconsideration. Additional forms will also need to be submitted: **SSA-3441** Disability Report - Appeal, **SSA-827** Authorization to Disclose Information to SSA, and a form **SSA-1696** Appointment of Representative if the attorney is retained at this level of appeal.

In Cessation Cases in which SSA has determined that a person previously found disabled is no longer disabled, a hearing by a Disability Hearing Officer is available at the Reconsideration level. **20 C.F.R. 404.914**, **20 C.F.R. 416.1414.** In this event a detailed decision is issued by the Hearing Officer, whose decision may be appealed by a Request for Hearing as in other reconsidered determinations.

E. The Hearing.

1. Location

The Office of Disability Adjudication and Review [ODAR] having

jurisdiction over the hearing according to the claimant's location will acknowledge receipt of the Request for Hearing and send a bar code for online submission of evidence. ODAR will attempt to schedule the hearing within a 75 mile radius of the claimant. Many hearings are held at remote sites, which are satellite ODAR offices for the purpose of hearings. Travel expenses to and from the hearing are reimbursable by ODAR by means of filing a Travel Voucher on the agency form when the claimant and/or his representative are required to travel more than 75 miles to reach the hearing site. Reimbursement is limited to the maximum mileage for travel to reach the hearing site from any location within the geographical area served by the ODAR office having jurisdiction of the hearing request. **20 C.F.R. 404.999a-404.999d**, **20 C.F.R. 416.1495-416.1499**. **HALLEX I-2-3-13.** Forms are available from the ODAR hearing office. The author was unable to locate the form on the SSA website.

Location of the applicable ODAR for a given West Virginia address can be found by using the ODAR Hearing Office Locator at www.socialsecurity.gov/appeals/ho_locator.html.

At present there are permanent ODAR offices in West Virginia at Huntington, Charleston, and Morgantown. Border state ODAR offices also hold hearings for claimants in certain areas of the state. Generally, judges of a given ODAR office are assigned in rotation with the other judges from that office to specific incoming cases.

2. Procedural Rules

An administrative law judge will be assigned to hear the case. Hearings are held with procedural due process safeguards for an on-record hearing by an impartial administrative law judge with notice and the opportunity to be heard. The ALJ decision informs the claimant of the specific legal and evidentiary basis for the decision. **42 U.S. §405(b)** outlines general provisions for SSA hearings and specifically provides that the formal rules of evidence do not apply. The Commissioner's regulations pertaining to ALJ hearings are found at **20 C.F.R. 404.929-404.961** and **20 C.F.R. 416.1429-416.1461**. Additional rules may be found in **HALLEX**. The Administrative Procedures Act is applicable in the absence of a specific provision of the Social Security Act.**5 U.S.C. §§ 511-599.**

3. Rotational Assignment of Judges

Rotational assignment of judges to cases ensures the fairness of the tribunal. **5 USC §3105**. The Hearing Office Chief must be able to provide reasonable justification for assigning cases to ALJs out of rotation if the issue arises. **Office of the Inspector General Audit Report A-12-07- 27091**, page 3. Rotational assignment is required by the **APA** and is also the Commissioner's policy. In event of severe backlog within the given ODAR office, judges from a different ODAR may be assigned to hear cases. Because of normal backlogs, it is not unusual for a claimant to wait for a year or more after requesting a hearing before one is scheduled. The claims are generally heard in order of the date on which the Request for Hearing is received by ODAR, unless terminal illness or other "dire need" is found to justify an earlier hearing date. **HALLEX I-2-1-40**.

4. Private Hearing

The hearing is not public and is conducted in a small room with the judge, the court reporter, the claimant, claimant's representative if any, a vocational expert and possibly one or two medical expert witnesses called by the ALJ. Expert witnesses are called in rotation from a list of approved witnesses maintained by ODAR. Often there are only five persons in the room unless medical expert witnesses are present. Judges and attorneys differ on having family members present during the hearing. Some judges wish to sequester any potential witnesses. Others will allow testimony from family members present during the claimant's testimony. The author's policy is not to allow family members in the room. The goal is to allow the claimant to testify in the most private and informal and least intimidating setting possible. In the permanent ODARs small courtrooms are maintained in which there are only the judge's bench and a large table in front at which the claimant, counsel, court reporter, and expert witnesses sit. Whether or not a video hearing is conducted, only an audio recording of the hearing is made. On appeal, the lack of a complete recording of the hearing may be reason for reversal of the decision and remand to the ALJ for a new hearing.

5. Hearing by Videoteleconference

The ALJ determines whether to hold the hearing by video teleconferencing. The claimant may make timely objection to attending the hearing by video teleconference. If the hearing is by video teleconference, it

is conducted in a small hearing room equipped with a large screen and video teleconferencing equipment. The judge and any expert witnesses are usually in the judge's home ODAR office while the claimant, the representative, and the hearing assistant who records the hearing are present in a different ODAR location, usually an ODAR satellite office nearer the claimant. It is not unusual that vocational and medical expert witness testimony be taken by telephone. A request for an in-person hearing must be made very soon after learning the ALJ's plan to hold a video hearing. The judge's staff must secure the appearance of the expert witnesses as well as make arrangements with the satellite office and the hearing assistant. Judges view late objections to the video hearing with disfavor. As a practical matter, there may be delay of several months before a live hearing can be scheduled depending upon the judge's schedule, but it will be rescheduled in order of the date of the Request for Hearing. The claimant should be consulted prior to objecting to the video hearing. In-state judges will usually allow the claimant and representative to attend the hearing in person at the judge's ODAR location so long as additional travel reimbursement costs to the agency do not ensue. Arrangements are made in writing prior to the hearing with written waivers of travel costs as appropriate. This arrangement can avoid delay in having the case heard. ODAR procedures for video hearings are found in **HALLEX I-5-1-16.**

6. Notice of Hearing

The ALJ decides the date, time and place of the hearing and issues a Notice of Hearing at least 20 days prior to the hearing date. As a practical matter the judge's staff will usually arrange by telephone with the attorney a date, time, and place of the hearing long before the hearing notice is issued, usually at least 60 days if not more. This practice saves the agency considerable time and money in rescheduling the hearing, which is less likely to occur if the attorney is consulted first. It also saves time and money of all parties, as the case is more likely to be completely developed and ready for hearing when the attorney is given sufficient advance notice.

The hearing notice identifies the claimant and the claim and informs the claimant regarding the issues to be decided. The claimant may object to the issues. If so, the attorney is advised to file written objections in advance of the hearing date.

The claimant may waive his or her presence at a hearing and request a decision on the evidence of record. **20 C.F.R. 404.948**, **20 C.F.R. 416.1449.** This is only to be used in limited circumstances, as a live hearing is almost always to be preferred so that the record contains sworn testimony of the claimant with regard to subjective symptoms and relevant facts. Much important information is contained in the "E" Section of the electronic file folder of the claim and consists of the forms upon which claimant has periodically reported important details of his or her medical treatment to the agency, statements as to functional abilities, and description of past jobs. Although strict rules of evidence do not apply and hearsay evidence is permitted, these statements are not a substitute for sworn testimony and often contain ambiguities and inconsistencies which must be resolved at the hearing.

Most hearings are scheduled forty-five minutes to one hour apart and can be a challenge to present in that length of time. Some judges are strict in adherence to the schedule but most will allow minor variations. Usually ten to fifteen minutes are needed for questioning the vocational expert after the claimant testifies. In the event that the ALJ has secured the presence of one or more medical expert witnesses, most judges will allow an additional half hour to the scheduled hearing time.

7. Submitting Evidence to ODAR

Some attorneys have secure electronic access to the file folder prior to the hearing and may examine the EF to determine exactly what evidence has been included in the exhibit file. Evidence is normally e-filed or e-Faxed into the EF, unless the claim involves an old paper claim file or unless the evidence is particularly voluminous. Receipts for evidence efiled and efaxed should be associated with the particular exhibits filed in the event that the evidence is not included in the EF. The ALJ's staff should be contacted by telephone and notified of exhibits filed by mail with a followup to be sure the evidence was admitted into the file.

8. Conduct of the Hearing

Judges differ as to the conduct of the hearing. The usual hearing begins with going "on the record" for the judge's short opening statement setting forth the identity of the claimant, the purpose of the hearing, the specific claims involved, and the applicable time periods covered by the claim. The ALJ assures the claimant that although being paid by the agency, he or she is not bound by the agency's prior decisions and will make an independent decision. The claimant and witnesses are sworn, the evidence is formally admitted. Most judges will enquire whether the record is complete and if not, what evidence is outstanding. **HALLEX I-2-7-20(A)** provides that when the attorney request additional time to submit evidence or arguments after the hearing, the ALJ must set a time limit for the posthearing actions to be completed and inform the attorney that if not received within the time limit, absent good cause to extend the time, the ALJ will issue a decision without the material. **HALLEX I-2-7-20**. There are judges who do not comply with the rules and will refuse to grant additional time to complete the record. However, any evidence which is acquired and submitted prior to the time a decision is rendered must be considered by the ALJ under existing law or is likely to result in reversal and remand by the Appeals Council if the evidence is relevant to the decision and ignored.

Administrative Law Judges are as different as people can be, and each has a preferred manner of conducting hearings. Formal rules do not apply, but the ALJ may conduct the hearing in any way that does not violate the claimant's rights. While some of these procedural quirks may be contrary to **HALLEX** rules they may or may not rise to the level of appealable offenses.

Most judges welcome an opening statement by the attorney setting forth the critical facts of the case and the claimant's position in the case with reference to applicable regulations and exhibit and page number citations to the evidence. In the "A" section of the electronic file folder are detailed explanations of the initial and reconsideration decisions reached below by DDS, which all but write an unfavorable decision for the ALJ. It is important that the attorney present an adequate assessment of claimant's case to the ALJ to overcome these earlier agency positions. ODAR requests that the attorney submit a brief to the ALJ prior to the hearing. However, this is not a legal requirement. The author prefers an oral statement on the record to the

submission of a brief in most cases.

The claimant is almost always questioned first unless there are medical expert witnesses present and there is a reasonable expectation by the ALJ that the claimant's impairments may meet or equal a listing. If so, this may cause a favorable decision without the necessity for testimony from the claimant and may considerably shorten the hearing. Some judges prefer to question the claimant first, often using a predictable set of questions for each claimant. Some judges prefer that the attorney "put on" the case, and reserve questions for areas of potential controversy after the attorney has completed questioning. Generally both the attorney and the judge question the claimant back and forth until both are satisfied that relevant issues have been addressed.

Expert witnesses are usually present for the entire hearing and hear the arguments of the attorney and testimony of the claimant and other witnesses. Experts present by telephone deposition are usually contacted and are on-record at the beginning of the hearing until excused after testifying if no recall is expected.

In most cases the ALJ does not inform the claimant and counsel of the outcome of the hearing. Claimant and the representative are mailed a copy of the decision and must wait until then to learn the judge's decision. Unless the decision is extremely easy to write, the decision is usually not received in less than a month. The rule of thumb in my office is approximately eight weeks. An unfavorable decision is much harder to write than a favorable decision as the ALJ expects that an appeal will be pursued and exceptional care must be taken in writing the decision. A long delay after the hearing in receiving the decision is usually not a good sign. The delay should be used to the claimant's benefit and additional updated supportive evidence should be obtained and submitted if possible.

9. Best Practices for Representatives

Available on the SSA website is a useful publication, **Best Practices for Claimants' Representatives, SSA Publication No. 10-061, January 2011.** Particularly useful are instructions for submitting a request for an on the-record favorable decision prior to the setting of a date for the hearing. In strong cases the attorney may be able to achieve an earlier favorable result

for the claimant without waiting for a hearing. Also included in the publication are dos and don'ts from the ALJ perspective.

F. The Hearing Decision.

The ALJ does not normally write the decision. The ALJ determines whether the claim[s] is to be awarded or denied, and a decision writer within ODAR is assigned to write the decision. The ALJ revises the written decision as needed and will sign the final draft. A copy of the decision is mailed to the claimant and the attorney or representative. Attached to the decision is an exhibit list of all documents present in the file folder and before the ALJ at the time of the decision.

Because the legal requirements for a valid decision are quite strict, most decisions are voluminous and consist of an average of twelve to twenty-four pages of single-spaced type, not including the exhibit list at the end. Attached to a favorable decision is also the judge's decision regarding whether the attorney's contract with the claimant is in proper form to permit "streamlined" processing and automatic payment of the fee without the necessity of filing a fee petition with the ALJ.

1. The Form of the ALJ decision.

There is a single written decision for all claims concurrently adjudicated. In the first part of the decision, the procedural history of the claims is set forth including prior claims. The claims are identified by the type of claim, the program such as Title II or Title XVI, and the date of filing. The specific issues for decision on each claim are noted. The claimant is informed in the decision of the definition of disability and the applicable law.

The body of the ALJ decision is organized according to the Commissioner's sequential evaluation of disability. The findings at each step in the analysis are set out in bold print and enumerated according to a template developed by the agency. After the findings of each step are the ALJ's analysis of and citation to the specific evidence considered in making that finding. The sequential steps of the decisional procedure logically lead to the ultimate conclusion that the claimant is or is not disabled for the purpose of the claims which were before the ALJ. The decision must list the severe medically determinable impairment, whether any listing is met or

equaled, and if not, the claimant's physical and mental residual functional capacity and whether the claimant can perform any past relevant work. If not, the ALJ must determine whether there are substantial numbers of jobs in the regional or national economy that the claimant can still perform despite his impairments. In making these findings the ALJ must evaluate the claimant's credibility using a two-step method and must evaluate the medical opinions in the record according to prescribed standards. The ALJ must not fail to consider any relevant evidence and a conclusory statement regarding the evidence supporting findings is not sufficient pursuant to the Commissioner's own regulations and rules and also before the Court. The ALJ is required to cite all relevant evidence and to explain his or her conclusions so that a reviewing entity is able to determine what evidence was considered and the ALJ's basis for the decision. The ALJ must comply with and properly apply the law in making the decision and must not have made factual errors which would affect the outcome of the decision.

An ALJ decision is appealed by filing a Request for Review by the Appeals Council within 60 days of the date of the unfavorable decision. The regulations allow 5 additional mailing days or more if the claimant can demonstrate that the decision was received later. Instructions for appeal are included with the ALJ decision and found on the website www.ssa.gov. Social Security **Form HA-520-U5** must be completed in writing and sent directly to the Appeals Council at the address shown on the decision. The local district Social Security Office can be contacted for assistance and will furnish needed forms. Also a telephone call for assistance may be made to 1-800-772-1213. Forms may be downloaded from the Social Security website, www.ssa.gov and can be located by usual search engines such as Google.

G. The Appeals Council.

The Appeals Council is the highest and last decisional level within the SSA administrative process and is part of the Office of Disability Adjudication and Review. The Council has its headquarters in Falls Church, Virginia, with additional offices in Baltimore and Crystal City, Virginia. As of January, 2014 the Council consists of seventy-two Administrative Appeals Judges, forty-

three Appeals Officers, and hundreds of support staff members. Over 173,000 Requests for Review were processed by the Council in fiscal year 2012. The average processing time for Requests for Review in that year was 395 days. www.ssa.gov/appeals/about_ac.html.

1. Regulations

The Commissioner's regulations regarding Appeals Council Review are found at **20 C.F.R. 404.966**-**404.985**, **20 C.F.R. 416.1466**-**416.1485.** When the Appeals Council is asked by the claimant to review an unfavorable administrative law judge's decision, it may ultimately deny or dismiss the Request for Review, in which case the decision of the ALJ becomes the "Final Decision" of the Commissioner. If the Appeals Council decides to review a case, it may grant the request and issue a new decision, which then becomes the Commissioner's Final Decision, or it may vacate the ALJ decision and remand the case to the Administrative Law judge with instructions, usually for further development of the evidence and a new hearing at which all issues are again open. The Commissioner's **HALLEX** rules provide that the same ALJ may rehear the case a second time (providing that the ALJ is still on the roster of the ODAR hearing office). In the event that the same claim is remanded twice by the Appeals Council, the claim is reassigned to a different ALJ.

2. Own Motion Review by the Appeals Council

The Appeals Council may review a decision of an ALJ on its own motion at any time within 60 days of the ALJ decision, usually on the basis of cases referred to the Appeals Council by other components of the agency in random and selective sampling for purposes of quality review. In such event the Appeals Council issues a Notice of Review to the claimant and the representative. New evidence and argument may be provided in the same manner as if the claimant requests review of the decision. When a favorable ALJ decision is reviewed, interim benefits are usually payable until the outcome of the review and if the outcome is unfavorable to the claimant, these benefits will not result in overpayments unless the benefits were fraudulently obtained.

3. A Copy of the File

The Appeals Council upon request will furnish a complete copy of the administrative file that was before the ALJ and a copy of the audio CD of the hearing or hearings conducted by the ALJ. The Appeals Council will notify the claimant and representative at some point that the case is being examined and that the claimant has a deadline by which any additional evidence and argument may be submitted. Requests for extension of the deadline are usually granted once, but are increasingly difficult to achieve subsequently. The deadline appears to be arbitrary, and the author knows of no actual bar to submission of argument and evidence at any time before the Appeals Council acts. The Order of the Appeals Council will list in general terms the new evidence and the claimant's brief[s] which it considered prior to acting. In the past the author has had to ask the Appeals Council on numerous occasions to vacate its action due to having failed to consider evidence and/or arguments previously submitted prior to the deadline.

4. When the AC Will Grant the Request for Review

The regulations set out the bases for Appeals Council [AC] review. The AC will review a case if one of the following is found;

(1) an abuse of discretion by the ALJ,
(2) an error of law,
(3) the findings of the ALJ are not supported by substantial evidence,
(4) there is a broad policy or procedural issue that may affect the general public interest. **20 C.F.R. 404.970**, **20 C.F.R. 416.1470.**

The AC may consider any issue that was before the ALJ, even those aspects of the ALJ decision which were favorable.

New evidence submitted to the Appeals Council will be accepted and considered so long as the new evidence pertains to the period of time and the claimant's condition prior to the ALJ decision. This does not mean that the evidence must be dated prior to the ALJ decision so long as it relates to impairments in existence or symptoms reported prior to the ALJ decision. For instance, a new EMG/NCS study verifying the presence of severe carpal tunnel syndrome would be accepted if the claimant had described symptoms of the condition prior to the decision. A new MRI of the spine would be pertinent to the claimant's back pain existing prior to the decision unless merely duplicative of MRIs in the claim file. An opinion of the treating

physician relating to functional limitations prior to the ALJ decision would also be pertinent, particularly if counsel had verified prior to the decision the failure of the physician to respond to requests for a functional assessment and the file did not contain a functional assessment by an examining physician.

If the Appeals Council considers that evidence does not pertain to the period of time prior to the ALJ decision, it may return the evidence with instructions regarding filing a new claim, if claimant is still eligible to file a new claim. If the evidence is found to be new and material, the AC will vacate the decision of the ALJ and remand the matter to the ALJ for consideration of the new evidence and a new decision.

5. Submission of Evidence to the AC

Because of the length of time that the Appeals Council has the file prior to acting upon the Request for Review, it is desirable to keep the file updated regularly with current treatment evidence. Sometimes the ALJ will have indicated in the decision that the file lacked documentation of some aspect of the claimant's disability which can be addressed at this point, providing "new and material evidence" reasonably likely to have caused the ALJ to make a different decision had the evidence been before the ALJ. In such case a vacation of the decision and remand to the ALJ may occur.

The author listens to the hearing CDs and endeavors to submit a good brief at this level, which also provides a timely look at the case to determine whether a civil action will be advisable if the Appeals Council denies the Request for Review. At the AC level the case is normally evaluated by a non-attorney legal assistant. The AC tends to respond to intra-agency arguments based upon the Rulings and HALLEX which are not always appropriate at the federal court level other than to demonstrate an abuse of discretion by the Commissioner in failing to follow his own rules.

6. The Decision of the Appeals Council

An unfavorable outcome as reflected in the Order of the Appeals Council denying the Request for Review or issuing a new unfavorable decision ends the administrative review process. The final decision of the Commissioner, either the unfavorable ALJ decision which was affirmed by the AC or the new decision of the Appeals Council may only be contested

by filing a civil action within 60 days of the action of the Appeals Council in the United States District Court for judicial review of the agency action under the Social Security Act, **42 U.S.C. 405(g).**

VI. The Sequential Evaluation Process.

A. Definition of Disability

For Title II disability claimants and adult claimants for SSI the definition of disability is as follows:

> **"the inability to do any substantial gainful activity by reason of any medically determinable physical or mental impairment(s) 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." 20 C.F.R. 404.1505**, **20 C.F.R. 416.905**.

B. The Five Step Sequential Evaluation Process.

The sequential evaluation process requires the SSA adjudicator to perform up to a five-step analysis in order to determine whether a person is or is not disabled. The same five step process applies to adult Title II disability claimants and Title XVI SSI disability claimants who are not blind. There is a different process for children. Briefly stated the steps are as follows:

1. Is the person working? If the person is employed and earning more than the substantial gainful activity amount, the claim is denied. Otherwise the evaluation proceeds to the next step.

2. Is there a medically determinable impairment or combination of impairments severe enough to interfere significantly with the ability to perform basic work functions for at least one year? If not, the claim is denied. Otherwise the evaluation proceeds to the next step.

3. Is the impairment or combination severe enough to meet or equal the criteria of any of SSA's medical listings? If yes, the person is found disabled pursuant to that listing and the claim is allowed. If no, the

evaluation proceeds to the next step.

4. In view of the person's residual functional capacity to perform basic work functions which must first be determined, does the person have the capacity to perform the requirements of any relevant employment performed in the past? If the answer is yes, the person is found not disabled and the inquiry ends. If no, the inquiry proceeds to the next step.

5. In view of the person's residual functional capacity to perform basic work functions, and in view of the person's age, education and work experience, does the person have the ability to adjust to other types of work? If the answer is no, the person is found disabled. If the person has the ability to adjust to other types of work, the person is found not disabled.

20 CFR 404.1520, **20 CFR 404.920**, **Appendix 1 to Subpart P of Part 404 of the regulations.**

C. Step One. Work Activity.

"At the first step, we consider your work activity, if any. If you are doing substantial gainful activity, we will find that you are not disabled." 20 C.F.R. 404.1520(a)(4)(i), **20 C.F.R. 416.920(a)(4)(I)**.

If a person is performing work of the type and amount described in SSA regulations, the person is not disabled no matter what medical condition [other than blindness] exists unless the work activity is found to be unsuccessful and not sustained SGA. Most claimants are no longer working when the claim[s] is filed. Due to the long delay in obtaining a hearing date, it is not unusual for the claimant to attempt to return to work while the claim is pending. If the person has worked during the period in which disability is alleged, it is necessary to demonstrate that the work was not "Substantial Gainful Activity" [SGA] or the inquiry stops at step one and the person is found not disabled. If the work is found to represent one or more unsuccessful work attempts, earnings at the SGA level for short periods will be disregarded and will not defeat the disability claim which requires inability to perform SGA for at least one year.

The definition and discussion of SGA for persons who are not statutorily blind are found in **20 C.F.R. 404.1571**-**404.1576**, **20 C.F.R. 416.971**- **416.976**. Generally work must be both "substantial" and "gainful". It

may be “substantial” even if done on a part-time basis or if paid less, or involves less responsibility than previous work. Gainful work activity is work of the type usually performed for pay or profit, whether or not pay or profit is realized. Ordinary activities such as self-care, household tasks, hobbies, therapy, school attendance, club activities, or social programs are not generally considered substantial gainful activity.

Earnings that will ordinarily show that a person is performing SGA are published by SSA and updated yearly. The 2014 amount of employee earnings above which will ordinarily show that SGA is performed is $1070 per month, computed as the gross and not the net amount of earnings. A chart of current and prior year SGA amounts may be found at www.socialsecurity.gov/OACT/COLA/sga.html.

Normally for wage-earners, SSA looks to the earnings to determine whether or not SGA has been performed. As expected, “Substantial Gainful Activity” is a term of art for which there are qualifications and exceptions. For instance, there are special rules for computing SGA for self-employed persons. There are special rules for computing employee earnings in situations where the employee is in a position to control the amount of earnings, such as in a family-owned corporation. Special work circumstances may show that the actual earnings are in part a “subsidy”, such as in a sheltered workshop or earnings paid by a relative or indulgent employer for work under special conditions for fewer hours, more breaks, special equipment or assignments. A person may have necessary impairment-related work expenses which allow the person to work which may be subtracted from earnings in considering the SGA amount.**20 CFR 404.1471-404.1476**, **20 CFR 416.971-416.976.**

Work at the SGA level performed after the alleged onset date of disability and during the period for which disability status is being sought can be considered an unsuccessful work attempt [UWA] if it lasted for a short period and had to be stopped or reduced below SGA because of medical impairments. The agency has guidelines to allow it to disregard relatively brief work attempts that do not demonstrate sustained substantial gainful activity. The UWA criteria differ depending upon whether the work effort was for “3 months or less” or “between 3 and 6 months”. Work attempts lasting more than 6 months at the SGA level are considered successful and preclude a finding of disability while the work was being performed. There

must be a substantial break in work activity of at least 30 consecutive days after prior work before the unsuccessful work attempt occurs. If so, and the work attempt ended or was reduced below SGA level in 3 months or less because of the impairment[s], SSA will consider the work an UWA and will disregard it. If the work attempt lasted between 3 and 6 months, if it ended or was reduced below SGA amounts because of the impairment[s] or because special conditions which allowed work were removed the earnings may be disregarded if additional information is provided. For the 3 to 6 month work attempt to be unsuccessful it must be shown that the impairment[s] caused (1) frequent absence from work, (2) the work performed was unsatisfactory, (3) the impairment[s] was in temporary remission, or (4) Work was performed under special conditions that were essential to work performance and which were removed. **20 CFR 404.1574(c)**, **20 CFR 416.974(c)**.

If there is no SGA other than unsuccessful work attempts, the analysis proceeds to Step Two.

D. Step Two. Severe Medically Determinable Impairments.

A "medically determinable physical or mental impairment" is an impairment that results from anatomical, physiological, or psychological abnormalities which can be shown by medically acceptable clinical and laboratory diagnostic techniques. A physical or mental impairment must be established by medical evidence consisting of signs, symptoms, and laboratory findings - not only by the individual's statement of symptoms. **20 CFR 404.1508**, **20 CFR 416.908**, **SSR 96-4p**.

Thus, an impairment must be established by medical evidence deemed diagnostic by SSA. Some impairments which may be shown on objective medical tests are easily established by an X-ray report or MRI signed by the radiologist. Some impairments require diagnosis by a medical practitioner. A diagnosis must be made by a person who is an "acceptable medical source" in order to establish a medically determinable impairment. **20 C.F.R. 404.1513**, **20 C.F.R. 416.913.** Acceptable medical sources include licensed medical and osteopathic physicians, licensed or certified psychologists, licensed optometrists for purposes of establishing visual disorders, licensed podiatrists for establishing impairments of the foot, and qualified speech-language pathologists for the purpose of establishing

speech or language impairments. Information from other sources may be considered regarding functional limitations due to a medically determinable impairment, but are not sufficient to establish a diagnosis: nurse-practitioners, physicians' assistants, naturopaths, chiropractors, audiologists and therapists. See **SSR 06-03p Considering Opinions and Other Evidence from Sources Who Are Not "Acceptable Medical Sources"...**

It is necessary for the attorney to point out to the claimant from the outset that no matter how severe they may be, statements of subjective symptoms such as pain, fatigue, shortness of breath, weakness or nervousness will not be found to affect the ability to work unless an impairment has been properly established which could reasonably be expected to produce the alleged symptoms. **SSR 96-3p**, **SSR 96-7p**. No matter how heart-rending the testimony, it cannot substitute for medical proof of the existence of the impairment. Most claimants of the author's experience are initially reluctant to undergo the sometimes painful and expensive testing necessary to provide documentation to SSA of all of their medically determinable impairments. The claimant may be reluctant to be seen by a specialist when he or she is satisfied with the treatment received by a nurse practitioner or physician's assistant. The attorney must warn the claimant of the consequences of the failure to document impairments. The attorney can only describe to the claimant what type of documentation is needed, but it is up to the claimant to act upon the attorney's advice

Medicaid or other insurance coverage is almost essential in allowing claimants to obtain the necessary medical documentation of impairments. SSA requires more proof than may be needed initially by the treating practitioner who may make an empirical diagnosis and treat the symptoms without going through the full diagnostic protocol. Insurance providers are not in the business of assisting claimants in Social Security claims; the diagnostic procedures sought must be reasonable and medically justified and ordinarily must be ordered by the medical practitioner.

Step Two of the sequential evaluation is described in **20 C.F.R. 404.1520(a)(4)(ii)**, **20 C.F.R. 416.920(a)(4)(ii).** Once established, the impairment or combination of impairments must be found to be "severe", that is, **"must significantly limit physical or mental ability to perform basic work activities".** Basic physical work activities include walking, standing, sitting, lifting, pushing, pulling, reaching, carrying, or handling, capacities for

seeing, hearing, speaking. Basic mental work activities include understanding, carrying out and remembering simple instructions, using judgment, responding appropriately to supervision, coworkers, and usual work situations, and dealing with changes in a routine work setting. The impairments must have lasted or be expected to last for at least 12 months.**20 C.F.R. 404.1521-404.1523**, **20 C.F.R. 416.921-416.923**.

Unrelated impairments cannot be combined in order to satisfy the one year duration requirement. For instance, consider the following: an automobile accident causes a severe incapacitating injury and the person recovers from the particular injury in 8 months, but a second automobile accident occurs 7 months after the first accident and causes a different incapacitating injury. SSA would consider that the impairments were not related and at the end of 12 months no severe impairment would be present which met the duration requirement. The second injury would have to last at least seven more months before it could be found that the person had a severe impairment which met the duration requirement. In concurrent impairments, the combination of impairments must be "severe" and continue for at least 12 months. In determining whether a combination of impairments is severe, SSA considers the combined effect of all impairments without regard to whether an impairment considered separately would be of sufficient severity. If an impairment or combination of impairments is found "severe", these must be considered throughout the disability determination process at each subsequent step in the sequential analysis. **20 C.F.R. 404.1523**, **20 C.F.R. 416.923**. The failure to consider severe impairments or combination of impairments at subsequent steps of the evaluation process often arises on appeal, when the ALJ has found a severe impairment at Step Two but fails to include functional limitations due to the impairment in the residual functional capacity [RFC] used at steps four and five.

E. Step Three. Meeting or Equaling a Listing

At the third step the medical evidence is evaluated to determine if any impairment or combination of impairments meets or equals any of the Commissioner's Listings. **20 C.F.R. 404.1520(a)(4)(iii)**, **20 C.F.R. 416.920(a)(4)(iii)**. The Listings are intended to describe impairments of a level of severity that preclude the performance of any gainful activity irrespective of the person's age, education or work experience. Thus, if a person's impairment is found to meet or equal a listing, he is presumed to be

disabled and no further inquiry is necessary.

An acceptable medical source within DDS, a state agency physician or psychologist, reviews the objective medical evidence of record [MER] and opines whether a listing is met or equaled. **20 CFR 404.1526(e)**, **20 CFR 416.926(e).** Many of the listings are extremely detailed and require understanding of medical technology and testing procedures. The Commissioner will not find that the medical evidence of an impairment meets a listing unless the evidence reveals that the listing is met exactly as written and all required criteria of the listing are satisfied. **20 CFR 404.1525(c)(3)**, **20 CFR 416.925(c)(3).**

1. Meeting a Listing

The Adult Listings are found in **Part A of Appendix 1 to Subpart P of Part 404, following 20 C.F.R. 404.1599**. The listings pertain to both Title II and Title XVI [SSI] claims but are found in Part 404 which pertains to wage-earner claims for disability. There are introductory sections to each broad category of impairments which include important and very detailed information regarding the requirements for meeting the individual listings within that category. Appendix 1 contains categories as follows:

1.00 Musculoskeletal System
2.00 Special Senses and Speech
3.00 Respiratory System.
4.00 Cardiovascular System.
5.00 Digestive System.
6.00 Genitourinary Disorders.
7.00 Hematological Disorders.
8.00 Skin Disorders.
9.00 Endocrine Disorders
10.00 Congenital Disorders That Affect Multiple Body Systems.
11.00 Neurological.
12.00 Mental Disorders.
13.00 Malignant Neoplastic Disorders.
14.00 Immune System Disorders.

SSA has published rulings to establish guidelines for establishing some common medical impairments for which no listing exists. See, for

instance, **SSR 99-2p** for Chronic Fatigue Syndrome, **SSR 00-3p** and **SSR 02-1p** for Obesity, and **SSR 12-2p** for Fibromyalgia.

2. Equaling a Listing

In the event that a listing is not met exactly as written, an impairment may be found to "medically equal" a listing in one of three ways:

1. There is a listed impairment but one or more of the specified findings is not present, or

2. There is a listed impairment and all of the listed findings are present, but one or more of the findings are not as severe as specified in the listing, or

3. An impairment or combination of impairments that is not listed, but the criteria of the most closely analogous listed impairment[s] are approximated.

In each of these situations, a finding of medical equivalence may be made by a physician who opines that the impairment or combination is nevertheless of equal medical significance to that described in the criteria for any listing. **20 C.F.R. 404.1526.** At the initial and reconsideration levels, the State Agency or other designee of the Commissioner has the responsibility for making the determination at Step Three. At the hearing level, the ALJ may call one or more medical expert witnesses to testify regarding whether or not a listing is met or equaled.

In **SSR 96-5p** the Commissioner states:

"Whether the findings for an individual's impairment meet the requirement of an impairment in the listings is usually more a question of medical fact than a question of medical opinion....In most instances the requirements of listed impairments are objective, and whether an individual's impairment manifests these requirements is simply a matter of documentation...When a treating source provides medical evidence that demonstrates that an individual has an impairment that meets a listing and the treating source offers an opinion that is consistent with this

evidence, the adjudicator's administrative finding .....will generally agree with the treating source's opinion..."

.....

"A finding of equivalence involves more than findings about the nature and severity of medical impairments. It also requires a judgment that the medical findings equal a level of severity set forth in 20 CFR 404.1525(a) and 416.925(a); i.e., that the impairment(s) is ' * severe enough to prevent a person from doing any gainful activity'. This finding requires familiarity with the regulations and the legal standard of severity set forth in 20 CFR 404.1525(a), 404.1526, 416.925(a), 416.925(a), and 416.926."**

In **SSR 96-6p** the Commissioner states that:

"An updated medical expert opinion must be obtained by the administrative law judge or the Appeals Council before a decision of disability based on medical equivalence can be made."

The ruling indicates that the ALJ and Appeals Council are bound by the previous DDS "expert opinions" at the initial and reconsideration levels that a listing is not equaled, unless a new medical opinion otherwise is obtained. The ALJ and Appeals Council analysts, not being physicians or psychologists, lack the medical expertise to make the finding of equivalence to a listing, although they can make a finding that a listing is met based upon factual documentation of listing criteria in the record.

3. Non-Agency Opinions on Equaling a Listing

SSA does not appreciate receiving an opinion from a non-agency physician on the issue of medical equivalence, as the Commissioner prefers an opinion from a medical expert from the agency roster of approved experts on the basis that other physicians are not familiar with the legal requirements for equaling a listing. However, the attorney can make sure that the doctor is properly informed and that copies of the listing and applicable introductory sections are provided to the physician. Although the non-agency opinion on equaling a listing is an opinion on an "issue reserved to the Commissioner" pursuant to **SSA 96-5p**, the ALJ risks reversal of the decision if a properly structured opinion from a non-agency physician is

disregarded or given no weight.

A helpful opinion would cite the diagnostic tests and/or clinical signs supporting the listed diagnosis or combination, cite the criteria of the pertinent or analogous listing that are present, opine that the listing is not met, explain why the medical condition is nevertheless as medically severe as described in the listing, and conclude that for a least a year due to the listed impairment the person has not been or will not be capable of performing any work activity. The Commissioner is not bound by any medical opinion on an "issue reserved to the Commissioner". However, such an opinion should normally be afforded more weight according to the Commissioner's instructions for evaluating medical opinions in **20 CFR 404.1527(c)** and **20 CFR 416.927(c)** than those of the non-examining state agency physicians at the initial and reconsideration levels, and if properly supported possibly more weight than contradictory testimony by an agency medical expert at the hearing.

4. Evaluating Mental Listings

There is a special method required by the regulations to evaluate mental impairments at Step Three. **20 CFR 404.1520a**, **20 CFR 416.920a.** At the initial and reconsideration level DDS obtains from the non-examining state agency psychologists or physicians, an opinion regarding whether there is a severe mental impairment[s] and whether the mental impairment meets or equals any of the mental listings. The opinion is obtained on a special form, the Psychiatric Review Technique Form [PRTF] , Form **SSA- 2506-BK** (6-2001). If the PRTF form includes only "mild" or "none" limitations in the B category, the form does not indicate that a "severe" mental impairment exists and the evaluator does not have to complete a Mental RFC form at the initial or reconsideration level. If the PRTF form finds at least moderate limitation in one of the B factors, a "severe" mental impairment is present and the DDS evaluator must complete an MRFC form for use at Steps Four and Five of the sequential evaluation.

Section 12.00 of Appendix 1 Medical Listings lists the categories of Mental Disorders and the criteria that "meet" a listing. Meeting a listing is deemed to be impaired sufficiently severely as to prevent performance of gainful activity:

12.2 Organic Brain Disorders
12.3 Schizophrenic, Paranoid, and Other Psychotic Disorders
12.4 Affective Disorders
12.5 Intellectual Disability
12.6 Anxiety Related Disorders
12.7 Somatoform Disorders
12.8 Personality Disorders
12.9 Substance Addiction Disorders

Part A of the PRTF is the diagnostic section of the form which inquires as to each category of mental disorders above. The evaluator identifies the signs and symptoms of the impairment[s] that are deemed diagnostic of that impairment.

The listings each state what is necessary to meet that listing. Part B of the PRTF is the evaluators opinion as to whether the listing is met and requires evaluation of four aspects of broad functioning:

1. Activities of Daily Living
2. Maintaining Social Functioning
3. Maintaining Concentration, Persistence and Pace
4. Repeated Episodes of Decompensation, each of extended duration.

Many of the listings are met if at least two of the four categories are assessed at the "Marked" level of limitation or one level at the "Extreme" level. Listing 12.05 for Intellectual Disorders has somewhat different requirements for meeting a listing.

Part C of the form is intended to cover disabling mental impairments when the B factors have not been met but. The claimant may equal a listing when treatment has occurred which has caused the severity of limitations to improve to less than the marked or extreme level of severity but there are still more than minimal mental work limitations and when the fragility of the claimant is such that despite improvement with treatment, the person is nevertheless deemed unable to work. C factors for Listing 12.02, 12.03, and are:

1. Repeated episodes of decompensation, each of extended duration.
2. Such marginal adjustment that even a minimal increase in mental

demands or change in the environment would be predicted to cause the individual to decompensate.

3. One or more years' inability to function outside a highly supportive living arrangement with a continued need for such an arrangement.

The C factor for Listing 12.06 is: Complete inability to function outside the area of one's home.

At the ALJ level, the PRTF form does not have to be completed by the ALJ, but the decision must incorporate the pertinent findings and conclusions into the decision based upon the technique as described in **20 CFR 404.1520a** and **20 CFR 416.920a**, which is reflected in the PRTF.

If the claimant's medical condition does not meet or equal a listing, the inquiry continues.

F. Residual Functional Capacity.

Before Steps Four and Five of the sequential analysis can be performed, the adjudicator must determine the claimant's residual functional capacity [RFC]. The RFC is made up of specific work limitations and is largely determinative of the outcome at Steps Four and Five. A bare diagnosis of a medical condition is generally insufficient to demonstrate what actual work limitations result from that condition. Often treatment records are inadequate to identify claimant's functional limitations, as the medical or psychological practitioner does not need to evaluate functional capacity for work in order to treat the patient. The limitations must be gleaned by the adjudicator from the totality of the evidence. The attorney must play an active role in assisting the claimant to identify and prove the functional limitations caused by medical/psychological impairments.

1. Definition of RFC

RFC is defined as:

"the most you can still do despite your limitations." ...

"We will consider all of your medically determinable impairments of which we are aware, including your medically determinable

impairments that are not severe, when we assess your residual functional capacity". 20 CFR 404.1545, 20 CFR 416.945.

2. Sustained Work Activity

SSA determines the capacity to perform sustained work activity for a 40 hour week for 8 hours 5 days a week, or an equivalent work schedule, with normal breaks, performed in an ordinary work setting. There are potentially both physical and mental work limitations which must be considered in determining the RFC. In the absence of any allegation or evidence of a limitation of a particular work function, the adjudicator must consider that none exists. The limitations must be affirmatively established. **SSR 96-8p**.

3. DDS Assessment of Physical RFC

DDS state agency non-examining doctors and psychologists review the evidence in the file at the initial and reconsideration levels and prepare RFC assessment forms for the physical and/or mental impairments that are deemed "severe".

The work functions and severity definitions in the physical RFC are derived from the **Dictionary of Occupational Titles**, published by the U.S. Department of Labor and available on-line and its companion publication, **Selected Characteristics of Occupations Described in the Dictionary of Occupational Titles, "the SCO"** and reflected in the DDS Physical RFC form, Form **SSA-4734-BK** (12-04). The Commissioner has by regulation adopted these reference publications as evidence of the types and demands of jobs in the national economy. **SSR 00-4p.**

"Exertional limitations" are addressed first: limitations in the seven basic work functions used to classify jobs into the four exertional categories of sedentary, light, medium and heavy to very heavy work. The seven basic exertional functions are the ability to sit, stand, walk, lift, carry, push and pull. "Occasional" ability to perform the function means from very little up to 1/3 of an 8 hour workday. "Frequent" ability to perform the function means from 1/3 to 2/3 of an 8 hour workday.

On the basis of these seven exertional limitations one may determine

the highest exertional category of work that the individual could be expected to sustain for an 8 hour day and 40 hour week with normal breaks based upon the **DOT** definitions of:

1. Sedentary work. Lifting no more than 10 pounds, sitting most of the time and walking and standing occasionally.
2. Light work. Lifting no more than 20 pounds, frequently lifting 10 pounds, a good deal of walking and standing, or sitting most of the time with some pushing and pulling of arm or leg controls.
3. Medium work. Lifting no more than 50 pounds, frequent lifting or carrying up to 25 pounds.
4. Heavy work. Lifting no more than 100 pounds, frequent lifting or carrying up to 50 pounds.
5. Very heavy work. Lifting more than 100 pounds with frequent lifting or carrying 50 pounds or more. **20 CFR 404.1567**, **20 CFR 416.967**.

After determining the exertional limitations, the RFC form requires the evaluator to identify any "non-exertional" limitations which may be present and to assess the degree of severity of each limitation.

1 Limitations in sitting, standing, or walking due to the need to periodically alternate sitting and standing or carry a medically required hand-held assistive device necessary for ambulation.
2. Postural limitations: climb, balance, stoop, kneel, crouch, crawl.
3. Manipulative limitations: reach, handle, finger, feel.
4. Sensory limitations: see, hear, speak.
5. Environmental limitations: extreme heat, extreme cold, wetness, humidity, noise vibration, fumes -dust-odors, etc., hazards such as hazardous machinery and heights.

4. DDS Assessment of Mental Capacity

The Mental Residual Functional Capacity Form is also organized in terms of basic work functions which are involved in the performance of most jobs. Form **SSA-4734-F4-SUP** (8-85). The functional limitations are rated in terms of Not significantly limited, Moderately limited, Markedly limited, No evidence of limitation in this category, Not ratable on available evidence. The limitations are as follows:

1. Ability to understand, remember locations and work-like procedures.
2. Ability to understand and remember very short and simple instructions.
3. Ability to understand and remember detailed instructions.
4. Ability to carry out very short and simple instructions.
5. Ability to carry out detailed instructions.
6. Ability to maintain attention and concentration for extended periods.
7. Ability to perform activities within a schedule, maintain regular attendance, and be punctual within customary tolerances.
8. Ability to sustain an ordinary routine without special supervision.
9. Ability to work in coordination with or proximity to others without being distracted by them.
10. Ability to make simple, work-related decisions.
11. Ability to complete a normal workday and workweek without interruptions from psychologically based symptoms and to perform at a consistent pace without an unreasonable number and length of rest periods.
12. Ability to interact appropriately with the general public.
13. Ability to ask simple questions or request assistance.
14. Ability to accept instructions and respond appropriately to criticism from supervisors.
15. Ability to get along with coworkers or peers without distracting them or exhibiting behavioral extremes.
16. Ability to maintain socially appropriate behavior and to adhere to basic standards of neatness and cleanliness.
17. Ability to respond appropriately to changes in the work setting.
18. Ability to be aware of normal hazards and take appropriate precautions.
19. Ability to travel in unfamiliar places or use public transportation.
20. Ability to set realistic goals or make plans independently of others.

The combination of the physical and mental limitations assessed at the initial and reconsideration levels by means of these forms represents Social Security's official RFC findings at these decisional levels. These forms are incorporated into the Disability Determination Explanations found in the A section of the electronic hearing file which sets forth the sequential

evaluation performed by DDS at the initial and reconsideration levels. The ALJ decision will include the ALJ's own assessment of RFC as part of the sequential analysis forming the basis of the decision.

G. Step Four. Ability to Perform Past Relevant Work.

At the fourth step of the Sequential Analysis the adjudicator must decide whether in view of the individual's RFC, the individual could perform any past relevant work.

> **"We will first compare our assessment our assessment of your residual functional capacity with the physical and mental demands of your past relevant work..."20 CFR 404.1560(b).**

An exception:

"If we do not have sufficient evidence about your past relevant work to make a finding at the fourth step, we may proceed to the 5th step...If we find that you can adjust to other work based solely on your age, education, and the same residual functional capacity assessment..., we will find that you are not disabled." 20 CFR 404.1520(h)**,** 20 CFR 416.920(h).

Otherwise when information regarding past work is available:

"Past relevant work is work that you have done within the past 15 years, that was substantial gainful activity, and that lasted long enough for you to learn to do it." 20 CFR 404.1560(b)(1), **20 CFR 416.960(b)(1)....**

"We will ask you for information about work you have done in the past. We may also ask other people who know about your work...We may use the services of vocational experts or vocational specialists, or other resources such as the "Dictionary of Occupational Titles" and its companion volumes and supplements, published by the Department of Labor, to obtain evidence we need to help us determine whether you can do your past relevant work, given your residual functional capacity." 20

CFR 404.1560(b)(2), 20 CFR 416.960(b)(2).

When a claimant files a disability claim under Title II or a Title XVI SSI disability claim, the Disability Report is completed by the claimant who informs SSA whether there has been work performed in the past 15 years and if so, whether more than one job has been performed. If so, the claimant is asked to complete a **Work History Report, Form SSA-3369-BK** (04-2011) upon which claimant is asked to list the job titles, types of businesses, and dates worked on the first page, and then to describe the demands of each job individually by checking off descriptors such as the pay rate, whether full or part-time, the skill level, exertional and non-exertional requirements, and any supervisory duties performed.

The agency also possesses electronic records related to the claimant's work history: **Summary Earnings Query (SEQY), Detailed Earnings Query (DEQY), Informational Earnings Record Estimate (ICERS Function 3) and Disability Insured Status Calculator Online (DISCO).** Through these reports, a work history can be reconstructed to include yearly wages from each employer and quarters worked, sometimes quarterly earnings. Nevertheless, SSA usually does not have available on these forms the necessary information to determine the job titles or demands of the jobs or in close cases, whether SGA was performed, needed at Step Four.

Although claimants' memories are sometimes insufficient to be able to accurately list all the employers and dates of employment on the Work History Report, the attorney can later use the agency earnings reports to refresh the claimant's memory, and most claimants will be able to recall the particular job and to describe it sufficiently at the hearing. At the initial and reconsideration levels, it is not unusual for an agency vocational consultant to contact a claimant by telephone to elicit further information about employment. The information sought and the information obtained from the claimant are noted on a "Contact" form signed and dated by the consultant and made a part of the file in the "E" exhibits.

1. Legal Standards for Evaluating Past Relevant Work

The Rulings give further guidance in evaluating past relevant work. **SSR 82-61** provides SSA's policy statement:

"...A claimant will be found 'not disabled' when it is determined that he or she retains the RFC to perform:

1. **The actual functional demands and job duties of a particular past relevant job; or**
2. **The functional demands and job duties of the occupation as generally required by employers throughout the national economy...."**

.....

"There may be cases involving significant variations between a claimant's description and the description shown in the DOT... Employer contact or further contact with the claimant may be necessary to resolve such a conflict. Also composite jobs have significant elements of two or more occupations and, as such, have no counterpart in the DOT. Such situations will be evaluated on the particular facts of each case....it may be necessary to utilize the services of a vocational expert." SSR 82-62 provides that:

> **"An individual who has worked only sporadically or for brief periods during the 15 year period, may be considered to have no relevant work experience."**

The ruling also indicates that determining relevancy of past work requires evaluation of 1. SGA, 2. Duration, and 3. Recency. The 15 year period is generally the 15 year period prior to the adjudication, or the 15 year period prior to the date last insured when that is an issue. The ruling provides:

"In finding that an individual has the capacity to perform a past relevant job, the determination or decision must contain among the findings the following specific findings of fact:

1. **A finding of fact as to the individual's RFC.**
2. **A finding of fact as to the physical and mental demands of the past job/occupation.**
3. **A finding of fact that the individual's RFC would permit a return to his or her past job or occupation." SSR-82-62.**

2. Developing Evidence of Past Relevant Work

Sometimes it will be perfectly plain that past relevant work cannot be performed, such as when the claimant has been employed for the last 15 years as a coal miner at the heavy level and is now restricted to light or sedentary work. DDS may have already found at the initial and reconsideration levels that past work could not be performed. In such cases, little effort need be expended at Step Four. Unless surprises are encountered in vocational expert testimony at the hearing, this is not a stumbling block to the claim.

On the other hand, the issue arises when the past work was sedentary, such as employment as a sedentary security guard or as a receptionist or secretary and DDS has assessed the claimant's physical RFC as light or sedentary. There will need to be particular care in researching the details of the past jobs with the particular employer and in the DOT/SCO in order to determine in advance of the hearing the particular demands of the past job as claimant actually performed it and as it is usually performed. The jobs may be inconsistent with the claimant's RFC because of job requirements not adequately considered by DDS or because claimant's RFC is more restrictive than found by DDS. The demands of past work are of particular importance when it required higher education and/or was highly skilled and performed at the sedentary level. When the exertional RFC does not rule out past work any mental or manipulative impairments assume greater importance to the case. A severe impairment may currently restrict the claimant to a mental RFC that permits only unskilled work. Any undocumented manipulative limitations will certainly need to be documented and properly assessed because sedentary jobs usually require considerable reaching, handling, and/or fingering and any significant limitations in those functions added to the RFC might well rule out the past work.

H. Step Five. Whether Claimant Can Perform Other Work.

1. The Commissioner's Burden of Proof

The Social Security Act provides:

"A person is under a disability only if his physical or mental impairment or impairments are of such severity that he is not only unable to do his previous work but cannot, considering his age, education, and work experience, engage in any other kind of substantial gainful work which exists in the national economy...For purposes of the preceding sentence (with respect to any individual), 'work which exists in the national economy' means work which exists in significant numbers either in the region where such individual lives or in several regions of the country." 42 USC §423(d)(2)(A).

When the claimant has demonstrated medical impairments which prevent the performance of past relevant work, the burden shifts to the Commissioner of going forward with proof that the claimant considering his age, education, work experience, skills, and physical shortcomings has the capacity to perform an alternate job and that this type of job exists in the national economy. **Hall v. Harris, 658 F. 2d 260, 264 (4th Cir.1981)** and more recently, **Hines v. Barnhart, 453 F.3d 559, 563 (4th Cir. 2006)**, see also **Pinion v. Colvin, USDC, MDNC, CA 1:10cv58, Memorandum Opinion and Order, 12/31/13.**

The Commissioner can meet this burden by proper reference to the Medical-Vocational guidelines set forth in **20 CFR Part 404, Subpart P, Appendix 2. Heckler v. Campbell, 461 U.S. 458, 461, 103 S. Ct. 1952, 1954 (1983).** These guidelines are commonly referred to as "The Grids".

The guidelines provide an ALJ with administrative notice of classes of jobs available in the national economy for person who have certain characteristics such as strength [exertional] limitations. However, the guidelines do not take into account nonexertional limitations such as pain, loss of hearing, loss of manual dexterity, postural limitations, and pulmonary impairment. **Grant v. Schweiker, 699 F. 2d 189, 192 (4th Cir. 1983)** When non-exertional limitations such as these occur in conjunction with exertional limitations, the guidelines are not to be treated as conclusive. **Roberts v. Schweiker, 667 F. 2d 1143 (4th Cir. 1981), Coffman v. Bowen, 829 F.2d 514 (4th Cir. 1987).**

The Medical-Vocational Guidelines are found in **Appendix 2 to Subpart P of Part 404 of the regulations** following **Appendix 1 to Subpart**

P of Part 404 of the regulations, which in turn follows **20 CFR 404.1599**. The guidelines are based upon exertional categories of work described in the **DOT** and are generally structured so that persons with higher educational and work skills are found able to adjust more easily to other work and found disabled at older ages than those with lower educational and work skills.

Those with lower educational and work skills who have performed past medium and heavy work are felt less able to adjust to other employment and are found disabled at earlier ages when restricted to light or sedentary work. appendix 2 is organized with tables ["grids"]:

> §201.00 Table 1-Residual Functional Capacity: Maximum Sustained Work Capability Limited to Sedentary Work
>
> §202.00 Table 2-Residual Functional Capacity: Maximum Sustained Work Capability Limited to Light Work
>
> §203.00 Table 3-Residual Functional Capacity: Maximum Sustained Work Capability Limited to Medium Work
>
> §204.00 Maximum sustained work capability limited to heavy or very heavy work. No table.

2. When the Grids are Used as a Framework

When the findings of fact show that the claimant has only exertional limitations and can perform substantially the full range of work in a given exertional category, the Medical-Vocational Guidelines can be used to direct a conclusion of disabled or not disabled. **20 CFR Part 404, Subpart P Appendix 2, §202.00**. **SSR 83-11.**

Unless the findings of fact coincide with all of the criteria in one of the "grid rules", the grids cannot be used to direct a finding of non-disability. The rules are based on exertional limitations alone. The term "exertional" has the same meaning as in the **DOT** and **SCO;** occupations are classified as sedentary, light, medium, heavy and very heavy according to the degree of primary strength requirements of the occupations which consist of three work positions, sitting standing and walking, and four worker movements, lifting, carrying, pushing, and pulling. These seven functions are the only exertional functions. **SSR 83-14.**

Any functional or environmental limitation which is not exertional is non-exertional. A non-exertional impairment is one which causes a non-exertional limitations of function. In the **SCO**, occupations are described in terms of demands for certain physical activities- climbing, balancing, stooping, kneeling, crouching, crawling, reaching, handling, fingering, feeling, talking, hearing, seeing. They are also rated for environmental conditions, such as humidity, dust, noise, pollutants, danger. These are non-exertional limitations. Mental activities are also non-exertional. **SSR 83-14.** In the Fourth Circuit pain can be a non-exertional impairment. **Walker v. Bowen, 889 F. 2d 47, 49 (4th Cir. 1989)**.

SSR 83-14 provides that when there are both exertional and non-exertional limitations in the RFC, the exertional capacity is used first to determine whether the person would be disabled under the grid rules on the basis of exertional limitations alone. If so, the grids may be used to direct a conclusion that the person is disabled. However, if the grid rules would not direct a conclusion of "disabled" then the rule is used as a framework and the non-exertional impairments must be considered in order to determine their impact in narrowing the range of jobs that the rules would otherwise show could be performed.

3. When Vocational Expert Testimony is Required

In the Fourth Circuit, a vocational expert must be called to give testimony at the hearing regarding the existence of and numbers of jobs that may exist that the claimant could perform despite the non-exertional impairments. **Grant v. Schweiker, 699 F. 2d 189, 192 (4th Cir. 1983).** Because of the above, virtually every case in West Virginia has a vocational expert called to the hearing.

Although there is existing case law in the Fourth Circuit that the testimony of the vocational expert should be based upon consideration of all of the medical evidence in the record and not just the testimony of the claimant, **Walker v. Bowen, 889 F. 2d 47, 49 (4th Cir. 1989),** currently ODARs in West Virginia are sending only the "E" exhibits to the vocational expert, which section does not include medical records. The VE is not allowed to make independent medical judgments outside his or her range of expertise. VE opinion is limited to characterizing the claimant's past work

activity for purposes of Step Four and at Step Five to identifying transferable skills and answering hypothetical questions identifying the types and numbers of jobs present in the national or regional economy for persons with claimant's impairments. Some judges do not want to allow the VE to hear the testimony of the claimant.

4. The Testimony of the Vocational Expert

The Commissioner has instructed that the opinions of the State Agency non-examining physicians are to be considered as expert opinion evidence and must not be ignored. **SSR 96-6p.** The ALJ must explain in the decision the weight afforded these opinions. At the hearing the ALJ usually begins the inquiry regarding other jobs that claimant might be able to perform by asking a hypothetical question based upon the DDS examiners' RFC and MRFC forms. Significant numbers of jobs will probably be identified. Some judges stop the questioning at this point and leave it to the attorney to ask hypothetical questions based upon treating source opinion[s], if available and evidence of more severe limitations than included in the DDS RFC and MRFC.

Many times the VE is asked to evaluate limitations which are not included in the **DOT/SCO** descriptions of jobs. For instance, the DOT does not describe a sit/stand option, does not distinguish between different types of reaching, and does not consider the impact of assistive devices which may be necessary. In that event, the VE opinion if given is at variance with the **DOT. SSR 00-4p** states that the ALJ must affirmatively inquire each time a vocational expert testifies, whether or not the testimony is consistent with the DOT. When vocational expert testimony at the hearing is at variance with the DOT or SCO, the ALJ must elicit an explanation from the VE to resolve the conflict. Neither the **DOT** nor the VE automatically trumps in such a situation. The ALJ must determine if the explanation given by the VE is reasonable and provides a basis for relying on the VE testimony rather than on the **DOT.**

In the Fourth Circuit long-standing precedent provides that in order for the testimony of a vocational expert to satisfy the Commissioner's burden of proof that there are other jobs that the impairment claimant could still perform, the hypothetical question relied upon must fairly include all of the claimant's impairments as supported by the record. See, for instance,

Walker v. Bowen, 889 F. 2d 47, 50-51 (4th Cir. 1989).

This concludes the sequential evaluation process for adults. If jobs cannot be identified in significant numbers that the claimant can still perform, a finding of disabled is appropriate.

VI. The Five Step Sequential Evaluation for Children.

Previously children were not found to be disabled unless an impairment[s] was demonstrated at the severity which met or equaled a medical listing of Appendix 1(B) of Part 404, subpart P of the regulations in which the children's medical listings are found. There was no justification for holding children to a stricter standard of disability than adults, and a process which allowed a functional assessment for children was added to the childhood sequential analysis. There are no grid rules for children. The functional limitations for children are assessed according to broad "domains" in which standards of severity vary according to the child's ability to perform age-appropriate functions identified for each domain.

The sequential analysis of disability for children is found in the SSI regulations at **20 CFR 416.924** which provides that the steps are:

1. Whether the child is working and performing substantial gainful activity [SGA]. If yes, the child is found not disabled and the inquiry ends. If no, the inquiry proceeds to the next step.
2. Whether the child has a medically determinable "severe" impairment that has lasted or expected to last for at least 12 months or is permanent, which causes more than minimal functional limitations. If no, the child is found not disabled and the inquiry ends. If yes, the inquiry proceeds to the next step.
3. Whether the child's medically determinable impairments meet all of the criteria of one of the medical listings of Appendix 1. If yes, the child is found disabled and the inquiry ends. If no, the inquiry proceeds to the next step.

4. Whether the child's medically determinable impairments are medically equal to one of the medical listings of Appendix 1. If yes, the child is found disabled and the inquiry ends. If no, the inquiry proceeds to the next step.

5. Whether the child's medically determinable impairments "functionally equal a listing" due to "Marked and Severe" functional limitations.

SSA considers all evidence in the case record - from acceptable medical sources, other medical sources, non-medical sources such as parents, caregivers, teachers, social programs in which the child participates such as early intervention, preschool programs and special education, and from other people who know the child. **20 CFR 416.924a.**

A. Step One. Whether the Child is Working.

SSA applies the usual standards for adults in order to determine if a child's earnings are Substantial Gainful Activity [SGA]. **20 CFR 416.971-416.976.**

B. Step Two. Whether there is a Severe Impairment.

SSA applies the usual standard for adults in order to determine if the child has a severe medically determinable impairment that meets the duration requirements. A "medically determinable physical or mental impairment" is an impairment that results from anatomical, physiological, or psychological abnormalities which can be shown by medically acceptable clinical and laboratory diagnostic techniques. A physical or mental impairment must be established by medical evidence consisting of signs, symptoms, and laboratory findings - not only by the individual's statement of symptoms. **20 CFR 416.924(c), 416.908**, **SSR 96-4p**.However, childhood areas of function are quite different from adults, as discussed below.

C. Step Three. Whether a listing is met.

SSA applies the usual standards for adults in order to determine that a listing is met. A DDS physician or psychologist, reviews the objective medical evidence of record [MER] and opines whether a listing is met. The Commissioner will not find that the medical evidence of an impairment meets a listing unless the evidence reveals that the listing is met exactly as written and all required criteria of the listing are satisfied. **20 CFR 416.925(b)(3).**
The childhood listings in Part B are used first, and if the diagnostic criteria apply but the listing criteria are not satisfied, the corresponding adult listings

in Part A are then considered. **20 CFR 416.925(b)(2)(I)**.

The childhood listings are found in **Part B of Appendix 1 to Subpart P of Part 404. Appendix 1** follows **20 CFR 404.1599**.

100.00 Growth Impairment.
101.00 Musculoskeletal System.
102.00 Special Senses and Speech.
103.00 Respiratory System.
104.00 Cardiovascular System.
105.00 Digestive System.
106.00 Genitourinary Impairments.
107.00 Hematological Disorders.
108.00 Skin Disorders.
109.00 Endocrine Disorders.
110.00 Congenital Disorders That Affect Multiple Body Systems.
111.00 Neurological.
112.00 Mental Disorders.
113.00 Malignant Neoplastic Disorders.
114.00 Immune System Disorders.

D. Step Four. Whether a Listing is Medically Equaled.

The Commissioner applies the usual standard for adults in determining whether a listing is medically equaled. **20 CFR 416.926(a).** In the event that a listing is not met exactly as written, an impairment may be found to "medically equal" a listing in one of three ways:**20 CFR 416.926(b)**.

1. There is a listed impairment but one or more of the specified findings is not present, or

2. There is a listed impairment and all of the listed findings are present, but one or more of the findings are not as severe as specified in the listing, or

3. An impairment or combination of impairments that is not listed, but the criteria of the most closely analogous listed impairment[s] are approximated.

In each of these situations, a finding of medical equivalence may be made by a physician who opines that the impairment or combination is nevertheless of equal medical significance to that described in the criteria for any child or adult listing. **20 C.F.R. 404.1526 (b)**. At the initial and reconsideration levels, the State Agency, Hearing Officer in cessation cases, or other designee of the Commissioner has the responsibility for making the equivalency determination at Step Three. At the hearing level the ALJ has the responsibility for making the equivalency determination.**20 CFR 416.926(e)**. The ALJ may utilize a Medical Expert to assist in making the equivalency determination. **SSR 96-6p.**

E. Step Five. Whether a Listing is Functionally Equaled.

1. Marked and Severe Limitations

This step requires that a child have an impairment that results in "marked" limitations in at least two of the Childhood Domains of Function or an "extreme" limitation in one domain. **20 CFR 416.926a(a).** A "marked" limitation is defined as "interferes seriously" with the ability to "independently initiate, sustain, or complete activities...more than moderate but less than extreme". An "extreme" limitation when the impairment[s] interferes "very seriously" with the ability to "independently initiate, sustain, or complete activities...more than marked...but not necessarily a total lack or loss of ability to function" **20 CFR 416.926a(e).** SSA considers (1) How well the chlld initiates activities, how much extra help is needed, and the effects of structured or supportive settings. (2) How the child functions in school. (3) The effects of medications or other treatment.

2. Definition of "Marked"

From birth until age three: "Marked" means functioning at a level that is more than one half the level of the child's age group but less than two thirds. "Extreme" means functioning at one half the level of the child's age group.

From birth to age eighteen: "Marked" means a valid standardized test score two standard deviations or more below the mean but less than three standard deviations and day to day function in domain-related

activities consistent with the score. “Extreme” means a valid standardized test score that is three standard deviations or more below the mean and function in domain-related activities is consistent. SSA does not rely on test scores alone without evidence of the child’s functioning.

From birth to age eighteen in the Domain of “Health and Physical Well-being” SSA will find a “Marked” limitation if the child is frequently ill or has frequent exacerbations of the impairment[s] occurring on an average of 3 times a year lasting 2 weeks or more, or more often but lasting for shorter periods or less often lasting for longer periods. SSA will find an “Extreme” limitation if illness or exacerbation occurs substantially in excess of the frequency and duration required for a marked limitation.

3. **The Childhood Functional Domains**

The six domains of childhood functioning are:

1. Acquiring and using information
2. Attending and completing tasks.
3. Interacting and relating with others.
4. Moving about and manipulating objects
5. Self-care. [Including Safety Rules and Self-control issues]
6. Health and Physical Well-being. [Effect of Chronic Illness on Sustaining Function] **20 CRF 416.926a(b)(1)**.

At the initial and reconsideration levels State Agency doctors, psychologists, or in cessation cases the Hearing Officer, make the determination of medical equivalence. At the hearing level, the ALJ has the responsibility for making the determination of equivalence. **20 CFR 416.926(n).**

4. **Age-Appropriate Function**

In making determinations regarding the child’s function, Social Security considers how the child’s function compares with children in the same age group who do not have impairments. **20 CFR 416.926a(f)(1).**This can be of particular importance in the context of Special Education when the child is

graded on a curve or scored in comparison to other special education students. The critical functional inquiry requires comparison with non-special education students.

SSA has described in **20 CFR 416.926a** behavioral norms for the first five of the six domains that are considered age-appropriate for that particular domain in age categories for: newborn to age 1, age 1 to 3, age 3 to 6, age 6 to 12, and adolescents age 12 to 18. Examples of limited function are given at the end of each section. For the sixth domain, Health and physical well-being, examples are provided of typical functional limitations for all children and at the end, are a list of specific impairments and limitations that SSA will find functionally equal to a listing.

The Commissioner promulgated eight comprehensive rulings in 2009 to explain the "functional equivalence" step of the sequential analysis for children. These rulings are of essential importance to the attorney in representing child claimants. They are:

SSR 09-1p	Title XVI: Determining childhood Disability Under the Functional Equivalence Rule - the "Whole Child" Approach
SSR 09-2p	Title XVI: Determining Childhood Disability - Documenting a Child's Impairment-Related Limitations.
SSR 09-3p	Title XVI: Determining Childhood Disability - The Functional Equivalence Domain of "Acquiring and Using Information"
SSR 09-4p	Title XVI: Determining Childhood Disability - The Functional Equivalence Domain of "Attending and Completing Tasks"
SSR 04-5p	Title XVI: Determining Childhood Disability - The Functional Equivalence Domain of "Interacting and Relating with Others"
SSR 04-6p	Title XVI: Determining Childhood Disability - The Functional Equivalence Domain of " Moving About and Manipulating Objects"
SSR 04-7p	Title XVI: Determining Childhood Disability - The Functional Equivalence Domain of "Caring for Yourself"

5. The Childhood Disability Evaluation Form

At the time of filing the application, a Disability Report-Child **SSA-3820-BK** (08-2010) is completed, usually by the parent or the child's custodian. An Age-Appropriate **Function Report-Child** is also filled out, usually by the parent or custodian:

SSA-3375 (Age Birth to 1st Birthday),
SSA-3376 (Age 1 to 3rd Birthday),
SSA-3377 (Age 3 to 6th Birthday),
SSA-3378 (Age 6 to 12th Birthday),
SSA 337 (Age 12 to 18th Birthday).

The parent or custodian signs release forms for Social Security. If the child is not performing SGA the file is sent to the DDS examiner assigned to the claim also sends a very detailed Request for Administrative Records, **SSA-5666** to the school and sends also a Teacher Questionnaire, **SSA-5665-BK** (09-11**)** and asks that the person most familiar with the child complete the form. This is an extremely detailed questionnaire which elicits the opinion of the teacher on multiple specific performance areas within each of the six childhood domains which are rated on a five point scale from "No problem" to "A very serious problem". The teacher is instructed to compare the child's function with that of same-aged children who do not have impairments and if in special education to compare the child's function with unimpaired children in regular education.

The examiner also requests any medical information from the claimant's medical providers which was reported on the Disability Form or otherwise made known to DDS. The examiner may order consultative examinations if the information received is not felt adequate for a determination.

When the examiner concludes that the file is adequately developed, it is sent to a state agency non-examining physician for completion of the

Childhood Disability Evaluation Form, **SSA 538-F6** (10-04)**.** The form elicits information from the evaluator for steps two through five in the sequential evaluation for children as set out above, and concludes with a functional equivalence assessment in which the evaluator rates the limitations in each of the six childhood domains in terms of No limitation, Less than Marked, Marked, or Extreme. This form represents SSA's position at the initial level. A Disability Determination and Transmittal Form is completed and a Notice is sent to the claimant awarding or denying the claim.

A similar form is completed by a different DDS examiner at the reconsideration level after reviewing any new evidence. A Disability Determination and Transmittal form is prepared and a Notice of the reconsideration decision is sent to the claimant.

6. The Hearing

The judge may secure a Medical Expert witness to attend the hearing but is not required to do so. Usually the only persons in the room are the judge, the hearing assistant, the attorney, the child and a parent, guardian, or custodian of the child. The hearing is recorded. The ALJ makes an opening statements, admits the evidence and the parties are sworn. If the child is of an age to be able to answer questions at the hearing, the ALJ may choose not to administer an oath to the child if the judge believes that the child may not understand the significance of the oath or affirmation. In this situation the ALJ must impress upon the child the importance of telling the truth. The ALJ must state on the record that the witness was not sworn and why. **HALLEX I-2-6-54.** The attorney generally makes an opening statement which identifies the claimant's position in the case, informing the ALJ what is the basis of disability and which items of evidence, cited by exhibit and page number, support the claimant's position. Generally the ALJ will question the child first to the extent that the age and the condition of the child permits.

After questioning the child is usually instructed to leave the hearing room and wait in the reception area. Prior to the hearing the parent should secure the presence of another adult to supervise the child in the reception area while the hearing continues. The parent answers questions asked by the attorney and the judge and is permitted to ask questions and make any comments. Most often the attorney will have

some indication of the probable outcome of the case at the end of the hearing, although many judges do not inform the parties of the outcome at the time of the hearing.

7. Difficulties Encountered in Child's Disability Claims.

Few children seeking representation meet or medically equal a listing, as these have been awarded by DDS early in the claims. The vast majority involve the "functional equivalence" step of the process. These claims require a great deal of case development and documentation, much more than the average adult claim. Even though records are relatively recent in time, they tend to be difficult to acquire. The records from social service agencies are generally scattered among multiple agencies and providers.

School records are difficult to collect and update from a single source within the school system. Parents and children frequently disagree regarding the child's functioning. Reports from the child's teachers tend to vary widely in assessing functional limitations depending upon the subject taught and whether the teacher is a regular or special education teacher. Teachers may be reluctant to give opinions at all. Physicians are often unable or unwilling to complete functional equivalence assessment forms because of the difficulty in assessing the "whole child" across domains of function outside the physician's expertise and knowledge of the patient. Sometimes severely impaired claimants are rendered unattractive or are caused to exhibit obnoxious behaviors and attitudes which can make a bad impression upon the ALJ. Despite these impediments the author still represents childhood claimants but requires a high level of credibility of the claimant and parents, and doctors and/or school personnel "on board" from the outset.

VII. Evaluating Cases Involving Drug and Alcohol Addiction [DAA]

In 2013 SSA issued Ruling **SSR 13-2p: Titles II and SVI: EVALUATING CASES INVOLVING DRUG ADDICTION AND ALCOHOLISM** which rescinded the prior ruling **SSR 82-60**. The ruling is intended to consolidate provisions from the Social Security Act and other regulatory sources to explain SSA's policy. This ruling applies to both child and adult disability decisions for purposes of initial claims or continuing disability review. Rulings are binding at all decisional levels

within SSA, DDS, the ALJs and the Appeals Council. At the Court level SSA's decisions lack substantial support on judicial review if the decisional process is not in compliance with SSA's regulations and rulings and the error is found to be prejudicial. The ruling is available on the www.ssa.gov website and is much more detailed than set forth here.

The Act provides that claimants will not be considered disabled if alcoholism or drug addiction would be a "contributing factor material to the Commissioner's determination that the individual is disabled".**42 USC §223(d)(2)(c) and 42 USC 1614(a)(3)(J).**

This ruling instructs SSA adjudicators in the proper method of adjudicating claims involving DAA and provides a decisional framework. State agency non-examining physicians and/or psychologists or the reconsideration Hearing Officer in the case of cessation claims, make the determinations at the initial and reconsideration levels of decision. The ALJ or the Appeals Council is responsible for making the decision at the hearing level.

A. When the Materiality Analysis Must Be Performed.

If substance use is found to be a medically determinable impairment at Step 1, the first sequential evaluation is performed at Step 2 in which DAA is considered. If the person would be found disabled, and if DAA is not the only impairment at Step 3, a second sequential analysis is performed at Step 4 in which DAA is not considered. If claimant would again be disabled as the result of the second sequential evaluation, the adjudicator must complete Step 5 to determine whether any of the remaining impairments were caused or affected by DAA, and if so, must decide at Step 6 whether these would improve to the point of non-disability in the absence of DAA [remission]. If not, claimant is disabled and DAA is not a contributing factor material to the determination of disability.

SSA does not make a materiality determination if the claimant's has a history of DAA that is not relevant to the period under consideration.

B. Definition of Drug and Alcohol Addiction [DAA]

Drug and Alcohol Addiction [DAA] is defined by SSA as "Substance Use Disorders", that is, "Substance Dependence" or "Substance Abuse" (as defined in the latest edition of the **Diagnostic and Statistical Manual of Mental Disorders (DSM).** Nicotine use disorders are not included in SSA's definition of DAA and do not require a materiality finding although the DSM includes Nicotine Use Disorders in Substance Use Disorders. "Drug addiction" and "alcohol addiction" are terms that are medically outdated but which SSA continues to use because they are used in the Social Security Act. In general, DSM defines Substance Use Disorders as maladaptive patterns of substance use that lead to clinically significant impairment or distress. Substances Use Disorders listed in DSM include maladaptive use of alcohol, illegal drugs, prescription medications, and toxic substances (such as inhalants).

A claimant's occasional maladaptive use or a history of occasional prior maladaptive use of alcohol or illegal drugs does not establish that the claimant has a medically determinable Substance Use Disorder.

C. The Six Step DAA Materiality Evaluation

The ruling describes a six step analysis which potentially includes within it the requirement that two separate sequential analyses be performed. The first sequential analysis includes consideration of DAA as a medically determinable impairment. If this analysis results in a finding that the person would be disabled, then a second sequential analysis is performed without considering DAA as a medically determinable impairment. The DAA analysis is as follows:

1. Is DAA a medically determinable impairment?

DAA is not considered in the sequential evaluation of disability unless it is a medically determinable impairment.

2. Is the claimant disabled considering all medically determinable impairments including DAA? The first sequential analysis is performed [**20 CFR 404 1520, 20 CFR 416. 920b** or in the case of a child, **20 CFR 416.924**]. If the claimant is not disabled, the claim is denied. If the

claimant is disabled, then the next step is evaluated.

3. Is DAA the only impairment? If yes, DAA is material to the finding of disability and the claim is denied. If no, the next step is evaluated.

4. Is the other impairment[s] disabling by itself while the claimant is still dependent upon or abusing drugs or alcohol? At this step a second sequential evaluation is performed in which DAA is not included as an impairment. If the other impairment[s] is not found to be disabling, DAA is material and the claim is denied. If the sequential analysis shows that the claimant would be disabled without considering DAA, the next step is evaluated.

5. Does the DAA cause or affect the claimant's other medically determinable impairments? If no, DAA is not material and claimant is disabled. If DAA does cause or affect other MDIs, DAA could be material and the next step is evaluated.

Note: The ruling indicates that an accident caused by driving intoxicated when severe resulting injuries are alleged as disabling, would be seen as a "cause" of the injuries by DAA and require a "yes" answer to this question. Also HIV resulting from sharing a needle for IV drug use would be seen as a "cause" of the HIV by DAA and require a "yes" answer. SSA looks at the behavior of DAA as the "proximate cause" other impairments acquired while using substance[s] as well as impairments which are "medically" caused by substance use.

6. Would the claimant's other impairment[s] improve to the point of non-disability in the absence of DAA? If yes, DAA is material and claimant is not disabled. If "No" the claimant is disabled.

The ruling is much more detailed than set forth here; readers are advised to refer to the ruling for more specific information.

VIII. Misconduct of Administrative Law Judges and Claimants' Attorneys

A. ALJ Misconduct.

In 2013 SSA issued **SSR 13-1p**, **"Titles II and XVI: Agency Processes for Addressing Allegations of Unfairness, Prejudice, Partiality, Bias, Misconduct, or Discrimination by Administrative Law Judges (ALJs)"**. The ruling states that there are three separate processes to guard against unfairness in the hearing process.

1. Appeals Council [AC] review process under which SSA reviews hearing decisions in accordance with **20 CFR 404.969-404.970** and **20 CFR 416.1469-416.1470** to ensure that ALJs fairly and impartially consider claims for benefits. The AC can act even when a party does not request review. The AC considers allegations under the standards of review set out in the above regulations:
   (1) Whether there is an abuse of discretion by the ALJ,
   (2) Whether there is an error of law
   (3) The actions, findings or conclusions of the ALJ are not supported by substantial evidence or
   (4) There is a broad policy or procedural issue that may affect the general public interest
   (5) There is new and material evidence that relates to the period prior to the ALJ decision and the case review shows that the ALJ's actions, findings, or conclusions are contrary to the weight of the evidence currently of record.

(2) The Division of Quality Service may review and, if warranted, investigate any complaints against an ALJ, including allegations of unfairness, prejudice, partiality, bias, or misconduct. Under this process, the Division of Quality Service evaluates allegations to determine whether it is necessary to recommend administrative or disciplinary action against an ALJ.

(3) Individuals who allege discrimination based on their race, color, national origin (including English language ability), religion, sex, sexual orientation, age, disability, or in retaliation for having previously filed a civil rights complaint,

may also file a separate discrimination complaint with SSA using the civil rights complaint process.

Under current regulations, an ALJ must not conduct a hearing if he or she is prejudiced or partial with respect to any party or has any interest in the pending matter. The ALJ will decide whether to proceed or withdraw. If the ALJ does not withdraw the claimant can present objections to the Appeals Council at the time of a Request for Review of the unfavorable decision of that judge.

An abuse of discretion occurs
(a) if the ALJ's action is erroneous and without any rational basis,
(b) is clearly not justified such as when the ALJ failed to allow the claimant to testify or cross-examine witnesses,
(c) when there is a failure to follow procedures required by law, or
(d) when the ALJ failed to recuse himself or herself if prejudiced or partial or having an interest in the pending matter.

The AC may remands the case to a different ALJ for a new hearing or revised decision pursuant to **20 CFR 404.940** and **20 CFR 416.1440.** The AC relies solely on information in the administrative record to determine an abuse of discretion and does not investigate or consider evidence that is not a part of the record. The sole remedy is a decision or remand.

If the Appeals Council receives a report of "general bias" or a pattern of bias or misconduct against a group or particular category of claimants, the Appeals Council will process the request for review and acknowledge the allegation in the notice, order, or decision, and will refer the matter to the Division of Quality Service[DQS]. Possible examples are "the ALJ is biased against claimants who receive workers compensation benefits or unemployment benefits" or "the ALJ is biased against women". The Appeals Council may refer a matter to the Division of Quality Service even if a claimant has not alleged it or filed a Request for Review by the AC.

DQS can receive complaints about ALJ conduct directly from claimants, members of the public, witnesses at a hearing, claimant representatives, or agency personnel such as those in the Office of the

Inspector General (OIG), Members of Congress, and the Federal Courts or ODAR regional offices. Filing a complaint which requires investigation by DQS must be done in writing within 180 days from the date of the action or the date the complainant became aware of the conduct. Specific information about the conduct, when and where it occurred, and whether it was witnessed. DQS follows set procedures for disposition of the complaint as set forth in the ruling.

Under the Civil Rights Complaint process, the Office of General Counsel (OCG) has the responsibility to investigate and decide complaints that individual file under this process. The Complaint is filed using Form **SSA-437-BK**. There are specific appeal procedures which must be followed in order to appeal the decision of OCG.

B. Attorney Misconduct

West Virginia attorneys must comply with the Rules of Professional Conduct, violations of which are investigated and heard by the Lawyer Disciplinary Board of the West Virginia State Bar with assistance of the Office of Disciplinary Counsel, which makes recommendations for disposition of the matter to the Supreme Court of Appeals of West Virginia. The SSA Commissioner's regulations pertaining to representatives of claimants is found at **20 CFR 404.1690-404.1799** and **20 CFR 416.1500-1599.**

All attorney and non-attorney representatives who practice before the Social Security Administration must comply with the Rules of Conduct and Standards of Responsibility for Representatives found at **20 CFR 404.1740** and **20 CFR 416.1540.** If a representative violates the Rules of Conduct, SSA may file charges and initiate proceedings to suspend or disqualify that representative from acting as a representative before SSA. These Rules were promulgated to implement Section 205 of the Social Security Protection Act of 2004 (SSPA) which amended Section 206(a)(1) of the Act with respect to the recognition, disqualification and reinstatement of certain individuals as claimants' representatives. www.ssa.gov/representantion/conduct_standards.htm. *In addition, the attorney may be charged with a federal crime and fined and imprisoned for forbidden acts.*

The rules provide that attorneys and non-attorney representatives act as agents and fiduciaries of the claimant and must "provide competent assistance to the claimant and recognize our authority to lawfully administer the process." Representatives must be "forthright" in their dealings with the claimant and the agency and must "comport themselves with due regard for the non-adversarial nature of the proceedings by complying with our rules and standards, which are intended to insure orderly and fair presentation of evidence and argument".

Affirmative duties are:

1. Act with reasonable promptness to obtain information and evidence that the claimant want to submit in support of the claim and forward the same to the agency as soon as practicable and bring to our attention "everything that shows that the claimant is disabled or blind".

2. Assist the claimant in complying as soon as possible with the agency's requests for information or evidence.

3. Act in a manner that furthers the efficient, fair and orderly conduct of the process including duties to:

    i. Provide competent representation by knowing the significant issue[s] in the claim and having a working knowledge of the applicable provisions of the Social Security Act, the regulations and rulings.
    ii. Act with reasonable diligence and promptness.
    Iii. Conduct business with us electronically at times on matters for which the representative seeks direct fee payment (**20 CFR§ 404.1713**, **20 CFR 416.1513 Mandatory use of electronic devices**)

Prohibited actions include:

1. Must not threaten, coerce, intimidate, deceive, or knowingly mislead a claimant or prospective claimant regarding

benefits or rights under the Social Security Act.

2. Must not knowingly charge, collect, or retain or make any arrangements to do so, from any source directly or indirectly, any fee for representational services in violation of any applicable law or regulation.

Note: Under **42 USC §406(a)** and **42 USC §1383(d)(2)** of the Social Security Act and **20 CFR 404.1720 and 20 CFR 416.1520** of the Commissioner's regulations, an attorney or representative who wants to charge a fee for services before the agency is required to file a written request before he or she may charge or receive a fee for his or her services. SSA decides the amount of the fee**.** Exception: when a third party business, firm, or government agency will pay the fee and the expenses from its own funds and the claimant and auxiliary beneficiaries incur no liability for the fee.

"...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." 20 CFR 404.1720(b)(3), 20 CFR 416.1520(b)(3).

42 USC § 406(a)(4)...if the claimant is determined to be entitled to past- due benefits under this title and the person representing the claimant is an attorney, the Commissioner of Social Security shall...certify for payment out of such past-due benefits...to such attorney an amount equal to so much of the maximum fee as does not exceed 25 percent of such past-due benefits.....(a)(5). Any person who shall, with intent to defraud, in any manner willfully and knowingly deceive, mislead, or threaten any claimant...or who shall knowingly charge or collect directly or indirectly any fee in excess of the maximum fee, prescribed by the Commissioner of Social Security, shall be deemed guilty of a misdemeanor and, upon conviction thereof, shall for each offense be punished by a fine not exceeding $500 or by imprisonment not exceeding one year, or both ...

3. Knowingly make, present, or participate in making or presenting false or misleading oral or written statements, assertions or representations about a material fact or law.

Criminal Penalties: **42 USC §707(a) "Whoever - (1) knowingly and willfully makes or causes to be made any false statement or representation of a material fact in connection with the furnishing of items or services for which payment may be made by a State from funds allotted to the State under this title, or (2) having knowledge of the occurrence of any event affecting his initial or continued right to any such payment conceals or fails to disclose such event with an intent fraudulently to secure such payment either in a greater amount than is due or when no such payment is authorized, shall be fined not more than $25,000 or imprisoned for not more than five years, or both**

Civil Penalties: **42 USC §1320a-8 CIVIL MONETARY PENALTIES AND ASSESSMENTS FOR TITLES II, VIII, AND XVI. "Any person...who-**

(A) makes, or causes to be made, a statement or representation of a material fact, for use in determining any initial or continuing right to or the amount of monthly insurance benefits under title II or benefits or payments under title VIII or XVI, that the person knows, or should know is false or misleading, (B) makes such a statement or representation for such use with knowing disregard for the truth, or (C) omits from a statement or representation for such use, or otherwise withholds disclosure of, a fact which the person knows or should know is material to the determination of any initial or continuing right to or the amount of monthly insurance benefits under title II or benefits or payments under title VIII or XVI, if the person knows, or should know, that the statement or representation with such omission is false or misleading or that the withholding of such disclosure is misleading, shall be subject to, in addition to any other penalties that may be prescribed by law, a civil money penalty of not more than $5000 for each such statement...or each receipt of such benefits or payments while withholding disclosure of such fact...also shall be subject to an assessment, in lieu of damages sustained by the United States ...of not more than twice the amount of benefits or payments paid as a result..."

4. Through his own actions or omissions unreasonably delay or cause to be delayed without good cause (494,911(b)) the processing of a claim at any stage of the administrative decision making process.

5. Divulge without the claimant's consent except as authorized by the regulations or Federal law, any information we furnish or disclose about a claim.

6. Attempt to influence directly or indirectly the outcome of a decision by making a loan, gift, entertainment, or anything of value to a presiding official, agency employee, or witness except as reimbursement for legitimate expenses or the services of an expert witness retained on a non-contingency basis to provide evidence.

7. Engage in actions or behavior prejudicial to the fair and orderly conduct of administrative proceedings including, not limited to:

    i. Repeated absences or tardiness at scheduled proceedings without good cause (404.911(b))..
    ii. Willful behavior which has the effect of improperly disrupting proceedings or the adjudicative process.
    iii. Threatening or intimidating language, gestures, or actions directed at a presiding official, witness, or agency employee that result in a disruption of the orderly presentation and reception of evidence.
    iv. Violate any section of the Act for which a criminal or civil monetary penalty is prescribed.
    v. Refuse to comply with any of our rules and regulations.
    vi. Suggest, assist, or direct another person to violate our rules and regulations.
    vii. Advise any claimant or beneficiary not to comply with any of our rules and regulations.

viii. Knowingly assist a person whom we suspended or disqualified to provide representational services in a proceeding or to exercise the authority of a representative (404.1710).
ix. Fail to comply with our sanction(s) decision.

IX. ATTORNEY FEES.

The Social Security Act provides for a contingent fee of 25% of the sum of all retroactive benefits obtained on behalf of a claimant and any auxiliary claims for family members for representative services before SSA. While there are other permitted fee arrangements, such as a flat fee for services, the vast majority of claims involve the statutory contingent fee. In any case, the amount of the fee must be approved by SSA in advance of charging or receiving the fee. Under no circumstances should an attorney charge or receive a fee (other than to be held in the client trust account) for any services to the claimant before the Social Security administration, which fee has not first been approved by the agency, or the Court in the case of judicial review of SSA decisions or falls within a specific exception.

Regulatory provisions for attorney's fees are found in **20 CFR 404.1720-1730**, **20 CFR 416.1520-1530. HALLEX** provisions are found in **I-1-2-52**, **I-1-2-56.**

When the attorney has been retained by the claimant, the claimant must execute a Form **SSA-1696** Appointment of Representative which is filed with the agency together with release forms permitting SSA to release specific information from the claimant's file[s] to the attorney.

An attorney must register with SSA in order to receive direct payment of approved fees from the agency as opposed to collecting the fee from the client. SSA must have a copy of Form **SSA-1699** Registration for Appointed Representative Services and Direct Payment filed one time, and a Form **SSA-1695** Identifying Information for Possible Direct Payment of Authorized Fees submitted each time the attorney is appointed to represent a claimant.

A Form **1099-MISC** is issued to each representative who receives annual aggregate fees of $600 or more. Firms that have individual

representatives as employees or partners may register to receive Forms 1099-MISC reported to the firm rather than the individual representative. The gross amount is reported on the 1099-MISC without deduction of the "services assessment" fees, which are later deducted as an expense on income tax forms.

An assessment is required to be withheld from the attorney fee for each claimant, not to exceed 6.3% of the fee or if lower, a dollar limit set by the Commissioner which is subject to increase by the automatic COLA. The dollar limit for 12/13 for processing each attorney fee is $89.00.

Attorneys may arrange for direct deposit of the attorney fee[s]. The financial institution receiving the direct deposit is given information which may assist attorneys in identifying the claimant who is the source of the particular payment including the claimant's social security number, which information is at the discretion of the financial institution to provide.www.socialsecurity.gov/representation/direct_payment_of_approval_fees_forms_10...

A. Administrative Fees

1. Fee Agreement

SSA has a "FEE AGREEMENT" process by which the attorney may receive automatic approval of the fee. The attorney must submit a copy of the fee agreement contract with the claimant to SSA before a favorable determination is made, usually at the outset of representation when Form 1696 is filed. A copy of the contract is maintained in the exhibit file of the claim and in the event of a favorable determination will allow the attorney to be paid automatically at the time the claimant and any dependents are paid. The statutory conditions for a valid fee agreement include:

1. Filing the agreement before the date SSA makes a favorable determination.

2. The claimant and if applicable, guardian or representative payee, must both sign the agreement if the claimant is legally

incompetent or under age 18.

3. The fee specified in the agreement does not exceed the lesser of 25% of the past-due benefits or the maximum fee set by the Commissioner (which was last increased in 2009 [74 FR 6080] to $6000). The maximum fee is the total amount of the fee awarded on all claims adjudicated at the same time, such as concurrent claims for disability insurance and SSI and including amounts awarded to dependents.

The attorney has the right to seek review of the amount that would otherwise be the maximum fee under **42 USC §406(a)(2)(A)** of the Social Security Act. The statute provides that the Commissioner will approve the fee agreement if in proper form, at the time of the favorable determination or decision, and shall provide the claimant and the representative a written notice of the dollar amount of the past-due benefits and the dollar amount payable to the claimant, the dollar amount of the maximum fee which may be charged, and a description of the procedures for review.

Within 15 days after receipt of the notice, the claimant or and ALJ or other adjudicator may submit a written request for reduction of the maximum fee, or the attorney may submit a written request to increase the amount of the maximum fee. **42 USC §406(a)(3)(A)**.

The fee agreement process does not apply to the following situations and the fee agreement contract[s] will not be approved.

1. If all representatives associated in a firm, partnership, or legal corporation did not sign a single fee agreement unless the representative who did not sign the fee waives payment.

2. The claimant appointed representatives who are not members of the same firm, unless any other appointed representative waives a fee.

3. Claimant discharged a representative or a representative withdrew from the claim before SSA favorably decided the claim and the former representative did not waive the fee.

4. The representative died before SSA issued the favorable decision.

5. A state court declared the claimant incompetent and the legal guardian did not sign the fee agreement.

The fee agreement may contain other provisions such as: informing claimant that the attorney may exercise the right to seek review of the amount that otherwise would be the maximum amount under **42 USC § 206(a)(2)(A)** of the Social Security Act. The fee agreement may contain provisions indicating that the attorney fee does not include costs of the claim, which will be the responsibility of the claimant. The attorney fee may be a two-tiered agreement, wherein the claimant and attorney agree that if the claim is not awarded at the first ALJ hearing, then the fee agreement will not apply and the attorney will file a fee petition at the time of a favorable award. This second tier provision protects the attorney in the event that protracted appeal[s] of the ALJ decision is necessary. The maximum fee under the fee agreement process would not be expected to result in a reasonable attorney fee and would justify the attorney's efforts in filing a fee petition for the full 25% of retroactive pay to the claimant and dependents.

Approved model fee agreement language may be found on the SSA website: www.socialsecurity.gov/representation/model_fee_agreement_language...

The author over the years has developed a relatively long fee agreement which contains paragraphs that are stricken when not applicable. When stricken the paragraphs are initialed by the parties at the time the fee agreement is signed. The agreement is multi-tiers and includes provisions for appeal of the ALJ decision and appeal of the Commissioner's decision to the federal courts. There are paragraphs for voluntary amendment of the onset date by the claimant, which amendment may significantly reduce back pay, for dealing with Worker's Compensation and/or Federal Debtor offsets which may reduce or eliminate the backpay, for an assignment of EAJA fees if the claim proceeds to federal court and for informing the claimant that the attorney

will claim the larger fee if the court awards fees under both EAJA and 406(b). There are details of costs of the claim for which the claimant is responsible, for the attorney's right to withdraw from the claim, and for providing for alternate method of obtaining a fee in cessation claims where the claimant elects to continue to receive benefits while the cessation is being adjudicated (which eliminates the backpay). Some of these paragraphs, if not stricken, will cause an ALJ NOT to approve the fee agreement for streamlined processing when the ALJ awards the claim.

However, the penalty for non-approval of the fee agreement will simply be the necessity to file a fee petition with the adjudicator who awarded the claim.

2. Fee Petition.

The fee petition Form **SSA-1560-U4** is available on the SSA website www.ssa.gov. This second method of obtaining fees is by filing a fee petition with the adjudicator who made the favorable decision awarding the claim[s] within 60 days of the decision, or to file within 60 days a letter of intent to file a fee petition. The importance of the letter is to prevent Social Security from releasing all of the back pay to the claimant and dependents, and failing to withhold the statutory 25% as the potential fee for the representative. The actual fee petition may not be filed for months after the favorable decision. The decision does not become "final" until 60 days plus 5 days for mailing time has elapsed. The representative usually will not know at that time the amount of the retroactive award[s] until all of the award notices pertaining to the favorable decision have been issued and, if necessary, corrected. There may be five or more award notices - the SSI payment, the Title II payment, and award notices for each eligible dependent. Separate amounts withheld may pertain to each notice received. When the award notices have all been received, the attorney computes the amount of the fee and compare it with the amount that SSA has actually withheld and file the fee petition.

In the event that the attorney has complied with the regulatory time provisions and given notice that a fee petition will be filed, if SSA erroneously releases all or part of the amount of the fee to the claimant[s] and if the claimant does not repay the fee amount to the attorney, SSA may pay the attorney fee and charge the claimant an

overpayment. This is not a desirable outcome, as SSA's error has the effect of creating a conflict of interest between attorney and client with regard to payment of the fee. Also, the claimant may need further assistance in contesting the overpayment in a separate proceeding to request waiver of the overpayment.

The back of the fee petition form includes detailed instructions about when and where to file the form, how the amount of the fee is evaluated, what to do if you disagree with the amount, and penalties for charging an unauthorized fee. The petition requires attachment of a list of itemized administrative services performed on behalf of the claimant from the onset of representation through the date of the end of representation, or the date of the fee petition if representation has not ended. Under normal circumstances the attorney will continue to represent the claimant until all award letters are received and back pay and attorney fee amounts paid before withdrawing from representation and sending a close out letter to the client. It is customary to list on the attachment to the fee petition all services performed by attorneys and staff. It is customary to list the administrative services in 15 minute increments. It is not necessary at the administrative level to identify the person in the attorney's office who actually performed the services. Specificity is important to justify the time entry: rather than "letter to client", it is better to say "letter to client setting office appointment for updated medical information", etc.

The completed fee petition is first sent to the client for review. The client is asked to state at the bottom whether or not the client is in agreement with the amount requested and to sign the petition. The client is not precluded from later contesting the fee even if agreement is noted on the petition form. If the claimant does not return the signed fee petition, an unsigned fee petition may be filed with an explanatory letter describing that the claimant did not return the fee petition.

The ALJ has the authority to award a fee not in excess of $10,000. In the event the amount of the fee is in excess of the authorized amount the ALJ must forward the fee petition to the Regional Chief ALJ for authorization. The attorney may appeal the amount of the Fee Authorization one time by filing a letter requesting review within 30 days. If the ALJ has made the determination for the Fee Authorization, the

review is by the Regional Chief. If the Regional Chief has determined the Fee Authorization, the review is by the Deputy Chief ALJ.

B. Court Fees.

If the attorney files a civil action in the United States District Court (and above) and achieves a favorable outcome in court, attorney fees may be sought.

1. Fees under the **Equal Access to Justice Act (EAJA), 28 USC §2412**.

The EAJA permits an award of attorney fees and other expenses to the prevailing party in a lawsuit against the United States and its agencies whenever the plaintiff sought redress from the court for actions of the agency that were not "substantially justified" and if special circumstances of the case do not make such an award unjust. The standard set forth by the U.S. Supreme Court in **Pierce v. Underwood, 108 S.Ct. 2542, 1550 (1988)** is whether the position of the agency was "reasonable in fact and law". The Court decided several early cases in which the EAJA was applied to judicial review of decisions of the SSA Commissioner. See, for instance, **Sullivan v. Finklestein, 110 S.Ct. 2658 (1990)**, **Melkonyan v. Sullivan, 111.S.Ct. 2157 (1991)**, **Shalala v. Shaefer, 113 S.Ct. 2625 (1993)**. These cases are a starting point for further research beyond the scope of this chapter. The Court of Appeals of the Fourth Circuit has decided a number of cases pertaining to EAJA awards in Social Security cases. See **United States v. 515 Granby, LLC, No.12-2161, Court of Appeals for the Fourth Circuit, 12/20/13** on the issue of "substantial justification.

The EAJA provides that an EAJA petition for attorney fees must be filed with the court within 30 days of final judgment. The court has the authority to affirm, modify, or reverse the decision of the Commissioner.

For purposes of EAJA, a "prevailing party" includes plaintiffs whose claims have been reversed and remanded to the Commissioner for action pursuant to the order of the Court.

The **Shaefer** case above identified the two types of remands prescribed by the Social Security Act, a "Sentence 4 remand" and

"Sentence 6 remand", pertaining to the provisions of **42 USC §405(g)**. A remand under Sentence 4 is generally a decision by the court on the merits of the case, a lack of substantial evidence to support the Commissioner's decision. The judgment of the Court does not become final until 60 days has elapsed. Therefore, in Sentence 4 remands the 30 day period for filing the EAJA is within 90 days after the judgment order of the court. In Sentence 6 remands, there is no entry of judgment by the court. The action is remanded to the Commissioner for post-remand proceedings, such as consideration of new and material evidence filed with the court.

After the post-remand decision of the Commissioner is made and filed with the court, a judgment order is entered. In such case, if the decision of the Commissioner was favorable, the time to file the EAJA is within 90 days after the entry of the judgment of the court. In Sentence 4 remands, time spent before the Commissioner after remand is not included in the EAJA petition. In Sentence 6 remands, the administrative time spent before the Commissioner may be included in the EAJA petition. Most court orders will specify which sentence applies to the remand. If not clear, the EAJA petition can be filed after the remand order and if necessary, proceedings stayed until completion of administrative action after remand and entry of the judgment of the court thereafter.

EAJA fees do not come out of the claimant's back pay and are paid by the government. The standards by which time entries are judged and the hourly fees which may be obtained are much more strict than administrative fees or 406(b) fees which come from the claimant's back pay. It is not unusual for EAJA petitions to be vigorously opposed by the government and for briefs and oral argument to be required. Often OCG attorneys will propose a settlement of the EAJA petition amount and filing of an agreed stipulated amount. The hourly rate for attorneys for EAJA time for the first half of 2012 was $183.73, which represented COLA increases through 7/12 over the $125.00 hourly rate. Public Law 104-121.

Courts have taken the position that the EAJA fee belongs to the plaintiff. The attorney is advised to obtain an assignment of any EAJA fee that may result from the court case at the time of filing the

complaint, which is filed with the complaint.

The government bears the burden of demonstrating that its position was substantially justified. The "position" of the government is both the position of the agency below and the government's position in litigation. The bare fact that the plaintiff has prevailed is not sufficient to demonstrate a lack of substantial justification. The government's failure to address contrary circuit precedent weighs against substantial justification in court. Generally if the government seeks a remand due to action below which was clearly inconsistent with established law, the remand would most likely result in an EAJA fee. On the other hand, if the court upholds the Commissioner on four out of five grounds for remand and remands on the fifth, the government's litigating position may be substantially justified and the focus would be the nature of the error below.

The EAJA petition requires extreme care in identifying time spent on the case and whether an attorney or paralegal performed the particular task. Reduced fees for non-attorney time may be added to the attorney time. Time recorded in increments of tenths of an hour is sufficiently precise.

2. Fees pursuant to §406b

20 CFR §406(b) provides: **"Whenever a court renders a judgment favorable to a claimant under this subchapter..., the court may determine and allow as part of its judgment a reasonable fee ..., not in excess of 25 percent of the total of the past-due benefits to which the claimant is entitled by reason of such judgment, and the Commissioner... may, ...certify the amount of such fee for payment to such attorney out of, and not in addition to, the amount of such past- due benefits, in case of any such judgment, no other fee may be payable or certified for payment for such representation except as provided in this paragraph."**

Thus, if all 25% of claimant's back pay is not awarded for administrative services under the fee agreement or fee petition at the conclusion of the case, the attorney may petition the court for an award of attorneys fees before the court, not to exceed the remaining amount of 25**%** of claimant's back pay.

The Attorney must not keep both a 406(b) fee and an EAJA award of fees. If an award under 406b is obtained and the attorney has also obtained an EAJA attorney fee award, the smaller of the two is reimbursed to the claimant. Because EAJA fees are usually obtained early in the case at the time of the court remand, and the ultimate outcome of the case below is still unknown, the EAJA fee should be held in trust pending the resolution of all fee matters before the agency and the court. The offset computation and any necessary refund to the claimant will be made at that time. However, only 406(b) fees are offset by the EAJA award provided the EAJA petition did not include administrative time which has already been compensated by the award of administrative fees by the Commissioner.

X. JUDICIAL REVIEW

A. Judicial Review. The Social Security Act.

The Social Security Act provides as follows:

"Any individual, after any final decision of the Commissioner of Social Security... may obtain a review of such decision by a civil action commenced within sixty days after the mailing to him of notice of such decision or within such further time as the Commissioner of Social Security may allow. Such action shall be brought in the district court of the United States for the judicial district in which the plaintiff resides, or has his principal place of business..."

"As part of the Commissioner's answer the Commissioner of Social Security shall file a certified copy of the transcript of the record including the evidence upon which the findings and decision complained of are based. The court shall have power to enter, upon the pleadings and transcript of the record, a judgment affirming, modifying or reversing the decision of the Commissioner of Social Security, with or without remanding the case for a rehearing."

"The findings of the Commissioner of Social Security as to

any fact, if supported by substantial evidence shall be conclusive, and where a claim has been denied by the Commissioner of Social Security or a decision is rendered under subsection (b) hereof which is adverse to an individual...because of failure of the claimant...to submit proof in conformity with any regulation prescribed under subsection (a) hereof, the court shall review only the question of conformity with such regulations and the validity of such regulations.

"The court may, on motion of the Commissioner of Social Security made for good cause shown before the Commissioner files the Commissioner's answer, remand the case to the Commissioner of Social Security for further action by the Commissioner of Social Security, and it may at any time order additional evidence to be taken before the Commissioner of Social Security, but only upon a showing that there is new evidence which is material and that there is good cause for the failure to incorporate such evidence into the record in a prior proceeding;

"and the Commissioner of Social security shall, after the case is remanded, and after hearing such additional evidence if so ordered, modify or affirm the Commissioner's findings of fact or the Commissioner's decision, or both and shall file with the court any such addition and modified findings of fact and decision and, in any case in which the Commissioner has not made a decision fully favorable to the individual, a transcript of the additional record and testimony upon which the Commissioner's action in modifying or affirming was based.

"Such additional or modified findings of fact and decision shall be reviewable only to the extent provided for review of the original findings of fact and decision.

"The judgment of the court shall be final except that it shall be subject to review in the same manner as a judgment in other civil actions…"
42 USC §405(g)."

A basic statement by the U.S. Supreme Court of the substantial evidence standard is: "Substantial evidence is such as a reasoning mind might accept as adequate to support a decision...more than a mere scintilla..but..somewhat less than a preponderance. **Richardson v. Perales, 402 U.S. 389, 401 (1971)**; **Blalock v. Richardson, 483 F. 2d 773 (4th Cir. 1972).**

A corollary in the Fourth Circuit is: **"**A factual finding by the ALJ is not binding if it was reached by means of an improper standard or misapplication of the law." **Coffman v. Bowen, 829 F 2d. 514 (4th Cir. 1987)**.

A compilation of older, very important Fourth Circuit cases has been omitted from the on-line **HALLEX** on SSA's website, formerly published by SSA in Volume II: II-1-102, **Significant Fourth Circuit Case Law** dated June, 1990. Many of these cases are still "good law" and represent a period in the Fourth Circuit when the Court was particularly claimant-friendly. They provide the judicial framework for current decisions in a not-nearly-as- friendly court. An attorney who wants a copy of this list of early cases with the topics noted may request a copy from the author. **HALLEX** Transmittal No. II-1-01 lists additional Fourth Circuit cases which were added to the list: **Walker v. Harris** (duty to develop record) and **Payne v. Sullivan** (Substantial Gainful Activity). **HALLEX** Transmittal No. II-1-03 lists additional Fourth Circuit cases added to the list: **Hunter v. Sullivan** (credibility), **Kasey v. Sullivan** (reopening/res judicata). **HALLEX** Transmittal No. II-1-04 lists additional Fourth Circuit cases without citation which were added to the list: **Bailey v. Chater** (onset date); **Hall v. Chater** (reopening, res judicata); **Pass v. Chater** (past relevant work).

The newer decisions are easily obtainable through the West Virginia State Bar's FASTCASE and through the usual search engines such as Google.

B. Procedure in the Federal Courts.

A complaint must be filed in the federal district court which serves the claimant's area, naming claimant as plaintiff and the Commissioner

of Social Security as defendant and requesting judicial review under **42 USC §405(g)** of the final decision of the Commissioner. The final decision is either the ALJ decision which was affirmed by the Appeals Council, or the new decision of the Appeals Council. The complaint must be filed within 60 days of the date of the Action of the Appeals Council.

The **Federal Rules of Civil Procedure** apply to the claim, as well as **Local Rules of Civil Procedure** which apply to the particular court. There are also **Administrative Procedures for Electronic Case Filing** for each court. To the extent that the Administrative Procedures conflict with Local Rules, the Local Rules take precedence. Forms and instructions for filing civil complaints may be located through the court's web page. Northern District: www.wvnd.uscourts.gov/understanding-law and Southern District www.wvsd.uscourts.gov/court-info/local-rules-and- orders .

1. Electronic Case Files.

The Court files are electronic. The attorney must have been admitted to practice before the federal courts of the Northern and Southern Districts of West Virginia and must be registered with the specific court providing the CM/ECF system. In addition the attorney must be registered with the PACER Service Center, the judiciary's centralized registration, billing, and technical support center which provides a login and password. Local rules apply if an attorney requests an exemption to filing electronically.

Each court has its own requirements for filing electronically. Most courts will provide an on-line tutorial, training database, FAQs and a user manual. An attorney does not have to register for CM/ECF more than once even if the attorney changes firms: the contact information is updated.
Passwords can be changed through the Utilities tab after logging in to CM/ECF.

Filing is available to authorized users only. The system is available 24 hours a day, 7 days a week except for routine or emergency maintenance. Each court maintains its own data bases with case

information. Each jurisdiction will have a different URL. The PACER system is operated by the Administrative Office of the United States Courts. http://pacer.psc.uscourts.gov/emecffaq.html . The attorney provides credit card information for the PACER system to bill the attorney for access fees of
.08 per page for retrieval of information through the system which applies to all attorneys and parties including *pro se* litigants. Attorneys and parties receive one free electronic copy of all documents filed electronically if receipt is required by law or directed by the filer. The free copy of newly filed documents is available through the hyperlink in the notice for 15 days for a single use before expiring. After that time a PACER login and password will be required and the viewer will be charged to view the document. No fee is owed until an account holder accrues charges of more than $10 in a calendar year.

There are separate logins and passwords for PACER and the CM/ECF for each court. A PACER user ID and password is required for querying cases and is provided by the PACER SERVICE Center. A different CM/ECF login ID and password are required for attorneys to file cases, documents and motions online. Email addresses are provided to the court for electronic notice. It is advisable for the attorney to provide email addresses for additional attorneys in the firm or staff members as a safeguard for receiving notices from the court. In most filings, the CM/ECF system generates a Notice of Electronic Filing or a Notice of Docket Activity - an email message containing a hyperlink to the document filed. Most courts permit this Notice to be used to serve parties.

Although the Case Management/Electronic Case File system [CM/ECF] is the same for all the federal courts, specific instructions for filing are somewhat different and the Local Rules should be consulted as well as that court's Administrative Procedures for Case Filing. If the attorney is not familiar with the system, free tutorial instruction is available at the time of registering with the Court. Information may be obtained by telephone from the individual Clerks and by consulting PACER technical support. Send Email to the PACER Service Center at pacer@psc.uscourts.gov or call (800)676-6856 between 8 a.m. and 6 p.m. Central Time. The training database is located at: https://ecf-train.COURT.uscourts.gov.

Case specific information can be obtained by public users of the CM/ECF system, such as the docket sheet, PDF copies of filed documents, and the cases report. Public users are not charged for filing documents using CM/ECF or for viewing calendar information. There is a cap of $2.40 (30 pages) for a single document or case specific report including docket sheets. Each attachment is considered a separate document. The cap will apply to each attachment over 30 pages separately.

2. A Typical Judicial Review Proceeding

The attorney must review the Local Rules for the court in which the civil action is filed. There are specific rules for Social Security. In the Northern District **LR Civ P 9.01-9.02** and **Adm P 5.00** pertain to Social Security Cases. In the Southern District **LR Civ P 9.1-9.9** and **Adm P 5.00** pertain to Social Security Cases.

The Social Security case usually proceeds through the District Court on the basis of the briefs without oral argument. The most common script is as follows: The plaintiff files the complaint. The rules specify the time periods allowed for each of the actions of the parties thereafter. The government files an Answer to the complaint and files the Administrative Transcript at the same time. The government may move to remand the case at any time before filing the Answer - for instance when the administrative transcript is incomplete due to inaudible hearing recording. Plaintiff then files a supporting Brief, with or without an accompanying motion for summary judgment depending upon the court rules. In the event that new and material evidence exists, the plaintiff may file a motion to remand, a brief, and a showing of the new evidence according to the local rules. The Government files its opposition to the complaint and or motion to remand in the manner prescribed by the local rules which requires a brief. Plaintiff may then file a reply brief. If the parties have not consented to the jurisdiction of the Magistrate Judge, the Magistrate Judge files an opinion and recommendation for disposition to which the parties must object if they disagree. If no objections are filed within prescribed time period allowed, the court may adopt the recommendation of the Magistrate Judge and enter judgment. If one or both parties object, the district court judge must review the record *de*

novo, consider the objections of the parties and the recommendation of the magistrate judge, and file a memorandum opinion and order and judgment of the court. This decision is final unless the plaintiff or the government files a Notice of Appeal to the Court of Appeals.

C. Filing For Attorney Fees For Court Time

If the plaintiff prevails in the district court by judgment for the plaintiff or by a remand to the Commissioner, a petition for EAJA fees may be filed [at different times according to whether under sentence 4 or sentence 6] if reasonably likely to result in EAJA fees based on the facts of the case. It is an ethical obligation of the attorney to file an EAJA petition if it may realistically result in reducing the amount of claimant's attorney fees. Usually the government will contact the attorney prior to the deadline for filing its opposition to the petition for EAJA fees if there will be an attempt made to settle the matter. If no agreement is reached with plaintiff's attorney, the government then files its brief in opposition to the EAJA petition. The plaintiff may also file a brief. Oral argument may be required. The magistrate judge or district judge then decides the EAJA petition. Appeal of the decision may be pursued.

It is to the advantage of both parties to compromise the fee as the EAJA proceeding can balloon into another full-fledged court action. However, time spent in preparing the EAJA petition and in pursuing the petition before the court may be included in the petition if the petitioner prevails in the EAJA proceeding.

If the EAJA fee is awarded, it is placed in the Attorney's client trust account pending the outcome of the claim before the Commissioner. If a favorable decision is made by the Commissioner below, the attorney files a fee petition for administrative fees. When the fee authorization is received, if the entire 25% back pay amount is not awarded as the administrative attorney fee, the plaintiff may choose to proceed before the Court for 406(b) fees for the remaining back pay for the time spent before the court.

The attorney has the option of proceeding before the court with a motion for attorney fees under 406(b) or may accept the EAJA fee and notify the Commissioner to refund the excess amount being withheld to

the claimant. If the remaining amount of backpay is awarded under 406(b) and is greater than the amount of EAJA fees awarded, then the attorney may keep the 406(b) fee and refund the EAJA to the claimant from the trust account. This type of EAJA offset [court fees offset by other court fees] can be made provided no administrative time was included in the EAJA petition and only time before the court was paid by the government. The attorney should always verify with the proper officials within the agency and/or the court to be sure that the correct offset of EAJA fees is made.

If the outcome below after court remand is not successful, claimant may return to the district court. If the case has been remanded under Sentence Four of 406(b), then a new civil action must be filed. If the case was remanded under Sentence Six, then the case is reinstated by the court for further proceedings and judicial review of the Commissioner's new decision and the additional evidence is added to the administrative record. If judgment is obtained for the plaintiff, the process of claiming fees is the same as described above.

5. Practice Before the Court of Appeals.

The author has not pursued a case to the Court of Appeals for a long while due to the conservative rulings of the court in recent years and the risk of inviting the court to retreat from earlier claimant-friendly cases which are still precedential at the district court level.

The National Organization of Social Security Claimants' Representatives [NOSSCR] will be able to provide names of attorneys whose practices emphasize appellate work before the circuit courts and the U.S. Supreme Court through its referral service. nosscr@nosscr.org; Telephone 201-567-4228, FAX 201-567-1542. The Executive Director is Barbara Silverstone.

XI. ELECTRONIC ACCESS TO THE SOCIAL SECURITY FILE

A **Representative Guide for Electronic Records Express** is

available on the SSA website, www.ssa.gov . There are detailed Evidence Submission Services prescribing the method of electronic submission of evidence into the Social Security electronic file folder [EF]. Questions regarding the instructions and the process for submitting evidence may be emailed to: odar.hq.rep.mail.@ssa.gov . There is a Home Page for SSA's Electronic Utility Express which provides instructions and a login function.

Currently there is no direct electronic access to claimant's electronic folder at the DDS level. The DDS disability examiner should be contacted to find out the contents of the file and to request a bar code for submission of evidence into the EF. At the ODAR level attorneys and representatives can obtain direct online access to the electronic folder and also Appeals Council level cases, if they have enrolled in Appointed Representative Services [ARS]. Status reports by the Appeals Council are on-line, eliminating the need to contact the AC.

Enrollment for ARS must be in-person to meet SSA's authentication requirements. The attorney may contact a hearing office and request to be placed on the list of representatives who wish to enroll. The primary disadvantage of ARS is that only the "principal representative" is officially designated to have access to the electronic folder [EF]. Other attorneys in a firm and the representatives staff do NOT have the authority to access the on-line file folder. Because of this limitation and other practical considerations, the author has not responded to the invitation to apply for ARS. ARS is not required for the electronic submission of evidence function. For attorneys who are not enrolled in ARS receive CDs of the EF at stated intervals. An updated CD of the EF should be requested shortly before the hearing to ensure that all evidence submitted has been included in the EF. An updated CD will also be provided to the attorney immediately before the hearing.

Concluding remarks:

Any corrections or comments would be appreciated and may be made by e-mail to mvn@frontiernet.net.