Table of Contents

I. ONLINE RESOURCES TAB

I. Online Resources

I.A. *A-Z Disability Training Index*

I.B. Adjudication Tips

I.C. Appeals Council Feedback

I.D. Vocational Tables Placement

I.E. *Available, Authorized Policy and Practice Information Programs*

1) Medical Resources:
   a) (b) (2) [redacted]
      i) Code Manager: (b) (2) [redacted]
         (1) Have to have a separate login – so create an account
         (2) When you just can't figure out what doctors are treating type in the ICD code and see what it is for . . .
      ii) Medical Encyclopedia: (b) (2) [redacted]
      iii) Medical Abbreviations: http://www.medilexicon.com/
   b) Outside webpages that are useful
      i) BMI calculator (keep in mind this is built in to eBB) http://www.cdc.gov/healthyweight/assessing/bmi/adult_bmi/english_bmi_calculator/bmi_calculator.html
      ii) NYHA Classification: http://www.heart.org/HEARTORG/Conditions/HeartFailure/AboutHeartFailure/Classes-of-Heart-Failure_UCM_306328_Article.jsp
      iii) ICD-10 codes: http://apps.who.int/classifications/icd10/browse/2016/en
      iv) DSM: http://allpsych.com/disorders/disorders_dsmIVcodes.html

2) Policy:
   a) Chief Judge's webpage (b) (2) [redacted]
      i) Adjudication Tips: (b) (2) [redacted]
      ii) Chief Judge Resources: (b) (2) [redacted]
         (1) Bench Decisions
         (2) Experts Handbook
         (3) OCEP materials
      iii) Benchmarks: (b) (2) [redacted]

b) From the Social Security Intranet home page: PolicyNet:
(b) (2) [redacted]
   i) There is plenty here, and the view is customizable, so you can make it show you want you most want to see
      (1) HALLEX
      (2) DIGR-ODAR
         (a) CFR
         (b) SSR and AR
   ii) SGA Tables: (b) (2) [redacted]
c) Grid Tool: (b) (2) [redacted]
d) Grid Regs: (b) (2) [redacted]

3) New ALJ Training Materials:
(b) (2) [redacted]

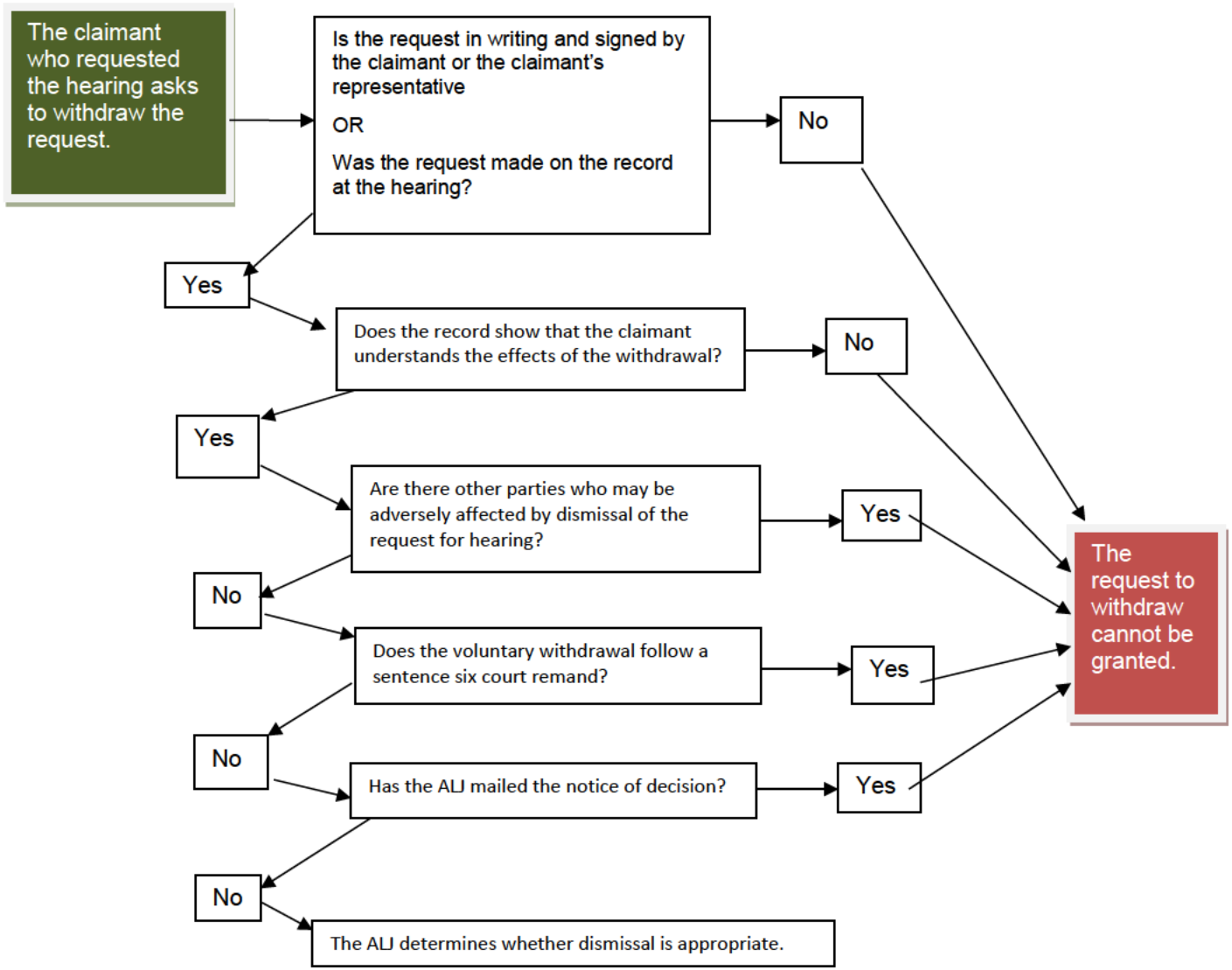
4) Bettering Yourself
http://techbus.safaribooksonline.com/home?uicode=ssa

II. DISMISSALS TAB

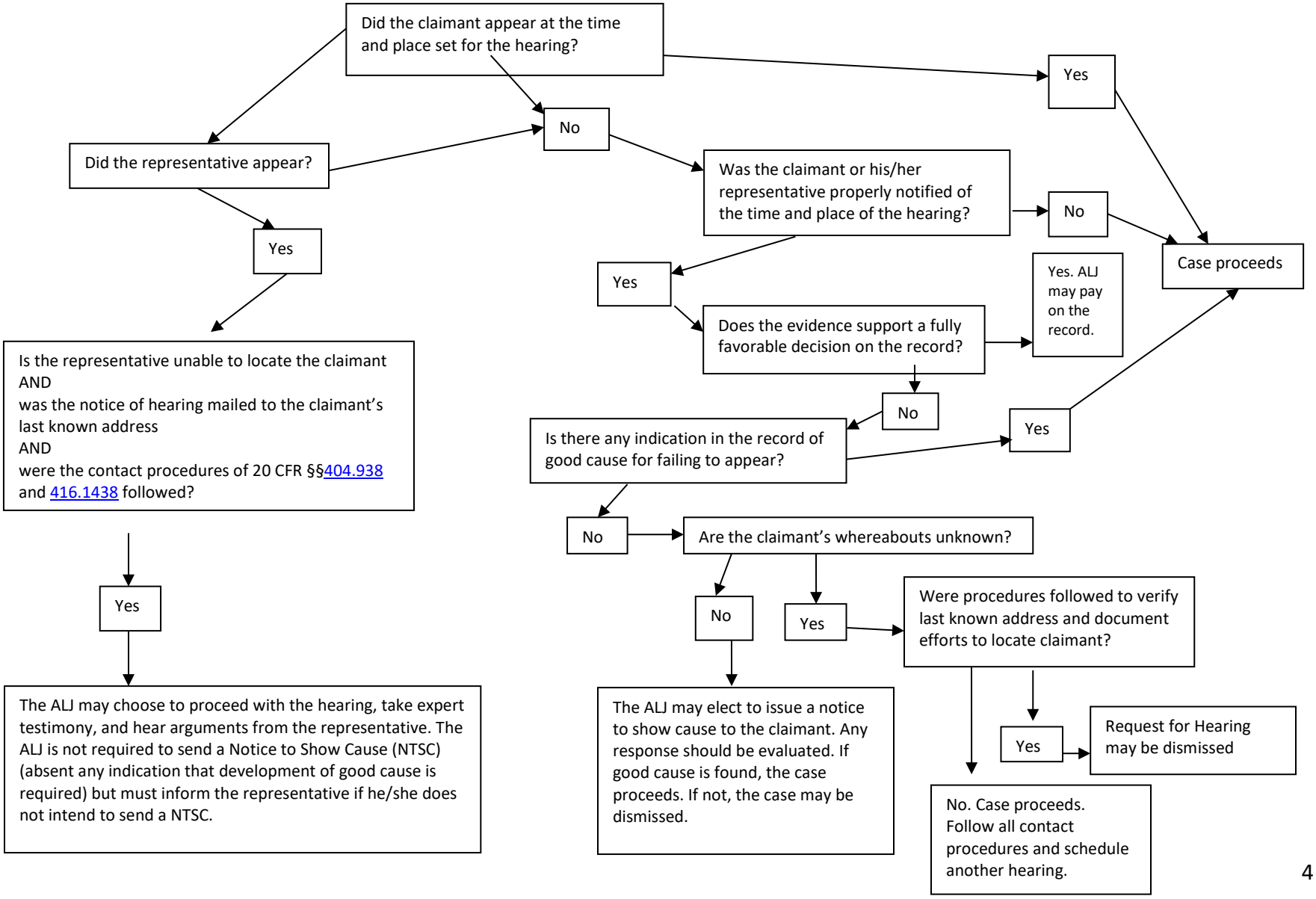
II. Dismissals

II.A. Dismissal Charts

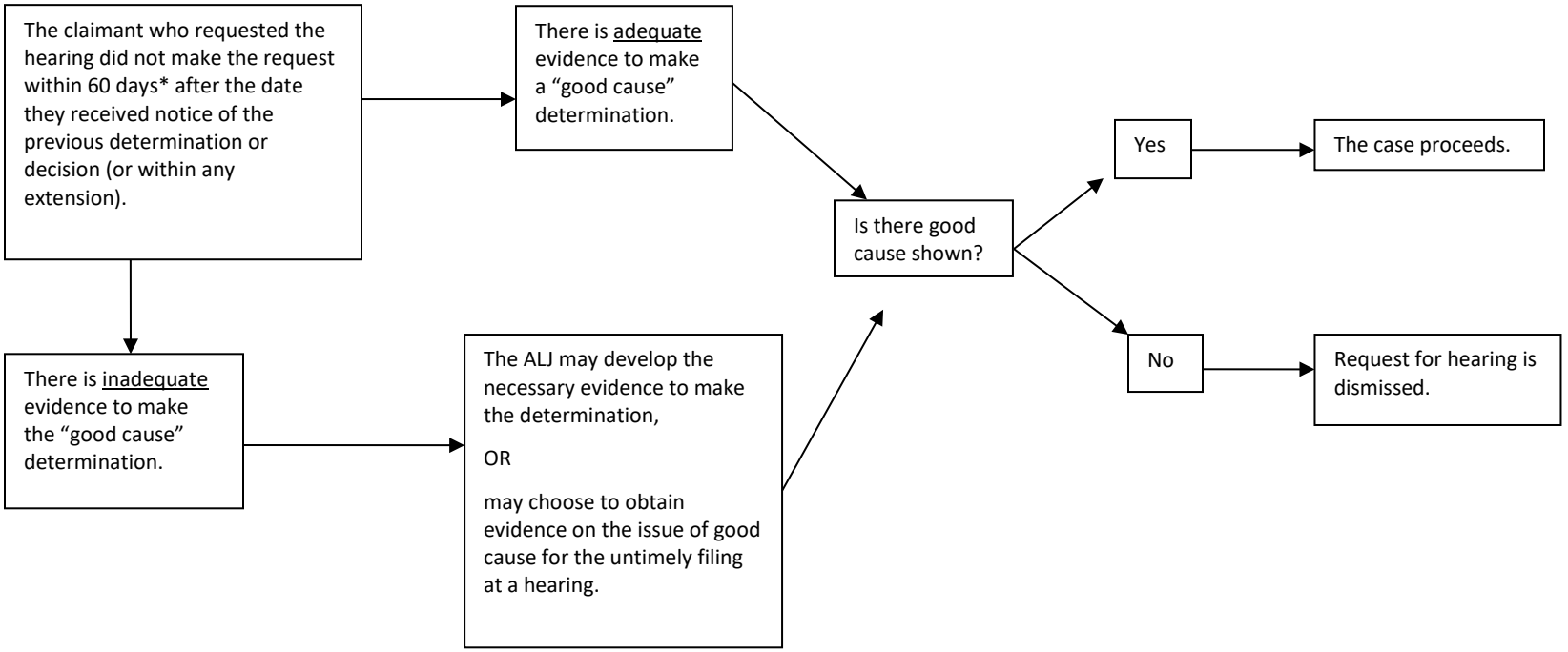
Processing Dismissals: Withdrawal of Request for Hearing



Processing Dismissals: Failure to appear

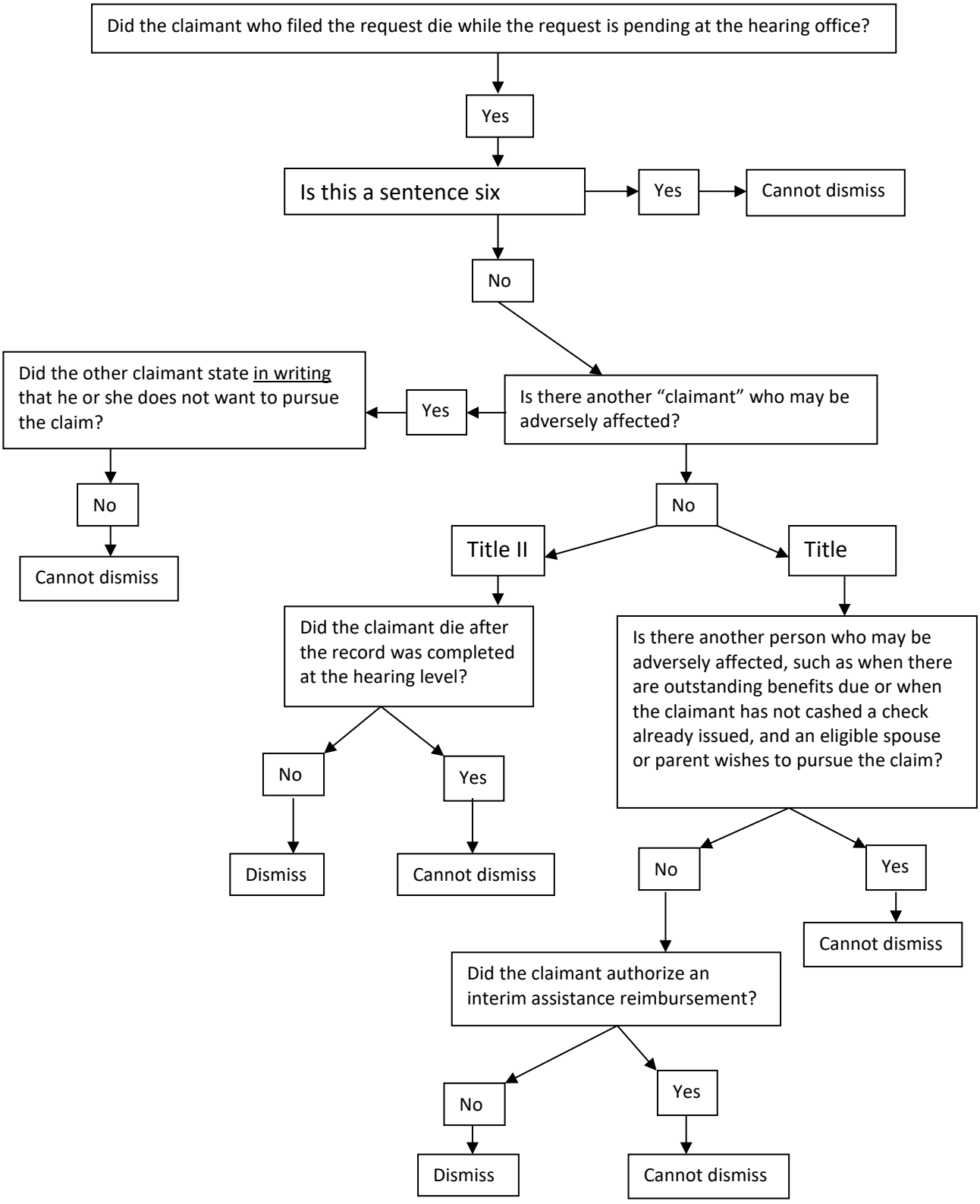


Processing Dismissals: Untimely filing



* *NOTE: If a request for hearing was mailed to the Agency AND using the date of receipt would result in a loss or lessening of the claimant's rights, use the US Postal Service "postmark" date on the envelope. If the postmark is unreadable or if there is no postmark, then the request is considered to be timely filed if it was received within 70 days of the date on the notice of the prior determination.*

Processing Dismissals: Death of claimant



II.B: Failure to Appear

II.B.1. Dismissal Due to Claimant's Failure to Appear; HALLEX I-2-4-25

I-2-4-25. Dismissal Due to Claimant's Failure to Appear

Last Update: 5/1/17 (Transmittal I-2-196)

A. Failure to Appear — Introduction

An administrative law judge (ALJ) may generally dismiss a request for hearing (RH) based on failure to appear in the following circumstances, except when a parent or guardian appears at the hearing on behalf of a claimant who is a minor. An ALJ's attempts to develop good cause, and any responses received, must be documented in the B section of the claim(s) folder.

1. Neither Claimant nor Representative Appears

An ALJ may dismiss an RH when neither the claimant nor the appointed representative, if any, appears at the time and place of a scheduled hearing and neither shows good cause for the absence. For authority, see 20 CFR 404.957(b) and 416.1457(b). Except in the circumstances set forth in this provision, an ALJ will develop whether there is good cause for the failure to appear.

2. Neither Claimant nor Representative Appears on Time

An ALJ may also dismiss an RH on the basis of failure to appear when an unrepresented claimant, or the claimant and his or her representative, fails to appear on time for the hearing. However, the ALJ must first develop whether there is good cause for the tardiness.

> **NOTE:**
> If a claimant appears at the hearing office (HO) after the time set for hearing, HO staff will document the appearance on the Form SSA-5002, Report of Contact, found in Hearings, Appeals and Litigation Law (HALLEX) manual I-2-4-91, and associate the completed form in the B section of the file. Whenever possible, staff must notify the ALJ while the claimant is still at the HO. In this situation, the ALJ has discretion to make a finding of good cause and proceed with the hearing, or to develop good cause using the procedures in this section. If the ALJ does not find good cause, he or she must exhibit the completed SSA-5002 and make specific reference to its contents in the dismissal order.

3. Third Party Appears on Behalf of Minor or Age 18 Claimant

Occasionally, a claimant may fail to appear at the hearing, but a parent or guardian who has not been appointed as a representative will appear at the hearing on the claimant's behalf. If an appointed representative is present, the ALJ will proceed as noted in D

below. If the parent or guardian indicates the claimant is late, the ALJ will proceed as noted in A.2. above.

The ALJ will not proceed with the hearing if:

- The claimant is age 18 or older, and
- The claim is an initial application for adult disability benefits or we are redetermining the eligibility of a claimant for supplemental security income under 20 CFR 416.987.

If the hearing cannot proceed, the next appropriate action depends on whether the claimant returned the acknowledgment of hearing form or otherwise indicated actual knowledge of the date and time of the hearing. See HALLEX I-2-3-20. If the claimant responded and indicated he or she would appear at the hearing, the ALJ may dismiss the request for hearing if the ALJ finds that the claimant does not have good cause for failing to appear. If the claimant was not the person who responded to the acknowledgment of hearing form, or the acknowledgment form was not returned, see the procedures noted in C below.

NOTE:
If the claimant is a minor, a parent or guardian may appear at the hearing on the claimant's behalf without an appointment as the claimant's representative.

B. Definition of Good Cause for Failure to Appear

The term “good cause” refers to a reasonable explanation for failing to comply with a requirement. When determining whether good cause exists for failure to appear, an ALJ must base his or her decision on the circumstances of each individual case. In doing so, the ALJ must consider any physical, mental, educational, or linguistic limitations that may have prevented the claimant from appearing at the scheduled time and place of the hearing, akin to the requirements for consideration of good cause for late filing in 20 CFR 404.911 and 416.1411 and Social Security Ruling 91-5p.

C. Considering Good Cause for Failure to Appear

1. Circumstances That Generally Establish Good Cause

There are no set criteria for determining what constitutes good cause for failure to appear at the time and place of a scheduled hearing. However, good cause generally exists in any one of the following three circumstances.

a. No Proper Notification of the Scheduled Hearing

Good cause for failure to appear at the scheduled time and place of hearing generally exists when the claimant did not receive proper notification of the scheduled hearing.

Before dismissing an RH for failure to appear, an ALJ must determine whether there is evidence in the record that shows the claimant was properly notified of the time and place set for the hearing, as described in HALLEX I-2-3-20. The ALJ will consider the following:

- If the claimant has an appointed representative, notification to the representative is sufficient to establish notification to the claimant.

- If the follow up contact was made by telephone, the ALJ must ensure the proper documentation is in the file, as noted in HALLEX I-2-3-20.

- If the claimant alleges he or she reported a new address to another agency component such as the field office or teleservice center but the notice of hearing was sent to an outdated address, the ALJ will review the queries noted in HALLEX I-2-3-15 B and carefully consider the allegation.

If the record does not show there was proper notification of the scheduled hearing, the ALJ must reschedule the hearing and provide proper notification of the rescheduled hearing. The ALJ and hearing office staff will follow the instructions in HALLEX I-2-3-15 to provide the notice of hearing.

If the claimant or appointed representative received proper notification and neither appears at the time of the scheduled hearing, see C.3.a. below.

> **NOTE:**
> Regardless of a failure to appear, if a preponderance of the evidence supports a fully favorable decision on every issue, the ALJ will consider whether it is appropriate to issue a fully favorable decision instead of dismissing the RH.

b. Unforeseeable Event

Good cause for failing to appear at the scheduled time and place of hearing generally exists when an unforeseeable event occurred that did not provide the claimant or the appointed representative enough time to notify the ALJ and request a postponement before the scheduled hearing.

c. Withdrawal of Representation Without Sufficient Notice

Good cause for failure to appear at the scheduled time and place of hearing generally exists when the appointed representative:

- Withdrew representation shortly before the scheduled hearing (approximately a week or less before the scheduled hearing), or appeared at the hearing and withdrew as representative, and

- There is no indication in the record that the claimant was aware the representative would not be appearing at the hearing on his or her behalf.

In this circumstance, the ALJ must develop for good cause. See C.2. below.

NOTE:
An ALJ may also find that special circumstances support a finding of good cause when the representative withdrew more than a week before the hearing and the claimant was unaware of the withdrawal.

2. Procedures to Develop Good Cause

To develop good cause, the HO will:

- Send a Form HA-L90, Request To Show Cause For Failure To Appear, to the claimant and the appointed representative, if any;
- Give the claimant and appointed representative 10 days from the date of the HA-L90 to respond; and
- Provide an additional 5 days for mailing time before proceeding.

It is important to check for any update to the claimant's address before sending the HA-L90 and associate the updated queries in the D section of the file. In addition to querying the Case Processing and Management System (CPMS), the HO staff must check the Personal Communications (PCOM) system queries, including:

- the Full Master Beneficiary Record (FACT) for title II cases,
- the Supplemental Security Income Display (SSID) for title XVI cases,
- the Modernized Development Worksheet (MDW) for either title,
- the Customer Service Record (CSR) for either title, and
- the Prisoner Update Processing System (PUPS) for either title.

NOTE:
In some cases, an updated address may also be found on medical evidence or in the Online Retrieval System (ORS). Additionally, when applicable, the HO will use the instructions in HALLEX I-2-5-69 C for verifying inmate information on the Internet.

3. When Developing Good Cause Is Not Necessary

If neither the claimant nor the appointed representative, if any, appears at the scheduled hearing, the ALJ may dismiss the RH without developing good cause in the following circumstances.

NOTE:
Although the ALJ is not required to develop whether the claimant had good cause for not appearing, under 20 CFR 404.957(b)(1)(i) and 416.1457(b)(1)(i) the ALJ must still consider and discuss whether information and the evidence of record establishes good cause.

a. Claimant Received the Notice of Hearing

The ALJ need not develop good cause if the record shows that the claimant received the Notice of Hearing and the claimant does not have a physical, mental, educational, or linguistic limitation that may affect his or her ability to understand the Notice of Hearing. If those criteria are met, the ALJ can generally presume the claimant fully understands the possible consequences of his or her failure to appear at the time and place of a scheduled hearing. The Notice of Hearing notifies a claimant that the RH may be dismissed without further notice if neither the claimant nor the appointed representative, if any, appears at the scheduled hearing.

NOTE:
For instruction when the representative appears without the claimant, see D below.

b. Claimant Did Not Return Acknowledgment Form

It is unnecessary to develop good cause when:

- the claimant did not return the acknowledgment form sent with the Notice of Hearing,
- the contact procedures required by 20 CFR 404.938 and 416.1438 were followed (as described in HALLEX I-2-3-20), and
- there is no indication of good cause for failure to appear.

Any documentation generated to comply with the regulatory procedures must be associated in the B section of the claim(s) file if the ALJ issues a dismissal. Documentation may include copies of letters sent to the claimant, reports of contact documenting telephone calls, and re-mailed copies of the Notice of Hearing and acknowledgment form.

An ALJ may not use an HA-L90 after the fact as an alternative to following proper notice procedures prior to the hearing. An HA-L90 is unnecessary if the ALJ followed all the contact procedures prior to the hearing.

c. Claimant's Whereabouts Are Unknown

If the postal service returns the Notice of Hearing to the HO as undeliverable, all attempts to contact the claimant by other means are unsuccessful, and it is concluded that the claimant's whereabouts are unknown, the ALJ may dismiss the RH after:

- Verifying that the address used on the Notice of Hearing and any other contact correspondence is the most recent address in CPMS and on the PCOM system queries, including the FACT for title II cases, the SSID for title XVI cases, the MDW for either title, the CSR for either title, and the PUPS for either title; and

- Ensuring that all attempts to contact the claimant are clearly documented in the B section of the claim(s) folder and the documentation is exhibited. For example, any envelopes returned by the post office as undeliverable must be associated with the claim(s) folder, as well as any statements made by individuals regarding the absence or disappearance of the claimant.

An ALJ may not dismiss the RH until after the time scheduled for the hearing because the claimant may learn of the scheduled hearing in another way and appear. If the claimant does not appear at the scheduled hearing, the ALJ may dismiss the RH but must describe all efforts to contact the claimant in the dismissal order.

D. Appointed Representative Appears at Hearing Without the Claimant

1. Representative Withdraws From Representing the Claimant at the Hearing

In some cases, an appointed representative will appear at the time and place of the scheduled hearing but will withdraw as representative if the claimant does not appear. If the claimant did not appear at the hearing but notified the HO that he or she is aware the representative was going to withdraw, and there is no indication of good cause for the claimant's failure to appear, the ALJ may dismiss the RH. However, if the HO did not receive notification from the claimant indicating he or she was aware the representative was going to withdraw at the hearing, the ALJ must develop good cause for failure to appear.

If the claimant alleges he or she did not appear at the hearing because the claimant believed the representative was appearing on his or her behalf, or the claimant otherwise indicates he or she wants to proceed with the hearing, the ALJ will generally find good cause for failure to appear, and the ALJ will reschedule the hearing. However, if the claimant does not respond to the HA-L90, the ALJ may dismiss the RH.

NOTE 1:

If a preponderance of the evidence supports an on-the-record fully favorable decision on every issue, the ALJ will consider whether it is more appropriate to issue a decision under 20 CFR 404.948 and 416.1448 rather than dismiss the RH.

NOTE 2:

In egregious situations, a representative's repeated failure to notify the claimant of the withdrawal before the hearing may constitute misconduct or may help to establish a pattern of possible misconduct under 20 CFR 404.1740 and 416.1540. For more information on making referrals for alleged representative misconduct, see HALLEX I-1-1-50.

2. Representative Continues to Represent the Claimant During the Hearing

If an appointed representative appears at the scheduled hearing without the claimant and continues to represent the claimant during the hearing, dismissal is never appropriate. However, the ALJ may determine that the claimant has constructively waived the right to appear at the hearing if:

The representative is unable to locate the claimant;

The Notice of Hearing was mailed to the claimant's last known address; and

The contact procedures required by 20 CFR 404.938 and 416.1438, as described in HALLEX I-2-3-20, have been followed.

a. Constructive Waiver of Right to Appear

If the ALJ finds that the claimant has constructively waived the right to appear at the hearing, the ALJ need not proceed with the hearing and may choose to issue a decision on the record. However, if medical expert or vocational expert testimony is needed to resolve the case, the ALJ may choose to proceed with the hearing, accepting the testimony of the witness(es) and allowing the appointed representative to question the witness(es) and make arguments on the claimant's behalf.

In any event, the ALJ will advise the appointed representative, either on the record during the hearing or in writing thereafter, that he or she will not send a Request to Show Cause for Failure to Appear to the claimant because the claimant has constructively waived the right to appear at a hearing. When done in writing, the ALJ must associate the writing with the record.

b. No Constructive Waiver

If the ALJ finds that the claimant has not constructively waived the right to appear at the hearing, the ALJ may choose to proceed with the hearing, accepting the testimony of the witness(es) and allowing the appointed representative to question the witness(es) and make arguments on the claimant's behalf. The ALJ will advise the appointed representative that a Request to Show Cause for Failure to Appear will be sent to the claimant to ask why he or she did not appear at the scheduled hearing and whether a supplemental hearing should be held. After the 10-day response period expires (with an additional five days for mailing time), the ALJ will either:

- Determine that the claimant has constructively waived his or her right to appear for a hearing (if the claimant fails to respond to the Request to Show Cause for Failure to Appear or fails to show good cause for failure to appear

at the scheduled hearing), and issue a decision based on the evidence of record; or

- Offer the claimant a supplemental hearing to provide testimony if the claimant establishes good cause for failure to appear at the scheduled hearing.

E. Claimant Requests Change in the Time or Place of the Hearing

Subject to 20 CFR 404.936 or 416.1436, if a claimant or his or her appointed representative, if any, requests that the ALJ change the time or place set for the hearing, the ALJ will consider whether the claimant or representative has good cause for requesting the change.

- If the ALJ finds there is not good cause for changing the time or place of the scheduled hearing, the ALJ will notify the claimant or appointed representative, if any, of his or her finding.

- If the ALJ finds there is good cause for changing the time or place of the scheduled hearing, the ALJ will notify the claimant of the time and place of the rescheduled hearing.

If, after proper notification of the scheduled hearing (see HALLEX I-2-3-20 and C above), neither the claimant nor the representative appears at the time and place set for the hearing, the ALJ must determine whether the claimant or representative received the notice of hearing. If the ALJ finds that the claimant or representative did receive the notice, the ALJ may dismiss the RH for failure to appear under the circumstances noted in C.3. above.

F. Claimant Waived Right to Oral Hearing — ALJ Nevertheless Scheduled Hearing

The ALJ may not dismiss an RH for failure to appear if the claimant waived the right to an oral hearing and the ALJ nevertheless scheduled a hearing. In this situation, the ALJ must decide the case based on the evidence of record.

II.B.2. CALJ Email, 7/30/15; Appeals Council Interpretation II-5-1-8 and Dismissals ACL 15-808

From: (b) (2)
Sent: Thursday, July 30, 2015 4:00 PM
Subject: Appeals Council Interpretation II-5-1-8 and Dismissals ACL 15-808

The Appeals Council (AC) has issued a new interpretation in Hearings, Appeals, and Litigation Law (HALLEX) manual II-5-1-8. This interpretation addresses whether the AC will grant review following an administrative law judge (ALJ) dismissal when the claimant did not appear at the hearing, but a person appeared for the claimant and submitted an appointment of representation for the first time at the hearing.

Under HALLEX I-2-4-25 D.2, "[i]f an appointed representative appears at the scheduled hearing without the claimant and continues to represent the claimant during the hearing, dismissal is never appropriate."

The interpretation in HALLEX II-5-1-8 will apply only in very rare circumstances when it is questionable whether an individual's appointment as a representative is valid. This interpretation applies when the claimant does not appear but another individual appears at the hearing, purports to be the claimant's representative, and submits an appointment of representation (signed by the claimant) for the first time. Under these circumstances, the ALJ may dismiss the hearing request if he or she articulates a good reason, supported by the record, for finding that the claimant was not aware of or did not specifically consent to the appointment of the person who appeared at the hearing.

If you have any questions, please let me know.

/s/
Debra Bice
Chief Administrative Law Judge

II.B.3. ACQUIESCENCE Ruling 16-1(7); 7th Circuit Rule on Judicial Review of ALJ's Dismissal for Untimely Filing

(b) (2)

II.C. Dismissal Due to Hearing Request Not Timely Filed

I.C.1. Request for Hearing Filing Requirements: HALLEX I-2-0-40

I-2-0-40. Request for Hearing Filing Requirements
Last Update: 5/1/17 (Transmittal I-2-202)

A. General

If a claimant is dissatisfied with one of the determinations or decisions listed in 20 CFR 404.930 and 416.1430, he or she may request a hearing. See 20 CFR 404.929 and 416.1429. The claimant must submit the request in writing within 60 days after receiving notice of the previous determination or decision by completing form HA-501, Request for Hearing, or by submitting a letter or other written document. We presume the claimant received notice of the prior determination or decision within five (5) days of the date of the notice, unless there is a reasonable showing to the contrary. (For more information on what constitutes the date of filing, see subsection D below).

NOTE 1:
The claimant may specifically ask for a hearing or may imply that he or she is requesting a hearing. A request is implied when the claimant expresses disagreement or dissatisfaction with the prior action or states the intent to pursue appeal rights.

NOTE 2:
While a writing is required to request a hearing, the regulations do not require that the writing be signed. See 20 CFR 404.933 and 416.1433. The agency accepts faxed requests.

B. Who May File a Request for Hearing (RH)

The claimant, his or her appointed representative, or another party to the hearing who is dissatisfied with the determination or decision can file an RH. See 20 CFR 404.932 and 416.1432. For a detailed explanation regarding parties to the hearing, see Hearings, Appeals and Litigation Law (HALLEX) manual I-2-1-45.

C. Where to File the RH

Generally, a claimant will file an RH online or with a Social Security field office (FO), but he or she may file the RH with a hearing office (HO). When an appointed representative is involved and wants direct payment of his or her fee (if authorized), the representative must, on the claimant's behalf, file the RH online.
Also note the following:

- A claimant residing in the Philippines may file an RH at the Department of Veterans Affairs Regional Office in the Philippines.

- A claimant with ten or more years of service in the railroad industry may file an RH at a Railroad Retirement Board office.

- A claimant residing in a foreign country (see definition in HALLEX I-2-0-72) may file an RH with an office maintained by the Foreign Service of the United States Department of State.

D. Date of Filing the RH

Ordinarily, we consider an RH filed as of the date it is received in any Social Security Administration office. If the 60-day time period for filing the RH ends on a Saturday, Sunday, Federal holiday, or other non-work day for Federal employees, we extend the time for filing to the next full workday. We also accept as the date of filing:

- The U.S. Postal Service stamp cancellation or “postmark” date on the envelope in which the RH is mailed to us, if using the date we receive the request would result in the loss of the claimant's rights. If the postmark is unreadable or there is no postmark, we consider the RH timely filed if we receive it by the 70th day after the date on the notice of the determination or decision being appealed. We will also consider other evidence of when the individual mailed the RH to us;

- The date an RH is received at the Department of Veterans Affairs Regional Office in the Philippines or by an employee of that Department in the Philippines authorized to receive such request at a place other than the Regional Office; or

- The date the Railroad Retirement Board receives the request, if an individual having 10 or more years of service in the railroad industry files the request.

When an RH is filed using iAppeals (i.e., the request is submitted online), the filing date is the date the completed HA-501 is submitted. The application start date and reentry number generated by iAppeals does not constitute a filing. For detailed information about iAppeals, see Program Operations Manual System GN 03101.125.

E. Extension of Time to File an RH

If a claimant does not file an RH within the 60-day time period, he or she can, in writing, request an extension of time to file and explain the reason(s) for filing late. As explained in HALLEX I-2-0-60, an administrative law judge (ALJ) will evaluate the request and determine whether the claimant has established good cause for missing the deadline. If the ALJ finds good cause for the extension request, he or she will extend the time period to submit the RH. If the ALJ concludes the claimant did not establish good cause for an extension, the ALJ will deny the request and dismiss the RH using the procedures in HALLEX I-2-4-15.

II.C.2. Hearing Request Not Timely Filed: HALLEX I-2-4-15

I-2-4-15. Hearing Request Not Timely Filed

Last Update: 8/23/16 (Transmittal I-2-188)

A. General

A claimant must file a request for hearing (RH) within 60 days after receiving notice of the previous determination or decision. For more information about filing requirements, see Hearings, Appeals and Litigation Law (HALLEX) manual I-2-0-40. An administrative law judge (ALJ) may dismiss an RH that was not filed within 60 days. Therefore, on receipt of an RH, hearing office (HO) staff evaluates whether it appears the request was timely filed. See HALLEX I-2-0-10.

NOTE:

To avoid erroneous dismissal of RHs in cases pulled for quality review at the reconsideration level, HO staff will confirm the reconsideration notice release date by checking the Case Review Screen under the Case Data Tab in eView.

B. Requesting Explanation for Untimely Filing

When an explanation for an untimely filing is not in the file, HO staff will prepare a letter to the claimant and representative, if any, requesting an explanation for the untimely filing. See also HALLEX I-2-0-60 C.
If, after developing the issue, the ALJ finds there is insufficient evidence or information to determine whether the claimant had good cause for untimely filing, see HALLEX I-2-0-60 D.

C. Evaluating Good Cause

When an HO receives an untimely filed RH, the ALJ will use the procedures in HALLEX I-2-0-60 to evaluate good cause.

The ALJ will incorporate as exhibits in the claim(s) file all documents used to evaluate good cause. This documentation includes any available documents relating to the date the claimant or appointed representative mailed the RH, such as the postmarked envelope used to mail the RH.
When the ALJ finds that the claimant established good cause for an untimely filing, HO staff and the ALJ will proceed with the actions necessary to complete the record and issue a decision.

When the ALJ finds that the claimant did not establish good cause for an untimely filing, the ALJ will dismiss the RH using the Untimely Request option from the Dismissal menu in the Document Generation System. In the dismissal order, the ALJ will include a complete rationale explaining why he or she found the claimant did not establish good cause for the untimely filing.

II.C.3. Good Cause for Late Filing: HaLLEX I-2-0-60

I-2-0-60. Good Cause for Late Filing

Last Update: 5/1/17 (Transmittal I-2-202)

Citations:

20 CFR 404.911, 416.1411, and Social Security Ruling 91-5p

A. Considerations When Evaluating Good Cause

When evaluating whether a claimant has shown good cause for missing a deadline to request a hearing, an administrative law judge (ALJ) considers whether:

- Circumstances kept the claimant from making the request on time;

- The claimant did not understand the requirements of the Social Security Act (Act) because of amendments to the Act, other legislation, or court decisions; and

- Agency action(s) misled the claimant; or

- The claimant had any physical, mental, educational, or linguistic limitations (including any lack of facility with the English language) which prevented him or her from filing a timely request or from understanding or knowing about the need to file a timely request for review.

B. Examples

An ALJ must evaluate whether a claimant has shown good cause based on the circumstances of the case. Examples of when good cause for late filing may exist include, but are not limited to, the following:

- The claimant was seriously ill and was prevented from contacting the Social Security Administration (SSA) in person, in writing, or through a friend, relative, or other person;

- There was a death or serious illness in the claimant's immediate family;

- Important records were destroyed or damaged by fire or other accidental cause;

- The claimant was trying very hard to find necessary information to support his or her claim but did not find the information within the stated time periods;

- The claimant asked us for additional information explaining our action within the time limit, and within 60 days of receiving the explanation the claimant requested reconsideration or a hearing;

- SSA gave the claimant incorrect or incomplete information about when and how to request administrative review;

- The claimant did not receive notice of the determination;

- The claimant sent the request to another government agency in good faith within the time limit, and the request did not reach SSA until after the time period had expired;

- Unusual or unavoidable circumstances existed which show that the claimant could not have known of the need to file timely, or which prevented the claimant from filing timely; or

- The claimant relied on a representative to timely file a request, and the representative failed to do so.

NOTE:
An ALJ must not infer good cause for late filing merely because a claimant has a representative, but must consider a claimant's good cause statement indicating reliance on a representative. If a representative has a pattern of filing untimely appeals, or the claimants of a particular representative develop a pattern of submitting good cause statements for late filing citing reliance on the representative, an ALJ will consider whether circumstances warrant a referral to the Office of the General Counsel (OGC) as a possible violation of our rules. See Hearings, Appeals and Litigation Law (HALLEX) manual I-1-1-50 for instructions on making referrals to OGC.

C. Developing Good Cause

If there is no evidence in the claim file indicating the reason for the late filing, send the claimant and the claimant's representative a letter requesting an explanation. Place a copy of the communication sent to the claimant in the claim file as an exhibit.

If the file is paper, ask the servicing field office to forward any pertinent information in its files, e.g., any letter or communication from the claimant, representative, or the claimant's family, a copy of any records containing information regarding pertinent contacts, etc. If the case is electronic, look in the electronic claim(s) file for any new pertinent information that may have been entered by another office.

D. Hearing on Issue of Good Cause

The ALJ may also elect to hold a hearing for the sole purpose of obtaining information on the issue of good cause for untimely filing.

To avoid confusion about the nature of the hearing, the notice of hearing on a good cause issue alone must be limited to that issue. The notice must indicate that it is not a hearing on disability issues.

- If good cause does not exist, then the request for hearing should be dismissed as the ALJ has no jurisdiction. See HALLEX I-2-4-15.

- If the ALJ finds that the claimant had good cause for his or her untimely filing, the case will be returned to Master Docket for further processing.

II.C.4. SSR 91-5p; Policy Interpretation Ruling: Mental Incapacity and Good Cause for Missing the Deadline to Request Review

SSR 91-5p

EFFECTIVE/PUBLICATION DATE: 07/01/91

SSR 91-5p: POLICY INTERPRETATION RULING Titles II and XVI: Mental Incapacity and Good Cause for Missing the Deadline to Request Review

PURPOSE: The purpose of this interpretative ruling is to clarify our policy on establishing good cause for missing the deadline to request review. It is being issued to avoid the improper application of res judicata or administrative finality when the evidence establishes that a claimant lacked the mental capacity to understand the procedures for requesting review.

CITATIONS (AUTHORITY): Sections 205(b) and 1631(c) of the Social Security Act, as amended; Regulations No. 4, sections 404.903(j), 404.909(b), 404.911, 404.925(c), 404.933(c), 404.957(c)(3), 404.968(b), 404.982; and Regulations No. 16, sections 416.1403(a)(8), 416.1409(b), 416.1411, 416.1425(c), 416.1433(c), 416.1457(c)(3), 416.1468(b), and 416.1482.

PERTINENT HISTORY: Our rules in 20 CFR, sections 404.909(a), 404.933(b), 404.968(a), 404.982, 416.1409(a), 416.1433(b), 416.1468(a), and 416.1482, respectively, provide that a request for reconsideration, hearing before an administrative law judge (ALJ), review by the Appeals Council, or review by a Federal district court must be filed within 60 days after the date of receipt by the claimant of the notice of the determination or decision being appealed. However, the regulations also provide that a claimant can request that the 60-day time period for filing a request for review be extended if the claimant can show good cause for missing the deadline. The request for an extension of time must be in writing and must give the reasons why the request for review was not filed timely.

When the claimant fails to timely request reconsideration, an ALJ hearing, Appeals Council review, or review by a Federal district court, the Appeals Council review, or review by a Federal district court, the Agency applies the criteria in section 404.911 or section 416.1411, as appropriate, in determining whether good cause for missing the deadline exists.

Section 404.911(a) states:

In determining whether you have shown that you had good cause for missing a deadline to request review we consider

(1) what circumstances kept you from making the request on time;
(2) whether our action misled you;
(3) whether you did not understand the requirements of the Act resulting from amendments to the Act, other legislation, or court decisions.

Section 416.1411(a) sets out essentially the same language.

If the claimant establishes good cause for missing the deadline to request review, we process the request for review in accordance with established procedures and the prior administrative action is not final or binding for purposes of applying the rules on either res judicata or administrative finality.

The rules on administrative finality (20 CFR, sections 404.987, 404.988, 404.989, 416.1487, 416.1488, 416.1489) provide that a final determination or decision cannot be reopened more than 4 years (2 years for supplemental security income cases) from the date of the notice of the initial determination on the claim unless one of the specified conditions in section 404.988(c) or section 416.1488(c) applies.

Similarly, the rules in 20 CFR, sections 404.957(c)(1) and 416.1457(c)(1) indicate that an ALJ may apply res judicata to dismiss a hearing request in cases where a previous determination or decision on a claim, involving the same facts and the same issues, has become final. A determination or decision becomes final for purposes of the application of res judicata, when the claimant fails to file a request for reconsideration, or a hearing before an ALJ, or review by the Appeals Council, or judicial review, whichever is appropriate, within the time periods provided by the regulations. If the claimant establishes good cause for missing the deadline to seek judicial review of an Appeals Council's decision or denial of review or expedited appeals process agreement, the time period will be extended.

POLICY INTERPRETATION: It has always been SSA policy that failure to meet the time limits for requesting review is not automatic grounds for dismissing the appeal and that proper consideration will be given to a claimant who presents evidence that mental incapacity may have prevented him or her from understanding the review process.

When a claimant presents evidence that mental incapacity prevented him or her from timely requesting review of an adverse determination, decision, dismissal, or review by a Federal district court, and the claimant had no one legally responsible for prosecuting the claim (e.g., a parent of a claimant who is a minor, legal guardian, attorney, or other legal representative) at the time of the prior administrative action, SSA will determine whether or not good cause exists for extending the time to request review. If the claimant satisfies the substantive criteria, the time limits in the reopening regulations do not apply; so that, regardless of how much time has passed since the prior administrative action, the claimant can establish good cause for extending the deadline to request review of that action.

The claimant will have established mental incapacity for the purpose of establishing good cause when the evidence establishes that he or she lacked the mental capacity to understand the procedures for requesting review.

In determining whether a claimant lacked the mental capacity to understand the procedures for requesting review, the adjudicator must consider the following factors as

they existed at the time of the prior administrative action:

-- inability to read or write;
-- lack of facility with the English language;
-- limited education;
-- any mental or physical condition which limits the claimant's ability to do things for him/herself.

If the claimant is unrepresented and has one of the factors listed above, the adjudicator will assist the claimant in obtaining any relevant evidence. The decision as to what constitutes mental incapacity must be based on all the pertinent facts in a particular case. The adjudicator will resolve any reasonable doubt in favor of the claimant.
If the adjudicator determines good cause exists, he or she will extend the time for requesting review and take the action which would have been appropriate had the claimant filed a timely request for review. A finding of good cause will result either in a determination or decision that is subject to further administrative or judicial review of the claim, or a dismissal (for a reason other than late filing) of the request for review, as appropriate.

If the adjudicator determines good cause does not exist to extend the time, the adjudicator will consider the claimant to have filed an untimely request for review, deny the request to extend the time for filing, and dismiss the request. The dismissal of the request for review will state the adjudicator's rationale for not finding good cause and advise the claimant that he or she can file a new application and use the written request for review as a protective filing date.

EFFECTIVE DATE: The right to establish good cause for missing the deadline to request review is a longstanding SSA policy. SSA will apply this policy to any case brought to its attention.

EXCEPTION: In addition to this Ruling, Acquiescence Ruling AR 90-4(4), which implements the *Culbertson* and *Young* cases, must be followed when adjudicating such cases arising in the Fourth Circuit.

CROSS-REFERENCE: Program Operations Manual System, Part 2, Chapter 031, Subchapter 01; Acquiescence Ruling AR 90-4(4).

II.D. Dismissal Due to Withdrawal of Request for Hearing: HALLEX I-2-4-20; HALLEX I-2-4-22

II.D.1 Withdrawal of Request for Hearing

I-2-4-20.Claimant Asks to Withdraw Request for Hearing

Last Update: 8/2/16 (Transmittal I-2-184)

At the request of a claimant, an administrative law judge (ALJ) may dismiss a request for hearing (RH) at any time before mailing notice of the decision if:

- The claimant or an appointed representative submitted a written request to withdraw the RH, or made such a request for withdrawal orally on the record at the hearing;
- The record shows the claimant understands the effects of withdrawing the RH (i.e., that a dismissal will be binding unless it is vacated by the ALJ or the Appeals Council);
- There are no other parties to the hearing (see Hearings, Appeals and Litigation Law (HALLEX) manual I-2-1-45) who may be adversely affected by dismissal of the RH;
- The voluntary withdrawal does not follow a sentence six court remand (see HALLEX I-2-4-37); and
- The ALJ determines that dismissal is appropriate.

NOTE:

If the claimant requests to withdraw the application instead of the RH, see HALLEX I-2-4-22.

If there is another party to the hearing who may be adversely affected by dismissal of the RH, the ALJ must notify the other party of the request to withdraw the RH and offer the party the opportunity to object before taking any action. If the other party objects to the withdrawal, the ALJ must proceed with the actions necessary to complete the record, hold a hearing (unless all parties waived the right to a hearing), and issue a decision.

If the ALJ dismisses the RH, hearing office staff will follow the instructions in HALLEX I-2-4-5. If the ALJ does not dismiss the RH, the ALJ will explain the reasons for not doing so in writing, either in correspondence to the claimant or, when the claimant waived the right to appear at the hearing, in the decision. Regardless of whether the ALJ dismisses the RH, the ALJ will ensure the claimant's request to withdraw and any associated correspondence between the hearing office and a party to the hearing is associated in the appropriate section of the claim(s) file.

II.D.2. Withdrawal of Application

I-2-4-22.Claimant Requests Withdrawal of Application at Hearing Level

Last Update: 5/26/17 (Transmittal I-2-207)

A. In General

As provided in 20 CFR 404.640 and 416.355, a claimant may withdraw an application in certain circumstances, even after the agency makes a determination. These regulatory sections use the term "determination," which is defined in 20 CFR 404.901 and 416.1401, as meaning the initial determination or reconsideration determination. For detailed information about when a claimant can withdraw an application, see Program Operations Manual System (POMS) GN 00206.005.

However, the regulations do not provide authority to withdraw an application after an administrative law judge (ALJ) has issued a decision or dismissal. Further, withdrawal of an application after the issuance of a decision could create processing conflicts with several Acquiescence Rulings that require the agency to adopt prior ALJ decisional findings. For similar reasons, a claimant may not withdraw an application after a case has been remanded by the Appeals Council or a Federal court. When a case has been remanded, see the instructions in Hearings, Appeals and Litigation Law (HALLEX) manual I-2-4-37 and I-2-8-18, as applicable.

II.E. Dismissal Due to No Right to a Hearing: HALLEX I-2-4-30(A)

I-2-4-30(A). Dismissal — No Right to a Hearing

Last Update: 2/7/14 (Transmittal I-2-104)

A. General

The administrative law judge (ALJ) may dismiss a request for hearing (RH) when the person requesting the hearing has no right to it under 20 CFR 404.930 and 416.1430. For authority, see 20 CF 404.957(c) and 416.1457(c).
In general terms, 20 CFR 404.930 and 416.1430 state:

- We will hold a hearing only if the claimant or another party to the hearing files the written request for a hearing; and
- We have made one of the determinations or decisions listed in the regulations (as detailed in HALLEX I-2-4-30 C below).

NOTE:

An individual is a party to a hearing if he or she is a party to the initial, reconsidered, or revised determination, or is another person who shows in writing that his or her rights may be adversely affected by the hearing. In addition, any other person may be made a party to the hearing if his or her rights may be adversely affected by the ALJ's decision or dismissal and we notify the person to appear at the hearing or to present evidence supporting his or her interest. See 20 CFR 404.932 and 416.1432. See also Hearings, Appeals, and Litigation Law (HALLEX) manual I-2-1-45.

II.F. Dismissal Due to Death of Claimant

II.F.1. Dismissal Due to Death of Claimant (General): HALLEX I-2-4-35

I-2-4-35. Dismissal Due to Death of a Claimant
Last Update: 12/29/14 (Transmittal I-2-131)

A. General Policy

An administrative law judge (ALJ) may not dismiss a request for hearing under title II or title XVI when the case was remanded by a court under sentence six of sections 205(g) and 1631(c) of the Social Security Act (Act). See Hearings, Appeals and Litigation Law (HALLEX) manual I-2-4-37.

However, as explained in the following paragraphs, an ALJ may dismiss a request for hearing under title II or title XVI based on the death of a claimant when the case was remanded by a court under sentence four of sections 205(g) and 1631(c) of the Act.

1. Title II

Under 20 CFR 404.957(c)(4), an ALJ may dismiss a request for hearing if:

- The claimant dies;
- There are no other parties (see HALLEX I-2-1-45); and
- The ALJ has no information to show that another person may be adversely affected by the dismissal action (see HALLEX I-2-1-50).

Under 20 CFR 404.957(c)(4), an ALJ will vacate the order of dismissal if, within 60 days after the date of the dismissal, another person submits a written request for a hearing on the claim and shows that he or she may be adversely affected by the determination that was to be reviewed by the ALJ.

2. Title XVI

Under 20 CFR 416.1457(c)(4), an ALJ may dismiss a request for hearing if:

- The claimant dies;
- There are no other parties (see HALLEX I-2-1-45);
- The ALJ has no information to show there may be a survivor who may be paid benefits under section 1631(b) of the Act, as set forth in 20 CFR 416.542(b), who wishes to pursue the request for hearing (see HALLEX I-2-1-50); or
- The applicant or recipient did not authorize interim assistance reimbursement (IAR) to a state pursuant to section 1631(g) of the Act.

> **NOTE 1:**
> Even though a state may not pursue the IAR claim of a deceased applicant or recipient, an ALJ may not dismiss a request for hearing if there is an IAR authorization in effect. Rather, the ALJ will consider the case on its merits and issue a decision.
>
> **NOTE 2:**
> Although Medicaid eligibility often flows from title XVI eligibility findings, merely showing that a survivor wishes to pursue Medicaid eligibility does not make the person a party to the proceeding or a qualified survivor. Unless the person otherwise meets the criteria as a party to the proceeding or a qualified survivor, the ALJ may dismiss the request for hearing.

Under 20 CFR 416.1457(c)(4), the ALJ will vacate the order of dismissal if within 60 days:

- A person who may be paid benefits under section 1631(b) of the Act, as set forth in 20 CFR 416.542(b), submits a written request for hearing and shows that a decision on the issues that were to be considered at the hearing may adversely affect him or her; or
- The ALJ receives information showing that the applicant or recipient authorized IAR to a state pursuant to section 1631(g) of the Act.

B. Claimant Dies Before the Hearing Is Held

Under title II, if there is any person who qualifies as a substitute party under 20 CFR 404.503(b), the ALJ will not dismiss the request for hearing because a substitute party is a person who may be adversely affected by a dismissal. Under title XVI, if there is any survivor who may be paid benefits under section 1631(b) of the Act (see also 20 CFR 416.542(b)) and who wishes to pursue the request for review, the ALJ will not dismiss the request for hearing because a qualified survivor is a person who may be adversely affected by a dismissal.

> **NOTE:**
> SSA develops substitute parties using form HA-539, Notice Regarding Substitution of Party Upon Death of Claimant, which can be accessed from the Program Operations Manual System OS 15030.019.

However, if there are no other parties and a substitute party or qualified survivor states in writing that he or she does not wish to proceed with the claim(s), the ALJ may dismiss the request for hearing. The ALJ may also dismiss the request for hearing if any of the other conditions for dismissal are met. For the other conditions for dismissal, see HALLEX I-2-4-5.

> **NOTE:**
> If the primary issue is revision of the wage earner's earnings record and a survivor establishes potential entitlement based on that earnings record, the hearing office will make the survivor a substitute party upon request. It is not necessary for the survivor to establish that he or she would be adversely affected by the ALJ's decision.

Although a qualified survivor may choose not to pursue the appeal rights of the deceased, the survivor may later request a hearing regarding his or her rights. In that situation, the survivor is not precluded from raising the issues appealed by the deceased as part of his or her hearing.

C. Claimant Dies After the Hearing Has Been Held

If the claimant dies after the ALJ holds a hearing, the ALJ will proceed with any actions needed to complete the record and will issue a decision. For instructions on routing the decision, see HALLEX I-2-8-37.

II.F.2. Death of the Claimant (Appropriate Substitute Parties): Adjudication Tip #53

#53 – Death of the Claimant
Greetings ODAR! Here is the latest Adjudication Tip. We will publish this tip on the Office of the Chief Administrative Law Judge's website shortly.

You know that the death of a claimant prior to an ALJ hearing *could* result in the dismissal of a claim(s). But did you know that there are different dismissal rules depending on whether the claimant filed a title II or title XVI claim?

Under both titles II and XVI, an ALJ may dismiss a request for hearing if the claimant dies, there are no other parties, and the ALJ has no information to show that another person may be adversely affected by the dismissal action (20 CFR 404.957(c)(4), 416.1457(c)(4) and HALLEX I-2-4-35). However, under both titles, an ALJ cannot dismiss the claim if there is an individual, also known as a substitute party, who would be entitled to receive the benefits due the deceased claimant and would be adversely affected by a dismissal action.

As illustrated in the chart below, appropriate substitute parties differ between the two titles:

APPROPRIATE SUBSTITUTE PARTIES	
Title II	Title XVI
20 CFR 404.503(b)	20 CFR 416.542(b)
(1) Surviving spouse living in same household (2) Entitled* child or children (3) Entitled* parent(s) (4) Surviving spouse nonqualifying under (b)(1) (5) Child or children nonqualifying under (b)(2) (6) Parent(s) nonqualifying under (b)(3) (7) Legal representative of deceased's estate	(1) Surviving spouse living in same household (2) Parent(s), **only if** the claimant was a disabled or blind child

**Entitled to a monthly benefit on the same earnings record as the deceased was for the month he or she died.*

Moreover, when determining whether dismissal is appropriate, title XVI cases require an additional consideration beyond the existence of an appropriate substitute party who

wishes to pursue the request for hearing. Specifically, if the claimant authorized interim assistance reimbursement (IAR) to a state, the ALJ cannot dismiss the request for hearing (20 CFR 416.1457(c)(4) and HALLEX I-2-4-35 A.2.). If the IAR authorization (SSI Notice of Interim Assistance Reimbursement) is not in the D Section of the electronic file, it can also be found in the Online Retrieval System (ORS). The SSID query will also show whether IAR is authorized as an entry under Miscellaneous Payment Data (MPMT) (*see* POMS SM 01311.030).

For additional resources on this issue, see HALLEX I-2-1-45; HALLEX I-2-1-50; POMS DI 12045.045; POMS GN 02301.030; POMS SI 02101.003; POMS SI 02003.001; EM-15029 (When to Recognize Same-sex Marriages in Title II Survivor and Lump-Sum Death Payment Claims)

In case you missed them, past adjudication tips are available on OCALJ's intranet site: (b) (2) *Please continue to send all comments and suggestions to* (b) (2) *. Thank you.*

II.G. Dismissal due to Res Judicata: HALLEX I-2-4-40

I-2-4-40. Administrative Res Judicata

II.H. Situations in which Dismissal is Precluded

II.H.1. After a Sentence Six Court Remand: HALLEX I-2-4-37

I-2-4-37. Dismissal After Court Remand

Last Update: 11/20/14 (Transmittal I-2-127)

A. General

An administrative law judge (ALJ) may not dismiss a request for hearing (RH) remanded by the court under sentence six of section 205(g) and 1631(c)(3) of the Social Security Act (Act), but the ALJ may dismiss if a court remanded under sentence four of section 205(g) and 1631(c)(3) of the Act. For more information about court remands, including the difference between a sentence four and a sentence six court remand, see Hearings, Appeals and Litigation Law (HALLEX) manual I-4-3-1.

B. Sentence Four

Under sentence four of section 205(g) and 1631(c)(3) of the Act, an ALJ may dismiss an RH remanded from court because the court's jurisdiction ended when the court issued its remand. For the conditions for dismissal, see HALLEX I-2-4-5. For sample language for an ALJ decision or dismissal after a sentence four court remand, see HALLEX I-2-4-96.

However, even if the conditions for dismissal are met, the ALJ will not dismiss an RH remanded under sentence four if:

- The court held that the claimant was disabled and remanded merely to determine the onset of disability; or
- The ALJ determines that the claimant's appearance at a hearing is not necessary to issue a favorable decision.

In these situations, the ALJ will develop the record as needed and comply with the court's order, including holding a hearing, if necessary.

C. Sentence Six

Under a sentence six court remand, the ALJ may not dismiss the RH, even when it appears a claimant has abandoned the RH or the claimant expressly states that he or she wants to withdraw the RH. In all circumstances in which a dismissal would normally be the appropriate action, the ALJ must issue a decision, specifically addressing the particular issue that would normally be the basis for a dismissal action.

For example, when a claimant fails to appear for the hearing and does not establish good cause for such failure to appear, or when the claimant asks to withdraw the RH, the ALJ must document the facts of the abandonment or withdrawal and the effect the claimant's action has on the proceedings. Under these circumstances, the ALJ's decision will specifically include the following:

- A statement of the procedural history on remand from the court;
- A discussion of the facts surrounding the conclusion that the claimant has either abandoned or withdrawn the RH (see HALLEX I-2-4-25 or I-2-4-20);
- A discussion of the supporting documents entered in the record (i.e., notices sent to the claimant, attempts to contact the claimant or the representative, and the claimant's statements, if any);
- An explanation that the claimant's action renders the controversy moot, thereby making additional administrative proceedings unnecessary; and
- A statement adopting the prior final decision of the Commissioner, as modified.

For a sample decision when the claimant abandons or requests withdrawal after a sentence six court remand, see HALLEX I-2-8-97.

II.H.2. Claimant Fails to Attend a Consultative Examination: HALLEX I-2-5-24

I-2-5-24. Claimant Does Not Attend or Refuses to Undergo a Consultative Examination or Test

Last Update: 10/9/15 (Transmittal I-2-156)

If a claimant does not attend or refuses to undergo a consultative examination (CE) or test requested by an administrative law judge (ALJ), the Disability Determination Services (DDS) will first assess whether the claimant had good cause for doing so using the general principles outlined in 20 CFR 404.911 and 416.1411. If DDS finds good cause, it will reschedule the CE or test.

However, if DDS finds the claimant does not establish good cause, or the claimant does not attend or refuses to undergo a CE or test in the second instance, DDS will return the request to the ALJ along with any reason(s) the claimant provided for missing the CE or test. The ALJ will associate any documentation from DDS with the claim(s) file.

The ALJ will then use the general principles in 20 CFR 404.911 and 416.1411 to determine whether the claimant had good cause for not attending or refusing to undergo a CE or test. Depending on the circumstances, the ALJ may need to further develop the issue. When evaluating the issue, the ALJ will consider whether the individual has any physical, mental, educational, or linguistic limitations (including any lack of facility with the English language) that may have bearing on the failure to cooperate. In addition to considering the regulatory criteria, ALJs will also evaluate the issue using the same

general principles outlined in Social Security Ruling (SSR) 91-5p, Policy Interpretation Ruling Titles II and XVI: Mental Incapacity and Good Cause for Missing the Deadline to Request Review.

> **NOTE 1:**
> If the claimant is 65 or older, note also the general principle outlined in SSR 03-3p, Policy Interpretation Ruling – Titles II and XVI: Evaluation of Disability and Blindness in Initial Claims for Individuals Aged 65 or Older. SSR 03-3p states, "[s]ome individuals aged 65 or older may not understand, or be able to comply with, our requests to submit evidence or attend a consultative examination (CE). Therefore, adjudicators must make special efforts in situations in which it appears that an individual aged 65 or older may not be cooperating."
>
> **NOTE 2:**
> In unusual circumstances where the medical record is unclear and resolution is needed to make a finding, an ALJ may obtain an opinion from a medical expert regarding the possible effect of an impairment on the failure to attend or undergo a CE or test.

If the ALJ determines the claimant had good cause for not attending or refusing to undergo the CE or test (and the claimant does not oppose attending or undergoing a CE or test), the ALJ will request that DDS schedule another CE or test as soon as possible. However, if the claimant cannot establish good cause for not attending or refusing to undergo a CE or test, the ALJ will:

- Exhibit any documents associated with the good cause decision;
- Proffer documents exhibited posthearing to the claimant and representative, if any (see Hearings, Appeals and Litigation Law (HALLEX) manual I-2-7-1); and
- Issue a decision based on the available evidence. For authority, see 20 CFR 404.1516, 404.1518, 404.1579(e)(2), 416.916, 416.918, and 416.994(b)(3)(iv)(D)(4)(ii)

> **NOTE 3:**
> There is no authority for an ALJ to dismiss a request for hearing based on the claimant's failure to attend or refusal to undergo a CE or test. However, if the claimant fails to appear at the time and place of the hearing after the ALJ gave proper notice, see 20 CFR 404.957 and 416.1457. See also HALLEX I-2-4-25.

II.H.3. Prior to Hearing, Even if Claimant Appears to Have Abandoned the Case: HALLEX I-2-4-25, Subsection C.3. I-2-4-25.Dismissal Due to Claimant's Failure to Appear

II.I. OCEP 1/16/13: Four Keys to Dismissals

Do not dismiss for failure to appear unless all notice and contact requirements were completed before the hearing

- If the acknowledgement of receipt of hearing notice has not been returned, you must attempt to contact the claimant BEFORE the hearing (HALLEX 1-2-4-25)
- If either the claimant or the representative returns the acknowledgement of receipt of the hearing notice, you have satisfied the regulation and need take no further action
- If the claimant or representative requests a postponement on the acknowledgement form, the ALJ must rule on the request and notify the claimant and representative
- Always check system for the claimant's latest address

Do not dismiss if the representative appears for the hearing but the claimant does not (HALLEX I-2-4-25 (D))

- Proceed with the hearing; take any expert testimony and permit cross-examination and arguments by the representative; send a show cause order to the claimant
- If the claimant offers good cause for failure to appear, offer a supplemental hearing; if no good cause, the ALJ may determine the claimant has constructively waived the right to appear and issue a decision on the merits

Consider the regulatory and SSR 91-5p factors for good cause before dismissing for untimely filing (20 CRF §§404.911, 416.1411 and 405.20)

- Ensure that good cause is developed if the request for hearing is untimely
- If good cause is not demonstrated, the request for hearing must be dismissed
- Provide sufficient rationale for your finding of no good cause in the Order

Ensure that the claimant understands the consequences of dismissal before granting withdrawal of the request for hearing

- The request may be in writing or orally at the hearing
- Although not required, consider having the claimant and representative sign a letter indicating the effects of the withdrawal have been specifically addressed

II.J. Vacating an Order of Dismissal: HALLEX I-2-4-10

I-2-4-10. Vacating an Order of Dismissal at the Request of a Claimant

Last Update: 2/7/14 (Transmittal I-2-104)

A. General

A claimant may request that an administrative law judge (ALJ) vacate a dismissal order within 60 days of the date of receiving the dismissal notice, unless the Appeals Council (AC) has jurisdiction. The AC has jurisdiction if the claimant has requested the AC review the order of dismissal or if the AC is reviewing the dismissal on its own motion. Subject to the timeframe and jurisdiction, an ALJ may vacate a dismissal order if the claimant shows the ALJ's dismissal of the request for hearing (RH) was erroneous.

> **NOTE:**
> If the claimant files a second request for hearing on the same application within 60 days, the ALJ will treat it as a request to vacate the prior dismissal.

A claimant may not submit both a request to the ALJ to vacate the order and a request to the AC asking it to review the dismissal order. If this occurs, the ALJ must take the action most favorable to the claimant. The ALJ will either:

- Immediately notify the AC (via email to ¦¦¦ODAR OAO) if the ALJ intends to vacate the order, or
- Respond in writing to the claimant indicating the ALJ will not review the request because the AC is reviewing the request, and associate a copy of the writing with the record.

For detailed instructions on requesting jurisdiction from the AC, see HALLEX I-2-4-11.

B. Determining Whether to Vacate an Order of Dismissal

The regulations at 20 CFR 404.960 and 416.1460 require that when requesting that an ALJ vacate an order of dismissal, the claimant must state why the dismissal of the request for hearing was erroneous. To determine whether the dismissal was erroneous, the ALJ generally considers whether the claimant establishes a “good cause” reason to vacate the dismissal order. There are no set criteria for determining what constitutes good cause to vacate a dismissal order but the concepts in HALLEX I-2-0-60 and I-2-4-25 B-C will generally apply to vacate requests.

1. Good Cause Is Not Established

If the ALJ concludes that the claimant has not established a good cause reason to vacate the dismissal order, the ALJ will:

- Inform the claimant, in writing, of the reasons for the conclusion;

- Advise the claimant that the ALJ's refusal to vacate the dismissal order is not subject to review by the AC; and
- Document the file by associating the claimant's request and a copy of the ALJ's letter to the claimant.

2. Good Cause Is Established

If the ALJ concludes that the claimant established a good cause reason to vacate the dismissal order, the ALJ will vacate the dismissal order, proceed with the actions necessary to complete the record, hold a hearing (if applicable), and issue a decision.

C. Preparing a Vacate Order

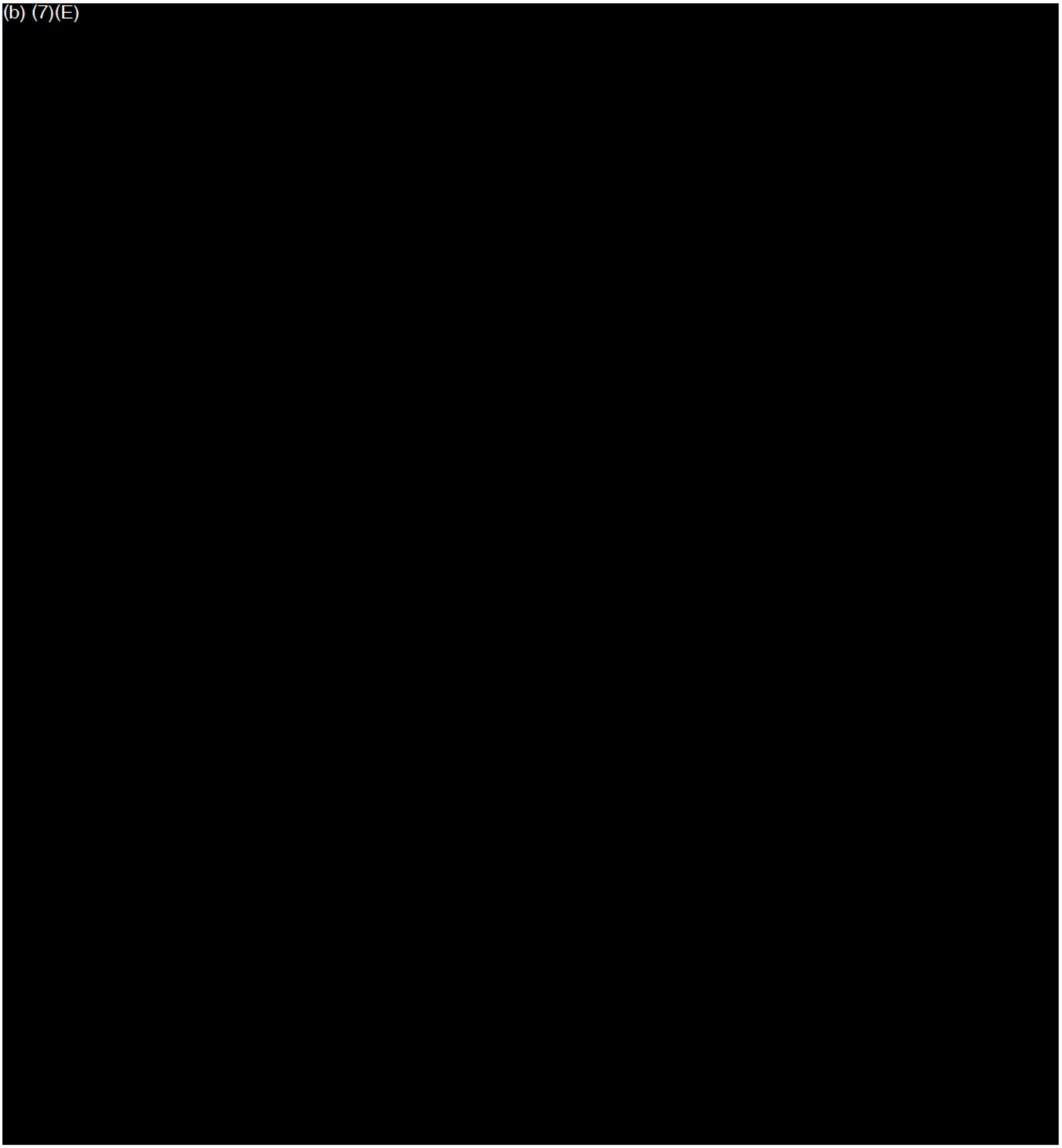
The Document Generation System (DGS) does not include a template for vacating a dismissal order. To prepare a vacate order, the user will select the “Blank Order” in the DGS Findings Integrated Templates Dismissal template.

III. PRE-HEARING Tab

III. Pre-Hearing

III.A. Screening

(b) (7)(E)



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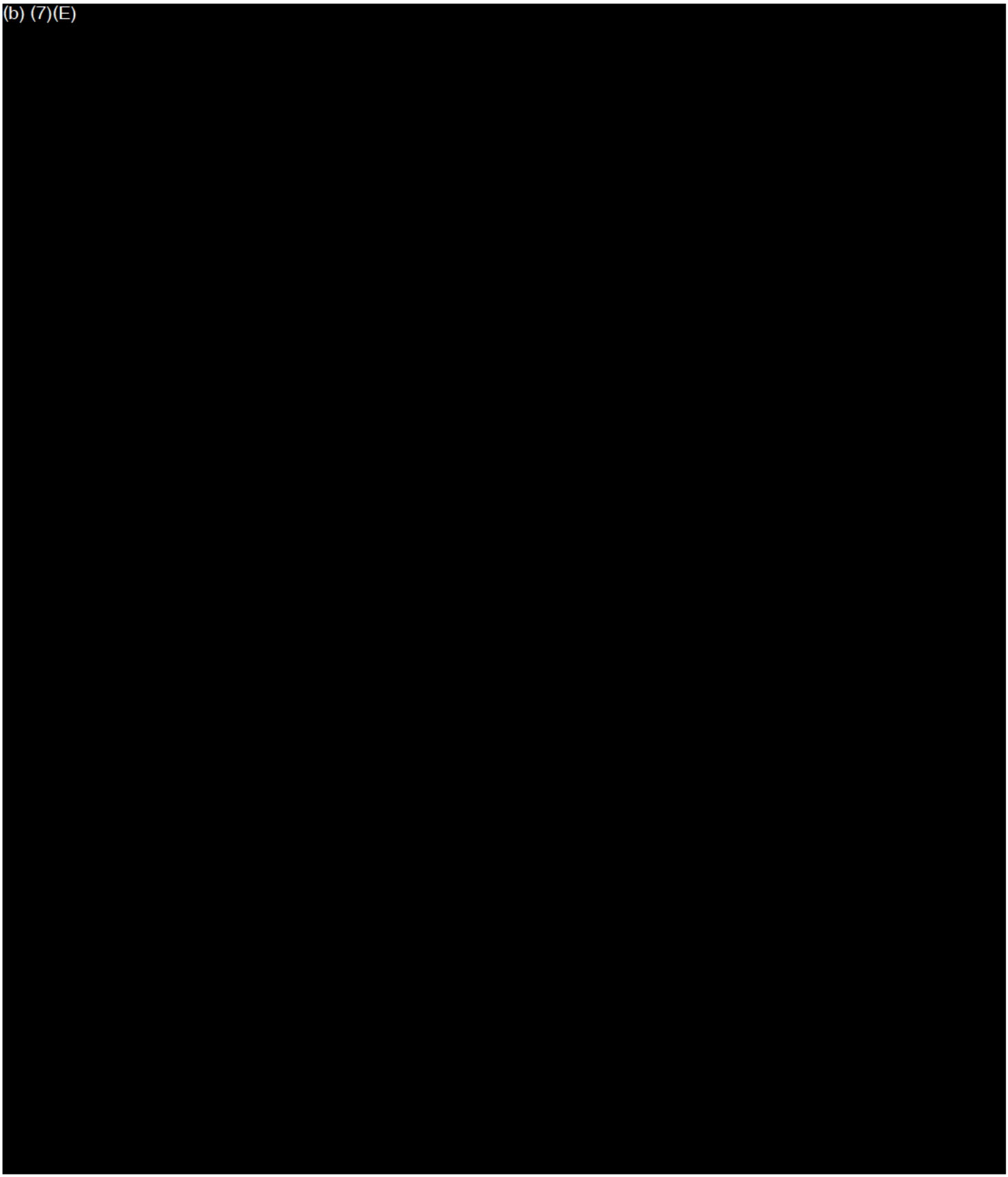

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III.A.2. Issues Before the ALJ: HALLEX I-2-2-1

I-2-2-1. Issues

Last Update: 1/13/16 (Transmittal I-2-159)

A claimant who files a request for a hearing may specifically indicate that he or she only disagrees with certain aspects of the determination. However, the issues before the administrative law judge (ALJ) include all the issues brought out in the initial, reconsidered, or revised determination that were not decided entirely in the claimant's favor. See 20 CFR 404.946(a) and 416.1446(a).

In addition to issues that are unfavorably decided, an ALJ may also reconsider issues previously decided in the claimant's favor if evidence causes the ALJ to question a favorable determination or if there was an error of law. See 20 CFR 404.946(a) and 416.1446(a). Additionally, under 20 CFR 404.946(b) and 416.1446(b), an ALJ may consider a new issue (i.e., one that has not previously been adjudicated) if:

- A party to the hearing (see Hearings, Appeals and Litigation Law (HALLEX) manual I-2-1-45) raises a new issue; or
- The ALJ, on his or her own initiative, raises a new issue over which he or she has jurisdiction. (See HALLEX I-2-2-10 for detailed information on jurisdiction issues and exceptions).

An ALJ will provide advance notice to the parties of the hearing of any issue, whether new or previously decided, that he or she will consider. For detailed instructions regarding notice of the issues, see HALLEX I-2-2-10.

> **NOTE:**
> If a prior claim is pending in Federal court, see HALLEX I-2-8-16 for a more detailed explanation of the timeframes and issues the ALJ will consider on the subsequent application.

III.A.3. Notice of Issues: HALLEX I-2-2-10

I-2-2-10. Notice of Issues

Last Update: 1/13/16 (Transmittal I-2-159)

A. General

The administrative law judge (ALJ) uses the notice of hearing to notify any party to the hearing of the issue(s) he or she will decide, unless the claimant has waived, in writing, the right to advance notice of hearing or the right to a hearing. For notice of hearing procedures, see Hearings, Appeals and Litigation Law (HALLEX) manual I-2-3-15. For information about a waiver of advance notice of hearing, see HALLEX I-2-3-25. For the definition of a party to the hearing, see HALLEX I-2-1-45.

B. Issues Previously Decided in Claimant's Favor

If new evidence presented before or during the hearing causes the ALJ to question a favorable determination, the ALJ will notify the claimant of any prior favorable issues that he or she will reconsider when making the hearing decision. See 20 CFR 404.946(a) and 416.1446(a). In the decision, the ALJ will make appropriate findings on the relevant issue(s).

Even when an ALJ does not receive additional evidence, an ALJ may question a favorable determination on an issue(s) if the determination is based on an error of law. In this situation, the ALJ must send advance notice to inform the claimant that the ALJ will consider the issue(s) at the hearing and make any appropriate findings in the decision.

C. New Issues

An issue is “new” if it has not been previously adjudicated. When an ALJ has jurisdiction to do so, he or she may agree to adjudicate a new issue(s) raised by a party to the hearing, or may adjudicate a new issue(s) on his or her own initiative.

When raising a new issue(s), an ALJ must notify all parties, in writing, about the new issue(s) at any time after receiving the request for hearing and before mailing a decision. See 20 CFR 404.946 and 416.1446. The ALJ may also raise a new issue(s) if, on the record during the hearing or in a writing the ALJ associates with the record, the claimant waives the right to advance notice of the new issue(s).

However, an ALJ may not raise a new issue(s) if it involves a claim that is within the jurisdiction of a State agency under a Federal-State agreement concerning the determination of disability, unless the ALJ is issuing a fully favorable decision on the issue of disability. If the ALJ does not intend to issue a fully favorable decision and there is a disability claim within the jurisdiction of the State agency, the ALJ will rule on the issues within his or her jurisdiction and dismiss the request for hearing with respect to the issue(s) within the State agency's jurisdiction. The ALJ will then return the claim(s) file to the State agency for action on the issue(s) within its jurisdiction.

Example 1:

An ALJ is adjudicating a claim for supplemental security income based on disability. The claim was previously denied because of the claimant's excess income and there is no medical evidence in the file. The ALJ is prepared to rule favorably on the excess income issue, but cannot issue a fully favorable decision on the issue of disability because the medical record has not been developed. The ALJ cannot raise the disability issue as it is “new.” The ALJ must rule only on the excess income issue and return the claim file to the State agency for action on the disability issue.

Example 2:

An ALJ is adjudicating a claim for supplemental security income based on disability. The claim was previously denied because of the claimant's excess income but there is medical evidence in the file. The ALJ is prepared to rule favorably on the excess income issue and find the claimant disabled, but at a date later than the claimant alleges. The

ALJ cannot raise the disability issue because, although it is “new,” the decision about disability would not be fully favorable. The ALJ must rule only on the excess income issue and return the claim file to the State agency for action on the disability issue. (NOTE: If the ALJ had found disability as of the claimant's alleged onset date, the ALJ could have issued a fully favorable decision.)

III.B. Issues Resulting from Prior or Parallel Proceedings

III.B.1. Prior Files

III.B.1.a. HALLEX I-2-1-13

I-2-1-13. Prior Claim(s) Files

Last Update: 5/26/17 (Transmittal I-2-206)

A. General

In some cases, it will be necessary for the administrative law judge (ALJ) to review a prior claim(s) file in order to fully adjudicate a current claim. Hearing office (HO) staff will determine whether the claimant filed a previous application by checking the Master Beneficiary Record for title II claims and the Supplemental Security Income Detailed query for title XVI claims. If there was a previous filing, HO staff will add a message in eView and a remark in the Case Processing and Management System.

HO staff will initially evaluate whether a prior claim(s) file is required, as set forth in B.1. below. If the prior claim(s) file is not required, HO staff will consult with the ALJ as to whether he or she needs the prior claim(s) file in order to fully evaluate the issue(s).

> **NOTE:**
> The availability of a prior claim(s) file is subject to Federal file retention periods as noted in Hearings, Appeals and Litigation Law (HALLEX) manual I-2-1-10 D.

B. When to Consider Evidence in a Prior Claim(s) File

1. Considering Evidence in Prior Claim(s) File is Required

HO staff will request a prior claim(s) file, without needing to consult with the ALJ, in the following circumstances:

- The pending claim is before the ALJ based on a continuing disability review. See 20 CFR 404.1593 and 416.993.
- The pending claim involves a collateral estoppel issue (HALLEX I-2-2-30). For example, if the claim before the ALJ is title II and there is a prior title XVI allowance addressing an overlapping time period, the ALJ will need to consider the evidence in the title XVI claim file.
- The pending claim involves a possible reopening or res judicata issue (HALLEX I-2-9 and I-2-4-40).

- The ALJ must consider findings of an ALJ or the Appeals Council on a prior claim(s) to comply with an Acquiescence Ruling (AR). (See HALLEX I-2-6-58 B for specific examples of ARs that may apply.)
- Fraud or similar fault may be involved in the current or prior claim (HALLEX I-1-3 and I-2-10).

2. Considering Evidence in Prior Claim(s) May Be Necessary

HO staff must consult with an ALJ about obtaining a prior claim(s) file when it may be necessary for a full adjudication of the issues before the ALJ. An ALJ will generally find that evidence in a prior claim(s) file is necessary for a full adjudication of the issues when the ALJ determines:

- There is a need to establish a longitudinal medical, educational, or vocational history; or
- The impairment is of a nature that evidence from a prior claim(s) file could make a difference in establishing whether disability is present in the current claim.

> **NOTE:**
> ALJs should keep in mind that even when a prior claim(s) file is not required, failure to obtain and consider evidence in a prior claim(s) file may constitute a reason for remand from the Appeals Council (depending on the facts of the case).

3. Prior Claim(s) File Is Not Needed

Unless one of the circumstances above exists, HO staff is not required to request a prior claim(s) file when:

- There is no possible reopening issue;
- The file shows that any onset date that might be established occurs after the disability earnings requirement is last met;
- The claimant alleges “onset” within the past year and medical evidence submitted does not indicate the presence of an impairment(s) that might warrant an onset more than one year ago; or
- Work that is determined to be substantial gainful activity was performed for more than six months during the one-year period preceding the filing date of the current application.

C. Requesting a Prior Claim(s) File

HO instructions for requesting a prior claim(s) file are set forth in the HO electronic business process (eBP) section 1.4. Generally, when a prior claim(s) file is not located in the HO, the HO will request it from the field office using an electronic assistance request. If there are additional prior claim(s) files that are paper, the HO will request them through the Automated Folder Location (AFL) website.

D. Exhibiting Evidence From a Prior Claim(s) File

Detailed HO instructions for exhibiting evidence from a prior claim(s) file are set forth in the HO eBP section 3.2. Generally, the policy is:

- If the prior claim(s) file was not exhibited, HO staff will add to the pending claim(s) file only documents from the prior claim(s) file that will be referenced as exhibits.
- If the prior claim(s) file is paper and the file was exhibited, HO staff will add to the pending claim(s) file only the exhibit list, ALJ decision, and any appeal documents from the prior claim(s) file. The ALJ will then reference the relied upon information in the decision using the prior exhibit numbers.

> **NOTE:**
> If the prior claim(s) file is paper, the original copies of documents must be returned to the appropriate section of the prior claim(s) file after they are photocopied. The prior claim(s) file remains the official record of the prior claim(s).

E. Providing the Claimant an Opportunity to Review Prior Claim(s) File

As explained in HALLEX I-2-1-35, a claimant and appointed representative, if any, have the right to examine material that constitutes or will constitute the evidence of record. Any information on which the ALJ relies from a prior claim(s) file will be added to the record (as described in subsection D above) and will be made available to the claimant and appointed representative, if any, for review.

> **NOTE:**
> If the information is added to the record after the hearing, the ALJ must proffer the information using procedures in HALLEX I-2-7-30.

An ALJ does not have an obligation to provide a claimant an opportunity to review a prior claim(s) file if the ALJ does not rely on any information from the prior claim(s) file. However, when the ALJ has decided the prior claim(s) file is not necessary for a full review of the pending case, and a claimant or appointed representative requests to review the prior claim(s) file, the ALJ will generally grant the request if it is administratively efficient to do so and the prior claim(s) file is available. In cases where it is possible and more efficient to do so, HO staff may provide a compact disc copy of a prior claim(s) file to the claimant or appointed representative, if any.

F. Decision Requirements

When an ALJ relies on information from a prior claim(s) file, the ALJ will make the evidence part of the record in the pending claim and address the evidence in the written decision using the instructions throughout HALLEX I-2-8. An ALJ is not required to address evidence on which he or she does not rely. Additionally, subject to applicable ARs, an ALJ need not address a prior filing when the ALJ does not rely on any information in the prior claim(s) file.

III.B.1.b. Adjudication Tip #58

When should an ALJ consider the evidence contained in a prior claim(s) file? The answer: it depends.

HALLEX I-2-1-13 addresses when the evidence in a prior claim(s) file ***must*** be considered, when the evidence in a prior claim(s) file ***may*** be considered, and when the evidence in a prior claim(s) file ***does not need to be considered.***

An ALJ *must* consider the evidence in a prior claim(s) file when:

- The current pending claim involves a continuing disability review; a possible reopening issue; or a res judicata or collateral estoppel issue (20 C.F.R. §§404.957 et seq. and 416.1457 et seq.);
- Considering findings of an ALJ or the Appeals Council on a prior claim to comply with an Acquiescence Ruling; or
- Fraud or similar fault may be involved in the current or prior claim.

An ALJ *may need to* consider the evidence in a prior claim(s) file when:

- The ALJ determines that there is a need to establish a longitudinal medical, educational, or vocational history; or
- The impairment is of a nature that the evidence from the prior claim could make a difference in establishing whether disability is present in the current pending claim.

The ALJ *does not need to* consider the evidence in a prior claim(s) file when:

- There is no possible reopening issue;
- The file shows that any onset date that might be established occurs after the disability earnings requirement is last met;
- The claimant alleges an onset date within the past year and the medical evidence submitted does not indicate the presence of an impairment that may warrant an onset of more than one year ago; or
- Work that is determined to be substantial gainful activity was performed for more than six months during the one-year period preceding the filing date of the current pending claim.

Note that an ALJ is not required to address any evidence upon which he or she does not rely, but when an ALJ relies on information from a prior claim(s) file, the ALJ must

make the evidence part of the record in the current pending claim, and must address this prior claim evidence in the written decision. We recommend that decisions address explicitly at the outset whether there have been prior claim(s) and, if so, whether they are being reopened and reconsidered.

Note further that when a claimant or appointed representative asks to review a prior claim(s) file, the ALJ will generally grant the request if it is administratively efficient to do so. Where it is possible and more efficient to do so, hearing office staff may provide a CD copy of a prior claim(s) file to the claimant or appointed representative. HALLEX I-2-1-13 E.

For further guidance on how prior claim(s) files should be requested and exhibited refer to HALLEX I-2-1-13.

III.B.1.c. Prior Claim File Pending in District Court: HALLEX I-2-8-16

I-2-8-16. Administrative Law Judge Decision When Prior Claim Is Pending in Court

Last Update: 11/20/14 (Transmittal I-2-128)

If the claimant files a subsequent application after commencing a civil action on a prior claim, the administrative law judge (ALJ) will limit his or her decision to the time following the period under review by the court. In other words, unless the claimant alleges a later onset, the ALJ will only evaluate disability onset as of the day following the date of the prior ALJ or Appeals Council decision.

> **NOTE 1:**
> If an ALJ issues a fully or partially favorable decision on the subsequent application and the claim(s) file is paper, the hearing office will ask the effectuating component to forward the claim(s) file to the Office of Appellate Operations (OAO) after the decision is effectuated. The Appeals Council may need to review the subsequent allowance to determine whether the favorable decision has any impact on the pending court case.

Generally, the hearing office can determine whether there is a pending court case by looking in the Case Processing and Management System. However, if it is unclear whether a prior claim is pending judicial review, the hearing office director or designee may contact the appropriate Office of the General Counsel (OGC) office to determine the status of the case. For information about the jurisdictions of each OGC office, see Hearings, Appeals and Litigation Law (HALLEX) manual I-4-1-116. For information about which OAO branch handles a particular court jurisdiction, see HALLEX I-3-0-6 or I-3-0-7.

> **NOTE 2:**
> Registered users may also learn the status of a civil action by using the Public Access to Court Electronic Records service.

III.B.2. Prior Claim Remanded by Court: HALLEX I-2-8-18

I-2-8-18. Administrative Law Judge Decision When Case Remanded by Court

Last Update: 5/26/17 (Transmittal I-2-208)

A. General

If the Appeals Council (AC) remands a case to the hearing level after a court remand, it generally vacates the entire administrative law judge (ALJ) decision, and the ALJ must consider all pertinent issues de novo. When the AC vacates an ALJ decision in an initial entitlement case, the AC will usually direct that the ALJ offer the claimant an opportunity for a new hearing and issue a new decision in the case. The ALJ will generally decide

the remanded issues through the date of the new hearing decision or, in title II cases involving an expired date last insured, through the date of last insured status. When appropriate, the ALJ may issue a recommended decision. See Hearings, Appeals, and Litigation Law (HALLEX) manual I-2-8-15.

The claimant may appeal an ALJ's decision after a court remand by filing written exceptions within 30 days of the date of the ALJ's decision (or within the time allowed by the AC after permitting an extension of time). See 20 CFR 404.984(b) and 416.1484(b). See also HALLEX I-4-8-20. Additionally, the AC may assume jurisdiction of the ALJ's decision under its own motion authority within 60 days of the date of the ALJ's decision. See 20 CFR 404.969 and 416.1469, and HALLEX I-3-6-1.

> **NOTE:**
> If the ALJ determines that the criteria for a dismissal are present, the ALJ will follow the instructions in HALLEX I-2-4-37. However, when the case was remanded by the court under sentence six of sections 205(g) and 1631(c) of the Social Security Act, an ALJ may not dismiss the request for hearing even when the usual dismissal criteria are present. Rather, the ALJ will issue a decision. See HALLEX I-2-4-37.

B. ALJ Actions

For hearing office (HO) staff actions on receipt of a case remanded by a court, see HALLEX I-2-1-59.

If the ALJ receives additional evidence in a court remand case, the ALJ will use the instructions in HALLEX I-2-6-56 and I-2-6-58 with regard to admitting and exhibiting the evidence.

The usual procedures apply to drafting the decision. However, the ALJ will ensure that the decision specifically addresses issues relating to the court and AC remand directives.

C. Routing a Paper Claim(s) File

If a court remand claim(s) file is paper, routing depends on whether the decision is unfavorable, partially favorable, or fully favorable. HO staff will route a paper claim(s) file as follows:

- If the decision is unfavorable, the HO staff will send the claim(s) file to the Social Security Administration's National Records Center, as described in HALLEX I-2-1-10 C.1.;

- If the decision is partially favorable, the HO staff will forward the claim(s) file to the effectuating component; or

- If the decision is fully favorable, the HO will forward the claim(s) file to the effectuating component and send a copy of the fully favorable decision to the appropriate Office of the General Counsel (OGC) office.

D. Representative(s) Fee

HALLEX I-1-2 sets forth detailed instructions for processing representative fees. An ALJ will first evaluate whether he or she has the authority to authorize the fee, as set forth in HALLEX I-1-2-6. When the ALJ does have authority to authorize a fee, the ALJ will only authorize a fee for services provided before the agency. See HALLEX I-1-2-5.

In some instances, OGC may request a copy of the fee authorized to a representative for administrative services. When requested, HO staff will provide a copy to OGC as quickly as possible.

III.B.3. ALJ Requests for Clarification of AC Remand Order:

- Requesting Clarification – Policy: HALLEX **I-2-1-85**
- Formal Requests for Clarification – Procedures **I-2-1-86**
- Expedited Requests for Clarification – Procedures **I-2-1-87**

III.B.4. Appeals Council Feedback Initiative: HALLEX I-2-1-88

III.B.5. Escalated Claims: HALLEX I-2-2-22

III.C. Pre-hearing File Review

III.C.1. In General: HALLEX I-2-5-2

I-2-5-2. Prehearing Case Review by the Administrative Law Judge

Last Update: 4/15/15 (Transmittal I-2-138)

A. General

The administrative law judge (ALJ) must perform a prehearing review of the evidence to determine whether the evidence is sufficient for a full and fair inquiry into the matters at issue or if additional action is needed in the case.

> **NOTE:**
> The hearing office staff, based on a prehearing analysis, may notify the ALJ prior to his or her case review of the potential need to develop additional evidence. See Hearings, Appeals and Litigation Law (HALLEX) manual I-2-1-5 A.

B. ALJ Procedures for Conducting a Prehearing Case Review

In conducting a prehearing case review, the ALJ will evaluate the claim(s) file to determine whether it is necessary to:

- Issue a formal or informal remand. See HALLEX I-2-5-10 and 1-2-5-12;
- Obtain evidence the claimant informed the agency about that relates to whether he or she is blind or disabled. See HALLEX I-2-5-13;
- Obtain updated medical evidence or testimony from the claimant's treating source or other medical source. See HALLEX I-2-5-14;
- Obtain technical or specialized medical tests or opinions (consultative examinations and tests). See HALLEX I-2-5-20;
- Obtain medical or vocational expert testimony or interrogatories. See HALLEX I-2-5-30 through I-2-5-61;
- Obtain non-medical evidence. See HALLEX I-2-5-62 through I-2-5-77;
- Obtain evidence by issuing a subpoena on his or her own motion or at the request of a claimant. See HALLEX I-2-5-78 through HALLEX I-2-5-82;
- Resolve conflicts or differences in the evidence;
- Determine the need for a prehearing conference. See HALLEX I-2-1-75; and
- Determine whether the case meets the criteria for expedited processing or an on-the-record decision. See HALLEX I-2-1-40.

III.C.2. Sample of ALJ Standing Orders

(b) (7)(E)

[redacted]

(b) (7)(E)

III.C.3. Holding the hearing: CALJ memo, 07/12/12; Proper Procedures for Exhibiting Queries

SOCIAL SECURITY

MEMORANDUM

Date: July 12, 2012 Refer To: ACL# 12-1405

To: ODAR All RO Management Teams

From: Debra Bice */s/*
Chief Administrative Law Judge

Subject: Proper Procedures for Exhibiting Queries – REMINDER

This is a reminder concerning proper procedures for exhibiting queries. ODAR's standard procedures are to exhibit the following queries at workup in disability cases:

- Information/Certified Earnings Record (ICER) – required for every Title 2 case
- Detailed Earnings Query (DEQY) – required for all cases except for those of young children
- Summary Earnings Query (SEQY) – required for all cases except for those of young children
- National Directory of New Hires (NDNH) query – required for all cases except for those of young children

Both claimant representatives and ODAR staff have reported that some offices/employees are not complying with these criteria and that cases are going to hearing without these exhibits. Please ensure that you are in compliance. Exhibiting these queries at workup allows the representatives to begin developing work issues prior to the hearing date.

Other queries should be run and viewed as necessary to obtain required information concerning prior filing, etc. However, you must review those queries very carefully if you intend to add them to the claim folder, because many of them (e.g., DIBwiz, SSID, MBR) often contain personally identifiable information (PII) for other individuals. If adding these queries to Section D of the claim file, you must first redact all PII.

For further information concerning proper exhibiting procedures, please refer to electronic Business Process (eBP) Section 3.2 Case Work Up, the CEF Exhibiting Desk Guide, Legal Assistant Training Modules 05 and 10, and HALLEX I-2-1-15.

Please share this information with your hearing offices.

III.C.4. Prehearing Questionnaires: HALLEX I-2-2-85

I-2-5-85. Use of Prehearing Questionnaires – General

Last Update: 1/15/16 (Transmittal I-2-162)

An administrative law judge (ALJ) may find a prehearing questionnaire useful to develop the record prior to conducting a hearing or to resolve issues that may result in issuing a favorable decision without the need for a hearing. Additionally, an ALJ may use a prehearing questionnaire to narrow the issues that he or she will decide at the hearing. In limited circumstances, a prehearing questionnaire may also be useful to obtain information needed to schedule and conduct a hearing.

When an ALJ uses a prehearing questionnaire, he or she will ensure that a copy of the questionnaire and any response is associated with the claim(s) file. When the questionnaire (and associated response) is material to the issues in a case, the ALJ will exhibit the document(s). See Hearings, Appeals and Litigation Law (HALLEX) manual I-2-1-15.

> **NOTE:**
>
> In some instances, an ALJ may find a prehearing questionnaire useful in conjunction with a prehearing conference (see HALLEX I-2-1-75).

The following are examples of when an ALJ may want to use a prehearing questionnaire:

- The ALJ wants to obtain evidence, including information from the claimant or an appointed representative, that may help determine whether the claimant's impairment(s) meets or equals a listing in 20 CFR Part 404, Subpart P, Appendix 1;
- The ALJ needs to clarify an issue(s) that would result in a favorable decision or might require development before the hearing (e.g., to obtain an explanation of earnings);
- The claimant's application includes a significant number of impairments, and it would be helpful for the ALJ to know which impairment(s) the claimant alleges meets the criteria for a severe impairment, meets or medically equals a listing, or results in functional limitations (NOTE: While collecting this information may help an ALJ focus the issue(s) at hearing, the ALJ may not limit the claimant's testimony at hearing based the claimant's response to this type of question in a prehearing questionnaire);
- The ALJ needs to obtain a list of witnesses from the claimant to determine the subject and scope of testimony (see HALLEX I-2-6-60) and to schedule the hearing with sufficient time; and
- The ALJ needs to obtain a stipulation.

An ALJ may not impose penalties, threaten sanctions, reduce an appointed representative's fee, suggest the request for hearing may be dismissed, or otherwise indicate the ALJ may take an adverse action if the claimant or appointed representative fail to complete and submit responses to the prehearing questionnaire.

III.D. Claimant and Representative's Duty to Submit Evidence

III.D.1. NATIONAL UNIFORMITY BASICS

Introduction:

On December 16, 2016, the Agency published a Final Rule in the Federal Register entitled "Ensuring Program Uniformity at the Hearing and Appeals Council Levels of the Administrative Review Process." The National Uniformity regulations became effective January 17, 2017, and compliance with the new procedures is required as of May 1, 2017. These regulations are similar to those of Region I (the Boston Region), which has operated under similar regulations for the past decade with good success.

IMPACT OF THE NATIONAL UNIFORMITY REGULATIONS ON THE HEARING OPERATION (OCALJ EMAIL OF 12/30/16)

Overview of the National Uniformity Procedures

The Notice of Hearing before an Administrative Law Judge (20 CFR 404.938 and 416.1438)

- We will mail or serve the notice at least 75 days in advance, unless the claimant or representative submits a written waiver of advanced notice. For instructions regarding obtaining a waiver of advance notice of hearing, see HALLEX I-2-3-25.

- All Notices issued after April 27, 2017, will explain the responsibility of the claimant and representative to make every effort to inform us of, identify, or submit all written evidence that is not in the record no later than five business days prior to the scheduled hearing. For Notices issued prior to April 27, 2017, a one time Notice was sent to these claimants and representatives in March 2017, informing them of thesec responsibilities (The Appeals Council issued their one time Notice in April 2017).

- Applies to initial as well as continued, postponed, or supplemental hearings, but ALJ can request waiver to expedite action on a claim.

- Objections to the issues must also be submitted no later than five business days prior to the hearing.

- The notice will identify the new deadline for requesting a subpoena, which is 10 business days prior to the scheduled hearing. (20 CFR 404.950 and 416.1450)

- Hearing office staff are responsible for the following activities:

    - mailing the notice of the hearing to the last known address, or give the notice to the claimant by personal service.

- mailing or serving the notice at least 80 days before the date of the hearing (75 days plus 5 days for mailing);

- identifying and notifying the ALJ of all written evidence, objections to the issues, and pre hearing memoranda submitted less than 5 days prior to the hearing;

- Regarding items submitted less than 5 days prior to the hearing, adding evidence as an exhibit if ALJ directs or retaining the evidence in case documents if the ALJ directs not to add the items as an exhibit.

Claimant and Representative Responsibilities

Submitting Written Evidence to an Administrative Law Judge (20 CFR 404.935 and 416.1435), **Objection to the Issues** (20 CFR 404.939 and 416.1439), **Presenting Written Statements and Oral Arguments** (20 CFR 404.949 and 416.1449), and **Presenting Evidence at the Hearing before the Administrative Law Judge** (20 CFR 404.950 and 416.1550).

- The claimant or representative must inform us about or submit all written evidence, objections to the issues, and pre-hearing written statements no later than five business days prior to the scheduled hearing. However, the five-day requirement does not apply to Title XVI CDRs and Age 18 Redeterminations, and does not apply to concurrent claims where the Title XVI portion is one of these two types of claims (20 CFR 416.1435 (c))

- Parties to a hearing that wish to subpoena documents or witnesses must file a written request with the ALJ at least ten business days prior to the hearing date (20 CFR 404.950 and 416.1450)

- Evidence is defined in HALLEX I-2-5-1.

Administrative Law Judge Responsibilities

Submitting Written Evidence to an Administrative Law Judge (20 CFR 404.935and 416.1435) and **Objections to the Issues** (20 CFR 404.939 and 416.1439).

- The ALJ will accept late submissions if the ALJ has not yet issued a decision and the claimant demonstrates that the late submission, objection, written statement, or subpoena request meets one of the circumstances described in the regulations.
    - Some action by the Agency misled the claimant;

- The claimant had a physical, mental, education, or linguistic limitation that prevented him or her from informing the Agency about or submitting the evidence earlier; or

- Some other unusual, unexpected, or unavoidable circumstance beyond the claimant's control prevented him or her from informing the Agency about or submitting the evidence earlier. Examples include, but not limited to:

    - A serious illness that prevented the claimant from contacting the Agency in writing, in person or through another person;

    - A death or serious illness in the claimant's immediate family;

    - A showing that the claimant or his or her representative "actively and diligently sought evidence from a source and the evidence was not received or was received less than five business days prior to the hearing."

- The ALJ may decline to obtain or consider late submissions of evidence, objections, written statements, or subpoena requests unless the claimant meets one of the circumstances cited above. (20 CFR 404.935(b) and 416.1435(b)).

- The ALJ will apply the procedures in HALLEX I-2-5-13 and I-2-6-58 to determine whether evidence may be obtained or considered.

- For objections to the issues, the ALJ will make a decision on the objections either at the hearing or in writing prior to the hearing.

- ALJ will articulate in the decision if the information or evidence is excluded.

Appeals Council Review

Cases the Appeals Council Will Review (20 CFR 404.970 and 416.1470)

- The Appeals Council will only review a case based on additional evidence if it is new, material, related to the period on or before the hearing decision, and there is a reasonable probability the evidence would change the outcome of the decision.

- The Appeals Council will only consider such evidence if the claimant shows good cause for not informing us about or submitting the evidence at least five business days before the date of the hearing. This is the same standard used by the ALJ for any late submission of evidence (20 CFR 404.970(b) and 416.1470(b))

III.D.2. Admitting Evidence Submitted at Least Five Business Days Before the Hearing: HALLEX I-2-9-58

I-2-6-58.Admitting Evidence Submitted At Least Five Business Days Before the Hearing

Last Update: 5/1/17 (Transmittal I-2-199)

A. General

Subject to the limitations for accepting evidence in 20 CFR 404.935 and 416.1435, an administrative law judge (ALJ) will generally admit into the record any evidence that he or she determines is material to the issues in the case. Evidence is material if it is relevant, i.e., involves or is directly related to issues being adjudicated.

The following are examples of evidence that may be material to a claim for disability:

- Evidence of work activity in the last 15 years;
- Evidence of the existence of a severe impairment;
- Evidence dated within 12 months of the alleged onset date under a title II application for disability insurance benefits;
- Evidence dated on or after the application date or protective filing date of a title XVI application claiming disability; and
- Evidence dated within a time-period covered by a prior application that may be subject to reopening. For reopening instructions, see Hearings, Appeals and Litigation Law (HALLEX) manual I-2-9-20.

When the claimant or appointed representative submits evidence, hearing office (HO) staff will place the evidence in the claim(s) file. While HO staff initially marks and lists proposed exhibits (see HALLEX I-2-1-15 and I-2-1-20), the ALJ makes the final decision on the information admitted into the record. The ALJ may admit information into the record, even if it would not be admissible in court under the rules of evidence.

If a claimant or appointed representative informs the agency about or submits evidence less than five business days before the date of the scheduled hearing, at, or after the hearing, the ALJ may decline to consider that evidence the circumstances in 20 CFR 404.935(b) and 416.1435(b) apply. For the definition of business day, see HALLEX I-2-5-1 NOTE 3. To determine whether the circumstances in 20 CFR 404.935(b) and 416.1435(b) apply, an ALJ will use the procedures in HALLEX I-2-6-59.

However, in title XVI cases other than those based on an application for benefits (e.g., age 18 redeterminations, continuing disability reviews, and terminations), an ALJ will accept any evidence submitted on or before the date of the hearing decision. See 20

CFR 416.1435(c). For all other title XVI cases, an ALJ will use the procedures referenced in this section to admit evidence into the record.

When a claimant or appointed representative informs the agency about or submits evidence less than five days before the hearing, at, or after the hearing, and the ALJ finds that the circumstances in 20 CFR 404.935(b) and 416.1435(b) do not apply, the ALJ will identify the evidence and explain his or her reason for not considering it. The ALJ can provide these reasons on the record at the hearing, in a written ruling that the ALJ exhibits, or in the ALJ's decision.

> **NOTE:**
> The ALJ does not need to explain why evidence was not admitted into the record if the evidence is merely duplicative of evidence already in the record. Rather, the ALJ will ensure duplicative evidence is clearly identified as such in the claim(s) file.

B. Prior ALJ Decision

If there was a prior ALJ decision, the ALJ must associate the prior ALJ decision with the current claim(s) file. This action is especially critical to comply with the following Acquiescence Rulings (AR):

- Fourth Circuit (Maryland, North Carolina, South Carolina, Virginia, West Virginia): AR 00-1(4), *Albright v. Commissioner of the Social Security Administration*, 174 F.3d 473 (4th Cir. 1999) (Interpreting *Lively v. Secretary of Health and Human Services*)—Effect of Prior Disability Findings on Adjudication of a Subsequent Disability Claim—Titles II and XVI of the Social Security Act.

- Sixth Circuit (Kentucky, Michigan, Ohio, Tennessee): AR 98-3(6), *Dennard v. Secretary of Health and Human Services*, 907 F.2d 598 (6th Cir. 1990)—Effect of A Prior Finding of the Demands of Past Work on Adjudication of a Subsequent Disability Claim Arising Under the Same Title of the Social Security Act—Titles II and XVI of the Social Security Act, and AR 98-4(6), *Drummond v. Commissioner of Social Security*, 126 F.3d 837 (6th Cir. 1997)—Effect of Prior Findings on Adjudication of a Subsequent Disability Claim Arising Under the Same Title of the Social Security Act—Titles II and XVI of the Social Security Act.

- Ninth Circuit (Alaska, Arizona, California, Guam, Hawaii, Idaho, Montana, Nevada, Northern Mariana Islands, Oregon, Washington): AR 97-4(9), *Chavez v. Bowen*, 844 F.2d 691 (9th Cir. 1988) —Effect of a Prior Final Decision That a Claimant is Not Disabled, And of Findings Contained Therein, On Adjudication of a Subsequent Disability Claim Arising Under the Same Title of the Social Security Act—Titles II and XVI of the Social Security Act.

For information about how an ALJ determines what evidence to include from a prior file and whether to exhibit the information, see HALLEX I-2-1-13.

C. Admitting Evidence Procedures

Subject to the limitations for accepting evidence in 20 CFR 404.935 and 416.1435, an ALJ will generally admit into the record any information that he or she determines is material to the issues in the case.

Before taking any testimony, the ALJ will make the proposed exhibits a part of the record by:

- Asking the claimant (or appointed representative, if any) whether he or she had an opportunity to examine the proposed exhibits;
- Asking the claimant (or appointed representative, if any) if there are any objections to admitting the proposed exhibits into the record; and
- Ruling on any objections to the proposed exhibits. See HALLEX I-2-6-34.

Whenever possible, the ALJ will rule on objections on the record at the beginning of the hearing. However, if circumstances warrant a ruling on an objection in writing, the ALJ may rule on the objections in a post-hearing order or as part of the written decision issued by the ALJ. If the ALJ issues the ruling in an independent document, the ALJ will exhibit the document and mail a copy to the claimant and appointed representative, if any.

NOTE:

If a claimant or appointed representative informs an ALJ about evidence at least five business days before the date of the scheduled hearing, but does not submit the evidence at least five business days before the date of the scheduled hearing, the ALJ will follow the procedures in HALLEX I-2-5-13 and will consider the evidence regardless of whether the circumstances in 20 CFR 404.935(b) and 416.1435(b) apply. The ALJ will admit the evidence into the record if it is material to the issues in the case. See HALLEX I-2-5-13.

III.D.3. Admitting Evidence Submitted Less Than Five Buisness Days Before the Hearing or At or After the Hearing: HALLEX I-2-6-59

I-2-6-59.Admitting Evidence Submitted Less Than Five Business Days Before the Hearing or At or After the Hearing

Last Update: 5/1/17 (Transmittal I-2-199)

A. General

Subject to 20 CFR 404.935(b) and 416.1435(b), an administrative law judge (ALJ) may admit additional evidence into the record during the hearing. However, before admitting any proposed exhibit into the record during the hearing, the ALJ will identify the proposed exhibit and offer the claimant the opportunity to inspect the proposed exhibit and offer any objections or comments.

Subject to 20 CFR 404.935(b) and 416.1435(b), an ALJ may also admit additional evidence into the record after the hearing. If a claimant submits additional evidence after the hearing, an ALJ will apply the procedures in subsection B below to determine whether to consider the evidence. If the ALJ plans to admit additional evidence into the record after the hearing, see generally the instructions regarding proffer in Hearings, Appeals and Litigation Law (HALLEX) manual I-2-7.

Generally, if a claimant informs the Social Security Administration (SSA) about or submits evidence less than five business days before the date of the scheduled hearing, at, or after the hearing, the ALJ may decline to obtain or consider the evidence, unless the circumstances in 20 CFR 404.935(b) and 416.1435(b) apply. For the definition of business day, see HALLEX I-2-5-1 NOTE 3. The ALJ will determine whether the circumstances in 20 CFR 404.935(b) and 416.1435(b) apply using the instructions in subsection B below.

> **NOTE:**
> The agency's Notice of Hearing form notifies the claimant about his or her responsibility to inform the agency about or submit written evidence at least five business days before the scheduled hearing. See HALLEX I-2-3-15.

However, in title XVI cases other than those based on an application for benefits (e.g., age 18 redeterminations, continuing disability reviews, and terminations), an ALJ will accept any material evidence submitted on or before the date of the hearing decision using the procedures in HALLEX I-2-6-58. See 20 CFR 416.1435(c).

B. Determining Whether the Circumstances in 20 CFR 404.935(b) and 416.1435(b) Apply

1. Untimely Evidence Submitted Prior to Issuing the Hearing Decision
If the claimant informs SSA about evidence or submits evidence to SSA less than five business days before the date of the scheduled hearing, at, or after the hearing, but before the hearing decision is issued, the ALJ will accept the evidence if the circumstances in 20 CFR 404.935(b) and 416.1435(b) apply. Generally, under 20 CFR 404.935(b) and 416.1435(b), an ALJ will find that the circumstances in 20 CFR 404.935(b) and 416.1435(b) apply when a claimant did not timely submit the evidence because:

- SSA action misled the claimant;
- The claimant has a physical, mental, educational, or linguistic limitation(s) that prevented him or her from informing SSA about or submitting the evidence earlier; or
- Some other unusual, unexpected, or unavoidable circumstances beyond the claimant's control prevented him or her from submitting the evidence earlier.

Examples of unusual, unexpected, or unavoidable circumstances include but are not limited to:

- The claimant was seriously ill, and his or her illness prevented him or her from contacting the Agency in person, in writing, or through a friend, relative, or other person;
- There was a death or serious illness in the claimant's immediate family;
- Important records were destroyed or damaged by fire or other accidental cause; or
- The claimant, or appointed representative, actively and diligently sought evidence from a source and the evidence was not received or was received less than five business days prior to the hearing.

> **NOTE:**
> The ALJ will not develop or require evidence that shows that the claimant or appointed representative has actively and diligently sought evidence. However, when the claimant or representative shows that he or she made a good faith effort to timely request, obtain, and submit evidence, but he or she did not receive the records at least five business days before the date of the scheduled hearing because of circumstances outside his or her control, the ALJ will find that the claimant has actively and diligently sought evidence.

2. Untimely Evidence Submitted After Issuing the Hearing Decision
If the claimant submits evidence after the hearing decision is issued, the ALJ will forward the information to the Appeals Council (AC) if the claimant submitted a request

for review of the ALJ's decision. If the claimant has not requested review by the AC, the ALJ may either:

- Consider revising his or her decision using the appropriate procedures in HALLEX I-2-9; or

- Return the evidence to the claimant noting in writing that the record is closed, but the claimant may request review by the AC.

C. Exhibiting and Decision Writing Considerations

If an ALJ finds that the claimant did not inform the agency about or submit evidence at least five business days before the scheduled hearing but the circumstances in 20 CFR 404.935(b) and 416.1435(b) apply, the ALJ will accept the evidence into the record and mark the evidence as an exhibit. The ALJ may, but is not required to, address in the decision why he or she considered the evidence.

However, if an ALJ does not find that the circumstances in 20 CFR 404.935(b) and 416.1435(b) apply, the ALJ will not exhibit the untimely evidence and will explain his or her reason for not considering it. The ALJ can provide these reasons on the record at the hearing, in a written ruling that the ALJ exhibits, or in the ALJ's decision. For example, the ALJ may briefly explain in the text of the decision that:

- Additional evidence was submitted (specifically identifying the evidence, usually by source, date, and number of pages);

- The claimant did not establish a reason under 20 CFR 404.935 and 416.1435 for not informing the agency about or submitting it within the required timeframes (addressing any specific reason raised by the claimant); and

- Therefore, the ALJ declined to consider the evidence under 20 CFR 404.935 and 416.1435.

For additional instructions about writing the decision, see HALLEX I-2-8-25.

III.D.4. Five-day Business Calculator for Determining 5-day Submission Compliance

(b) (2) [redacted]

III.D.5. Evidence – General: HALLEX I-2-5-1

I-2-5-1.Evidence — General

Last Update: 5/1/17 (Transmittal I-2-198)

A claimant must inform the Social Security Administration (SSA) about or submit to SSA all evidence, in its entirety, known to him or her that relates to whether or not he or she is blind or disabled. See 20 CFR 404.1512 and 416.912. If a claimant has a representative, then the representative must help the claimant obtain the information or evidence that the claimant must submit. See 20 CFR 404.1740(b)(1) and 416.1540(b)(1). As set forth in our regulations, we will assist claimants in developing the record when appropriate. See 20 CFR 404.1512(b) and 416.912(b).

> **NOTE 1:**
> Evidence generally does not include a representative's analysis of the claim or oral or written communications between a claimant and his or her representative that are subject to the attorney-client privilege, or that would be subject to the attorney-client privilege if a non-attorney representative was an attorney. 20 CFR 404.1513(b) and 416.913(b).

> **NOTE 2:**
> If a representative has a pattern of not submitting evidence that relates to the claim, or if the claimants of a particular representative develop a pattern of not submitting evidence to us or not informing us about evidence that relates to their claims, an administrative law judge (ALJ) will consider whether circumstances warrant a referral to the Office of the General Counsel (OGC) as a possible violation of our rules. See Hearings, Appeals, and Litigation Law (HALLEX) manual I-1-1-50 for instructions on making referrals to OGC.

At the hearings level, a claimant generally must inform SSA about or submit evidence, as required in 20 CFR 404.1512 and 416.912, no later than five business days before the date of the scheduled hearing. If the claimant informs the agency about or submits evidence less than five business days before the date of the scheduled hearing, at, or after the hearing, the ALJ may decline to obtain or consider the evidence, unless the circumstances in 20 CFR 404.935(b) and 416.1435(b) apply (see HALLEX I-2-6-58 and I-2-6-59). To determine whether the circumstances in 20 CFR 404.935(b) and 416.1435(b) apply, see HALLEX I-2-6-59 B.

> **NOTE 3:**
> A business day is any weekday excluding Federal holidays. The business day ends after 11:59PM in the time zone where the hearing office (HO) servicing the claimant's current address is located.

If a claimant informs SSA about evidence, the ALJ will generally determine whether to obtain the evidence using the procedures in HALLEX I-2-5-13. If a claimant submits

evidence to SSA, the ALJ will generally determine whether to consider the evidence using the procedures in HALLEX I-2-6-58 and I-2-6-59.

NOTE 4:

In title XVI cases other than those based on an application for benefits (e.g., age 18 redeterminations, continuing disability reviews, and terminations), the ALJ will accept any evidence submitted on or before the date of the hearing decision. See 20 CFR 416.1435(c).

An ALJ may also decide that he or she needs additional medical or non-medical evidence to make a proper decision in a case. In this circumstance, the ALJ will make all reasonable attempts to fully and fairly develop the record. The ALJ, or HO staff, will add to the record and exhibit documentation of all attempts to obtain evidence.

In addition, an ALJ may decide that witnesses are needed to fully and fairly evaluate the issues in a case. The ALJ or HO staff will schedule appropriate witnesses for the hearing or solicit interrogatories from sources, experts, or other relevant persons. The ALJ may issue a subpoena if a witness indicates he or she will not appear voluntarily or if the witness refuses to produce requested evidence, and the witness's testimony or evidence is reasonably necessary for the full presentation of the case. See 20 CFR 404.950(d) and 416.1450(d). See also HALLEX I-2-5-78 and I-2-5-80.

If an ALJ receives additional evidence after the hearing from a source other than the claimant or the appointed representative, and the ALJ proposes to admit the evidence into the record, the ALJ will proffer the evidence using the instructions in HALLEX I-2-7-1. The ALJ will make a decision based on the evidence in the record, including evidence the ALJ has obtained directly.

III.D.6. OCEP KEYS TO PROGRAM UNIFORMITY

We must provide notice of hearing 75 days in advance, unless the claimant or representative submits a written waiver of advanced notice.

- Applies to initial as well as continued, postponed, or supplemental hearings, but ALJ can request waiver to expedite action on a claim.
- General policy regarding waiver of advanced notice of hearing remains the same (HALLEX I-2-3-25).

Claimants and representatives must inform us about or submit all written evidence, objections to the issues, and pre-hearing written statements no later than five business days prior to the scheduled hearing and must submit subpoena requests no later than 10 business days prior to hearing.

- Agency sent a one-time notice in March to claimants with pending hearing requests, and in April to claimants with pending requests for review, to explain the new regulatory changes; hearing notice language will be updated by the end of April.
- Staff will need to watch for and alert ALJ to any late submissions of evidence, objections, statements, or subpoena requests.

The ALJ may decline to obtain or consider late submissions of evidence, objections, written statements, or subpoena requests unless the claimant meets one of the circumstances in 20 CFR 404.935(b) and 416.1435(b).

- ALJ will accept a late submission or develop evidence informed about after the deadline if a decision has not yet been issued and the claimant demonstrates that the submission meets one of the circumstances described in the regulations.
- ALJs should evaluate any late submissions on a case-by-case basis and identify the reason for not admitting the evidence on the record at the hearing, in a written ruling that the ALJ exhibits, or in the ALJ's decision (HALLEX I-2-6-58).

The Appeals Council will only review a case based on additional evidence if it is new, material, related to the period on or before the hearing decision, and there is a reasonable probability the evidence would change the outcome of the decision.

- The Appeals Council will only consider such evidence if the claimant shows good cause for not informing us about or submitting the evidence at least five business days before the date of the hearing. The Appeals Council will no longer exhibit evidence it does not consider when denying a request for review; it will instead include language in the denial notice identifying the evidence and explaining why it was not considered.

III.D.7. CALJ Memo, 08/08/14; Making "Every Reasonable Effort" to Obtain All Evidence And Documenting Those Efforts—REMINDER

SOCIAL SECURITY

MEMORANDUM

Refer To: 14-723

Date: August 8, 2014

To: All Hearing Office Personnel

From: Debra Bice ***/s/****John R. Allen* for
Chief Administrative Law Judge

Subject: Making "Every Reasonable Effort" to Obtain All Evidence and Documenting Those Efforts -- **REMINDER**

The Office of the Inspector General (OIG) recently studied whether staff at the Disability Determination Services and hearing levels fully developed all available medical evidence before making disability determinations. OIG found that staff did not always obtain all available evidence, or follow the regulations and policies on making "every reasonable effort" to obtain evidence and documenting those efforts. The full report is available here: (b) (2) [redacted]

Please remember to follow our regulations and policies on making every reasonable effort to obtain all evidence and documenting the attempts in the disability folder. More specifically:

- 20 C.F.R. §§ 404.1512(d) and 416.912(d) provide, before making a disability determination, we will develop the claimant's complete medical history for at least the 12 months preceding the month in which the claimant filed the application, unless there is a reason to believe that development of an earlier period is necessary or the claimant says that his or her disability began less than 12 months before filing the application.

- Moreover, we "will make every reasonable effort" to help the claimant get medical reports from his or her own medical sources when the claimant

gives us permission to request the reports. 20 C.F.R. §§ 404.1512(d) and 416.912(d).

- "Every reasonable effort" means that "we will make an initial request for evidence from [the claimant's] medical source and, at any time between 10 and 20 calendar days after the initial request, if the evidence has not been received, we will make one followup request to obtain the medical evidence necessary to make a determination. The medical source will have a minimum of 10 calendar days from the date of our followup request to reply, unless our experience with that source indicates that a longer period is advisable in a particular case." 20 C.F.R. §§ 404.1512(d)(1) and 416.912(d)(1).

- Generally, we will not request a consultative examination (CE) until we have made every reasonable effort to obtain evidence from the claimant's own medical sources. 20 C.F.R. §§ 404.1512(e) and 416.912(e).

- However, in some instances, such as when a source is known to be "unable to provide certain tests or procedures" or "nonproductive or uncooperative," we may order a CE while awaiting receipt of medical source evidence. We will not evaluate this evidence until we have made every reasonable effort to obtain evidence from the claimant's medical sources. 20 C.F.R. §§ 404.1512(e) and 416.912(e).

- HALLEX I-2-5-14 sets forth specific procedures for obtaining medical evidence from a treating or other medical source. Among other things, this section discusses preparing Reports of Contact to document evidence requests and placing them in the claim(s) folder.

- Finally, "the established onset date must be fixed based on the facts and can never be inconsistent with the medical evidence of record." Social Security Ruling 83-20. For additional guidance on this topic, please see Adjudication Tip #13, "Proper Onset Date."

Hearing office staff should contact their regional office with questions. The staff contact for regional inquiries is (b) (6), who may be reached at (b) (6).

III. E. Development of Evidence

III.E.1. Claimant Informs Hearing Office of Additional Evidence: HALLEX I-2-5-13

I-2-5-13. Claimant Informs Hearing Office of Additional Evidence

Last Update: 5/1/17 (Transmittal I-2-198)

A. General

A claimant must inform the Social Security Administration (SSA) about or submit all evidence, in its entirety, known to him or her that relates to whether or not he or she is blind or disabled. See 20 CFR 404.1512 and 416.912. At the hearings level, a claimant must generally inform SSA about or submit evidence, as required in 20 CFR 404.1512 and 416.912 no later than five business days before the date of the scheduled hearing. If the claimant informs SSA about or submits evidence less than five business days before the scheduled hearing, at, or after the hearing, the administrative law judge (ALJ) may decline to obtain or consider the evidence, unless the circumstances in 20 CFR 404.935(b) and 416.1435(b) apply (see Hearings, Appeals and Litigation Law (HALLEX) manual I-2-6-58 and I-2-6-59). Subject to these rules, when a claimant informs SSA about evidence, we will make necessary attempts, as referenced in this section, to obtain the evidence. For the definition of business day, see HALLEX I-2-5-1 NOTE 3.

NOTE 1:

If a claimant or appointed representative informs SSA about evidence no later than five business days before the scheduled hearing date or the ALJ finds the circumstances in 20 CFR 404.435(b) and 416.1435(b) apply, the ALJ will accept and consider the evidence when it is received.

However, in title XVI cases other than those based on an application for benefits (e.g., age 18 redeterminations, continuing disability reviews, and terminations), if the claimant informs SSA about the evidence at any time on or before the date of the hearing decision, the ALJ will make necessary attempts, as referenced in this section, to obtain the evidence and admit the evidence into the record when it is received. See 20 CFR 416.1435(c).

NOTE 2:

A representative may inform SSA about evidence that relates to whether or not the claimant is blind or disabled (20 CFR 404.935 and 416.1435). However, a representative also has an affirmative duty to act with reasonable promptness to help obtain the information or evidence that the claimant must submit under the regulations, and forward the information or evidence to SSA for consideration as soon as practicable (20 CFR 404.1740(b)(1) and 416.1540(b)(1)). If a representative has a pattern of informing SSA about evidence that relates to the claim instead of acting with reasonable promptness to help obtain and forward the evidence to

SSA, an ALJ will consider whether circumstances warrant a referral to the Office of the General Counsel (OGC) as a possible violation of our rules. See HALLEX I-1-1-50 for instructions on making referrals to OGC.

If after the hearing a claimant or appointed representative requests additional time to submit evidence, the ALJ will evaluate the request using the procedures in HALLEX I-2-7-20.

B. Procedures to Develop Evidence When Claimant Informs Hearing Office (HO) of Additional Evidence

When a claimant informs an ALJ or HO staff about additional evidence but does not submit the evidence, the ALJ or HO staff will make every reasonable effort to obtain the evidence using the procedures in this HALLEX section if:

- The claimant informed SSA about the evidence no later than five business days before the date of the scheduled hearing;

- The ALJ finds that the claimant missed the five-day deadline but the circumstances in 20 CFR 404.935(b) and 416.1435(b) apply (see HALLEX I-2-6-58 and I-2-6-59); or

NOTE:
An ALJ will follow the procedures in HALLEX I-2-6-59 B to determine whether the circumstances in 20 CFR 404.935(b) and 416.1435(b) apply. If the ALJ finds that the circumstances do not apply, the ALJ will follow the procedures in HALLEX I-2-6-59 C.

- The case involves a title XVI claim that is not based on an application for benefits (e.g., age 18 redeterminations, continuing disability reviews, and terminations).

To make every reasonable effort to obtain evidence, the ALJ or HO staff will first request that the claimant or representative submit the evidence. If necessary, the ALJ or HO staff will provide the claimant or representative with form SSA-827, Authorization To Disclose Information To The Social Security Administration (SSA), to facilitate obtaining the evidence. See HALLEX I-2-5-14 A.

1. Medical Evidence

If the evidence identified by the claimant is medical evidence, HO staff will diary the case for 30 days and wait for the claimant or representative to submit the evidence. If the claimant or representative does not submit the requested evidence by the diary date, HO staff will contact the claimant or representative, preferably by telephone, to determine why he or she has not submitted the evidence and then consult with the ALJ. Depending on the claimant or representative's reason(s) for not providing the evidence, the ALJ may:

- Extend the time for the claimant or representative to provide the evidence (e.g., if the claimant or representative indicates that a medical source has promised to provide the evidence within a reasonable period);

- Request the evidence from the identified medical source, either directly (see HALLEX I-2-5-14 B) or through the State agency (see HALLEX I-2-5-14 C); or

- Obtain similar information by way of a consultative examination or specific test (e.g., if the claimant or representative informs the ALJ that the requested evidence is not available). See HALLEX I-2-5-20.

HO staff will document all attempts to obtain the evidence on a form SSA-5002, Report of Contact (RC), and associate the RC with the record. The ALJ will exhibit RCs relating to developing evidence.

2. Non-Medical Evidence

If the evidence identified by the claimant is non-medical evidence, HO staff will diary the case for 15 days for the claimant or representative to submit the evidence. If the claimant or representative does not submit the requested evidence by the diary date, HO staff will contact the claimant or representative, preferably by telephone, to determine why he or she has not submitted the evidence and then consult with the ALJ. Depending on the claimant's or representative's reason(s) for not providing the evidence, the ALJ may:

- Extend the time for the claimant or representative to provide the evidence (e.g., if the claimant or representative indicates that a source has promised to provide the evidence within a reasonable period); or

- Request the evidence directly from the identified source (see HALLEX I-2-5-68).

HO staff will document all attempts to obtain the evidence on an RC and associate the RC with the record. The ALJ will exhibit RCs relating to developing evidence.

III.E.2. Obtaining Medical Evidence from a Medical Source: HALLEX I-2-5-14

I-2-5-14. Obtaining Medical Evidence From a Medical Source

III.E.3. Claimant Does Not Attend or Refuses to Undergo a CE Exam: HALLEX I-2-5-24

I-2-5-24. Claimant Does Not Attend or Refuses to Undergo a Consultative Examination or Test

Last Update: 10/9/15 (Transmittal I-2-156)

If a claimant does not attend or refuses to undergo a consultative examination (CE) or test requested by an administrative law judge (ALJ), the Disability Determination Services (DDS) will first assess whether the claimant had good cause for doing so using the general principles outlined in 20 CFR 404.911 and 416.1411. If DDS finds good cause, it will reschedule the CE or test.

However, if DDS finds the claimant does not establish good cause, or the claimant does not attend or refuses to undergo a CE or test in the second instance, DDS will return the request to the ALJ along with any reason(s) the claimant provided for missing the CE or test. The ALJ will associate any documentation from DDS with the claim(s) file.

The ALJ will then use the general principles in 20 CFR 404.911 and 416.1411 to determine whether the claimant had good cause for not attending or refusing to undergo a CE or test. Depending on the circumstances, the ALJ may need to further develop the issue. When evaluating the issue, the ALJ will consider whether the individual has any physical, mental, educational, or linguistic limitations (including any lack of facility with the English language) that may have bearing on the failure to cooperate. In addition to considering the regulatory criteria, ALJs will also evaluate the issue using the same general principles outlined in Social Security Ruling (SSR) 91-5p, Policy Interpretation Ruling Titles II and XVI: Mental Incapacity and Good Cause for Missing the Deadline to Request Review.

> **NOTE 1:**
>
> If the claimant is 65 or older, note also the general principle outlined in SSR 03-3p, Policy Interpretation Ruling – Titles II and XVI: Evaluation of Disability and Blindness in Initial Claims for Individuals Aged 65 or Older. SSR 03-3p states, “[s]ome individuals aged 65 or older may not understand, or be able to comply with, our requests to submit evidence or attend a consultative examination (CE). Therefore, adjudicators must make special efforts in situations in which it appears that an individual aged 65 or older may not be cooperating.”
>
> **NOTE 2:**
>
> In unusual circumstances where the medical record is unclear and resolution is needed to make a finding, an ALJ may obtain an opinion from a medical expert regarding the possible effect of an impairment on the failure to attend or undergo a CE or test.

If the ALJ determines the claimant had good cause for not attending or refusing to undergo the CE or test (and the claimant does not oppose attending or undergoing a

CE or test), the ALJ will request that DDS schedule another CE or test as soon as possible. However, if the claimant cannot establish good cause for not attending or refusing to undergo a CE or test, the ALJ will:

- Exhibit any documents associated with the good cause decision;
- Proffer documents exhibited posthearing to the claimant and representative, if any (see Hearings, Appeals and Litigation Law (HALLEX) manual I-2-7-1); and
- Issue a decision based on the available evidence. For authority, see 20 CFR 404.1516, 404.1518, 404.1579(e)(2), 416.916, 416.918, and 416.994(b)(3)(iv)(D)(4)(ii)

NOTE 3:

There is no authority for an ALJ to dismiss a request for hearing based on the claimant's failure to attend or refusal to undergo a CE or test. However, if the claimant fails to appear at the time and place of the hearing after the ALJ gave proper notice, see 20 CFR 404.957 and 416.1457. See also HALLEX I-2-4-25.

III.E.4. Action Following Receipt of Requested Evidence: HALLEX I-2-5-28

I-2-5-28. Action Following Receipt of Requested Evidence

Last Update: 4/1/16 (Transmittal I-2-170)

A. General

As outlined in Hearings, Appeals, and Litigation Law (HALLEX) manual chapter I-2-5, there are many circumstances in which an administrative law judge (ALJ) may request additional evidence. When requested evidence is received, the ALJ must review the evidence to ensure it is complete, responsive, material, and relevant. See HALLEX I-2-6-58 for a discussion of when evidence is considered “material.”

B. Requested Evidence Is Complete and Responsive

If the requested evidence is material, relevant to the issues of the case, complete, and responsive, hearing office (HO) staff will:

- Mark the new evidence as a proposed exhibit (see HALLEX I-2-1-15);
- Prepare and mark the professional qualifications of each source as an exhibit (see HALLEX I-2-1-30); and
- Review the total record for sufficiency of the evidence and any material conflicts.

C. Requested Evidence Is Incomplete or Unresponsive

When HO staff requested the evidence through a State agency and the evidence is incomplete or unresponsive, the HO staff will follow the procedures in HALLEX I-2-5-14 D.3.

When HO staff requested the evidence directly from a treating or other source and the evidence is incomplete or unresponsive, HO staff will contact the source again to determine if additional evidence is available. HO staff can contact the source directly or contact the source through the claimant or the representative, if any. HO staff may request assistance from the State agency if necessary using the procedures in HALLEX I-2-5-14 D.

D. Requested Evidence Is Not Material and Relevant

If evidence requested through a State agency or directly from a treating or other source is complete and responsive but is not material and relevant, HO staff will not exhibit the evidence. In paper cases, HO staff will place the evidence in the C section (Temporary) of the claim(s) file.

E. Disclosure of New Evidence Before the Hearing

Before the hearing, the ALJ will give the claimant or appointed representative, if any, an opportunity to review any information the ALJ proposes to exhibit. Additionally, before the hearing, an ALJ (or assisting staff) will proffer prehearing consultative examination reports, or medical or vocational expert interrogatories obtained before the hearing. Proffering this evidence before the hearing allows the claimant to timely object to or present additional questions to the author of the evidence that will be made part of the record. For more information about prehearing proffer, see HALLEX I-2-5-29. An ALJ (or other authorized designee) is not required to proffer evidence if he or she intends to issue a fully favorable decision without a hearing.

> **NOTE:**
> If a claimant or appointed representative requests to review all information in the claim(s) file, rather than just the information the ALJ proposes to exhibit, the ALJ will provide an opportunity for the claimant or representative to do so. See HALLEX I-2-1-35.

If the new evidence contains information that may be detrimental to the claimant's health (such as a serious illness of which the claimant and the treating source may not be aware), the ALJ will exercise appropriate discretion to avoid adversely affecting the claimant's medical situation, while proceeding with the actions necessary to protect the claimant's right to due process. See generally HALLEX I-2-7-30 B.

F. Disclosure of New Evidence After the Hearing

If an ALJ receives new evidence after the hearing from a source other than the claimant or representative, if any, and the ALJ proposes to enter the evidence into the record as an exhibit, the ALJ will follow the proffer procedures in HALLEX I-2-7-1, I-2-7-30 and I-2-7-35. See also HALLEX I-2-5-91, I-2-5-92, and I-2-6-99.

III.E.5. Prehearing Proffer of Evidence: HALLEX I-2-5-29

I-2-5-29 Prehearing Proffer of Evidence

Last Update: 4/1/16 (Transmittal I-2-170)

A. Definition of Proffer

Generally, to "proffer" means to offer or present for consideration. In the context of evidence development, to "proffer" means to provide an opportunity for a claimant (and appointed representative, if any) to review additional evidence that has not previously been seen and that an adjudicator proposes to make part of the record. Proffering evidence allows a claimant to:

- Comment on, object to, or refute the evidence by submitting other evidence; or
- If required for a full and true disclosure of the facts, cross-examine the author(s) of the evidence.

B. When Proffer is Required Prehearing

Under most circumstances, proffer is not necessary when an administrative law judge (ALJ) receives additional evidence before the hearing from a source other than the claimant or the appointed representative, if any. Proffer is not usually required because other hearing procedures require that an ALJ provide the claimant or representative an opportunity to review any information in the claim(s) file before the hearing. See Hearings, Appeals and Litigation Law (HALLEX) manual I-2-1-35.

However, if an ALJ agrees to take certain actions during a prehearing conference, the ALJ must summarize the actions to be taken in writing and proffer the writing to the claimant and representative. See HALLEX I-2-1-75 E. Additionally, if the ALJ (or assisting staff) requested interrogatories from a medical or vocational expert, and the received responses would not result in a fully favorable decision, the ALJ (or assisting staff) is required to proffer the evidence to the claimant and appointed representative, if any. Proffer is necessary to allow the claimant or appointed representative to object to or present additional questions to the author of the evidence. Wherever possible, the ALJ will proffer this evidence as soon as possible after receiving the responses to avoid the possibility that the author of the evidence will be unavailable to respond to additional questions.

> **NOTE 1:**
> If the author of opinion evidence is unavailable when follow up questions are submitted, the ALJ will carefully consider a claimant's or appointed representative's comments or objections to the opinion and determine whether responses are necessary for a full and true disclosure of the facts. If the comments or objections raise legitimate concerns about the opinion, the ALJ will consider this in determining the weight to give to the opinion and address the issue in the decision. If objections are raised, the ALJ must specifically rule on the objection in a writing marked as an exhibit or on the record during the hearing. See HALLEX I-2-2-20 and I-2-5-44.

When proffering the evidence, the ALJ will use the same general procedures for proffering posthearing evidence, as set forth in HALLEX I-2-7-30. When proffer occurs prehearing, there is no need for the ALJ to offer the claimant the opportunity for a hearing at the time of the proffer (i.e., a hearing will be subsequently scheduled unless a fully favorable on-the-record decision is later warranted).

NOTE 2:

If an ALJ becomes aware of the need to proffer prehearing evidence at or after the hearing, the ALJ will take the steps necessary to proffer the evidence, and, as required, offer a supplemental hearing. For more information about proffer and supplemental hearings, see the instructions in HALLEX I-2-7-1.

III.E.6. Consultative Examinations

III.E.6.a. When We Will Purchase a CE and How We Will Use It: 20 CFR 404.1519a and 416.919a

§ 404.1519a. When we will purchase a consultative examination and how we will use it.

- (a) ***General.*** If we cannot get the information we need from your medical sources, we may decide to purchase a consultative examination. See § 404.1512 for the procedures we will follow to obtain evidence from your medical sources and § 404.1520b for how we consider evidence. Before purchasing a consultative examination, we will consider not only existing medical reports, but also the disability interview form containing your allegations as well as other pertinent evidence in your file.
- (b) ***Situations that may require a consultative examination.*** We may purchase a consultative examination to try to resolve an inconsistency in the evidence, or when the evidence as a whole is insufficient to allow us to make a determination or decision on your claim. Some examples of when we might purchase a consultative examination to secure needed medical evidence, such as clinical findings, laboratory tests, a diagnosis, or prognosis, include but are not limited to:

  (1) The additional evidence needed is not contained in the records of your medical sources;
  (2) The evidence that may have been available from your treating or other medical sources cannot be obtained for reasons beyond your control, such as death or noncooperation of a medical source;
  (3) Highly technical or specialized medical evidence that we need is not available from your treating or other medical sources; or
  (4) There is an indication of a change in your condition that is likely to affect your ability to work, but the current severity of your impairment is not established.

[56 FR 36956, Aug. 1, 1991, as amended at 77 FR 10655, Feb. 23, 2012]

III.E.6.b. Consultative Examinations and Tests: HALLEX I-2-5-20

I-2-5-20 Consultative Examinations and Tests

Last Update: 9/28/05 (Transmittal I-2-68)

If the claimant does not provide adequate evidence about his or her impairment(s) for the ALJ to determine whether the claimant is disabled or blind, and the ALJ or the HO staff is unable to obtain adequate evidence from the claimant's treating source(s) or other medical source(s), the ALJ may request a CE(s) and/or test(s) through the State agency.

> **NOTE:**
> An ALJ should request only the specific examination(s) or test(s) that he or she needs to make a decision. For example, an ALJ should not request a complete medical examination if the only evidence needed is a special test (such as an x-ray, blood study or electrocardiogram) or a medical source statement of the claimant's ability to do work-related activities.

A. Requesting a CE

When requesting a CE, the ALJ or HO staff should provide the State agency with the following:

1. A “Request for DDS Assistance in Obtaining Consultative Examination(s)” (and other medical evidence as indicated) [HA-4489]. To access this document, go to the Document Generation System (DGS) and click on the tab “CE and Evidence Request” then click on the “Request for DDS Assistance in Obtaining a Consultative Examination” tab. The ALJ or HO staff should request a medical source statement by checking the appropriate block. Specific information, including the type of evaluation and any specific test(s), including any equivalent test(s), requested by the ALJ should be clearly stated.
2. Signed and dated Form SSA-827, Authorization to Disclose Information to the Social Security Administration (SSA).

> **NOTE:**
> The Form SSA-827 was revised in February 2003 to comply with the Health Insurance Portability and Accountability Act (HIPAA). The form carries an expiration date of 12 months from the date signed. If there is no signed and dated SSA-827 (2-2003 edition or later) in the claim file, or if there is one but the 12-month period has expired or will expire within 30 calendar days, annotate the Specific Information Requested section of the “Request for DDS Assistance” (Form HA-4489) with “Updated SSA-827 Needed”. This will alert the State agency to take steps to have the claimant provide a new authorization.

3. A medical exhibits folder which contains evidence relating to the type of examination ordered with instructions for the State agency to send the folder to the consultative examiner for review. (See I-2-5-22, Medical Exhibits Folder.)
4. A medical source statement form (i.e., HA-1151, Medical Assessment of Ability to Do Work-Related Activities (Physical), or HA-1152, Medical Assessment of Ability to do Work-Related Activities (Mental), but only if directed by the ALJ. To access these documents, go to DGS, click on the "CE and Evidence Request," then click on the "Medical Source Physical" tab or the "Stand Alone Medical Source Statement" then you can choose either the physical or mental medical source statement.
5. The name, email address and telephone number of a person in the HO that the State agency may contact.
6. A postage-paid return envelope suitable for the evidence requested.

> **NOTE:**
> In the electronic environment, the provider will be given the number to the DDS fax scanner. DDS will electronically notify OHA when the evidence is received.

7. The HO staff will place a copy of the CE request in the CF and will add a development action to the CPMS record.

B. Requesting Specific Tests

If an ALJ decides that he or she needs the results of a specific medical test(s) to make a decision, the ALJ may request the State agency to arrange for the test(s) to be performed either in conjunction with a CE or alone. Whenever possible, the ALJ should indicate that an equivalent test(s) may be substituted for the specific test(s) requested.

> **NOTE:**
> Some diagnostic tests or procedures, such as treadmill exercise testing, may involve significant risk to the claimant. The State agency medical consultant will review the evidence and determine whether a requested diagnostic test or procedure involves significant risk. (See I-2-5-26, State Agency Physician Determines that Requested Tests Would Involve Significant Risk.)

When requesting a State agency to have a specific medical test(s) performed in conjunction with a CE or alone, the ALJ or HO staff should provide the State agency with the information described above in subsection A., and describe the specific medical test(s) in section 3 (Specific Information Requested) of the HA-4489.

The HO staff will place a copy of the request in the CF and will add a development action to CPMS.

NOTE:

Requesting Medical Test Data

See I-2-5-14.D., Medical Test Data, which discusses requesting background medical test data (e.g., X-ray films, and "raw" psychological test data such as answer sheets or drawings). Because consulting sources are, by regulation, subject to special oversight provisions, as described in 20 CFR §§ 404.1519p through 404.1519t and 416.919p through 416.919t, it should not be necessary to request background medical test data from consulting sources.

C. Selecting the Medical Source Who Is to Conduct the CE or Test(s)

The ALJ usually will not need to specify a particular medical source to conduct a CE or test. Because SSA considers a claimant's treating source(s) to be the primary source of medical information about a claimant's impairment, the State agency will, if possible, select a treating source who is qualified, equipped, and willing to perform the CE or test for the amount allowed under its fee payment schedule.

An ALJ may request that the State agency use a particular nontreating medical source or other medical source to conduct a CE or test only if the Appeals Council or a court has so ordered.

An ALJ may request that the State agency not use a particular treating, nontreating, or other medical source to conduct a CE or test if he or she has a good reason. If an ALJ requests a State agency to use or not use a particular treating or nontreating medical source to conduct a CE or test, the ALJ must:

- provide the medical source's name, address, and telephone number, and explain the reason(s) for the special request; and
- place a copy of the special request in the CF.

The State agency may decline to use a particular treating, nontreating, or other medical source to conduct a CE or test if it has a good reason, e.g., the medical source has a history of not providing timely or complete reports. When the State Agency declines to use a particular treating, nontreating or other medical source, the reason should be provided in writing to the ALJ or HO.

D. Follow-up Procedures

If the State agency does not provide the requested evidence by the end of the diary period, the HO staff should follow the procedures in I-2-5-14 C.2.

E. Problems with the State Agency's Response

1. CE Report is Inadequate or Incomplete

If the State agency does not provide a CE report, or provides a CE report that is inadequate or incomplete, the HO staff should follow the procedures in I-2-5-14 C.3.

2. CE Report is Unsigned or Improperly Signed

If the State agency provides a CE report that is unsigned or improperly signed, or if the CF contains such a CE report, which would otherwise be proposed as an exhibit, the HO staff should ask the State agency to obtain a properly signed CE report, and then follow the procedures in E.3., or E.4., below.

NOTE:

A CE source's signature on a report annotated “not proofed” or “dictated but not read” is not acceptable. A rubber stamp signature, or a signature entered by another person is also not acceptable.

NOTE:

In the electronic environment, DDS will scan the signature page of a CE report into the Electronic Folder. The CE report would contain a “wet signature”.

3. Decision Fully Favorable

The ALJ should not delay issuing a fully favorable disability decision pending receipt of a properly signed CE report. The ALJ should issue the fully favorable decision, and the HO staff should send the decision and CF to the appropriate component for effectuation.

4. Decision Less Than Fully Favorable

The ALJ should not use an unsigned or improperly signed CE report as basis for a decision that is less than fully favorable. If the ALJ needs a CE report to issue a decision, but the CE report is unsigned or improperly signed, and the State agency cannot obtain the proper signature on the report, the ALJ should not use the report, but rather should request the State agency to arrange for another CE or test with a different CE source.

III.E.7. USE OF SUBPOENAS: HALLEX I-2-5-78

I-2-5-78.Use of Subpoenas - General

Last Update: 5/1/17 (Transmittal I-2-198)

A. General

When it is reasonably necessary for the full presentation of a case, an administrative law judge (ALJ) may issue a subpoena on his or her own initiative or at the request of a claimant or appointed representative. See 20 CFR 404.950(d) and 416.1450(d). An ALJ may issue a subpoena for the appearance and testimony of a witness(es), and for the production of books, records, correspondence, papers, or other documents that are material to an issue at the hearing. For example, an ALJ may find a subpoena necessary when a person having knowledge of a material fact or possession of documentary evidence is reluctant or unwilling to testify or provide the evidence.

> **NOTE:**
> In the Fifth Circuit, if a claimant requests a subpoena to cross-examine an examining physician, and the claimant makes the request prior to the closing of the record, the ALJ must issue the subpoena. See Acquiescence Ruling 91-1(5), *Lidy v. Sullivan*, 911 F.2d 1075 (5th Cir. 1990) – Right to Subpoena an Examining Physician for Cross-examination Purposes – Titles II and XVI of the Social Security Act.

B. Claimant Requests Subpoena

1. Receipt of Request

A claimant has a right to request that an ALJ issue a subpoena, but he or she must make the request in writing at least ten business days before the hearing date. See 20 CFR 404.950(d)(2) and 416.1450(d)(2). If the claimant does not submit the request at least ten business days before the hearing date, the ALJ may deny the request at his or her discretion, unless the circumstances in 20 CFR 404.935(b) and 416.1435(b) apply (see HALLEX I-2-6-58 and I-2-6-59). An ALJ will follow the procedures in HALLEX I-2-6-59 B to determine whether the circumstances in 20 CFR 404.935(b) and 416.1435(b) are met.

> **NOTE 1:**
> For the definition of “business day,” see HALLEX I-2-5-1 NOTE 3.

A claimant's request for a subpoena must:

- Give the name(s) of the witness(es) or document(s) to be produced;
- Describe the address or location of the witness(es) or document(s) with sufficient detail to find them;
- State the important fact(s) that the witness(es) or document(s) is expected to prove; and

- Indicate why the fact(s) could not be proven without issuing a subpoena.

2. Evaluating the Request

If a claimant submits a subpoena request at least ten business days before the hearing date or an ALJ finds that the circumstances in 20 CFR 404.935(b) and 416.1435(b) apply, the ALJ will evaluate the request. When all other means of obtaining the information or testimony have been exhausted (as described in the following paragraphs), an ALJ will issue a subpoena if:

- The claimant or ALJ cannot obtain the information or testimony without the subpoena; and

- The evidence or testimony is reasonably necessary for the full presentation of the case.

When evaluating a subpoena request, the ALJ or hearing office staff will first review the claim(s) file to determine whether the requested information or testimony is already a part of the record. If the requested information or testimony is already part of the record, the ALJ will deny the subpoena request. For denial procedures, see subsection D below. For example, if a claimant requests a subpoena to compel a person to testify at a supplemental hearing, and the record shows that the individual testified at the initial hearing and that the claimant or appointed representative had the opportunity to cross-examine the individual, the ALJ may deny the subpoena request.

In some cases, the requested information or testimony is not part of the record, but has already been requested or can be developed by hearing office staff. In these situations, the ALJ will delay ruling on the subpoena request until development is completed. If development is completed and it is clear that the usual procedures used to obtain the information or testimony have been unsuccessful, the ALJ will determine whether issuing a subpoena for the requested information or testimony is reasonably necessary for a full presentation of the case.

> **NOTE 2:**
> If a claimant requests a subpoena to obtain testimony from an author of a written report, the ALJ must carefully consider whether a cross-examination is required for a full presentation of the case.

C. Subpoena on ALJ's Initiative

Generally, an ALJ will only issue a subpoena on his or her own initiative when an individual has information or can offer testimony that the ALJ determines is reasonably necessary for the full presentation of the case and all other means of obtaining this information or testimony have been exhausted. (See generally the instructions in subsection B above).

NOTE:

Medical experts, vocational experts, and consultative examiners who will not appear voluntarily (i.e., as requested by an ALJ without a subpoena) may be subpoenaed to appear under the same standard applicable to other witnesses. However, an ALJ will usually attempt to obtain testimony from these individuals via video teleconferencing or by telephone.

D. Denying a Subpoena Request

If an ALJ denies a claimant's request for a subpoena, the ALJ must notify the claimant of the denial, either in writing or on the record at the hearing. In either situation, the ALJ will enter the request into the record as an exhibit. If the denial is in writing, the ALJ will also enter the denial notice into the record as an exhibit. Whether on the record or in writing, the ALJ will explain why the ALJ declined to issue a subpoena.

III.E.8. Using the Internet as a Source of Information in Case Adjudication: HALLEX I-2-5-69

I-2-5-69. Using the Internet as a Source of Information in Case Adjudication

Last Update: 8/30/13 (Transmittal I-2-95)

A. Introduction

Generally, when adjudicating a claim, an administrative law judge (ALJ) and other hearing office staff may not rely on information from the Internet that has not been corroborated by a Cooperative Disability Investigations Unit (CDIU). Further, entering an individual's personally identifiable information (PII) in an Internet search engine or social media network may compromise the confidentiality of PII. The responsibility to protect PII within an ALJ's or employee's control applies at all times, regardless of whether the individual is at an official duty station, another official work location, an alternate duty station, or off duty. This policy applies whether the individual is using a computer or personal device such as a smartphone.

B. Internet Sites and Social Media Networks

Adjudicators and hearing office staff must not use Internet sites and social media networks to obtain information about claimants to adjudicate cases. If the information was entered into the record by a Social Security Administration (SSA) or state agency employee at the initial or reconsideration level, the adjudicator will not consider or exhibit the evidence.

However, adjudicators will consider information from Internet sites or social media networks in the following situations:

- If information from an Internet site or social media network has been corroborated by the CDIU and associated with the record, adjudicators will consider that information when adjudicating the case, as explained in Hearings, Appeals and Litigation Law (HALLEX) manual I-2-5-69 B.2. in this section.
- If the information was submitted by the claimant or an appointed representative, the adjudicator will consider the evidence when adjudicating the case.

1. Symptom Evaluation

When applicable, documenting symptom evaluation findings is necessary to show that the claimant received a full and fair review of his or her claim, and that the ALJ made a well-reasoned decision. An ALJ cannot evaluate symptoms based on intangible assumptions or intuition. The ALJ must consider the entire case record, ground the symptom evaluation findings in the evidence, and articulate the reasons in the decision. The ALJ may also consider observations about the claimant recorded by Disability Determination Services (DDS) and SSA employees during interviews, whether in person or by telephone. When the claimant attends a hearing, the ALJ may consider his or her own observations of the individual as part of the overall evaluation of the claimant's symptoms.

ALJs must not use information from Internet sites and social media networks when determining disability, unless it has been corroborated by the CDIU or was submitted by the claimant or an appointed representative as evidence. Further, an ALJ must not instigate an independent investigation to determine the validity of a statement made on the Internet.

Rather, ALJs must apply the factors in 20 CFR 404.1529 and 416.929, as well as the principles in Social Security Ruling 96-7p regarding an individual's statements about the intensity, persistence, or functionally limiting effects of pain or other symptoms. The decision must include specific reasons for symptom evaluation findings and be supported by the evidence in the case record. In addition, the decision must be sufficiently specific to make clear to the claimant, and any subsequent reviewers, the weight the adjudicator gave to the claimant's statements about his or her symptomms and the reasons for that weight.

If a Report of Investigation (ROI) in the file contains evidence obtained from an Internet site or social media network, and a CDIU corroborated that evidence, the ALJ must consider this information along with the other evidence in the file.

2. Suspected Fraud

If an ALJ becomes aware of a potential fraud situation, he or she must report the suspected fraud following established procedures, per the instructions found in HALLEX I-1-3.

If the evidence in the file supports an allowance, but relates to suspicious allegations that are part of a fraud investigation, the ALJ must not make a decision on the case until he or she receives notification from CDIU to continue processing the case.

The primary mission of CDIUs is to obtain factual evidence that can resolve questions of fraud in SSA's disability program before benefits are paid. CDIUs often use Internet sites or social media networks as a starting point for their investigations. However, they corroborate information on which they rely and do not base their findings on uncorroborated information. If the CDIU completes an investigation and prepares an ROI, adjudicators and reviewers must use the corroborated evidence found in the ROI to assess potential fraud or similar fault. When using an ROI to assess potential fraud or similar fault, the role of the ROI is to allow the DDS or other adjudicator to disregard questionable evidence, when warranted. Adjudicators and reviewers must consider all evidence in the case record before determining whether to disregard specific evidence.

C. Verifying Inmate Information on the Internet

SSA must make sure that any website accessed for inmate information is not protected by privacy and disclosure laws, and that the website administrator does not charge a fee for accessing information on the website. Each website that SSA visits for prisoner information must provide reliable and current information on its inmate population. The website must also have the information displayed in a clear and readable format that is unlikely to result in misinterpretation of any of its content or an incorrect conclusion about a claimant's identity or inmate status.

SSA has designated regional prisoner coordinators (RPC) who identify websites that are accurate and reliable, as noted in Program Operations Manual System (POMS) GN 02607.680C. An RPC supplies information for the prisoner Internet website page available through the regional office's Intranet site, which provides addresses for the approved correctional and mental institution websites broken down by State in each of the corresponding regions. The Philadelphia region's Intranet site includes links to approved Internet sites for prison facilities throughout the country.

> **NOTE:**
> While it is acceptable to verify inmate information on the Internet, it is not acceptable for an ALJ to instigate an independent investigation of a claimant's criminal history on the Internet.

For procedures on using the Internet as a third-party source of inmate verification, see POMS GN 02607.680D.

For alternative methods of verifying or obtaining inmate information, see POMS GN 02607.680B.

III.E.9. CALJ Memo, Earned Income Tax Credit (EITC) Suspected Fraud (08/28/15 REVISION)

SOCIAL SECURITY
- Office of Disability Adjudication and Review

MEMORANDUM

Date: August 28, 2015 Refer To: 15-509

To: All ODAR Hearing Office Personnel

From: Debra Bice ***/s/***
Chief Administrative Law Judge

Subject: Earned Income Tax Credit (EITC) Suspected Fraud -- **REVISED INFORMATION**

This memorandum updates and supersedes the guidance provided in the June 17, 2013, memorandum on addressing suspected EITC fraud that is identified at the hearing level.

The EITC is a special tax credit that reduces the Federal tax liability of certain low-income working individuals, and it may or may not result in a payment to the individual. These payments can occur either as an advance from an employer or as a refund from the Internal Revenue Service (IRS). EITC fraud arises when an individual who does not have self-employment income reports such income to the IRS to receive the EITC and a possible payment. In the context of a claim for disability benefits, EITC fraud may be suspected when a claimant denies having performed any self-employment but the earnings record reflect that self-employment income was reported to the IRS. POMS RS 01804.525.

If any hearing operation personnel identifies suspected fraud, he or she must refer the matter in accordance with HALLEX I-1-3-9. EITC fraud may be subject to criminal prosecution as it may constitute making or causing to be made any false statement or representation as to whether net earnings from self-employment income were received. See HALLEX I-1-3-3. If the suspected EITC fraud is related to an issue being adjudicated, Administrative Law Judges (ALJs) will follow the instructions in HALLEX I-1-3-18. If the suspected criminal violation comes to the ALJ's attention during testimony at a hearing, and the suspected criminal violation is unrelated to the case's merits, the

ALJ will limit the hearing to the issues in the notice of hearing, and will avoid initiating further inquiry during the hearing. However, after the hearing, the ALJ will refer the criminal matter to the Office of the Inspector General. If the ALJ has concerns about adjudication issues based on the testimony, the ALJ will consult with the Hearing Office Chief Administrative Law Judge and the Regional Chief Administrative Law Judge. HALLEX I-1-3-9 A, Note 2, and I-1-3-18 A, Note.

Finally, in addition to the steps above, an ALJ should notify a hearing office (HO) or National Hearing Center (NHC) Hearing Office Chief Administrative Law Judge (HOCALJ) of the suspected EITC fraud. The HOCALJ should refer the matter to the servicing Field Office (FO). Do not contact any third parties, such as the tax preparer, regarding the suspected EITC fraud. POMS RS 01804.525. The FO will follow the EITC fraud referral instructions outlined in POMS RS 01804.525. The HOCALJ should note the referral in the "Remarks" section of Case Processing and Management System, and the HO or NHC will continue routine processing of the case. Do not notify the claimant or representative, if any, of the referral.

The staff contact for regional inquiries is Attorney-Advisor (b) (6), who can be reached at (b) (6). Hearing office staff should contact their regional office with questions.

cc: Associate Chief Administrative Law Judges
Regional Chief Administrative Law Judges
Regional Office Management Teams
Hearing Office Management Teams

III.E.10. Cooperative Disability Investigations

HA Volume I Division 2 Chapter 10: Fraud, Similar Fault, and Administrative Sanctions
HA I-2-10-0: Fraud, Similar Fault, and Administrative Sanctions
HA I-2-10-1: Overview
HA I-2-10-2: Acknowledging a Request for Hearing When Investigative Evidence Is In the Record
HA I-2-10-3: Receipt of the Investigative Report While Request for Hearing Is Pending
HA I-2-10-4: Claimant Asks to Review Investigative Evidence
HA I-2-10-6: Notice of Hearing
HA I-2-10-8: Office of the Inspector General (OIG) Agents or Others as Witnesses at a Hearing
HA I-2-10-10: Considering Evidence When Fraud or Similar Fault Is Involved
HA I-2-10-14: Writing a Decision When Fraud or Similar Fault Is at Issue
HA I-2-10-16: Administrative Sanction Cases

III.E.11. Fraud and Similar Fault

SSR 16-1p Titles II and XVI: Fraud and Similar Fault Redeterminations Under Sections 205(u) and 1631(e)(7) of the Social Security Act

SSR 16-2p Titles II and XVI: Evaluation of Claims Involving the Issue of Similar Fault in the Providing of Evidence

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III.F. Setting the hearing

III.F.1 In General: HALLEX I-2-3-10

I-2-3-10. Scheduling Hearings

Last Update: 8/29/14 (Transmittal I-2-117)
Citations: 20 CFR 404.936, 404.999a-d, 416.1436, and 416.1495-416.1499

Unless the agency exercises its authority under the pilot program in 20 CFR 404.936 and 416.1436 that began on August 9, 2010, the administrative law judge (ALJ) sets the time and place for the hearing. The ALJ may change the time and place, if necessary. The objective is to hold a hearing as soon as possible after the request for hearing (RH) is filed, at a site convenient to the claimant. The hearing office (HO) staff will generally contact hearing participants to ascertain availability before scheduling the hearing.

> **NOTE:**
> If a claimant threatens violence against the general public or HO personnel, or has been banned from entering a Federal or Social Security facility, see the instructions for scheduling a hearing in 20 CFR 404.937 and 416.1437 and in Chapter I-1-9-0 of the Hearings, Appeals and Litigation Law (HALLEX) manual.

A. Determining the Time and Place for Hearing

When an ALJ sets the time and place for a hearing, the ALJ will consider:

- The number and types of cases to be set for hearing,
- The proximity of the hearing site to the claimant's residence, and
- The availability of the claimant, representative, and witnesses on the proposed hearing date.

To the extent possible, the location of the hearing site will be within 75 miles of the claimant's residence. The ALJ will also consider scheduling the hearing by video teleconferencing (VTC) or, in certain extraordinary circumstances, by telephone. See HALLEX I-2-0-15.

1. Determining the Claimant's Manner of Appearance

The ALJ determines the claimant's manner of appearance at the hearing, and will notify the claimant of the manner of appearance in the notice of hearing. See 20 CFR 404.936 and 416.1436. However, in determining how the claimant will appear at the hearing, the ALJ must approve a claimant's timely submitted objection to appearing by VTC (unless the claimant changes residences while the request for hearing is pending), as explained in HALLEX I-2-0-15 and I-2-0-21. Regardless of a claimant's manner of appearance at the hearing, the ALJ must inquire fully into all matters at issue and conduct the hearing in a fair and impartial manner. See HALLEX I-2-6-1.

A claimant or other party to the hearing will not be denied the right to a hearing because of geographic considerations. See HALLEX I-2-1-45 D.

a. Appearance in Person

An ALJ will schedule a claimant to appear in person at the hearing when:

- An in-person hearing will be more timely and efficient than a hearing by VTC; or
- The claimant properly objected to a hearing by VTC, as described in HALLEX I-2-0-21, and the claimant has not changed his or her residence while the request for hearing is pending.

NOTE 1:
See HALLEX I-2-3-11 B for circumstances when an ALJ will honor a claimant's objection to appearing via VTC even if he or she changed residences while the request for hearing is pending.

NOTE 2:
A claimant's confinement in a prison or other institution may require an ALJ to schedule the hearing at the place of confinement, unless other arrangements can be made. See HALLEX I-2-3-10 A.1.b below.

III.F.2 .Medical Experts

III.F.2.a HALLEX I-2-5-32; Medical Experts – General

I-2-5-32. Medical Experts — General

Last Update: 8/29/14 (Transmittal I-2-118)

A. General Description of Medical Expert (ME)

MEs are physicians, mental health professionals, and other medical professionals who provide impartial expert opinion at the hearing level on claims under title II and title XVI of the Social Security Act.

MEs provide opinions by either testifying at a hearing or responding to written interrogatories. An administrative law judge (ALJ) may use an ME before, during, or after a hearing. The need for ME opinion evidence is generally left to the ALJ's discretion, except in the circumstances outlined in Hearings, Appeals and Litigation Law (HALLEX) manual I-2-5-34 B.

B. ME Opinions

The primary reason an ALJ will request an ME opinion is to help the ALJ evaluate the medical evidence in a case. When needed, use of an ME will result in a more complete record to support the ALJ's conclusion on the ultimate issue of disability. See HALLEX I-2-5-34 for examples of when an ALJ may need to obtain an ME opinion. See also HALLEX I-2-5-38 and hearing office electronic business process sections 3.3, 3.4, and 4.2 for procedures on obtaining ME testimony.

Before requesting an ME opinion, an ALJ will:

- Review the evidence to determine if it adequately documents the course of the claimant's alleged impairment(s) and treatment;
- Identify and obtain any additional evidence that is needed; and
- Develop a list of questions to ask the ME. (See HALLEX I-2-5-93 for examples of questions that might be appropriate.)

An ME's opinion is not binding on an ALJ. The weight an ALJ gives an ME's opinion depends upon the extent to which the opinion is supported by the signs and laboratory findings and is consistent with the other evidence of record, in accordance with 20 CFR 404.1527(e) and 416.927(e).

C. Special Considerations

An ALJ must be mindful of the following issues when using an ME. An ALJ may not:

- Use an ME who has treated the claimant in the past or who has examined the claimant on a consultative basis.
- Engage in off-the-record discussions with the ME about a claimant's case. If such a discussion occurs, the ALJ must summarize the discussion on the record at the hearing or enter a written summary of it into the record as an exhibit.
- Ask an ME to provide an opinion on vocational matters, even if the ME is a certified vocational expert.

III.F.2.b HALLEX I-2-5-34; When to Obtain Medical Expert Opinion

I-2-5-34. When to Obtain Medical Expert Opinion

Last Update: 4/1/16 (Transmittal I-2-170)

A. When to Obtain a Medical Expert (ME) Opinion

1. When an Administrative Law Judge (ALJ) Must Obtain an ME Opinion (Not Discretionary)

The ALJ must obtain an ME opinion, either in testimony at a hearing or in responses to written interrogatories in the following circumstances:

- The Appeals Council or Federal court ordered an ME opinion.
- There is a question about the accuracy of medical test results reported, requiring evaluation of background medical test data. For more information, see Hearings, Appeals and Litigation Law (HALLEX) manual I-2-5-14 E.
- The ALJ is considering finding that the claimant's impairment(s) medically equals a listing.

2. When an ALJ May Obtain an ME Opinion (Discretionary)

An ALJ may need to obtain an ME opinion, either in testimony at a hearing or in responses to written interrogatories, when the ALJ:

- Determines whether a claimant's impairment(s) meets a listed impairment(s);

- Determines the usual dosage and effect of drugs and other forms of therapy;
- Assesses a claimant's failure to follow prescribed treatment;
- Believes a claimant's drug addiction or alcoholism may be material to finding a claimant disabled;
- Determines the degree of severity of a claimant's physical or mental impairment;
- Believes an ME may be able to suggest additional relevant evidence because there is reasonable doubt about the adequacy of the medical record;
- Believes an ME may be able to clarify and explain the evidence or help resolve a conflict because the medical evidence is contradictory, inconsistent, or confusing;
- Believes an ME may be able to assist the ALJ by explaining and assessing the significance of clinical or laboratory findings in the record that are not clear;
- Is determining the claimant's residual functional capacity, e.g., the ALJ may ask the ME to explain or clarify the claimant's functional limitations and abilities as established by the medical evidence of record;
- Has a question(s) about the etiology or course of a disease and how it may affect the claimant's ability to engage in work activities at pertinent points in time, e.g., the ALJ may ask the ME to explain the nature of an impairment and identify any medically contraindicated activities; or
- Needs an expert medical opinion regarding the onset of an impairment.

> **NOTE:**
> An ALJ will never ask or permit an ME to perform an examination of a claimant. If an ALJ finds an examination is necessary because there is not enough evidence about an impairment(s) for the ALJ to make a finding, the ALJ will request a consultative examination. See HALLEX I-2-5-20.

B. Determining Medical Specialty and Manner of Receiving Opinion

If a staff designee is assigned to screen or perform a review of a case before the hearing and believes an ME opinion is necessary, the designee will make a recommendation to the ALJ regarding the need for an ME and the desired medical specialty of the ME. The designee will recommend the specialty whose expertise is most appropriate to the claimant's diagnosed impairment(s).

> **NOTE:**
> A National Adjudication Team (NAT) attorney advisor who is assigned a NAT case and has consulted with their NAT lead attorney or designee may obtain ME opinions through interrogatories if the requested opinion is likely to result in a fully favorable decision on the record.

If the ALJ agrees with a recommendation or independently determines that an ME opinion is needed, the ALJ will decide:

- The medical specialty of the ME; and

- The manner in which to receive the ME's opinion (i.e., whether to receive the opinion in testimony at the hearing in person, by video teleconferencing or telephone, or in response to written interrogatories).

III.F.2.c HALLEX I-2-5-36; Selecting a Medical Expert

I-2-5-36. Selecting a Medical Expert

Last Update: 4/1/16 (Transmittal I-2-170)

A. Selection of Medical Expert (ME) from Regional Office (RO) Roster

1. Selection in Rotation

Each RO maintains a roster of MEs who have agreed to provide impartial expert opinion pursuant to a blanket purchase agreement (BPA) with the Office of Disability Adjudication and Review (ODAR). RO rosters are subdivided by hearing office (HO). For information about BPAs, see generally Hearings, Appeals and Litigation Law (HALLEX) manual I-2-5-31.

NOTE 1:

A National Hearing Center (NHC) generally uses experts on the roster of the HO associated with the case, to the extent possible. NHCs coordinate with HOs and ROs as necessary and follow the same procedures as HOs when securing experts.

Assisting HO staff will select an ME from the HO's roster in rotation, subject to the ME's availability and based upon a request from the administrative law judge (ALJ) for a particular medical specialty. MEs must be rotated equitably. When HO staff selects an ME from the roster, the ME will go to the bottom of the roster and will not be selected again until all other available MEs on the roster with the same medical specialty have been selected.

NOTE 2:

When an ME is next in rotation but is unavailable because he or she has already been scheduled to testify at another hearing, the HO will use the ME in the next available spot in rotation. However, if the ME is unavailable for an extended period of time, the ME will be removed from rotation until he or she is again available.

NOTE 3:

Although HO staff is responsible for selecting the particular expert, the ALJ determines how the ME appears at the hearing, whether in person, or via video teleconferencing or telephone. See HALLEX I-2-3-10 A.2.

2. Specialty Required

When an ALJ requests an ME with a particular specialty, but an ME with the requested specialty is not available on the HO roster, HO staff will use the roster of the nearest HO in the region to select an available expert with the required medical specialty. Similarly, if an HO roster has limited MEs in a particular specialty and ALJs frequently request that specialty, the HO will rotate MEs with nearby HOs for in-person hearings, to the extent practicable. For video teleconferencing or telephone hearings, HO staff will use rosters from other HOs in the region.

If there are no MEs with the required specialty available in the HO's region, the HO may coordinate, through the RO, an ME from a roster in another region. If the HO uses an ME from another RO roster, HO staff will prepare a Contractor Invoice using WebBass. HO staff can access the Contractor Invoice (form HA-590) in the Document Generation System in the “Contractor's Invoice” tab.

B. Selection of ME Not on RO Roster

Occasionally, an HO may use an ME who does not have a BPA with ODAR when:

- The ALJ requires a particular medical specialty not represented on any RO roster; or
- There are other extenuating circumstances that require a one-time purchase of an ME's services.

The same terms and conditions that apply to an ME providing services pursuant to a BPA also apply to an ME providing services without a BPA. The HO will authorize payment to an ME without a BPA by completing Optional Form 347, Order of Supplies or Services. The OF-347 is available in fillable form on the SSA Electronic Forms System Form Filler program (E-forms) or via the General Services Administration website.

C. Notifying the Claimant of the Selection

When an ALJ determines that ME testimony is needed at the hearing, the ALJ will inform the claimant and any appointed representative by including the information in the notice of hearing. See HALLEX I-2-3-15 D. Any discussions an ALJ has with an ME about a case must be in a writing associated with the record or on the record at the hearing.

D. Before the Hearing

Before the hearing, the ALJ or assigned designee will provide the ME with copies of pertinent medical reports or evidence. If the claimant submits additional medical evidence at the hearing, the ALJ will provide time for the ME to review the additional evidence before the ME testifies, if possible. If the evidence is substantial or it is otherwise not possible to provide the ME with sufficient time to review the evidence

before the hearing, the ALJ will proceed with the hearing, including obtaining ME testimony. If it appears the additional evidence will impact the ME's testimony at hearing, the ALJ will explain that he or she will send the ME interrogatories after the hearing to address the new evidence and will proffer the interrogatories with the ME's responses to the claimant and representative, if any. For general instructions on proffering evidence, when to offer a supplemental hearing, or handling posthearing evidence, see generally HALLEX I-2-7.

III.F.2.d HALLEX I-2-1-32; Disqualification and Referral of ME

I-2-1-32. Disqualification and Referrals of Medical Experts, Vocational Experts, or Consultative Examiners

Last Update: 7/18/14 (Transmittal I-2-113)

A. Notification of a Disqualification From Disability Determination Services

When the Disability Determination Services (DDS) identifies a medical provider who is disqualified from performing consultative examinations on behalf of the Social Security Administration, DDS may provide formal notice to the Office of Disability Adjudication and Review (ODAR) through the regional consultative examination coordinator (CEC). For a list of CECs, see the Office of Disability Determinations intranet site. In most circumstances, DDS will identify cases pending in ODAR that require further action because the record contains a consultative examination performed by the disqualified consultative examiner.

If the Office of the Chief Administrative Law Judge (OCALJ) is the component notified by DDS, OCALJ will notify the ODAR regional office (RO) for each affected region, identify any affected cases pending with servicing hearing offices (HO) in the region, and issue instructions on how to adjudicate the cases. If DDS first notifies the ODAR RO of the disqualified consultative examiner, the RO will notify OCALJ before notifying the affected HOs.

B. Claimant Alleges Disqualification

A claimant or appointed representative may allege in the request for hearing or other correspondence that a consultative examiner is not licensed or has otherwise been medically disqualified. In this circumstance, the assigned administrative law judge (ALJ) or other HO personnel must evaluate the allegation of disqualification on a case-by-case basis, relying on the medical evidence of record, and issue a decision after appropriately weighing the evidence. In considering whether a referral is appropriate, the HO will also follow the instructions in the Hearings, Appeals and Litigation Law (HALLEX) manual I-2-1-32 C.1. below.

> **NOTE:**
> The ALJ will not rely on or associate evidence of a consultative examiner disqualification submitted by one claimant with a different claimant's file.

If the claimant or appointed representative alleges that a consultative examiner is not licensed in the state where the consultative examination occurred, see Program Operations Manual System DI 39545.175. To be qualified, the consultative examiner must be licensed or certified in the state in which the examination was performed.

C. HO Referrals of Medical Experts (ME), Vocational Experts (VE), or Consultative Examiners

1. Referral to RO

Occasionally, HO personnel may discover potential issues regarding the conduct or qualifications of an ME, VE, or consultative examiner during case adjudication. When a referral for further consideration may be warranted, the person who discovers the issue will notify an HO manager. The manager will discuss the issue with the ALJ assigned to the case. If the case has not yet been assigned to an ALJ, the manager will discuss the issue with the Hearing Office Chief Administrative Law Judge (HOCALJ).

If the ALJ or HOCALJ agrees that a referral of an ME or VE is appropriate, the ALJ or HOCALJ will direct the manager to send an email to the RO contact with the subject line "Possible Expert Misconduct Referral." However, while the matter is fully reviewed, the ME or VE is permitted to provide testimony.

If the ALJ or HOCALJ agrees a referral of a consultative examiner is appropriate, the ALJ or HOCALJ will direct the HO manager to notify the appropriate regional DDS CEC and email the RO contact with the subject line "Possible Consultative Examiner Misconduct Referral."

The content of the email will include the following information:

- The claimant's name and Social Security Number;
- The name of the ME, VE, or consultative examiner;
- A brief description of the conduct or possible qualification issue; and
- The exhibit number or location of the relevant information in the file.

> **NOTE:**
> If the case is paper, the appropriate HO personnel will transmit copies of any relevant documents to the DDS and RO via email, fax, or regular mail.

After sending the email, the person making the referral will add the expert conduct case characteristic "EXCN" in the Case Processing and Management System (CPMS).

> **NOTE:**
> If HO personnel suspect fraudulent behavior, the person need not consult with a manager before referring the matter to the Office of the Inspector General (OIG), as explained in HALLEX I-1-3-9.

2. RO Actions

The RO will review and evaluate each referral on a case-by-case basis. If the RO determines that further investigation of an ME or VE is warranted, it will refer the

information to the Division of Field Procedures (DFP) in OCALJ at (b) (2) [redacted]. If the expert is removed, OCALJ will notify the RO and hearing office management team of the disqualification, and instruct that the expert be removed from the witness roster and from CPMS.

The RO will ensure all allegations of an unlicensed consultative examiner have been referred to the regional DDS CEC and will also refer the matter to DFP.

III.F.3 Vocational Experts

III.F.3.a HALLEX I-2-5-48; Vocational Experts – General

I-2-5-48. Vocational Experts — General

Last Update: 6/16/16 (Transmittal I-2-174)

A vocational expert (VE) is a vocational professional who provides impartial expert testimony either at a hearing or in written response to interrogatories during the hearings process on claims under title II and title XVI of the Social Security Act. The authority for VEs is set forth in 20 CFR 404.1566(e) and 416.966(e). See also Social Security Ruling 00-4p: *Titles II and XVI: Use of Vocational Expert and Vocational Specialist Evidence, and Other Reliable Occupational Information on Disability Decisions*.

Before scheduling the hearing, the assigned administrative law judge (ALJ) will review a case to determine whether VE testimony is needed, using the instructions in Hearings, Appeals and Litigation Law (HALLEX) manual I-2-5-50. A designee may also perform this task and make a recommendation to the ALJ. A VE provides testimony by either testifying at a hearing (see HALLEX I-2-6-74) or providing a written response to interrogatories (see HALLEX I-2-5-57). See also HALLEX I-2-5-30.
The following general guidelines apply to an ALJ's use of a VE in the hearing proceedings:

Before the hearing, the ALJ (or designee) will provide the VE with copies of all evidence relating to the claimant's vocational history. If additional vocational evidence is received at the hearing, the ALJ will provide it to the VE for review before the VE testifies.

The ALJ may use a VE before, during, or after the hearing.

The ALJ must avoid any off-the-record discussion with the VE. If such a discussion occurs, the ALJ must summarize the discussion on the record at the hearing or by entering a written summary into the record as an exhibit.

All ALJ contact with a VE about a case must be in writing or on the record at a hearing, and all correspondence with the VE must be made part of the record.

The ALJ may not use a VE who has had prior professional contact with the claimant.

The ALJ may not ask a VE to provide testimony on psychological (i.e., medical) matters even if the VE is a certified mental health professional. See HALLEX I-2-5-61.

The VE's testimony is not binding on the ALJ. The ALJ must consider a VE's testimony along with all other evidence.

III.F.3.b. HALLEX I-2-5-50; When to Obtain Vocational Expert Opinion

I-2-5-50. When to Obtain Vocational Expert Opinion

Last Update: 8/29/14 (Transmittal I-2-118)

A. When an Administrative Law Judge (ALJ) May Need To Obtain Vocational Expert (VE) Opinion

An ALJ may need to obtain a VE's opinion, either in testimony at a hearing or in written responses to interrogatories, when the ALJ is determining whether the claimant's impairment(s) prevents the performance of past relevant work.

An ALJ may also determine a VE's opinion is necessary when the ALJ is determining whether the claimant's impairment(s) prevents the performance of any other work and he or she cannot decide the case under any of the tables in 20 CFR Part 404 Subpart P Appendix 2, for any of the following reasons:

- The claimant's residual functional capacity falls between two exertional levels (e.g., the claimant may be able to perform more than the full range of sedentary work, but less than the full range of light work);
- The claimant has solely nonexertional limitations; or
- The claimant has a combination of exertional and nonexertional limitations.

B. When the ALJ Must Obtain VE Opinion

The ALJ must obtain a VE's opinion when directed by the Appeals Council or a court. The ALJ must also obtain a VE opinion if an Acquiescence Ruling (AR), such as one of the following, requires VE evidence.

- Third Circuit (Delaware, New Jersey, Pennsylvania): AR 01-1(3): Sykes v. Apfel, 228 F.3d 259 (3d Cir. 2000) — Using the Grid Rules as a Framework for Decisionmaking When an Individual's Occupational Base is Eroded by a Nonexertional Limitation — Titles II and XVI of the Social Security Act.
- Eighth Circuit (Arkansas, Iowa, Minnesota, Missouri, Nebraska, North Dakota, South Dakota): AR 2014-1(8): Brock v. Astrue, Requiring Vocational Specialist (VS) or Vocational Expert (VE) Evidence When an Individual has a Severe Mental Impairment(s) - Titles II and XVI of the Social Security Act

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III.F.3.c. HALLEX I-2-5-52; Selecting a Vocational Expert

I-2-5-52. Selecting a Vocational Expert

Last Update: 6/16/16 (Transmittal I-2-174)

A. Selecting a Vocational Expert (VE) from the Regional Office (RO) Roster

Each Office of Disability Adjudication and Review (ODAR) regional office (RO) maintains a roster of VEs who have agreed to provide impartial expert opinion pursuant to a blanket purchase agreement (BPA) with ODAR. For more information on BPAs, including how to invoice when a BPA is used, see Hearings, Appeals and Litigation Law (HALLEX) manual I-2-5-31. Except in the limited circumstances outlined in B below, hearing office (HO) staff will select a VE from the RO roster. If a VE is not available on the RO roster, HO staff will coordinate with the RO to obtain the services of a VE from another ODAR RO's roster.

Assisting HO staff will select VEs from the roster in rotation whenever possible. VEs must be rotated equitably. When HO staff selects a VE from the roster, the VE will go to the bottom of the roster and will not be selected again until all other available VEs who are higher on the roster have been selected.

NOTE:

For administrative efficiency reasons, HO staff may select a VE to provide expert opinion evidence at multiple hearings held on the same day. Although HO staff is responsible for selecting the particular expert, the ALJ determines how the VE appears at the hearing, whether in person or via video teleconferencing or telephone. HALLEX I-2-3-10 A.2.

B. Selecting a VE Not on the RO Roster

An ALJ may use a VE who does not have a BPA with ODAR only if:

No VE on any RO roster is available; or

Other extenuating circumstances require a one-time purchase of VE services.

For more information on qualifying a VE who is not under a BPA and paying the VE, see HALLEX I-2-1-31.

C. Notifying the Claimant of the Selection

When an ALJ determines that VE testimony is needed and HO staff selects a VE, the ALJ will inform the claimant and appointed representative, if any, in the notice of hearing. See HALLEX I-2-3-15.

III.F.3.d. HALLEX I-2-1-32; Disqualification and Referral of VE

See II.F.2.d., above

III.F.4 Interpreters

III.F.4.a Memo Re: Limited English Proficiency

Providing Access and Services for Persons with Limited English Proficiency
We are committed to providing fair and equitable world class service to the American public, regardless of an individual's inability to communicate effectively in English. We recognize that providing access and services for persons with limited English proficiency (LEP) is not only the right thing to do, but it is also consistent with Attorney General Eric Holder's February 17, 2011 memo (attached) reaffirming Executive Order (EO) 13166. The EO requires meaningful access to each agency's programs and activities to LEP persons.

In order to support this commitment, we wanted to make you familiar with our LEP services, such as those centering on our interpreter and translation policies. For example, we wanted you to have the information, guidance, and references below on cases where a claimant has difficulty understanding or communicating in English. Including this information in your training is not only essential to compliance with the EO, but it also facilitates your role in the administrative review process and ensures that LEP individuals are not disadvantaged.

As a part of your initial ODAR training, you will learn, for example, that we:

- provide an interpreter free of charge to any individual requesting language assistance or when it is evident that such assistance is necessary to ensure that the individual is not disadvantaged;

- do not require individuals needing language assistance to provide their own interpreters; however, if the individual prefers to use his or her own interpreter, such as a family member, friend, or third party, we determine whether the interpreter meets SSA's requirements;

- consult HALLEX I-2-1-70, on whether a claimant needs an interpreter, the criteria for a qualified foreign language interpreter, sources of qualified interpreters, and how to obtain an interpreter;

- outline hearing office procedures for foreign language interpreters in HALLEX I-2-6-10; and,

- provide resources to both the public and SSA employees to assist LEP individuals, e.g., LEP.gov, which promotes the importance of language access to federal programs, and the Internet Multi-Language Gateway website (http://www.socialsecurity.gov/multilanguage/), which we designed for our employees who serve people who prefer to conduct business in a language other than English.

SSA not only provides written materials in languages other than English through our Multilanguage Gateway, but also our redesigned “En Español” website http://www.socialsecurity.gov/espanol/ (that contains over 100 Spanish public information materials). HALLEX I-2-3-45 also provides information for Spanish language translations of forms and notices.

Your familiarity with these policies supports SSA’s commitment to providing equal access to services for LEP individuals, its recognition of the rich diversity of the American public, and the importance of being sensitive to the special needs of the LEP population.

III.F.4.b CALJ Memo, 03/05/14; Use of Foreign Language Interpreters

SOCIAL SECURITY

MEMORANDUM

Date: March 5, 2014

Refer To: ACL 14-238

To: All Administrative Law Judges

From: Debra Bice ***/s/****John R. Allen* for
Chief Administrative Law Judge

Subject: Use of Foreign Language Interpreters – INFORMATION AND REMINDER

This memorandum is a reminder of prior guidance provided in the August 7, 2009 Memorandum, "Consideration of a Claimants Ability to Communicate in English – Information and Reminder," that you must comply with agency policy with respect to the use of foreign language interpreters during hearings. Specifically, HALLEX I-2-6-10 provides, in part, that "SSA will provide an interpreter **free of charge**, to any individual requesting language assistance, or when it is evident that such assistance is necessary to ensure that the individual is not disadvantaged" (emphasis in original). Thus, when a claimant affirmatively requests an interpreter, the agency must provide one.

There also may be situations when SSA must provide an interpreter although the claimant has not specifically requested language assistance. HALLEX I-2-6-10 also provides, in part that "[i]f a claimant has difficulty understanding or communicating in English, the ALJ will ensure that an interpreter, fluent in both English and a language in which the claimant is proficient, is present throughout the hearing." HALLEX I-2-1-70 similarly instructs hearing office staff, at the direction of the ALJ, to arrange for a qualified interpreter to assist the claimant and the ALJ at the hearing "[w]hen a claimant has limited proficiency in English."

HALLEX I-2-1-70.A. indicates that a review of CPMS, and specific forms in the claimant's case file (such as Form HA-501, Request for Hearing, and SSA-3368, Disability Report), can help determine whether an interpreter is needed. Reports of contact or other statements in the claimant's case file also may indicate the need for an interpreter.

Therefore, if a claimant requests language assistance, or when it is evident that such assistance is necessary to ensure that the claimant is not disadvantaged, the ALJ must ensure that an interpreter is present throughout the hearing. HALLEX I-2-6-10. The use of an interpreter serves to assist both the claimant and the ALJ at the hearing, and can safeguard the claimant's due process rights in the processing of his or her claim(s).

Please share this information with your hearing offices. The staff contact for regional inquiries is (b) (6), Attorney Advisor, who can be reached at (b) (6).

cc: Regional Office Management Teams
Hearing Office Directors

III.F.4.c HALLEX I-2-1-70; Foreign Language Interpreters; Determining Need

I-2-1-70; Foreign Language Interpreters; Determining Need

Last Update: 11/14/14 (Transmittal I-2-124)

A. Determining Whether a Claimant Needs an Interpreter

When a claimant has limited proficiency in English, an administrative law judge (ALJ) will request that hearing office (HO) staff arrange for a qualified interpreter to assist the claimant and the ALJ at the hearing. See Hearings, Appeals and Litigation Law (HALLEX) manual I-2-6-10. The Social Security Administration (SSA) will provide interpreters free of charge if a claimant requests an interpreter or a claimant needs an interpreter to ensure that he or she is not disadvantaged.

While not exhaustive, any of the following may indicate that a claimant needs an interpreter at the hearing:

- The claimant notes on the request for hearing that a foreign language interpreter is needed;
- The field office indicates that a foreign language interpreter is needed (noted in either eView or the Case Processing and Management System);
- The claimant indicates on form SSA-3368, Disability Report-Adult, that his or her ability to speak and understand English is limited; or
- The record includes reports of contact or other statements that suggest the claimant may need a foreign language interpreter.

B. Criteria for a Qualified Foreign Language Interpreter

A qualified foreign language interpreter is an individual or vendor who:

- Reads, writes, and demonstrates fluency in the English language;
- Reads, writes, and demonstrates fluency in a specified foreign language;
- Demonstrates familiarity with basic SSA terminology;
- Agrees to comply with SSA's disclosure and confidentiality of information requirements;
- Has no personal stake in the outcome of the case or other association with the case that would create a conflict of interest; and
- Agrees to provide an accurate interpretation of both the questions and the claimant's responses, and agrees not to assume or infer facts or dates not actually provided by the claimant.

> **NOTE:**
> A person under age 18 may not serve as an interpreter.

C. Obtaining an Interpreter

1. Contracted Interpreter Services Under the Blanket Purchase Agreement

HO staff must utilize the language interpreter services provided under the blanket purchase agreement (BPA) for in-person interpreters to assist the claimant and the ALJ at the hearing.

Under the BPA, only certified and accredited linguists and personnel are provided. Therefore, additional certification of the BPA contract interpreter by the ALJ on the record at the hearing is not needed. See HALLEX I-2-6-10.

HO staff procures, schedules, and documents the BPA services using a Delivery Ticket Form, and the assigned ALJ certifies that the services were rendered.

2. Telephone Interpreter Services (TIS)

TIS is a telephone service that provides immediate interpreter services and is available 24 hours a day, seven days a week. TIS has over 3,000 interpreters who can interpret over 150 languages and dialects.

HO staff may schedule TIS interpreters by contacting Language Select at 1-800-200-7236. TIS is usually able to connect the HO with a qualified interpreter within a few minutes.

The HO staff does not need any authorization to use TIS and additional certification of the interpreter by the ALJ on the record at the hearing is not necessary. See HALLEX I-2-6-10. For specific instructions on using TIS, see the Multi-language Resources Page.

III.F.4.d HALLEX I-2-6-10; Hearing Procedures – Foreign Language Interpreters

I-2-6-10. Hearing Procedures — Foreign Language Interpreters

Last Update: 10/6/15 (Transmittal I-2-153)

A. General

Prior to the hearing, the administrative law judge (ALJ) will determine whether an interpreter is necessary at the hearing, as described in Hearings, Appeals and Litigation Law (HALLEX) manual I-2-1-70 A. If, before or during the hearing, the claimant or appointed representative requests an interpreter or the claimant demonstrates the need for an interpreter, the ALJ will ensure a qualified interpreter is present at the hearing.

> **NOTE 1:**
> If a claimant or appointed representative withdraws a prior request for an interpreter, either before or at the hearing, the ALJ may proceed without an interpreter if, based on the information provided and the facts of the case, the ALJ finds an interpreter is not necessary for a full and fair hearing. Any such withdrawal must be in a writing associated with the record (and exhibited) or must be obtained on the record during the hearing.

If it becomes clear at the hearing that a claimant has difficulty understanding or communicating in English but did not previously request or indicate the need for an interpreter, the ALJ will stop the proceedings until he or she can ensure that a qualified interpreter (see HALLEX I-2-1-70 B) is present through the remainder of the hearing. Similarly, if the ALJ determines that the testimony of a witness with limited proficiency in English is needed to inquire fully into the issues, the ALJ will ensure that an interpreter is present during that witness' oath and testimony. Depending on the circumstances, the ALJ may adjourn the hearing proceedings temporarily to call the Telephone Interpreter Services (TIS) and request a telephone interpreter. (See further instructions in HALLEX I-2-1-70 C.)

> **NOTE 2:**
> The criteria in HALLEX I-2-1-70 and I-2-6-10 regarding the need for an interpreter at a hearing is distinct from vocational factors assessed during a hearing. Using an interpreter at the hearing does not mean that an ALJ must find that a claimant has an “inability to communicate in English” as a vocational factor under 20 CFR 404.1564(b)(5) and 416.964(b)(5).

B. Certification for the Record

An ALJ need not certify a contract interpreter hired under the language interpreter services blanket purchase agreement, or an interpreter from TIS. In all other circumstances, the ALJ must certify the interpreter on the record, either during the hearing or in writing.

To certify on the record during the hearing, the ALJ will verify the interpreter's identity and require the interpreter to certify “under penalty of perjury” that:

- He or she has no prior relationship to the person testifying;
- He or she is not acting as the legal representative for the person testifying; and
- He or she will accurately interpret the questions asked and the answers given to the best of his or her ability.

If the ALJ certifies the interpreter in writing, the ALJ may use Form SSA-795, Statement of Claimant or Other Person, or another written statement with the following information:

- “I am acting as an interpreter for (individual's name) to perform the specific function of providing accurate interpretation between (individual's name) and the ALJ. I solemnly (swear or affirm) that I will accurately interpret the questions asked and the answers given in this case to the best of my ability, under penalty of perjury”;
- Interpreter's name, address, and telephone number;
- A statement that the interpreter has no prior relationship to the person testifying, nor is he or she acting as the claimant's legal representative;
- Any relevant comments that the interpreter wishes to include;
- Any relevant comments that the ALJ wishes to document over the interpreter's signature; and
- The interpreter's signature.

If an interpreter refuses to provide the required certification, or the ALJ doubts an interpreter's qualifications or suspects fraudulent activity, the ALJ will adjourn or postpone the hearing until the services of an acceptable interpreter are obtained.

> **NOTE:**
> If the ALJ suspects fraudulent activity involving an interpreter, the ALJ will also refer the matter to the Office of the Inspector General using the instructions in HALLEX I-1-3-9.

C. Verbatim Interpretation

Prior to obtaining testimony, the ALJ will direct the interpreter to interpret the questions and answers verbatim without changing the original meaning of the questions or answers. The ALJ will also instruct the interpreter not to add personal comments to either the questions or the answers.

When obtaining testimony, the ALJ will direct all questions and comments to the person providing testimony, not to the interpreter. The ALJ will phrase questions and comments as simply as possible, and should not use idiomatic or slang expressions when questioning hearing participants.

If, while translating, an interpreter changes the form of the question to the third person (that is, uses “he” or “she” instead of “I”), the ALJ will instruct the interpreter, on the record, to correct the interpretation and caution the interpreter against the practice.

D. Difficulties With Interpretation

If the ALJ determines that the claimant or the witness is having difficulty understanding the interpretation, or the claimant or the witness objects to the interpretation, the ALJ must determine whether the claimant is receiving a full and fair hearing.

- If the ALJ concludes the claimant is receiving a full and fair hearing, the ALJ will note the objection on the record, proceed with the hearing, and address the objection in the decision.
- If the ALJ concludes the claimant is not receiving a full and fair hearing, the ALJ will adjourn or postpone the hearing until the services of an acceptable interpreter are obtained. Depending on the circumstances, the ALJ may adjourn temporarily to call TIS and request a telephone interpreter.

III.F.4.e HALLEX I-2-5-76; Translation of Foreign Language Documents

I-2-5-76; Translation of Foreign Language Documents

Last Update: 11/22/11 (Transmittal I-2-85)

A. Obtaining Translation of Foreign Language Document

If documents necessary for the development of a claim are in a foreign language, hearing offices are responsible for the cost of obtaining translations. Lists of non-SSA translators, who contract to provide such services, are offered by the Translation and Priority Work Unit (TPWU) in the Division of International Operations (DIO) in the Office of International Operations (OIO) at (b) (2) [redacted], and the General Services Administration (GSA) Language Services.

- Each document to be translated must have a completed Form SSA-533 accompanying it.
- If more than one SSA-533 is submitted for a party, indicate under Item 3, the total number of documents to be translated for that individual (one of four, two of four, three of four, etc.).
- Item 5 on the SSA-533 must state the facts needing proof if known (date of birth, date of marriage, etc.).
- The translator must sign the translation.
- A translation form must include any descriptive information, such as the language involved, the type of document, the issuing agency, etc.
- The translation must be of the original document or a certified copy.
- The original document and the translation must be made exhibits.

B. Jurisdiction and Authority of the Office of International Operations (OIO), Division of International Operations (DIO)

OIO/DIO has overall responsibility for the administration of Social Security programs abroad, including liaison and coordination, as well as Field Office (FO), Disability Determination Services (DDS), and Program Service Center (PSC) functions. For development of international cases pending at the hearing level, the Administrative Law Judge (ALJ) must request assistance from OIO/DIO through the Office of Disability

Adjudication and Review (ODAR) regional office, except for claimants residing in Canada or Mexico. Instructions for claimants living in Canada and Mexico can be found in subsection D below.

C. Obtaining Foreign Law Interpretation

An ALJ may not take administrative notice of foreign law. Therefore, the ALJ must develop adequate proof of relevant foreign law and admit this evidence into the record at the hearing level. If the ALJ needs proof or interpretation of a foreign law, he or she must request the information from the Office of the General Counsel (OGC) through the ODAR regional office.

D. Obtaining Foreign Evidence

SSA uses the FOs located near the Canadian and Mexican borders to obtain development in those countries, and has agreements with other agencies for obtaining development in other countries.

- For development in Canada and Mexico, the ALJ or Hearing Office (HO) staff must request the development through the appropriate border area FO by following the procedure outlined in I-2-5-70, Obtaining Evidence Through an SSA Field Office.
- For development in other countries, the ALJ or HO staff must request the development through the ODAR regional office, which obtains the needed assistance from OIO/DIO.

> **NOTE:**
> For information concerning HO jurisdiction in processing foreign claims, see I-2-0-72, Assigning and Processing Requests for Hearing Filed by Claimants Who Do Not Reside in the United States.

III.F.5 Alternate Methods of Holding Hearings

III.F.5.a Video: HALLEX I-2-3-10(A)(1)(b); Appearance by VTC

I-2-3-10. Scheduling Hearings

Last Update: 8/29/14 (Transmittal I-2-117)

Citations:
20 CFR 404.936, 404.999a-d, 416.1436, and 416.1495-416.1499

Unless the agency exercises its authority under the pilot program in 20 CFR 404.936 and 416.1436 that began on August 9, 2010, the administrative law judge (ALJ) sets the time and place for the hearing. The ALJ may change the time and place, if necessary. The objective is to hold a hearing as soon as possible after the request for hearing (RH)

is filed, at a site convenient to the claimant. The hearing office (HO) staff will generally contact hearing participants to ascertain availability before scheduling the hearing.

> **NOTE:**
> If a claimant threatens violence against the general public or HO personnel, or has been banned from entering a Federal or Social Security facility, see the instructions for scheduling a hearing in 20 CFR 404.937 and 416.1437 and in Chapter I-1-9-0 of the Hearings, Appeals and Litigation Law (HALLEX) manual.

B. Estimating the Time Required for the Hearing

When an ALJ schedules several hearings in succession, the ALJ will estimate the time required for each hearing to ensure that the schedule allows sufficient time for each hearing.

C. Adjourning, Postponing, or Continuing the Hearing

Before the time set for a hearing, an ALJ may postpone the hearing, or an ALJ may adjourn a hearing that is in progress and continue it at a later date. In either circumstance, the ALJ will give the claimant reasonable notice of postponement or continuance of a hearing. See HALLEX I-2-3-35.

III.F.5.b. Telephone

HALLEX I-2-3-10 A.1.c; Appearance by Telephone, including hearing by telephone for an incarcerated claimant (CJB 10-04 rescinded; policy incorporated into HALLEX)

See II.F.5.a., Above

III.F.5.c Decisions Where Claimant Waives Appearance or Right to Hearing

I-2-6-1. Hearings — General

Last Update: 7/28/15 (Transmittal I-2-146)

NOTE:
While a claimant must request a hearing to continue through the administrative process, he or she can also waive the right to appear at the hearing. See 20 CFR 404.929 and 416.1429. For more information regarding a waiver of the right to appear at the hearing, see 20 CFR 404.948(b), 416.1448(b), 404.950(b), 416.1450(b), and HALLEX I-2-1-45 E. See also Social Security Ruling 79-19, Titles II, XVI, and XVIII: Waiver of Personal Appearance At A Hearing. However, even if all parties waive the right to appear at a hearing, the ALJ may still notify them of the time and place of the hearing if the ALJ finds that a personal appearance and testimony by a party to the hearing is necessary to decide the case. For more information, see 20 CFR 404.950(b), 416.1450(b), and HALLEX I-2-1-45 E.3.

I-2-1-82 Claimant Waives the Right to Appear at the Hearing

Last Update: 5/1/17 (Transmittal I-2-203)

A. General

A claimant may waive the right to appear at a hearing and request that the administrative law judge (ALJ) decide the case based on the evidence of record. A waiver of the right to appear at a hearing must be in writing and the claimant must sign the writing. A waiver must also be made voluntarily and knowingly, as defined in Social Security Ruling 79-19, Titles II, XVI and XVIII: Waiver of Personal Appearance at a Hearing.

Form HA-501, Request for Hearing by Administrative Law Judge, includes a checkbox that says, “I do not wish to appear at a hearing and I request that a decision be made based on the evidence in my case. (Complete Waiver Form HA-4608).” While useful in assessing the claimant's intent, this checkbox does not show the claimant “knowingly” submitted a waiver. Therefore, when this checkbox is marked, hearing office (HO) staff will take additional action, as explained in subsection B below.

An ALJ may schedule a hearing notwithstanding the waiver if he or she believes a personal appearance and testimony from the claimant are necessary to decide the case. See 20 CFR 404.950(b), 416.1450(b), and Hearings, Appeals and Litigation Law (HALLEX) manual I-2-6-1. For additional instruction, see subsection D below.

NOTE:

An ALJ will consider all evidence received on or before the date of the hearing decision when a claimant waives his or her right to appear at the hearing and no hearing was held. (See 20 CFR 404.935 and 416.1435.)

B. Receipt of Waiver

If a claimant states in the request for hearing or other writing that he or she waives the right to appear at a hearing, the ALJ or the HO staff will take the following actions:

- If the claimant is unrepresented, advise the claimant of the right to representation;
- Advise the claimant of the advantages of appearing at a hearing (including the opportunity to provide testimony regarding his or her impairment(s) and to question witnesses);
- Ensure the claimant is fully advised of the possible consequences of his or her waiver; and
- Explain that even though he or she has waived the right to appear, the ALJ may schedule and conduct a hearing if the ALJ deems it necessary.

If the claimant still elects to waive the right to appear at a hearing, HO staff will obtain written documentation from the claimant using form HA-4608, Waiver of Your Right to Personal Appearance Before an Administrative Law Judge. HO staff can access the HA-4608 through the Document Generation System by clicking on "Correspondence," "Prehearing" and "Waiver of Oral Hearing." HO staff will associate the form and any correspondence with the record to help establish that the claimant submitted the waiver voluntarily and knowingly.

NOTE 1:

It is acceptable if the claimant elects to respond in a signed writing rather than by completing and returning the HA-4608.

NOTE 2:

Even when a claimant voluntarily and knowingly waives the right to a hearing, the ALJ must still afford the claimant the right to submit written comments, responses to interrogatories, or other evidence. See generally HALLEX I-2-5-29.

C. Prehearing Conference

An ALJ may schedule a prehearing conference, when necessary, to narrow and clarify issues. See HALLEX I-2-1-75.

D. Hearing Despite Waiver

When an ALJ schedules a hearing after the claimant has waived the right to a hearing, the ALJ will issue a detailed notice of hearing to specify the facts and issues that require development at a hearing.

If an ALJ schedules and holds a hearing despite a waiver, the ALJ must proffer any evidence received at the hearing, unless the claimant also waived the right to examine the evidence or to appear at a supplemental hearing. See HALLEX I-2-7-1, I-2-7-15, and I-2-7-30.

If the claimant or the appointed representative, if any, does not appear at the scheduled hearing, the ALJ may not dismiss the request for hearing. See HALLEX I-2-4-25 F. Rather, the ALJ must decide the case based on the evidence of record. The ALJ will explain in the decision:

- The reason for requesting the claimant's appearance and the ALJ's efforts to put the claimant on notice of the need for the hearing; and

- Any adverse presumptions regarding the weight of the evidence, etc., that arose from the claimant's refusal to appear.

NOTE:

If circumstances suggest that a representative routinely advises his or her clients to waive appearance at a hearing or to ignore a scheduled hearing despite the waiver, the ALJ will ensure the claimant receives notice that failure to appear at the scheduled hearing could jeopardize successful resolution of the claim and take any other action necessary to adjudicate the claim. The ALJ will also consider submitting a referral to the Office of the General Counsel under HALLEX I-1-1-50 for possible representative misconduct.

I-2-4-25. Dismissal Due to Claimant's Failure to Appear

F. Claimant Waived Right to Oral Hearing — ALJ Nevertheless Scheduled Hearing

The ALJ may not dismiss an RH for failure to appear if the claimant waived the right to an oral hearing and the ALJ nevertheless scheduled a hearing. In this situation, the ALJ must decide the case based on the evidence of record.

IV. HEARING Tab

IV. Hearing

IV.A. Opening Statement: HALLEX I-2-6-52

I-2-6-52. Opening Statement

Last Update: 5/4/15 (Transmittal I-2-144)

A. Opening Statement

The administrative law judge (ALJ) will open the hearing with a brief statement explaining how the hearing will be conducted, the procedural history of the case, and the issues involved. In supplemental hearings, the ALJ need only identify the case, state the purpose of the supplemental hearing, and describe the issue(s) to be decided.

Generally, the content and format of the opening statement are within the discretion of the ALJ.

B. Advisement of the Right to Representation

If the claimant is unrepresented, the ALJ will ensure on the record that the claimant has been properly advised of the right to representation and that the claimant is capable of making an informed choice about representation.

The ALJ is not required to recite specific questions regarding the right to representation or the claimant's capacity to make an informed choice about representation. However, below are examples of questions the ALJ could ask an unrepresented claimant on the record:

- Did you receive the hearing acknowledgement letter and its enclosure(s)?
- Do you understand the information contained in that letter, specifically concerning representation?

If the unrepresented claimant did not receive the hearing acknowledgement letter and its enclosure(s), the ALJ will provide the claimant with a copy and the opportunity to read the letter. The ALJ will enter into the record the acknowledgement letter and all enclosure(s) sent to the unrepresented claimant or provided at the hearing.

The ALJ will answer any questions the claimant may have, including explaining the claimant's options regarding representation, as outlined in the acknowledgement letter.

If the claimant is illiterate, the ALJ must ensure that the claimant is aware of his or her options for representation. Specifically, the ALJ will explain the availability of both free legal services and contingency representation, as well as access to organizations that assist individuals in obtaining representation.

Once the ALJ has determined that the claimant is capable of making an informed choice, he or she will either secure on the record the claimant's decision concerning representation or obtain from the claimant a written waiver of the claimant's right to representation, which will be marked as an exhibit. For a sample waiver of representation, see Hearings, Appeals and Litigation Law (HALLEX) manual I-2-6-98.

NOTE:

If the ALJ or a hearing office designee provided all the above-referenced information at a prehearing conference (PHC), the ALJ may adopt that information by reference at the hearing. However, if the claimant submitted a waiver of the right to representation during the PHC, the ALJ must re-affirm on the record during the hearing that the claimant understands the waiver of the right to representation and does not wish to revoke the waiver.

C. Postponement of the Hearing to Obtain Representation

If the claimant asks to postpone the hearing to obtain a representative and it is the first request, the ALJ will typically grant the requested postponement. The ALJ will:

- Go on the record and advise the claimant of the right to be represented;
- Provide the claimant with information about organizations that provide free legal services;
- Advise the claimant to notify the hearing office if representation is obtained;
- Advise the claimant that the hearing will be postponed and rescheduled;
- Advise the claimant that normally only one postponement is permitted to obtain representation, unless he or she can show good cause that requires an additional postponement;
- Advise the claimant that if he or she appears at the rescheduled hearing without a representative, the hearing will proceed with the unrepresented claimant unless he or she shows good cause; and
- Obtain an “Acknowledgement of Postponement in Order to Obtain Representative” from the claimant (see sample provided in HALLEX I-2-6-97) with his or her witnessed signature. The ALJ will mark the acknowledgement as an exhibit and provide a copy of the acknowledgement to the claimant.

D. Claimant Requests to Make a Private Recording of the Hearing

If the claimant or representative requests to make a private recording of the hearing and the ALJ decides to grant the request, the ALJ's opening statement will include language reflecting the following information:

You asked if you may make a private recording of the proceedings of this hearing. This request is granted for the purpose of providing information for your personal use and convenience in pursuing this claim. However, if your recording interferes with the orderly

conduct of the hearing, I will withdraw this permission. The hearing proceedings are confidential, and unauthorized use or disclosure of this information is prohibited by law, except as expressly permitted by the Privacy Act and the Freedom of Information Act. I also remind you that the recording I am making will be the official verbatim record of this proceeding.

E. Procedural Rulings

The ALJ will rule on the record regarding any prehearing requests or motions of the claimant or representative, *i.e.*, requests for postponement (20 CFR 404.936 and 416.1436), disqualification of the ALJ (20 CFR 404.940 and 416.1440) and subpoenas (20 CFR 404.950(d) and 416.1450(d)).

IV.B. Admitting Evidence into the Record

IV.B.1. Admitting Evidence Submitted at Least Five Business Days Before the Hearing: HALLEX I-2-6-58

I-2-6-58.Admitting Evidence Submitted At Least Five Business Days Before the Hearing

Last Update: 5/1/17 (Transmittal I-2-199)

IV.B.2. Admitting Evidence Submitted at Less than Five Business Days Before the Hearing or at or After the Hearing: HALLEX I-2-6-59

I-2-6-59.Admitting Evidence Submitted Less Than Five Business Days Before the Hearing or At or After the Hearing

Last Update: 5/1/17 (Transmittal I-2-199)

IV.C. Testimony of Claimants and Witnesses

I-2-6-60 Testimony of Claimants and Witnesses

Last Update: 1/15/16 (Transmittal I-2-163)

A. Administrative Law Judge (ALJ) Responsibilities

The ALJ determines the subject and scope of testimony from a claimant and any witness(es), as well as how and when the person testifies at the hearing. For example, an ALJ may decide to use a question and answer method, or the ALJ may allow the claimant or witness to testify in his or her own way, such as making a detailed statement on the record.

If a claimant or witness requests to testify in a particular way, or asks to testify at a particular time during the hearing, the ALJ will consider whether there is a good reason for the request. Additionally, if a claimant or witness objects to the presence of any other individual during his or her testimony, the ALJ will consider whether there is a good reason for the objection.

If the ALJ finds there is a good reason, the ALJ will make every reasonable effort to accommodate the person's request or objection. If the ALJ does not grant the request, the ALJ will either deny the request in writing before the hearing (and exhibit the

document) or deny the request on the record during the hearing. In either circumstance, the ALJ will explain the reason(s) he or she denied the request.

B. Right to Question Witnesses

The claimant and an appointed representative, if any, have the right to question witnesses to inquire fully into the matters at issue. Generally, the ALJ will provide a claimant or representative broad latitude in questioning witnesses. However, the ALJ is not required to permit testimony that is repetitive or cumulative, or allow questioning that has the effect of intimidating, harassing, or embarrassing the witness.

> **NOTE:**
> An ALJ will issue a subpoena when information or testimony that is reasonably necessary for a full presentation of the case cannot be obtained without a subpoena and the ALJ has exhausted other means of obtaining the information or testimony. See Hearings, Appeals and Litigation Law (HALLEX) manual I-2-5-78. If a witness appears at the hearing because of a subpoena, the ALJ must be sure to question the witness about the facts or information that prompted the subpoena (i.e., the facts or information necessary for full and true disclosure of the facts).

The ALJ determines when the claimant or representative may question a witness. The ALJ will usually provide a claimant or representative the opportunity to question a witness after the ALJ completes his or her initial questioning of the witness. If necessary, the ALJ may recall a witness for further questioning.

An ALJ may choose to exclude a witness from the hearing while others are testifying. For example, an ALJ may find it appropriate to exclude a witness from the hearing when he or she is not testifying if the ALJ believes the presence of the witness during other portions of the hearing may:

- Affect the testimony of the witness or the testimony of another individual;
- Influence or embarrass another individual providing testimony; or
- Be harmful to the witness or another individual providing testimony.

C. Claimant's Right to Be Present During the Entire Hearing

The claimant and appointed representative, if any, generally have the right to be present during the entire hearing. However, the ALJ may excuse the claimant from the hearing in circumstances such as the following:

- The claimant requests that the ALJ proceed without his or her attendance, the ALJ has fully advised the claimant of the right to be present and participate in the hearing, and the record demonstrates that the claimant understands the right to be present and the consequences if he or she is not present.
- The appointed representative asks that the claimant be excused for the remainder of the hearing, the claimant agrees to be excused on the record, and the representative will be present throughout the remainder of the hearing.

- The claimant is a minor, the claimant's attendance is no longer needed, a guardian or appointed representative will be present through the remainder of the hearing, and a responsible person who is not an agency employee can wait with the minor while the hearing continues.

D. Disruptive Claimant or Representative

1. Disruptive Claimant

If the claimant is disruptive during the hearing, and continues the behavior after the ALJ fully advises the claimant on the record that the conduct is disrupting the proceedings, the ALJ will take one of the following actions:

- If the claimant is represented and the representative is unable to address the behavior (either during the proceedings or after a short recess), the ALJ will discuss with the representative whether to proceed with the hearing only in the presence of the representative. If the representative agrees to continue without the claimant present, the ALJ may proceed with the hearing, allowing the representative to question any witness(es). If the ALJ reschedules the hearing and the claimant is again disruptive at the supplemental hearing, the ALJ will excuse the claimant and inform the representative that the supplemental hearing will proceed only in the presence of the representative.
- If the claimant is not represented, the ALJ will take a short recess to provide the claimant time to compose himself or herself. When the ALJ goes back on the record, the ALJ will explain what behavior is disruptive. The ALJ will also explain that the claimant has the right to be present throughout the remainder of the hearing and to question witness(es), but that if the disruptive behavior continues, the claimant will be indicating that he or she waives the right to be present during the hearing and the ALJ will issue a decision on the record. If the disruptive behavior continues, the ALJ will adjourn the hearing and issue a decision on the record.

NOTE:

If the disruptive behavior is threatening, alternative service policies may also apply. See 20 CFR 404.937, 416.1437, and 422.901 *et seq*. See also applicable procedures in HALLEX I-1-9-0.

2. Disruptive Representative

If an appointed representative causes a disruption before or during hearing proceedings that significantly impacts the ALJ's ability to effectively conduct the hearing, there may be circumstances when it is appropriate for the ALJ to excuse or exclude the representative from the hearing. If the disruption occurs during the hearing, the ALJ will only excuse the representative after fully advising the representative, on the record, that the conduct is disrupting the proceedings.

NOTE:

> An ALJ may not excuse or exclude a representative from a hearing based solely on past behavior or the ALJ's personal opinion of the representative. The record must clearly document disruptive behavior in the case currently before the ALJ and demonstrate why the disruptive behavior prevented the ALJ from effectively conducting the hearing.

If the ALJ removes or excludes an appointed representative from the hearing, the ALJ may not question or continue to question the claimant or any other witness(es). Rather, the ALJ will explain to the claimant, on the record:

- The reasons the representative was removed or excluded from the hearing;
- The hearing cannot continue at this time; and
- The hearing will be rescheduled.

The ALJ will then close the record and reschedule the proceeding. After the hearing, depending on the nature of the disruptive behavior, the ALJ will consider whether a referral to the Office of the General Counsel is appropriate, especially if disruptive behavior has been repeated or is systemic. For referral procedures, see HALLEX I-1-1-50. If repeated disruptive behavior results in an inordinate delay in processing a claimant's case, the ALJ will discuss how to proceed with hearing office management.

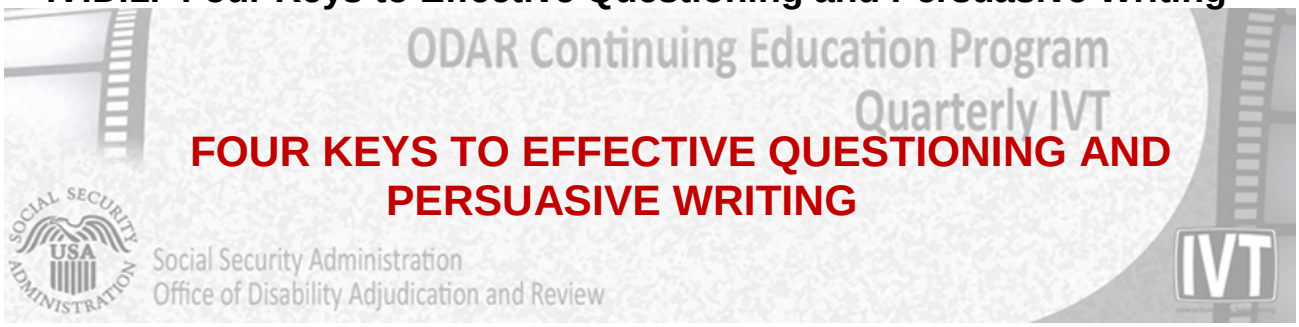
E. Obtaining Testimony When There Are Multiple Parties to the Hearing

When there is more than one party to a hearing, the ALJ will obtain testimony from all parties at one hearing whenever possible. For more information on who is a party to the hearing and what notice is required, see HALLEX I-2-1-45. See also HALLEX I-2-3-10 for issues relating to determining the manner of appearance at a hearing and handling a claimant's objections to how another person will appear at a hearing.

Usually, each party to a hearing will testify in the presence of the other parties. However, if a party specifically requests to testify separately, the ALJ will allow separate testimony if the other parties consent or the ALJ decides it is appropriate. If the ALJ decides on his or her own initiative to take testimony from a party outside the presence of other parties to the hearing, the ALJ will explain, either on the record or in a writing that is exhibited, the reasons the ALJ chose to permit testimony outside the presence of the other parties.

IV.D. OCEP 10/17/12; TIPS ON EFFECTIVE QUESTIONING

IV.D.1. Four Keys to Effective Questioning and Persuasive Writing



PREPARE: Review the File and Identify the Issues To Be Developed At The Hearing

- Effective file review leads to a comprehensive hearing and decision.
- There are many ways to review a file but any review should focus on understanding the evidence and identifying ambiguities or inconsistencies.

LISTEN: Don't Question By Rote from a Hearing Script

- An effective file review prepares you to recognize testimony that is ambiguous or inconsistent with documentary evidence.
- Be alert to ambiguities and inconsistencies in answers given. Fully developing these issues leads to a more complete decision.

FOLLOW-UP: Follow Where The Answers Lead. Ask Questions to Clarify New, Ambiguous or Inconsistent Evidence

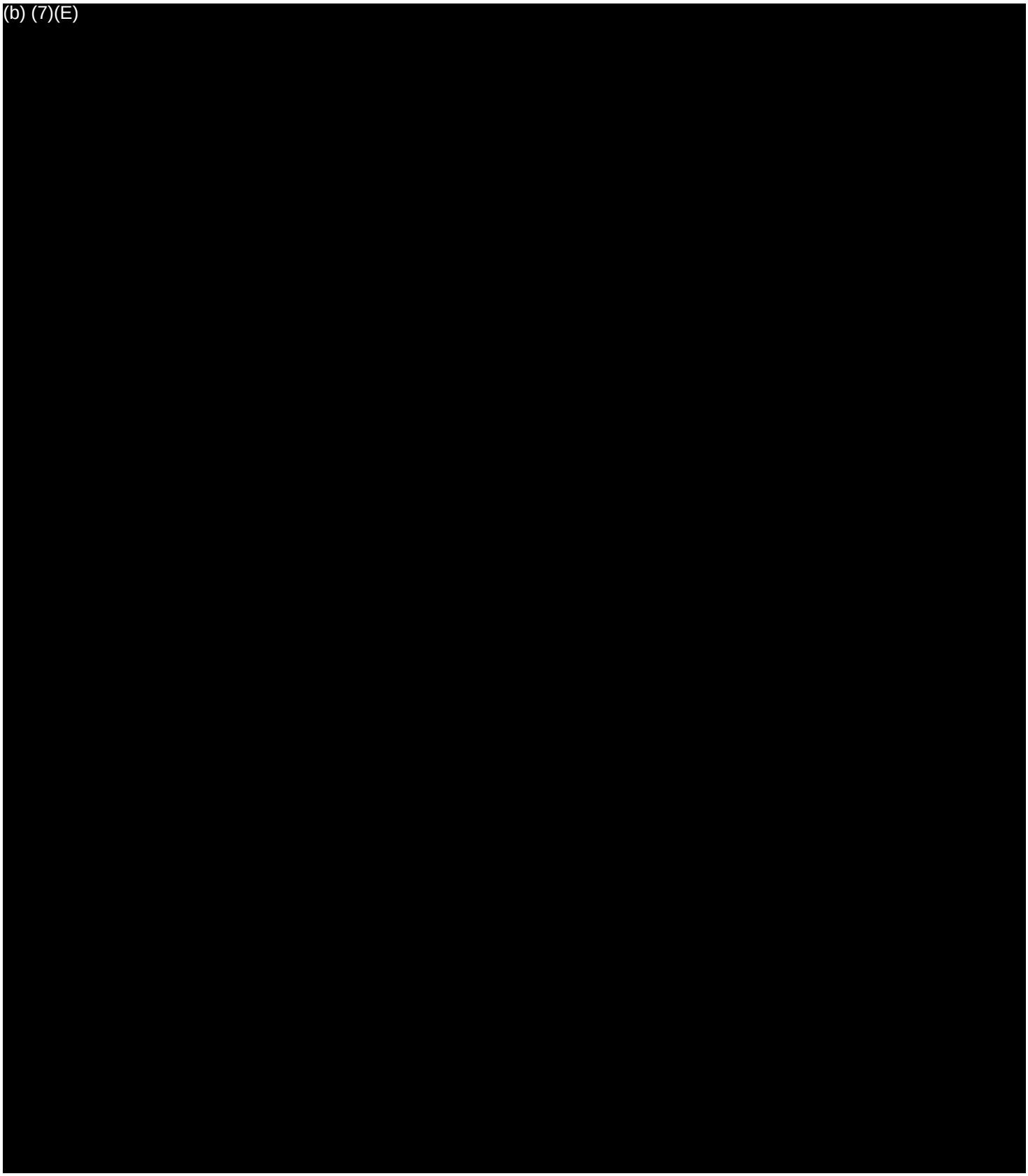
- Be aware of tone; use open-ended questions; use the 5-Ws (who, what, when, where, and why) to frame questions; use techniques such as polite interruption to redirect or focus the claimant.
- Remember the authority governing hearings and decision writing (20 CFR §§404.944, 416.1444, and HALLEX I-2-6-60 to 74).

FOLLOW-THROUGH: Identify and Evaluate Testimony in the Decision

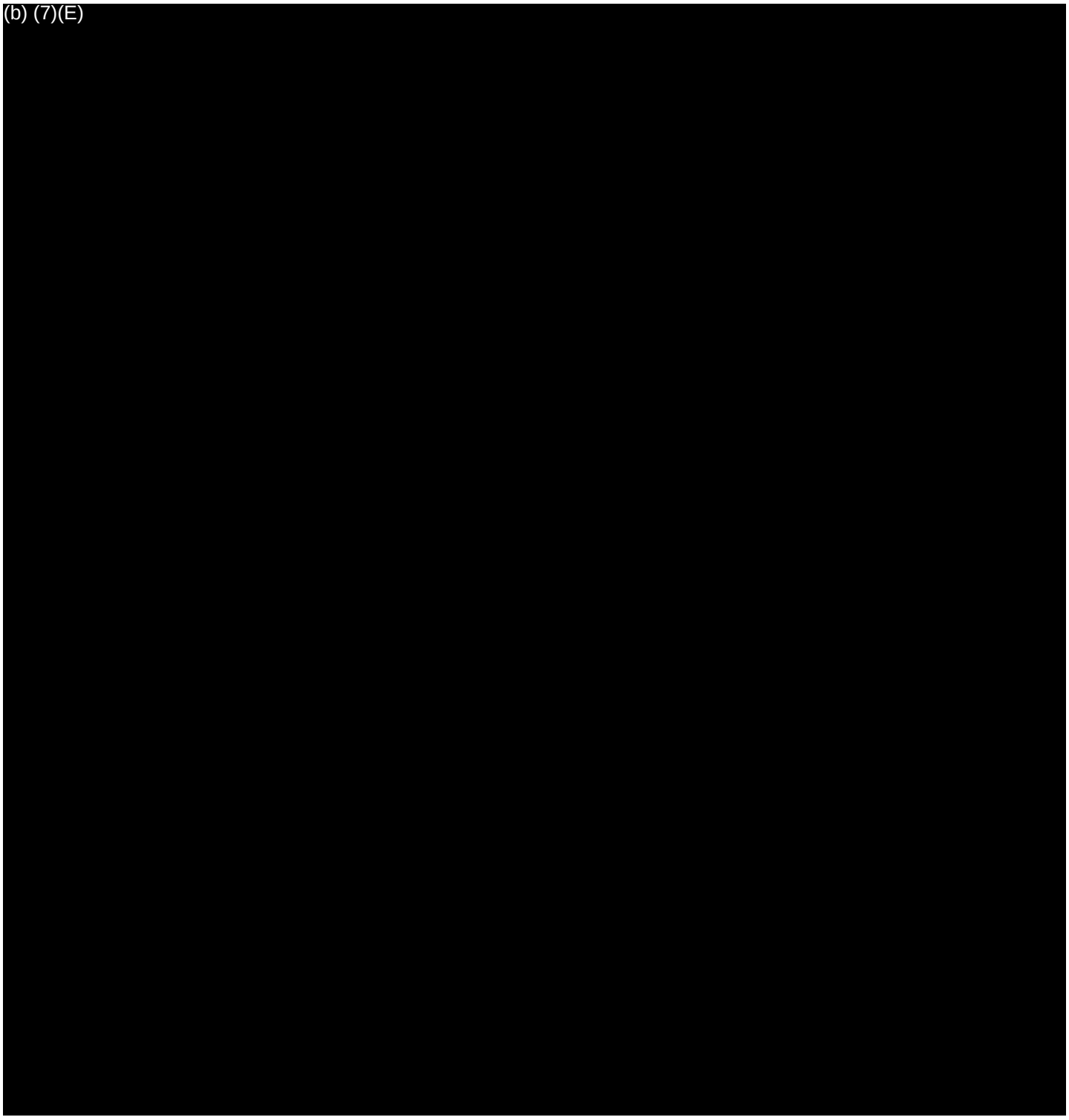
- Ensure that key testimony is accurately and persuasively reflected in the decision.
- ARTICULATE: answer the "why" questions by citing specific evidence in the decision.
- Remember, only evidence actually cited in the decision can beconsidered on appellate review.

IV.D.2. Best Questions Document

(b) (7)(E)



(b) (7)(E)



IV.E. REVISED RULES FOR EVALUATING MEDICAL EVIDENCE

IV.E.1. IN GENERAL

III.E.1.a. PROCEDURAL CONSIDERATIONS

03/24/17 OCALJ EMAIL MEMORANDUM

IV.E.1.b. POLICY ON DETERMINING FILING DATE

DI 24503.050 Determining the Filing Date (D)

IV.E.1.c. HALLEX I-5-3-30

I-5-3-30.Revisions to Rules Regarding the Evaluation of Medical Evidence

Table of Contents

I. Purpose

On January 18, 2017, the Social Security Administration (SSA) published revisions to the rules regarding the evaluation of medical evidence (82 FR 5844). These revisions became effective on March 27, 2017 (see IV below). These instructions explain why SSA revised its rules regarding the evaluation of medical evidence and when the Office of Disability Adjudication and Review (ODAR) will apply the revised rules.

II. Background

In 1991, SSA adopted new rules creating a uniform national policy about how to consider medical opinions from treating physicians. Based on the state of healthcare at that time, SSA determined that opinions from a claimant's treating physician tended to have a special intrinsic value, because he or she was likely to be the medical professional most able to provide a detailed, longitudinal picture of a claimant's

impairments. Accordingly, the “treating physician rule” allowed adjudicators to give controlling weight to treating source opinions under certain circumstances. In 1996 and 2006, SSA issued Social Security Rulings (SSR) that provide further instructions on how to evaluate evidence from medical and non-medical sources, including treating physicians (SSRs 96-2p, 96-5p, 96-6p, and 06-3p, all of which were rescinded effective March 27, 2017).

However, since adopting these rules over twenty-five years ago, changes in healthcare delivery and SSA's adjudicative experience necessitated revision of the rules. Healthcare delivery has changed dramatically since the 1991 rules were implemented. Many people now receive healthcare from coordinated and managed care organizations instead of a single treating physician. People typically visit multiple medical professionals, including primary physicians, specialists, and nurse practitioners, and they do so in a variety of medical settings, such as managed care and specialty clinics, hospitals, ambulatory care centers and public healthcare centers. As a result, people are less likely to develop a sustained relationship with a single treating physician. Additionally, due to changes in the national healthcare workforce, people now receive medical care from a wider range of medical sources with rigorous state licensure and extensive education and training requirements, such as Advanced Practice Registered Nurses, audiologists, and physician assistants.

Further, SSA's remand data from both the Appeals Council (AC) and Federal courts revealed that consideration and evaluation of opinion evidence has consistently remained one of the highest reasons for remand at both levels. The Federal courts differed in how strictly they have interpreted the articulation requirements for evaluating opinion evidence and developed varying standards for determining what constitutes a treating physician relationship and how SSA must address multiple opinions from multiple treating sources. The various approaches moved SSA's adjudication away from the content of medical opinions and towards weighing treatment relationships against each other. Consequently, the reviewing courts have focused more on whether SSA sufficiently articulated the weight we gave treating source opinions rather than on whether substantial evidence supported a final decision.

In light of the changes in healthcare delivery and SSA's adjudicative experience, SSA requested that the Administrative Conference of the United States (ACUS) provide recommendations on how SSA could improve considering medical opinion evidence in the disability and blindness claims evaluation process. In 2013, ACUS issued its final report. Additionally, the Bipartisan Budget Act (BBA) of 2015 amended the Social Security Act in several ways, including revising the requirements about medical consultants (MC) and psychological consultants (PC).

III. Revisions to the Rules for Evaluating Medical Evidence

Based on changes in healthcare delivery, ACUS's final report, the requirements of the BBA, and SSA's adjudicative experience, we updated our regulations to:

- Redefine and reorganize several key terms related to evidence;

- Revise the rules about acceptable medical sources (AMS);
- Revise the manner in which SSA considers and articulates consideration of medical opinions and prior administrative medical findings;
- Revise the rules about MCs and PCs; and
- Revise the rules about treating sources.

SSA expects these changes will simplify the rules and make them easier to understand and apply, and allow SSA adjudicators to continue to make accurate and consistent disability determinations and decisions. SSA will apply most of these revisions only in claims filed on or after March 27, 2017. See subsection IV below for information on determining whether, for purposes of these rules, a claim was filed before March 27, 2017 or on or after that date, and for more information on which rules to apply depending on the filing date of a claim(s).

IV. Implementation of the Rules for Evaluating Medical Evidence

The revised rules became effective on March 27, 2017. While some of the revised rules apply in all claims, many of the most significant changes for evaluating evidence will apply only in claims filed on or after March 27, 2017 (see IV.A. below for instructions on how to determine the filing date). Accordingly, the filing date of a claim(s) determines which set of rules to apply when evaluating medical and nonmedical evidence in a claim.

The rules applicable in cases filed before March 27, 2017, but not applicable in cases filed on or after that date, include the following or similar language: “For claims filed before March 27, 2017, the rules in this section apply.” For simplicity, these rules are referred to as the “prior rules.” The rules applicable in cases filed on or after March 27, 2017, but not applicable in cases filed before that date, include the following or similar language: “For claims filed on or after March 27, 2017, the rules in this section apply.” For simplicity, these rules are referred to as the “current rules.”

The following chart highlights which rules depend on the filing date of a claim(s) and includes citations to applicable rules:

Topic	Prior Rule Citation	Current Rule Citation
AMS	20 CFR 404.1502(a)(1)-(5) and 416.902(a)(1)-(5)	20 CFR 404.1502(a)(1)-(8) and 416.902(a)(1)-(8)
Medical Opinion Definition	20 CFR 404.1527(a) and 416.927(a)	20 CFR 404.1513(a)(2) and 416.913(a)(2)
Other Medical Evidence Definition	20 CFR 404.1513(a)(3) and 416.913(a)(3)	20 CFR 404.1513(a)(3) and 416.913(a)(3)
Consideration and Articulation of Opinion Evidence and Prior Administrative Medical Findings	20 CFR 404.1513a, 404.1527, 416.913a and 416.927	20 CFR 404.1513a, 404.1520c, 416.913a and 416.920c
Statements on Issues Reserved to the Commissioner	20 CFR 404.1527(d) and 416.927(d)	20 CFR 1520b(c)(3), and 416.920b(c)(3)
Decisions by other Governmental and Nongovernmental Entities	20 CFR 404.1504 and 416.904	20 CFR 404.1504, 1520b(c)(1), 416.904, and 416.920b(c)(1)

The following subsections provide information on which set of rules will apply in a given case. Importantly, even where different claims in a case have different filing dates, only one set of rules will apply in a claim, i.e., either the prior rules or the current rules, but never both. See IV.B. below for common filing date scenarios. For a more comprehensive overview of filing date scenarios, see Program Operations Manual System (POMS) DI 24503.050.

A. Determining the Filing Date – Generally

The Office of Disability Policy has established policies for determining whether to use the prior rules or the current rules in a given case. See POMS DI 24503.050 for filing

date scenarios and GN 00204.007 for more information about how we determine when a claim is filed. Both the hearing level and the AC will follow these policies to determine whether to apply the prior rules or the current rules in an individual case.

To assist adjudicators in determining when a claim(s) was filed and which rules to apply, the eView header contains a Medical Evidence indicator identifying whether the claim(s) was filed before March 27, 2017, or on or after March 27, 2017. For claims filed before March 27, 2017, the eView header will show the following indicator: "MedEv: Prior Rules." For claims filed on or after March 27, 2017, the eView header will show the following indicator: "MedEv: Current Rules."

NOTE:

The eView indicator is first set at the initial level before the field office transfers the claim to the State agencies. There are situations where the filing date may change after the indicator is first set (see IV.C. below for an example). Accordingly, it is important in all cases to verify the claim(s) filing date by reviewing relevant information in the file.

B. Determining Which Rules Apply – Common Scenarios

With exceptions noted in POMS DI 24503.050, use the earliest possible filing date of a claim(s) to determine which set of rules to follow. The following chart displays common filing date scenarios and which rules to apply in a given case:

Filing Scenario	**Rules to Apply**
Single claim (title II or title XVI) with a filing date before March 27, 2017	Prior rules
Single claim (title II or title XVI) with a filing date on or after March 27, 2017	Current rules
Title II or title XVI concurrent, with a filing date(s) before March 27, 2017	Prior rules for both claims
Title II or title XVI concurrent, with a filing date(s) on or after March 27, 2017	Current rules for both claims
Title II claim with a filing date before March 27, 2017, and a title XVI claim filed on or after March 27, 2017	Prior rules for both claims
Title XVI claim with a filing date before March 27, 2017, and a title II claim filed on or after March 27, 2017	Prior rules for both claims

NOTE:

The filing date of an age 18 redetermination is the date the individual attains age 18, which is one day before the calendar date of their 18th birthday. If the claimant attains age 18 before March 27, 2017, the prior rules apply, and if the claimant attains age 18 on or after March 27, 2017, the current rules apply.

C. Determining Which Rules Apply – Protective Filing Dates

In certain situations, the AC will advise the claimant that if he or she files a new application within 6 months of the date of the AC's notice in a title II claim, or within 60 days of the AC's notice in a title XVI claim, then the agency will use the date of the request for review as the filing date for the new application. See 20 CFR 404.970(c) and 416.1470(c) and Hearings, Appeals and Litigation Law (HALLEX) manual I-3-4-3 D, I-3-5-20 A , I-3-8-1 C, and I-4-8-25 C.

The prior rules will apply when:

- the AC issues a protective filing date that is before March 27, 2017, and
- the claimant files the new application(s) within 6 months of the date of the AC's notice containing the protective filing date (in a title II claim), or within 60 days of the date of the AC's notice containing the protective filing date (in a title XVI claim).

The prior rules will also apply when a claimant files new concurrent claims even if only one of the claims has a protective filing date before March 27, 2017, provided the claim(s) is filed within the required time period(s).

D. Determining Which Rules Apply – Subsequent Applications

Adjudicators occasionally have to consolidate a subsequent application(s) with a pending application(s) when there are overlapping periods. In ODAR, this most often happens when an exception to file a subsequent application has been granted under SSR 11-1p or when a case is remanded from Federal court and the claimant filed a subsequent application(s). See HALLEX I-1-10 for detailed information about subsequent applications.

If the subsequent application(s) is filed on or after March 27, 2017, and is an allowance, adjudicators will use the current rules to evaluate the subsequent application(s) to determine if reopening is appropriate (see HALLEX I-1-10-30). If the subsequent application(s) is not reopened and instead is affirmed, adjudicators should continue to adjudicate the pending claim(s) using the filing date of the pending claim.

If the subsequent application(s) is filed on or after March 27, 2017, involves an overlapping period on the same title, and is pending, denied, or reopened, then consolidation of the pending and subsequent applications is necessary for further

adjudication (see HALLEX I-1-10-25). If the subsequent and pending applications were filed on or after March 27, 2017, adjudicators will apply the current rules to the consolidated case. If the subsequent application(s) is filed on or after March 27, 2017 and the pending application(s) is filed before March 27, 2017, adjudicators will apply the prior rules to the consolidated case.

For example, a Federal court remands concurrent claims with filing dates of January 12, 2014. Subsequent concurrent applications with filing dates of March 27, 2017, were denied at the reconsideration level. The AC will remand the pending court claims to the administrative law judge (ALJ) and, in the remand order, instruct the ALJ to consolidate the pending court claims with the subsequent applications and adjudicate them under the prior rules.

E. Determining Which Rules Apply – Continuing Disability Reviews (CDR)

Adjudicators must apply the rules in effect at the time of the application filing date (not the most recent comparison point decision (CPD)) for the final favorable determination or decision in the claim when adjudicating a CDR. For example, the claimant filed an application for benefits on May 1, 2010, and the claimant was found disabled in a decision dated December 20, 2013. The agency initiated a CDR and found the claimant's disability continued in a CPD dated February 23, 2015. The agency initiated another CDR on April 13, 2017. In adjudicating the second CDR, the prior rules must be applied, because the original application filing date for the favorable decision was May 1, 2010, which is before March 27, 2017.

F. Applying the "Prior Rules" in Claim(s) Filed Before March 27, 2017

For claim(s) filed before March 27, 2017, adjudicators must use the prior rules throughout the entire appeals process. While the prior rules are similar to the regulations as they existed before March 27, 2017, the agency made some changes.

Most importantly, the agency rescinded the following four SSRs and incorporated the policies in those SSRs into the rules applicable in claim(s) filed before March 27, 2017:

- SSR 96-2p: Titles II and XVI: Giving Controlling Weight to Treating Source Medical Opinions.
- SSR 96-5p: Titles II and XVI: Medical Source Opinions on Issues Reserved to the Commissioner.
- SSR 96-6p: Titles II and XVI: Consideration of Administrative Findings of Fact by State Agency Medical and Psychological Consultants and Other Program Physicians and Psychologists at the Administrative Law Judge and Appeals Council Levels of Administrative Review; Medical Equivalence.
- SSR 06-03p: Titles II and XVI: Considering Opinions and Other Evidence from Sources Who Are Not "Acceptable Medical Sources" in Disability Claims; Considering Decisions on Disability by Other Governmental and Nongovernmental Agencies.

For claim(s) filed before March 27, 2017, cite the following authorities instead of the four rescinded SSRs:

- 404.1527(d) and 416.927(d) provide guidance on how to consider medical source opinions on issues reserved to the Commissioner, which was previously provided in SSR 96-5p.
- 404.1527(e) and 416.927(e) provide guidance on considering administrative findings of fact by State agency medical and psychological consultants and other program physicians and psychologists, which was previously provided in SSR 96-6p.
- SSR 17-2p: Titles II and XVI: Evidence Needed by Adjudicators at the Hearings and Appeals Council Levels of the Administrative Review Process to Make Findings about Medical Equivalence, provides guidance on issues relating to medical equivalence, which was previously provided in SSR 96-6p.
- 404.1527(f) and 416.927(f) provide guidance on considering opinions and other evidence from sources who are not AMSs and on considering decisions on disability by other governmental and nongovernmental agencies, which was previously provided in SSR 06-03p.

V. Inquiries

Hearing office staff will direct all program-related and technical questions through appropriate management channels. ODAR regional offices may refer questions or unresolved issues to the appropriate headquarters contact.

In the Office of Appellate Operations, staff and adjudicators will direct any program-related or technical questions to the Executive Director's Office.

IV.E.1.d. "REVISIONS TO RULES REGARDING THE EVALUATION OF MEDICAL EVIDENCE ADJUDICATOR DESK GUIDE"

Supplemental ALJ Training

Social Security Administration

Effect of a Claim's Filing Date on Policies – Side-by-Side Chart

- A claim's filing date is relevant only for the following definitions and policies:

Topic	Claim filed before 3/27/17	Claim filed on or after 3/27/17
AMS	Does not include APRNs, PAs, or audiologists.	Includes APRNs, PAs, and audiologists.
Medical opinion definition	See page 8. Includes diagnosis, prognosis, and statements about symptoms	See page 5. Does not include diagnosis, prognosis, and statements about symptoms.
Other medical evidence definition	Does not include diagnosis, prognosis, and statements about symptoms.	Includes diagnosis, prognosis, and statements about symptoms.
How to consider and provide written analysis about medical opinions and prior administrative medical findings	See pages 8 and 9.	See pages 10 and 11.
Statements on issues reserved to the Commissioner	Written analysis may be required. See page 6.	No written analysis. See page 6.
Decisions by other governmental agencies and nongovernmental entities	Written analysis about the decision itself may be required. See page 7.	No written analysis about the decision itself. See page 7.

- See DI 24503.050 Determining the Filing Date for Evaluating Evidence

Acceptable Medical Sources (AMS)

- Status as an AMS is relevant for only a few policies:
    - We need objective medical evidence from an AMS to establish the existence of a medically determinable impairment (MDI) at step 2 of the sequential evaluation process
    - Listings
        - A few Listings require additional evidence from an AMS: otologic and audiometric testing for hearing loss, cystic fibrosis, hematological disorders, non-mosaic Down syndrome, genetic photosensitivity disorders, and catastrophic congenital disorder (child claim only)
        - A few Listings often have additional evidence from an AMS: testing for visual disorders, chronic kidney disease on dialysis, and amyotrophic lateral sclerosis (ALS)
    - For claims filed before 3/27/17: Only an AMS can be a treating source, whose medical opinion may get controlling weight
- For all claims, the AMS list includes licensed:
    - Physicians (medical or osteopathic doctors)
    - Psychologists (at the independent practice level)
    - School psychologists (for impairments of intellectual disability, learning disabilities, and borderline intellectual functioning only)
        - May have alternative titles and certification instead of licensure
    - Optometrists (for impairments of visual disorders, or measurement of visual acuity and visual fields only)
    - Podiatrists (for impairments of the foot, or foot and ankle only)
    - Speech-language pathologists (for speech or language impairments only)
        - May have certification instead of licensure
- For claims filed on or after 3/27/17, the AMS list also includes licensed:
    - Advanced Practice Registered Nurses (APRN) (for impairments within the licensed scope of practice)
        - May have alternative titles, such as Advanced Practice Nurse (APN) or Advanced Practice Registered Nurses (APRN)
        - Includes:
            - Certified Nurse Midwife (CNM)
            - Nurse Practitioner (NP)
            - Certified Registered Nurse Anesthetist (CRNA)
            - Clinical Nurse Specialist (CNS)
    - Audiologists (for impairments of hearing loss, auditory processing disorders, and balance disorders within the licensed scope of practice only)
    - Physician Assistants (for impairments within the licensed scope of practice)
- See DI 22505.003 Evidence from an Acceptable Medical Source (AMS)

Establishing the existence of an MDI at step 2

- We need objective medical evidence from an AMS to establish the existence of an medically determinable impairment (MDI) at step 2 of the sequential evaluation process
    - Objective medical evidence means: "signs, laboratory findings, or both"
    - **Never** establish an MDI based on an individual's statement of symptoms, a diagnosis, or a medical opinion
- Definitions
    - Signs: one or more anatomical, physiological, or psychological abnormalities that can be observed, apart from your statements (symptoms). Signs must be shown by medically acceptable clinical diagnostic techniques. Psychiatric signs are medically demonstrable phenomena that indicate specific psychological abnormalities, e.g., abnormalities of behavior, mood, thought, memory, orientation, development, or perception, and must also be shown by observable facts that can be medically described and evaluated.
    - Laboratory findings: one or more anatomical, physiological, or psychological phenomena that can be shown by the use of medically acceptable laboratory diagnostic techniques. Diagnostic techniques include chemical tests (such as blood tests), electrophysiological studies (such as electrocardiograms and electroencephalograms), medical imaging (such as X-rays), and psychological tests.
- See 24501.020 Establishing a Medically Determinable Impairment (MDI)

New Categories of Evidence

Each piece of evidence fits into one category of evidence

Category of Evidence	Source	Summary of Definition
Objective medical evidence	Medical sources	Signs, laboratory findings, or both

Medical opinion	Medical sources	**For claims filed on or after 3/27/17**: A statement about what an individual can still do despite his or her impairment(s) and whether the individual has one or more impairment-related limitations or restrictions in one or more specified abilities:
		• Adult claims: (FOCUS ON RESIDUAL FUNCTIONAL CAPACITY (RFC))
		  • ability to perform physical demands of work activities,
		  • ability to perform mental demands of work activities,
		  • ability to perform other demands of work (using senses), and
		  • ability to adapt to environmental conditions.
		• T16 child claims: abilities in the 6 domains of functioning
		For claims filed before 3/27/17: see the definition on page 8

Other medical evidence	Medical sources	All other evidence from medical sources that is not objective medical evidence or a medical opinion
Evidence from nonmedical sources	Nonmedical sources	All evidence from nonmedical sources
Prior administrative medical finding	Medical Consultants (MC) and Psychological Consultants (PC)	A finding, other than the ultimate determination about whether the individual is disabled, about a medical issue made by an MC or PC at a prior administrative level in the current claim

Issues Reserved to the Commissioner

- Statements on issues reserved to the Commissioner are inherently neither valuable nor persuasive to us
- For claims filed on or after March 27, 2017, we will not provide any written analysis about how we consider this evidence
- Consider the context of the statement
- These are the issues reserved to the Commissioner:
    - A statement that a claimant is or is not disabled, blind, able to work, or able to perform regular or continuing work
    - A statement about whether or not a claimant has a severe impairment
    - A statement about whether or not an impairment(s) meets the duration requirement
    - A statement about whether or not an impairment(s) meets or medically equals any listing in the Listing of Impairments
    - In title 16 child claims, a statement about whether or not an impairment(s) functionally equals the listings
    - A statement about what a claimant's RFC is that uses our programmatic terms about the functional exertional levels instead of descriptions about the claimant's functional abilities and limitations
    - A statement about whether or not a claimant's RFC prevents him or her from doing past relevant work
    - A statement that a claimant does or does not meet the requirements of a medical-vocational rule
    - A statement about whether an individual's disability continues or ends when we conduct a continuing disability review
- See DI 24503.040 Evaluating Statements on Issues Reserved to the Commissioner

Other Governmental Agency and Nongovernmental Entity Decisions

- Other governmental agencies and nongovernmental entities make decisions about disability, blindness, employability, Medicaid, workers' compensation, and other benefits for their programs using their own rules
- They are inherently neither valuable nor persuasive to us
- For claims filed on or after 3/27/17, we will not provide any written analysis about how we consider this evidence
- We may provide written analysis about how we consider the underlying evidence supporting that agency's or entity's decision that we receive
- Never adopt a VA disability rating
- See DI 24503.045 Evaluating Decisions by Other Government Agencies and Nongovernment Entities

Medical opinions and prior administrative medical findings: Claims filed before 3/27/17: Policies

- Assign a "weight" to each
    - Controlling weight: give a treating source's medical opinion controlling weight only when it is well-supported by medically acceptable clinical and laboratory diagnostic techniques and is not inconsistent with the other substantial evidence in the case record
    - Treating source: an AMS who has provided a claimant with medical treatment or evaluation and who has had an ongoing treatment relationship
    - Medical opinion: a statement from an AMS that reflect judgments about the nature and severity of impairment(s), including symptoms, diagnosis and prognosis, what a claimant can still do despite impairment(s), and physical or mental restrictions.
- There are 6 factors to consider (see page 9)
- Articulation requirements
    - Prior administrative medical findings: ODAR adjudicators must always include explanation
    - Medical opinions:
        - If giving controlling weight, then must include an explanation for that medical opinion
        - If not giving controlling weight, then must include an explanation for all medical opinions from AMSs
    - Opinions from medical sources who are not AMSs and from nonmedical sources: should explain the weight given to these opinions or otherwise ensure the discussion of evidence allows a reader to follow our reasoning if the opinion could affect the outcome. We must discuss these opinions when they get more weight than AMS medical opinions.
- See DI 24503.035 Evaluating and Required Written Analysis about Opinions – Claims filed before March 27, 2017

Medical opinions and prior administrative medical findings: Claims filed before 3/27/17: Factors to consider

- **Examining relationship:** Generally, we give more weight to the medical opinion of a source who has examined a claimant
- **Treatment relationship:**
  - Generally, we give more weight to medical opinions from treating sources
  - Consider
    - Length of the treatment relationship and frequency of examination
    - Nature of the treatment relationship and extent of the treatment relationship
- **Supportability:**
  - The more a medical source presents relevant evidence to support a medical opinion, particularly objective medical evidence, the more weight we will give that medical opinion.
  - The better an explanation a source provides for a medical opinion, the more weight we will give that medical opinion.
- **Consistency:** Generally, the more consistent a medical opinion is with the record as a whole, the more weight we will give to that medical opinion.
- **Specialization:** Generally, we give more weight to the medical opinion of a specialist about medical issues related to his or her area of specialty than to the medical opinion of a source who is not a specialist.
- **Other factors:** Consider any other factors which tend to support or contradict the medical opinion
  - Amount of understanding of our disability programs and their evidentiary requirements
  - The extent to which a medical source is familiar with the other information in a case record
- See DI 24503.035 Evaluating and Required Written Analysis about Opinions – Claims filed before March 27, 2017

Medical opinions and prior administrative medical findings: Claims filed on or after 3/27/17: Policies

- Consider the persuasiveness of the quality of the evidence
- Do not assign any "weight"
- There is a new definition of "medical opinion" focusing on functional abilities and limitations (see page 4)
- There are 5 factors to consider (see page 11)
- Most important factors are supportability and consistency
- Articulation requirements
    - Must include an explanation about how persuasive we find all medical opinions from all medical sources and all prior administrative medical findings
    - May include an explanation about all of a medical source's medical opinions together
    - Must include an explanation about the supportability and consistency factors
    - Remaining 3 factors
        - Must discuss when two or more medical opinions or prior administrative medical findings about the same issue are both equally well-supported and consistent but are not exactly the same
        - Discretionary whether to discuss in other situations
- See
    - DI 24503.025 Evaluating Medical Opinions and Prior Administrative Medical Findings
    - DI 24503.030 Required Written Analysis about Medical Opinions and Prior Administrative Medical Findings

Medical opinions and prior administrative medical findings: Claims filed on or after 3/27/17: Factors to consider

- **Supportability:** The more relevant the objective medical evidence and supporting explanations presented by a medical source are to support his or her medical opinion(s) or prior administrative medical finding(s), the more persuasive they will be.
- **Consistency:** The more consistent a medical opinion(s) or prior administrative medical finding(s) is with the evidence from other medical sources and nonmedical sources in the claim, the more persuasive they will be.
- **Relationship with the claimant:** This factor combines consideration of these five issues:
    - **Length of the treatment relationship:** The length of time a medical source has treated a claimant may help demonstrate whether the medical source has a longitudinal understanding of the claimant's impairment(s).
    - **Frequency of examinations:** The frequency of a claimant's visits with the medical source may help demonstrate whether the medical source has a longitudinal understanding of the claimant's impairment(s).
    - **Purpose of the treatment relationship:** The purpose for treatment a claimant received from the medical source may help demonstrate the level of knowledge the medical source has of the claimant's impairment(s).
    - **Extent of the treatment relationship:** The kinds and extent of examinations and testing the medical source has performed or ordered from specialists or independent laboratories may help demonstrate the level of knowledge the medical source has of a claimant's impairment(s).
    - **Examining relationship:** A medical source may have a better understanding of a claimant's impairment(s) if he or she examines the claimant than if the medical source only reviews evidence in the folder.
- **Specialization:** The medical opinion or prior administrative medical finding of a medical source who has received advanced education and training to become a specialist may be more persuasive about medical issues related to his or her area of specialty than the medical opinion or prior administrative medical finding of a medical source who is not a specialist in the relevant area of specialty.
- **Other factors:** We will consider other factors that tend to support or contradict a medical opinion or prior administrative medical finding. This includes, but is not limited to, evidence showing a medical source has familiarity with the other evidence in the claim or an understanding of our disability program's policies and evidentiary requirements. When we consider a medical source's familiarity with the other evidence in a claim, we will also consider whether new evidence we receive after the medical source made his or her medical opinion or prior administrative medical finding makes the medical opinion or prior administrative medical finding more or less persuasive.

- See DI 24503.025 Evaluating Medical Opinions and Prior Administrative Medical Findings

Medical and Psychological Consultants

- **Medical consultants**: Licensed physicians only
- **Psychological consultants:** Licensed psychiatrists or qualified psychologists
    - To be qualified, a psychologist must:
        - (1) Be licensed or certified as a psychologist at the independent practice level of psychology by the State in which he or she practices; AND
        - (2) Either
            - (i) Possess a doctorate degree in psychology from a program in clinical psychology of an educational institution accredited by an organization recognized by the Council on Post-Secondary Accreditation; OR
            - (ii) Be listed in a national register of health service providers in psychology which the Commissioner of Social Security deems appropriate (Note: there is no such list in use currently); AND
        - (3) Possess 2 years of supervised clinical experience as a psychologist in health service, at least 1 year of which is post-masters degree.
- **Initial and reconsideration claims involving physical impairments**
    - We must make every reasonable effort to ensure that a licensed physician has completed the medical portion of the case review and any applicable residual functional capacity (RFC) assessment
    - Both allowances and denials
- **Initial and reconsideration claims involving mental impairments**
    - We must make every reasonable effort to ensure that a qualified psychiatrist or psychologist has completed the medical portion of the case review and any applicable residual functional capacity (RFC) assessment.
    - Both allowances and denials
- See DI 24501.001 The Disability Determination Services (DDS) Disability Examiner (DE), Medical Consultant (MC), and Psychological Consultant (PC) Team, and the Role of the Medical Advisor (MA)

Social Security Rulings (SSR)

- We are rescinding four existing SSRs
  - SSR 96-2p: Giving Controlling Weight to Treating Source Medical Opinions
  - SSR 96-5p: Medical Source Opinions on Issues Reserved to the Commissioner
  - SSR 96-6p: Consideration of Administrative Findings of Fact by State Agency Medical and Psychological Consultants and Other Program Physicians and Psychologists at the Administrative Law Judge and Appeals Council Levels of Administrative Review; Medical Equivalence
  - SSR 06-03p Considering Opinions and Other Evidence from Sources Who Are Not "Acceptable Medical Sources" in Disability Claims; Considering Decisions on Disability by Other Governmental and Nongovernmental Agencies
- We are adding one new SSR to retain current policy about when to obtain medical expert evidence at the hearing and Appeals Council levels

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IV.E.2. EVALUATION OF MEDICAL EVIDENCE

IV.E.2.a. PRIOR RULE -- APPLICABLE TO CLAIMS FILED BEFORE MARCH 27, 2017

§ 404.1527 Evaluating opinion evidence for claims filed before March 27, 2017.

§ 404.1527. Evaluating opinion evidence.

For claims filed (see § 404.614) before March 27, 2017, the rules in this section apply. For claims filed on or after March 27, 2017, the rules in § 404.1520c apply.

(a) *Definitions.*

(1) *Medical opinions.* Medical opinions are statements from acceptable medical sources that reflect judgments about the nature and severity of your impairment(s), including your symptoms, diagnosis and prognosis, what you can still do despite impairment(s), and your physical or mental restrictions.

(2) *Treating source.* Treating source means your own acceptable medical source who provides you, or has provided you, with medical treatment or evaluation and who has, or has had, an ongoing treatment relationship with you. Generally, we will consider that you have an ongoing treatment relationship with an acceptable medical source when the medical evidence establishes that you see, or have seen, the source with a frequency consistent with accepted medical practice for the type of treatment and/or evaluation required for your medical condition(s). We may consider an acceptable medical source who has treated or evaluated you only a few times or only after long intervals (*e.g.,* twice a year) to be your treating source if the nature and frequency of the treatment or evaluation is typical for your condition(s). We will not consider an acceptable medical source to be your treating source if your relationship with the source is not based on your medical need for treatment or evaluation, but solely on your need to obtain a report in support of your claim for disability. In such a case, we will consider the acceptable medical source to be a nontreating source.

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

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

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

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

(i) *Length of the treatment relationship and the frequency of examination.* Generally, the longer a treating source has treated you and the more times you have been seen by a treating source, the more weight we will give to the source's medical opinion. When the

treating source has seen you a number of times and long enough to have obtained a longitudinal picture of your impairment, we will give the medical source's medical opinion more weight than we would give it if it were from a nontreating source.

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

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

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

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

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

(d) *Medical source opinions on issues reserved to the Commissioner.* Opinions on some issues, such as the examples that follow, are not medical opinions, as described in paragraph (a)(1) of this section, but are, instead, opinions on issues reserved to the

Commissioner because they are administrative findings that are dispositive of a case; *i.e.,* that would direct the determination or decision of disability.

(1) *Opinions that you are disabled.* We are responsible for making the determination or decision about whether you meet the statutory definition of disability. In so doing, we review all of the medical findings and other evidence that support a medical source's statement that you are disabled. A statement by a medical source that you are ''disabled'' or ''unable to work'' does not mean that we will determine that you are disabled.

(2) *Other opinions on issues reserved to the Commissioner.* We use medical sources, including your treating source, to provide evidence, including opinions, on the nature and severity of your impairment(s). Although we consider opinions from medical sources on issues such as whether your impairment(s) meets or equals the requirements of any impairment(s) in the Listing of Impairments in appendix 1 to this subpart, your residual functional capacity (see §§ 404.1545 and 404.1546), or the application of vocational factors, the final responsibility for deciding these issues is reserved to the Commissioner.

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

(e) *Evidence from our Federal or State agency medical or psychological consultants.* The rules in § 404.1513a apply except that when an administrative law judge gives controlling weight to a treating source's medical opinion, the administrative law judge is not required to explain in the decision the weight he or she gave to the prior administrative medical findings in the claim.

(f) *Opinions from medical sources who are not acceptable medical sources and from nonmedical sources.*

(1) *Consideration.* Opinions from medical sources who are not acceptable medical sources and from nonmedical sources may reflect the source's judgment about some of the same issues addressed in medical opinions from acceptable medical sources. Although we will consider these opinions using the same factors as listed in paragraph (c)(1) through (c)(6) in this section, not every factor for weighing opinion evidence will apply in every case because the evaluation of an opinion from a medical source who is not an acceptable medical source or from a nonmedical source depends on the particular facts in each case. Depending on the particular facts in a case, and after applying the factors for weighing opinion evidence, an opinion from a medical source who is not an acceptable medical source or from a nonmedical source may outweigh the medical opinion of an acceptable medical source, including the medical opinion of a treating source. For example, it may be appropriate to give more weight to the opinion of a medical source who is not an ''acceptable medical source'' if he or she has seen the individual more often than the treating source, has provided better supporting

evidence and a better explanation for the opinion, and the opinion is more consistent with the evidence as a whole.

(2) *Articulation.* The adjudicator generally should explain the weight given to opinions from these sources or otherwise ensure that the discussion of the evidence in the determination or decision allows a claimant or subsequent reviewer to follow the adjudicator's reasoning, when such opinions may have an effect on the outcome of the case. In addition, when an adjudicator determines that an opinion from such a source is entitled to greater weight than a medical opinion from a treating source, the adjudicator must explain the reasons in the notice of decision in hearing cases and in the notice of determination (that is, in the personalized disability notice) at the initial and reconsideration levels, if the determination is less than fully favorable.

IV.E.2.b. CURRENT RULE -- APPLICABLE TO CLAIMS FILED ON OR AFTER MARCH 27, 2017

§ 404.1520c How we consider and articulate medical opinions and prior administrative medical findings for claims filed on or after March 27, 2017.

§ 404.1520(c)

For claims filed (see § 404.614) on or after March 27, 2017, the rules in this section apply. For claims filed before March 27, 2017, the rules in § 404.1527 apply.

(a) *How we consider medical opinions and prior administrative medical findings.* We will not defer or give any specific evidentiary weight, including controlling weight, to any medical opinion(s) or prior administrative medical finding(s), including those from your medical sources. When a medical source provides one or more medical opinions or prior administrative medical findings, we will consider those medical opinions or prior administrative medical findings from that medical source together using the factors listed in paragraphs (c)(1) through (c)(5) of this section, as appropriate. The most important factors we consider when we evaluate the persuasiveness of medical opinions and prior administrative medical findings are supportability (paragraph (c)(1) of this section) and consistency (paragraph (c)(2) of this section). We will articulate how we considered the medical opinions and prior administrative medical findings in your claim according to paragraph (b) of this section.

(b) *How we articulate our consideration of medical opinions and prior administrative medical findings.* We will articulate in our determination or decision how persuasive we find all of the medical opinions and all of the prior administrative medical findings in your case record. Our articulation requirements are as follows:

(1) *Source-level articulation.* Because many claims have voluminous case records containing many types of evidence from different sources, it is not administratively feasible for us to articulate in each determination or decision how we considered all of the factors for all of the medical opinions and prior administrative medical findings in your case record. Instead, when a medical source provides multiple medical opinion(s) or prior administrative medical finding(s), we will articulate how we considered the medical opinions or prior administrative medical findings from that medical source together in a single analysis using the factors listed in paragraphs (c)(1) through (c)(5) of this section, as appropriate. We are not required to articulate how we considered each medical opinion or prior administrative medical finding from one medical source individually.

(2) *Most important factors.* The factors of supportability (paragraph (c)(1) of this section) and consistency (paragraph (c)(2) of this section) are the most important factors we consider when we determine how persuasive we find a medical source's medical opinions or prior administrative medical findings to be. Therefore, we will explain how we considered the supportability and consistency factors for a medical source's medical opinions or prior administrative medical findings in your determination or decision. We may, but are not required to, explain how we considered the factors in paragraphs (c)(3) through (c)(5) of this section, as appropriate, when we articulate how we consider medical opinions and prior administrative medical findings in your case record.

(3) *Equally persuasive medical opinions or prior administrative medical findings about the same issue.* When we find that two or more medical opinions or prior administrative medical findings about the same issue are both equally well-supported (paragraph (c)(1) of this section) and consistent with the record (paragraph (c)(2) of this section) but are not exactly the same, we will articulate how we considered the other most persuasive factors in paragraphs (c)(3) through (c)(5) of this section for those medical opinions or prior administrative medical findings in your determination or decision.

(c) *Factors.* We will consider the following factors when we consider the medical opinion(s) and prior administrative medical finding(s) in your case:

(1) *Supportability.* The more relevant the objective medical evidence and supporting explanations presented by a medical source are to support his or her medical opinion(s) or prior administrative medical finding(s), the more persuasive the medical opinions or prior administrative medical finding(s) will be.

(2) *Consistency.* The more consistent a medical opinion(s) or prior administrative medical finding(s) is with the evidence from other medical sources and nonmedical sources in the claim, the more persuasive the medical opinion(s) or prior administrative medical finding(s) will be.

(3) *Relationship with the claimant.* This factor combines consideration of the issues in paragraphs (c)(3)(i) through (v) of this section.

(i) *Length of the treatment relationship.* The length of time a medical source has treated you may help demonstrate whether the medical source has a longitudinal understanding of your impairment(s).

(ii) *Frequency of examinations.* The frequency of your visits with the medical source may help demonstrate whether the medical source has a longitudinal understanding of your impairment(s).

(iii) *Purpose of the treatment relationship.* The purpose for treatment you received from the medical source may help demonstrate the level of knowledge the medical source has of your impairment(s).

(iv) *Extent of the treatment relationship.* The kinds and extent of examinations and testing the medical source has performed or ordered from specialists or independent laboratories may help demonstrate the level of knowledge the medical source has of your impairment(s).

(v) *Examining relationship.* A medical source may have a better understanding of your impairment(s) if he or she examines you than if the medical source only reviews evidence in your folder.

(4) *Specialization.* The medical opinion or prior administrative medical finding of a medical source who has received advanced education and training to become a specialist may be more persuasive about medical issues related to his or her area of specialty than the medical opinion or prior administrative medical finding of a medical source who is not a specialist in the relevant area of specialty.

(5) *Other factors.* We will consider other factors that tend to support or contradict a medical opinion or prior administrative medical finding. This includes, but is not limited to, evidence showing a medical source has familiarity with the other evidence in the claim or an understanding of our disability program's policies and evidentiary requirements. When we consider a medical source's familiarity with the other evidence in a claim, we will also consider whether new evidence we receive after the medical source made his or her medical opinion or prior administrative medical finding makes the medical opinion or prior administrative medical finding more or less persuasive.

(d) *Evidence from nonmedical sources.* We are not required to articulate how we considered evidence from nonmedical sources using the requirements in paragraphs (a)–(c) in this section.

IV.E.3. Acceptable Medical Sources

IV.E.3.a. Prior Rule – Acceptable Medical Sources – Before 3/27/17

§ 404.1513. Medical and other evidence of your impairment(s).

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

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

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

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

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

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

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*IV.E.3.*b Current Rule – Acceptable Medical Source – 3/27/17 and after

§ 404.1502 Definitions for this subpart.

As used in the subpart—

Acceptable medical source means a
medical source who is a:

(1) Licensed physician (medical orosteopathic doctor);

(2) Licensed psychologist, which includes:

(i) A licensed or certified psychologist at the independent practice level; or

(ii) A licensed or certified school psychologist, or other licensed or certified individual with another title who performs the same function as a school psychologist in a school setting, for impairments of intellectual disability, learning disabilities, and borderline intellectual functioning only;

(3) Licensed optometrist for impairments of visual disorders, or measurement of visual acuity and visual fields only, depending on the scope of practice in the State in which the optometrist practices;

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

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

(6) Licensed audiologist for impairments of hearing loss, auditory processing disorders, and balance disorders within the licensed scope of practice only (with respect to claims filed (see § 404.614) on or after March 27, 2017);

(7) Licensed Advanced Practice Registered Nurse, or other licensed advanced practice nurse with another title, for impairments within his or her licensed scope of practice (only with respect to claims filed (see § 404.614) on or after March 27, 2017); or

(8) Licensed Physician Assistant for impairments within his or her licensed scope of practice (only with respect to claims filed (see § 404.614) on or after March 27, 2017).

Commissioner means the Commissioner of Social Security or his or her authorized designee.

Laboratory findings means one or more anatomical, physiological, or psychological phenomena that can be shown by the use of medically acceptable laboratory diagnostic techniques. Diagnostic techniques include chemical tests (such as blood tests), electrophysiological studies (such as electrocardiograms and electroencephalograms), medical imaging (such as X-rays), and psychological tests.

Medical source means an individual who is licensed as a healthcare worker by a State and working within the scope of practice permitted under State or Federal law, or an individual who is certified by a State as a speech-language pathologist or a school

psychologist and acting within the scope of practice permitted under State or Federal law.

Nonmedical source means a source of evidence who is not a medical source. This includes, but is not limited to:

(1) You;
(2) Educational personnel (for example, school teachers, counselors, early intervention team members, developmental center workers, and daycare center workers);
(3) Public and private social welfare agency personnel; and
(4) Family members, caregivers, friends, neighbors, employers, and clergy.

Objective medical evidence means signs, laboratory findings, or both.

Signs means one or more anatomical, physiological, or psychological abnormalities that can be observed, apart from your statements (symptoms). Signs must be shown by medically acceptable clinical diagnostic techniques. Psychiatric signs are medically demonstrable phenomena that indicate specific psychological abnormalities, *e.g.,* abnormalities of behavior, mood, thought, memory, orientation, development, or perception, and must also be shown by observable facts that can be medically described and evaluated.

State agency means an agency of a State designated by that State to carry out the disability or blindness determination function.

Symptoms means your own description of your physical or mental impairment.

We or *us* means, as appropriate, either the Social Security Administration or the State agency making the disability or blindness determination.

You or *your* means, as appropriate, the person who applies for benefits or for a period of disability, the person for whom an application is filed, or the person who is receiving benefits based on disability or blindness.

IV.E.3.b. EVALUATION OF NON-AMS OPINIONS

IV.E.3.b.(i) Prior Rule – Non AMS Opinions – Before 3/27/17

20 CFR 404.1527(f)

(f) *Opinions from medical sources who are not acceptable medical sources and from nonmedical sources.*

(1) *Consideration.* Opinions from medical sources who are not acceptable medical sources and from nonmedical sources may reflect the source's judgment about some of the same issues addressed in medical opinions from acceptable medical sources. Although we will consider these opinions using the same factors as listed in paragraph (c)(1) through (c)(6) in this section, not every factor for weighing opinion evidence will apply in every case because the evaluation of an opinion from a medical source who is not an acceptable medical source or from a nonmedical source depends on the particular facts in each case. Depending on the particular facts in a case, and after applying the factors for weighing opinion evidence, an opinion from a medical source who is not an acceptable medical source or from a nonmedical source may outweigh the medical opinion of an acceptable medical source, including the medical opinion of a treating source. For example, it may be appropriate to give more weight to the opinion of a medical source who is not an ''acceptable medical source'' if he or she has seen the individual more often than the treating source, has provided better supporting evidence and a better explanation for the opinion, and the opinion is more consistent with the evidence as a whole.

(2) *Articulation.* The adjudicator generally should explain the weight given to opinions from these sources or otherwise ensure that the discussion of the evidence in the determination or decision allows a claimant or subsequent reviewer to follow the adjudicator's reasoning, when such opinions may have an effect on the outcome of the case. In addition, when an adjudicator determines that an opinion from such a source is entitled to greater weight than a medical opinion from a treating source, the adjudicator must explain the reasons in the notice of decision in hearing cases and in the notice of determination (that is, in the personalized disability notice) at the initial and reconsideration levels, if the determination is less than fully favorable.

IV.E.3.b.(ii) Current Rule – Medical opinions – 3/27/17 and after

20 CFR 404.1520c(a)

(a) *How we consider medical opinions and prior administrative medical findings.* We will not defer or give any specific evidentiary weight, including controlling weight, to any medical opinion(s) or prior administrative medical finding(s), including those from your medical sources. When a medical source provides one or more medical opinions or prior administrative medical findings, we will consider those medical opinions or prior administrative medical findings from that medical source together using the factors listed in paragraphs (c)(1) through (c)(5) of this section, as appropriate. The most important factors we consider when we evaluate the persuasiveness of medical opinions and prior administrative medical findings are supportability (paragraph (c)(1) of this section) and consistency (paragraph (c)(2) of this section). We will articulate how we considered the medical opinions and prior administrative medical findings in your claim according to paragraph (b) of this section.

IV.E.4. SDM FINDINGS

CALJ Memo, 10-1691; Consideration of SDM Residual Functional Capacity Assessments and Other Findings -- REVISED

IV.E.5. Medical Source Opinions on Issues Reserved to the Commissioner

IV.E.5.a. PRIOR RULE; NOW APPLICABLE ONLY TO CLAIMS FILED BEFORE MARCH 27, 2017

20 CFR 404.1527(d)

(d) *Medical source opinions on issues reserved to the Commissioner.* Opinions on some issues, such as the examples that follow, are not medical opinions, as described in paragraph (a)(1) of this section, but are, instead, opinions on issues reserved to the Commissioner because they are administrative findings that are dispositive of a case; *i.e.,* that would direct the determination or decision of disability.

(1) *Opinions that you are disabled.* We are responsible for making the determination or decision about whether you meet the statutory definition of disability. In so doing, we review all of the medical findings and other evidence that support a medical source's statement that you are disabled. A statement by a medical source that you are ''disabled'' or ''unable to work'' does not mean that we will determine that you are disabled.

(2) *Other opinions on issues reserved to the Commissioner.* We use medical sources, including your treating source, to provide evidence, including opinions, on the nature and severity of your impairment(s). Although we consider opinions from medical sources on issues such as whether your impairment(s) meets or equals the requirements of any impairment(s) in the Listing of Impairments in appendix 1 to this subpart, your residual functional capacity (see §§ 404.1545 and 404.1546), or the application of vocational factors, the final responsibility for deciding these issues is reserved to the Commissioner.

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

IV.E.5.b. CURRENT RULE; APPLICABLE TO CASES FILED ON OR AFTER MARCH 27, 2017

20 CFR 404.1520b(c)

(c) *Evidence that is inherently neither valuable nor persuasive.* Paragraphs (c)(1) through (c)(3) apply in claims filed (see § 404.614) on or after March 27, 2017. Because the evidence listed in paragraphs (c)(1) through (c)(3) of this section is inherently neither valuable nor persuasive to the issue of whether you are disabled or blind under the Act, we will not provide any analysis about how we considered such evidence in our determination or decision, even under § 404.1520c:

(1) *Decisions by other governmental agencies and nongovernmental entities.* See § 404.1504.

(2) *Disability examiner findings.* Findings made by a State agency disability examiner made at a previous level of adjudication about a medical issue, vocational issue, or the ultimate determination about whether you are disabled.

(3) *Statements on issues reserved to the Commissioner.* The statements listed in paragraphs (c)(3)(i) through (c)(3)(viii) of this section would direct our determination or decision that you are or are not disabled or blind within the meaning of the Act, but we are responsible for making the determination or decision about whether you are disabled or blind:

(i) Statements that you are or are not disabled, blind, able to work, or able to perform regular or continuing work;

(ii) Statements about whether or not you have a severe impairment(s);

(iii) Statements about whether or not your impairment(s) meets the duration requirement (see § 404.1509);

(iv) Statements about whether or not your impairment(s) meets or medically equals any listing in the Listing of Impairments in Part 404, Subpart P, Appendix 1;

(v) Statements about what your residual functional capacity is using our programmatic terms about the functional exertional levels in Part 404, Subpart P, Appendix 2, Rule 200.00 instead of descriptions about your functional abilities and limitations (see § 404.1545);

(vi) Statements about whether or not your residual functional capacity prevents you from doing past relevant work (see § 404.1560);

(vii) Statements that you do or do not meet the requirements of a medicalvocational rule in Part 404, Subpart P, Appendix 2; and

(viii) Statements about whether or not your disability continues or ends when we conduct a continuing disability review (see § 404.1594).

IV.E.6. DETERMINATIONS BY OTHER GOVERNMENTAL OR NON-GOVERNMENTAL BODIES (See CALJ Memo on Page 142)

IV.E.6.a. PRIOR RULE; NOW APPLICABLE ONLY TO CLAIMS FILED BEFORE MARCH 27, 2017

§ 404.1504. Determinations by other organizations and agencies.

A decision by any nongovernmental agency or any other governmental agency about whether you are disabled or blind is based on its rules and is not our decision about whether you are disabled or blind. We must make a disability or blindness determination based on social security law. Therefore, a determination made by another agency that you are disabled or blind is not binding on us.

§ 404.1527(f). Opinions from medical sources who are not acceptable medical sources and from nonmedical sources.

(1) Consideration. Opinions from medical sources who are not acceptable medical sources and from nonmedical sources may reflect the source's judgment about some of the same issues addressed in medical opinions from acceptable medical sources. Although we will consider these opinions using the same factors as listed in paragraph (c)(1) through (c)(6) in this section, not every factor for weighing opinion evidence will apply in every case because the evaluation of an opinion from a medical source who is not an acceptable medical source or from a nonmedical source depends on the particular facts in each case. Depending on the particular facts in a case, and after applying the factors for weighing opinion evidence, an opinion from a medical source who is not an acceptable medical source or from a nonmedical source may outweigh the medical opinion of an acceptable medical source, including the medical opinion of a treating source. For example, it may be appropriate to give more weight to the opinion of a medical source who is not an ''acceptable medical source'' if he or she has seen the individual more often than the treating source, has provided better

supporting evidence and a better explanation for the opinion, and the opinion is more consistent with the evidence as a whole.

(2) *Articulation.* The adjudicator generally should explain the weight given to opinions from these sources or otherwise ensure that the discussion of the evidence in the determination or decision allows a claimant or subsequent reviewer to follow the adjudicator's reasoning, when such opinions may have an effect on the outcome of the case. In addition, when an adjudicator determines that an opinion from such a source is entitled to greater weight than a medical opinion from a treating source, the adjudicator must explain the reasons in the notice of decision in hearing cases and in the notice of determination (that is, in the personalized disability notice) at the initial and reconsideration levels, if the determination is less than fully favorable.

IV.E.6.b CURRENT RULE; APPLICABLE ONLY TO CLAIMS ON OR AFTER MARCH 27, 2017

§ 404.1504 Decisions by other governmental agencies and nongovernmental entities.

Other governmental agencies and nongovernmental entities—such as the Department of Veterans Affairs, the Department of Defense, the Department of Labor, the Office of Personnel Management, State agencies, and private insurers— make disability, blindness, employability, Medicaid, workers' compensation, and other benefits decisions for their own programs using their own rules. Because a decision by any other governmental agency or a nongovernmental entity about whether you are disabled, blind, employable, or entitled to any benefits is based on its rules, it is not binding on us and is not our decision about whether you are disabled or blind under our rules. Therefore, in claims filed (see § 404.614) on or after March 27, 2017, we will not provide any analysis in our determination or decision about a decision made by any other governmental agency or a nongovernmental entity about whether you are disabled, blind, employable, or entitled to any benefits. However, we will consider all of the supporting evidence underlying the other governmental agency or nongovernmental entity's decision that we receive as evidence in your claim in accordance with § 404.1513(a)(1) through(4).

20 CFR 404.1450b(c)(1)

(c) *Evidence that is inherently neither valuable nor persuasive.* Paragraphs (c)(1) through (c)(3) apply in claims filed (see § 404.614) on or after March 27, 2017. Because the evidence listed in paragraphs (c)(1) through (c)(3) of this section is inherently neither valuable nor persuasive to the issue of whether you are disabled or blind under the Act, we will not provide any analysis about how we considered such evidence in our determination or decision, even under § 404.1520c:

(1) *Decisions by other governmental agencies and nongovernmental entities.* See § 404.1504.

IV.E.7. ADMINISTRATIVE FINDINGS BY DDS AND OTHER PROGRAM PHYSICIANS AND PSYCHOLOGISTS

IV.E.7.a. PRIOR RULE; NOW APPLICABLE ONLY TO CLAIMS FILED BEFORE MARCH 27, 2017

404.1527(e)

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

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

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

subpart, and your residual functional capacity. These administrative findings of fact are based on the evidence in your case but are not in themselves evidence at the level of the administrative review process at which they are made.

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

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

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

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

(ii) When an administrative law judge considers findings of a State agency medical or psychological consultant or other program physician, psychologist, or other medical specialist, the administrative law judge will evaluate the findings using the relevant factors in paragraphs (a) through (d) of this section, such as the consultant's medical specialty and expertise in our rules, the supporting evidence in the case record, supporting explanations the medical or psychological consultant provides, and any other factors relevant to the weighing of the opinions. Unless a treating source's opinion is given controlling weight, the administrative law judge must explain in the decision the weight given to the opinions of a State agency

medical or psychological consultant or other program physician, psychologist, or other medical specialist, as the administrative law judge must do for any opinions from treating sources, nontreating sources, and other nonexamining sources who do not work for us.

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

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

404.1513a

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

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

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

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

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

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

Clinical Competence from the American Speech-Language-Hearing Association.

IV.E.7.b. CURRENT RULE; APPLICABLE ONLY TO CLAIMS ON OR AFTER MARCH 27, 2017

404.1520c(a)

(a) *How we consider medical opinions and prior administrative medical findings.* We will not defer or give any specific evidentiary weight, including controlling weight, to any medical opinion(s) or prior administrative medical finding(s), including those from your medical sources. When a medical source provides one or more medical opinions or prior administrative medical findings, we will consider those medical opinions or prior administrative medical findings from that medical source together using the factors listed in paragraphs (c)(1) through (c)(5) of this section, as appropriate. The most important factors we consider when we evaluate the persuasiveness of medical opinions and prior administrative medical findings are supportability (paragraph (c)(1) of this section) and consistency (paragraph (c)(2) of this section). We will articulate how we considered the medical opinions and prior administrative medical findings in your claim according to paragraph (b) of this section.

IV.E.8. Global Assessment of Function (GAF) Evidence in Disability Adjudication Scores

AM-13066 REV 2

Instruction

Identification Number	**AM-13066 REV 2**	**Effective Date:** June 28, 2017
Intended Audience:	CSTs/ODAR/DDSs/OMVE/OQR/CO	
Originating Office:	ORDP ODP	
Title:	**Global Assessment of Functioning (GAF) Evidence in Disability Adjudication - REV**	
Type:	AM - Admin Messages	
Program:	**Disability**	
Link To Reference:	See References at the end of this AM.	

Retention Date: December 28, 2017

Revision 06/28/2017: We revised this Administrative Message (AM) to make it consistent with the final rules, "Revisions to Rules Regarding the Evaluation of Medical Evidence," effective on March 27, 2017.

A. Purpose

This AM provides guidance to all State and Federal adjudicators (including administrative law judges) on how to consider Global Assessment of Functioning (GAF) ratings when assessing disability claims involving mental disorders. Specifically, for claims filed on or after March 27, 2017, we consider a GAF score to be “other medical evidence.” For details, see section E.

B. Background

The previous version of this AM mentioned the Daily Living Assessment-20 (DLA-20) in the first paragraph along with the discussion of GAF ratings, but did not state how adjudicators should characterize the DLA-20. The DLA-20 is a standardized psychological instrument that allows for estimated GAF ratings:

- For claims filed prior to March 27, 2017, we consider the DLA-20 to be medical evidence.
- For claims filed on or after 3/27/17, we consider the DLA-20 to be other medical evidence.

The DLA-20 is a measure of functioning, but it differs from the GAF in some significant ways. First, it does fall into the category of a standardized psychological instrument. It has validation studies including inter-rater reliability testing. Second, unlike the GAF, the clinician is rating 20 specific activities across five domains. The rating for each behavior is on a 7-point scale and the test materials provide descriptive anchors for each rating point. Characterization of the DLA-20 as medical evidence for claims filed prior to March 27, 2017 and as other evidence for claims filed on or after March 27, 2017 is similar to our guidance on other rating scales. With any standardized instrument, we do not rely on scores alone, but rather on the supporting evidence about the individual’s functioning.

The Diagnostic and Statistical Manual of Mental Disorders (DSM), published periodically by the American Psychiatric Association (APA), provides the common language and standard criteria for classification of mental disorders. The DSM, Fourth Edition, Text Revision (DSM-IV-TR) provided for a multi-axial assessment of mental disorders with Axis V being a GAF rating.

The APA published a fifth edition (DSM-5) on June 1, 2013, that does not include GAF rating for assessment of mental disorders. However, we continue to receive and consider GAF in medical evidence. This guidance relates to the evaluation of this evidence.

C. What is the GAF?

The GAF is a rating reporting a medical source’s judgment of an individual’s overall ability to function in daily life. It reflects the medical source’s subjective judgment about the individual’s symptom severity and psychological, social, and occupational functioning. The rating does not reflect impairment in function caused by physical or environmental limitations.

Each 10-point range (decile) within the GAF has two components:

1. symptom severity, and

2. functioning

A GAF rating is within a particular decile if either the symptom severity or the level of functioning falls within the range. In situations where an individual's symptom severity and level of functioning differ, the final GAF rating always reflects the worse of the two, but the multi-axis diagnosis will not clearly indicate whether the GAF assigned reflects the symptom severity or level of functioning. In other words, the single score is a numeric representation reflecting the worse of an individual's symptom severity or overall functioning involving mental demands without clarity about which of those two the score represents.

By definition, it is not clear what any GAF score actually represents or upon which symptom(s) or functional limitations it may rely.

For example, a person with a number of psychological symptoms and very few functional limitations could receive a GAF rating consistent with his or her reported psychological symptoms.

D. Problems with using the GAF to evaluate disability

Some medical sources gave inflated or unrealistically low GAF ratings because the GAF rating instructions in the DSM-IV-TR were unclear. Inter-rater reliability ratings are low in the clinical setting because there is great variability of training and experience levels amongst clinicians. These rating problems, alone or in combination, can lead to improper assessment of impairment severity. Because of the four drawbacks below, adjudicators should not rely on GAF evidence as the primary support for findings of impairment severity or of mental limitations:

1. GAF ratings are not standardized

GAF ratings lack standardization, meaning adjudicators cannot draw reliable inferences from differences in GAF ratings assigned by different medical sources or from a single GAF rating. A GAF rating compares a patient with the distinctive population of patients the source has known. This process limits direct comparability of GAF ratings assigned by different evaluators or even by the same evaluator at substantially different points in time.

Although the GAF rating is numerical, the actual number assigned can be misleading because the rating does not quantify differences in function between people.

For example, a GAF rating of 75 does not mean a person was functioning 10 units better than a person with a score of 65 was, nor does a GAF of 40 indicate a person was functioning half as well as a person with a score of 80.

2. GAF ratings need supporting detail

The GAF Scale anchors are very general and there can be a significant variation in how medical sources rated a GAF.

For example, if an individual had a GAF of 20, it could mean that he or she was not maintaining minimal personal hygiene (a clinical observation) or that he or she had some potential to hurt himself, herself, or others (a clinical judgment). Evaluators rarely noted whether the score reflected function, symptoms, or both.

3. GAF ratings are not specific

A GAF rating is not specific enough to be useful to determine symptom severity or limitation in a specific mental functional ability. By definition, it is not clear what any GAF score actually represents or upon which symptom(s) or functional limitations it may rely.

4. GAF ratings lack longitudinal context

A GAF rating is only a snapshot about symptom severity and level of functioning. A GAF rating is usually an estimate of the best level of functioning over the last week or so, or over the entirety of the past year. It rarely overrides a more specific longitudinal picture. Unless the medical source clearly explains the reasons behind his or her GAF rating and the period to which the rating applies, the GAF rating does not help provide a reliable longitudinal picture of the claimant's alleged impairments.

E. GAF ratings as evidence

An adjudicator considers a GAF rating as evidence in a claim. However, as explained above, several problems with a GAF rating make it inherently of little evidentiary value in our adjudication process.

1. **Claims filed on or after March 27, 2017.** For claims with a filing date on or

after March 27, 2017, we categorize a GAF rating as "other medical evidence" because:

- It includes consideration of symptoms categorized as other medical evidence, under our regulations. More specifically, for claims filed as of this date, our regulations indicate that a medical opinion does not include a statement about symptoms. For claims filed as of this date, our regulations define a medical opinion as a statement from a medical source about what the claimant can still do despite the impairment(s) and whether the claimant has one or more impairment-related limitations or restrictions. Thus, a GAF rating is not a medical opinion;

- The single score is a numeric representation reflecting the worse of the individual's symptom severity or overall functioning involving mental demands without clarity about which of those two the score represents; and

- If the score reflects functioning involving mental demands, it is not specified which specific mental abilities are being reflected in the score, rendering it not useful in assessing functioning.

Adjudicators follow the articulation requirements for this category of evidence as provided in our regulations and POMS.

2. **Claims filed before March 27, 2017.** For claims with a filing date before March 27, 2017, we categorize a GAF rating as a "medical opinion" if it was made by an acceptable medical source (AMS) or as an "opinion" if it was made by a medical source who is not an AMS. For claims filed prior to March 27, 2017, our regulations define a medical opinion as a statement from an AMS that reflects judgments about the nature and severity of the claimant's impairments; including symptoms, diagnosis, and prognosis, as well as what the claimant can still do despite the impairments. Adjudicators will follow the articulation requirements for these categories of evidence as provided in our regulations and POMS.

F. Guidance about how to consider GAF within the sequential evaluation process

A GAF rating alone is never dispositive of impairment severity. **DO NOT:**

1. **Use a GAF rating as objective medical evidence that the claimant has a medically determinable mental impairment**.
A GAF rating is neither a sign nor a laboratory finding that you can use as a basis for concluding that the claimant has a medically determinable impairment.

2. **Rely solely upon a GAF rating to support a disability determination or decision.**
When case evidence includes a GAF rating from a medical source, the adjudicator must consider the GAF rating and the medical source's support for assigning that specific rating, along with all of the relevant evidence in the claim. In cases where there are multiple GAF ratings from a provider, the articulation requirement for claims filed before March 27, 2017 can be addressed through a "representative" GAF rating if the GAF scores are similar or, when the GAF ratings are significantly divergent, by addressing whether the range of GAF ratings is supported by the evidence of record.

3. **Equate any particular GAF rating with a listing-level limitation.**
The adjudicator cannot use a GAF rating to determine whether a claimant's impairment meets the diagnostic criteria of intellectual disorder in listing 12.05, because the rating lacks specificity, may not reflect a claimant's functioning over time, and is not a standardized measure of anything, including intelligence or adaptive behavior.

4. **Equate a particular GAF rating with a particular mental residual functional capacity assessment.**
The GAF rating does not measure the ability to meet the mental demands of unskilled work. There have been no published studies of how, or if, GAF ratings relate to meeting the demands of unskilled work. Additionally, there is no correlation between GAF ratings and the B criteria in the mental disorders listings.

For evaluation and articulation requirements for evidence, see POMS DI 24503.001 through DI 24503.050.

Questions

Direct all program–related and technical questions to your Regional Office (RO) support staff or Program Service Center (PSC) Operations Analysis (OA) staff. RO support staff or PSC OA staff may refer questions or problems to their Central Office contacts. The Office of Disability Adjudication and Review (ODAR) personnel should direct questions through their management chain.

References:
20 CFR 404.1502 General definitions and terms for subpart P
20 CFR 416.902 General definitions and terms for subpart I
20 CFR 404.1513 Categories of evidence
20 CFR 404.913 Categories of evidence
20 CFR 404.1520a Evaluation of mental impairments
20 CFR 416. 920a Evaluation of mental impairments
20 CFR 404.1527 Evaluating opinion evidence for claims filed before March 27, 2017

20 CFR 416.927 Evaluating opinion evidence for claims filed before March 27, 2017
20 CFR 404.1520c How we consider and articulate medical opinions and prior administrative medical findings for claims filed on or after March 27, 2017
20 CFR 416.920C How we consider and articulate medical opinions and prior administrative medical findings for claims filed on or after March 27, 2017
DI 22505.001 Medical and Nonmedical Evidence
DI 22505.003 Evidence from an Acceptable Medical Source (AMS)
DI 22505.007 Developing Initial Evidence from Medical Sources
DI 24510.065 Section III of SSA-4734-F4-SUP Functional Capacity Assessment
DI 24503.001 Evaluating Evidence – Basic Policy
DI 24503.005 Categories of Evidence
DI 24503.010 Evaluating Objective Medical Evidence
DI 24503.015 Evaluating Other Medical Evidence
DI 24503.020 Evaluating Evidence from Nonmedical Sources
DI 24503.025 Evaluating Medical Opinions and Prior Administrative Medical Findings – Claims filed on or after March 27, 2017
DI 24503.030 Articulation Requirements for Medical Opinions and Prior Administrative Medical Filings – Claims Filed before March 27, 2017
DI 26530.015 Personalized Disability Explanation in Initial Closed Period and Unfavorable Onset Date Allowances
DI 26530.020 Personalized Disability Explanation in Initial Denials
DI 33015.020 Writing the Disability Hearing Officer's (DHO's) Decision
HALLEX 1-2-5-1 Evidence – General
HALLEX 1-2-5-14 Obtaining Medical Evidence from a Medical Source
Acta Psychiatr Scand. 2007 Apr; 115(4):326-30. Are GAF scores reliable in routine clinical use? Vatnaland T, Vatnaland J, Friis S, Opjordsmoen S.
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Ann Gen Psychiatry. 2010 May 7;9:20. doi: 10.1186/1744-859X-9-20. Global Assessment of Functioning (GAF): properties and frontier of current knowledge. Aas IH.
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The Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR), American Psychiatric Association (2000).

IV.F. Evaluation of Symptoms

IV.F.1. How we evaluate symptoms, including pain: 20 CFR § 404.1529

§ 404.1529 How we evaluate symptoms, including pain.

(a) *General.* In determining whether you are disabled, we consider all your symptoms, including pain, and the extent to which your symptoms can reasonably be accepted as consistent with the objective medical evidence and other evidence. We will consider all of your statements about your symptoms, such as pain, and any description your medical sources or nonmedical sources may provide about how the symptoms affect your activities of daily living and your ability to work. However, statements about your pain or other symptoms will not alone establish that you are disabled. There must be objective medical evidence from an acceptable medical source that shows you have a medical impairment(s) which could reasonably be expected to produce the pain or other symptoms alleged and that, when considered with all of the other evidence (including statements about the intensity and persistence of your pain or other symptoms which may reasonably be accepted as consistent with the medical signs and laboratory findings), would lead to a conclusion that you are disabled. In evaluating the intensity and persistence of your symptoms, including pain, we will consider all of the available evidence, including your medical history, the medical signs and laboratory findings, and statements about how your symptoms affect you. We will then determine the extent to which your alleged functional limitations and restrictions due to pain or other symptoms can reasonably be accepted as consistent with the medical signs and laboratory findings and other evidence to decide how your symptoms affect your ability to work.

* * * * *

(c) * * *

(1) * * * In evaluating the intensity and persistence of your symptoms, we consider all of the available evidence from your medical sources and nonmedical sources about how your symptoms affect you. We also consider the medical opinions as explained in § 404.1520c. * * *

* * * * *

(3) *Consideration of other evidence.* Because symptoms sometimes suggest a greater severity of impairment than can be shown by objective medical evidence alone, we will carefully consider any other information you may submit about your symptoms. The information that your medical sources or nonmedical sources provide about your pain or other symptoms (*e.g.,* what may precipitate or aggravate your symptoms, what medications, treatments or other methods you use to alleviate them, and how the symptoms may affect your pattern of daily living) is also an important indicator of the

intensity and persistence of your symptoms. Because symptoms, such as pain, are subjective and difficult to quantify, any symptomrelated functional limitations and restrictions that your medical sources or nonmedical sources report, which can reasonably be accepted as consistent with the objective medical evidence and other evidence, will be taken into account as explained in paragraph (c)(4) of this section in reaching a conclusion as to whether you are disabled. We will consider all of the evidence presented, including information about your prior work record, your statements about your symptoms, evidence submitted by your medical sources, and observations by our employees and other persons. Section 404.1520c explains in detail how we consider medical opinions and prior administrative medical findings about the nature and severity of your impairment(s) and any related symptoms, such as pain. Factors relevant to your symptoms, such as pain, which we will consider include:

* * * * *

(4) * * * We will consider whether there are any inconsistencies in the evidence and the extent to which there are any conflicts between your statements and the rest of the evidence, including your history, the signs and laboratory findings, and statements by your medical sources or other persons about how your symptoms affect you.

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IV.F.2. Evaluation of Symptoms in Disability Claims: SSR 16-3p

SSR 16-3p
Effective Date: March 28, 2016

POLICY INTERPRETATION RULING

Titles II and XVI: Evaluation of Symptoms in Disability Claims

This SSR supersedes SSR 96-7p: Policy Interpretation Ruling Titles II and XVI: Evaluation of Symptoms in Disability Claims: Assessing the Credibility of an Individual's Statements.

PURPOSE:

We are rescinding SSR 96-7p: Policy Interpretation Ruling Titles II and XVI Evaluation of Symptoms in Disability Claims: Assessing the Credibility of an Individual's Statements and replacing it with this Ruling. We solicited a study and recommendations from the Administrative Conference of the United States (ACUS) on the topic of symptom evaluation. Based on ACUS's recommendations[1] and our adjudicative experience, we are eliminating the use of the term “credibility” from our sub-regulatory policy, as our

regulations do not use this term. In doing so, we clarify that subjective symptom evaluation is not an examination of an individual's character. Instead, we will more closely follow our regulatory language regarding symptom evaluation.

Consistent with our regulations, we instruct our adjudicators to consider all of the evidence in an individual's record when they evaluate the intensity and persistence of symptoms after they find that the individual has a medically determinable impairment(s) that could reasonably be expected to produce those symptoms. We evaluate the intensity and persistence of an individual's symptoms so we can determine how symptoms limit ability to perform work-related activities for an adult and how symptoms limit ability to function independently, appropriately, and effectively in an age-appropriate manner for a child with a title XVI disability claim.

CITATIONS (AUTHORITY):

Sections 216(i), 223(d), and 1614(a)(3) of the Social Security Act as amended; Regulations no. 4, sections 404.1508, 404.1512(d), 404.1513, 404.1520, 404.1526, 404.1527, 404.1528, 404.1529, 404.1545 and 404.1594; and Regulations No. 16 sections 416.908, 416.912(d), 416.913, 416.920, 416.924(c), 416.924a(b)(9)(ii-iii), 416.926a, 416.927, 416.928, 416.929, 416.930(c), 416.945, 416.994, and 416.994a.

BACKGROUND:

In determining whether an individual is disabled, we consider all of the individual's symptoms, including pain, and the extent to which the symptoms can reasonably be accepted as consistent with the objective medical and other evidence in the individual's record. We define a symptom as the individual's own description or statement of his or her physical or mental impairment(s).[2] Under our regulations, an individual's statements of symptoms alone are not enough to establish the existence of a physical or mental impairment or disability. However, if an individual alleges impairment-related symptoms, we must evaluate those symptoms using a two-step process set forth in our regulations.[3]

First, we must consider whether there is an underlying medically determinable physical or mental impairment(s) that could reasonably be expected to produce an individual's symptoms, such as pain. Second, once an underlying physical or mental impairment(s) that could reasonably be expected to produce an individual's symptoms is established, we evaluate the intensity and persistence of those symptoms to determine the extent to which the symptoms limit an individual's ability to perform work-related activities for an adult or to function independently, appropriately, and effectively in an age- appropriate manner for a child with a title XVI disability claim.

This ruling clarifies how we consider:

- The intensity, persistence, and functionally limiting effects of symptoms,
- Objective medical evidence when evaluating symptoms,

- Other evidence when evaluating symptoms,
- The factors set forth in 20 CFR 404.1529(c)(3) and 416.929(c)(3),
- The extent to which an individual's symptoms affect his or her ability to perform work-related activities or function independently, appropriately, and effectively in an age-appropriate manner for a child with a title XVI disability claim, and
- Adjudication standards for evaluating symptoms in the sequential evaluation process.

POLICY INTERPRETATION:

We use a two-step process for evaluating an individual's symptoms.

The two-step process:

Step 1: We determine whether the individual has a medically determinable impairment (MDI) that could reasonably be expected to produce the individual's alleged symptoms

An individual's symptoms, such as pain, fatigue, shortness of breath, weakness, nervousness, or periods of poor concentration will not be found to affect the ability to perform work-related activities for an adult or to function independently, appropriately, and effectively in an age-appropriate manner for a child with a title XVI disability claim unless medical signs or laboratory findings show a medically determinable impairment is present. Signs are anatomical, physiological, or psychological abnormalities established by medically acceptable clinical diagnostic techniques that can be observed apart from an individual's symptoms.[4] Laboratory findings are anatomical, physiological, or psychological phenomena, which can be shown by the use of medically acceptable laboratory diagnostic techniques.[5] We call the medical evidence that provides signs or laboratory findings objective medical evidence. We must have objective medical evidence from an acceptable medical source[6] to establish the existence of a medically determinable impairment that could reasonably be expected to produce an individual's alleged symptoms.[7]

In determining whether there is an underlying medically determinable impairment that could reasonably be expected to produce an individual's symptoms, we do not consider whether the severity of an individual's alleged symptoms is supported by the objective medical evidence. For example, if an individual has a medically determinable impairment established by a knee x-ray showing mild degenerative changes and he or she alleges extreme pain that limits his or her ability to stand and walk, we will find that individual has a medically determinable impairment that could reasonably be expected to produce the symptom of pain. We will proceed to step two of the two-step process, even though the level of pain an individual alleges may seem out of proportion with the objective medical evidence.

In some instances, the objective medical evidence clearly establishes that an individual's symptoms are due to a medically determinable impairment. At other times,

we may have insufficient evidence to determine whether an individual has a medically determinable impairment that could potentially account for his or her alleged symptoms. In those instances, we develop evidence regarding a potential medically determinable impairment using a variety of means set forth in our regulations. For example, we may obtain additional information from the individual about the nature of his or her symptoms and their effect on functioning. We may request additional information from the individual about other testing or treatment he or she may have undergone for the symptoms. We may request clarifying information from an individual's medical sources, or we may send an individual to a consultative examination that may include diagnostic testing. We may use our agency experts to help us determine whether an individual's medically determinable impairment could reasonably be expected to produce his or her symptoms. At the administrative law judge hearing level or the Appeals Council level of the administrative review process, we may ask for and consider evidence from a medical or psychological expert to help us determine whether an individual's medically determinable impairment could reasonably be expected to produce his or her symptoms. If an individual alleges symptoms, but the medical signs and laboratory findings do not substantiate any medically determinable impairment capable of producing the individual's alleged symptoms, we will not evaluate the individual's symptoms at step two of our two- step evaluation process.

We will not find an individual disabled based on alleged symptoms alone. If there is no medically determinable impairment, or if there is a medically determinable impairment, but the impairment(s) could not reasonably be expected to produce the individual's symptoms, we will not find those symptoms affect the ability to perform work-related activities for an adult or ability to function independently, appropriately, and effectively in an age-appropriate manner for a child with a title XVI disability claim.

Step 2: We evaluate the intensity and persistence of an individual's symptoms such as pain and determine the extent to which an individual's symptoms limit his or her ability to perform work-related activities for an adult or to function independently, appropriately, and effectively in an age- appropriate manner for a child with a title XVI disability claim.

Once the existence of a medically determinable impairment that could reasonably be expected to produce pain or other symptoms is established, we recognize that some individuals may experience symptoms differently and may be limited by symptoms to a greater or lesser extent than other individuals with the same medical impairments, the same objective medical evidence, and the same non-medical evidence. In considering the intensity, persistence, and limiting effects of an individual's symptoms, we examine the entire case record, including the objective medical evidence; an individual's statements about the intensity, persistence, and limiting effects of symptoms; statements and other information provided by medical sources and other persons; and any other relevant evidence in the individual's case record.

We will not evaluate an individual's symptoms without making every reasonable effort to obtain a complete medical history[8] unless the evidence supports a finding that the individual is disabled. We will not evaluate an individual's symptoms based solely on

objective medical evidence unless that objective medical evidence supports a finding that the individual is disabled. We will evaluate an individual's symptoms based on the evidence in an individual's record as described below; however, not all of the types of evidence described below will be available or relevant in every case.

1. Consideration of Objective Medical Evidence

Symptoms cannot always be measured objectively through clinical or laboratory diagnostic techniques. However, objective medical evidence is a useful indicator to help make reasonable conclusions about the intensity and persistence of symptoms, including the effects those symptoms may have on the ability to perform work-related activities for an adult or to function independently, appropriately, and effectively in an age-appropriate manner for a child with a title XVI claim.[9] We must consider whether an individual's statements about the intensity, persistence, and limiting effects of his or her symptoms are consistent with the medical signs and laboratory findings of record.

The intensity, persistence, and limiting effects of many symptoms can be clinically observed and recorded in the medical evidence. Examples such as reduced joint motion, muscle spasm, sensory deficit, and motor disruption illustrate findings that may result from, or be associated with, the symptom of pain.[10] These findings may be consistent with an individual's statements about symptoms and their functional effects. However, when the results of tests are not consistent with other evidence in the record, they may be less supportive of an individual's statements about pain or other symptoms than test results and statements that are consistent with other evidence in the record.

For example, an individual with reduced muscle strength testing who indicates that for the last year pain has limited his or her standing and walking to no more than a few minutes a day would be expected to have some signs of muscle wasting as a result. If no muscle wasting were present, we might not, depending on the other evidence in the record, find the individual's reduced muscle strength on clinical testing to be consistent with the individual's alleged impairment-related symptoms.

However, we will not disregard an individual's statements about the intensity, persistence, and limiting effects of symptoms solely because the objective medical evidence does not substantiate the degree of impairment-related symptoms alleged by the individual.[11] A report of minimal or negative findings or inconsistencies in the objective medical evidence is one of the many factors we must consider in evaluating the intensity, persistence, and limiting effects of an individual's symptoms.

2. Consideration of Other Evidence

If we cannot make a disability determination or decision that is fully favorable based solely on objective medical evidence, then we carefully consider other evidence in the record in reaching a conclusion about the intensity, persistence, and limiting effects of an individual's symptoms. Other evidence that we will consider includes statements from the individual, medical sources, and any other sources that might have information

about the individual's symptoms, including agency personnel, as well as the factors set forth in our regulations.[12] For example, for a child with a title XVI disability claim, we will consider evidence submitted from educational agencies and personnel, statements from parents and other relatives, and evidence submitted by social welfare agencies, therapists, and other practitioners.[13]

a. The Individual

An individual may make statements about the intensity, persistence, and limiting effects of his or her symptoms. If a child with a title XVI disability claim is unable to describe his or her symptoms adequately, we will accept a description of his or her symptoms from the person most familiar with the child, such as a parent, another relative, or a guardian.[14] For an adult whose impairment prevents him or her from describing symptoms adequately, we may also consider a description of his or her symptoms from a person who is familiar with the individual.

An individual may make statements about symptoms directly to medical sources, other sources, or he or she may make them directly to us. An individual may have made statements about symptoms in connection with claims for other types of disability benefits such as workers' compensation, benefits under programs of the Department of Veterans Affairs, or private insurance benefits.

An individual's statements may address the frequency and duration of the symptoms, the location of the symptoms, and the impact of the symptoms on the ability to perform daily living activities. An individual's statements may also include activities that precipitate or aggravate the symptoms, medications and treatments used, and other methods used to alleviate the symptoms. We will consider an individual's statements about the intensity, persistence, and limiting effects of symptoms, and we will evaluate whether the statements are consistent with objective medical evidence and the other evidence.

b. Medical Sources

Medical sources may offer diagnoses, prognoses, and opinions as well as statements and medical reports about an individual's history, treatment, responses to treatment, prior work record, efforts to work, daily activities, and other information concerning the intensity, persistence, and limiting effects of an individual's symptoms.

Important information about symptoms recorded by medical sources and reported in the medical evidence may include, but is not limited to, the following:

- Onset, description of the character and location of the symptoms, precipitating and aggravating factors, frequency and duration, change over a period of time (e.g., whether worsening, improving, or static), and daily activities. Very often, the individual has provided this information to the medical source, and the information may be compared with the individual's other statements in the case record. In addition, the evidence provided by a medical source may contain

medical opinions about the individual's symptoms and their effects. Our adjudicators will weigh such opinions by applying the factors in 20 CFR 404.1527 and 416.927.

- A longitudinal record of any treatment and its success or failure, including any side effects of medication.
- Indications of other impairments, such as potential mental impairments, that could account for an individual's allegations.

Medical evidence from medical sources that have not treated or examined the individual is also important in the adjudicator's evaluation of an individual's statements about pain or other symptoms. For example, State agency medical and psychological consultants and other program physicians and psychologists may offer findings about the existence and severity of an individual's symptoms. We will consider these findings in evaluating the intensity, persistence, and limiting effects of the individual's symptoms. Adjudicators at the hearing level or at the Appeals Council level must consider the findings from these medical sources even though they are not bound by them. [15]

c. Non-Medical Sources

Other sources may provide information from which we may draw inferences and conclusions about an individual's statements that would be helpful to us in assessing the intensity, persistence, and limiting effects of symptoms. Examples of such sources include public and private agencies, other practitioners, educational personnel, non-medical sources such as family and friends, and agency personnel. We will consider any statements in the record noted by agency personnel who previously interviewed the individual, whether in person or by telephone. The adjudicator will consider any personal observations of the individual in terms of how consistent those observations are with the individual's statements about his or her symptoms as well as with all of the evidence in the file.

d. Factors to Consider in Evaluating the Intensity, Persistence, and Limiting Effects of an Individual's Symptoms

In addition to using all of the evidence to evaluate the intensity, persistence, and limiting effects of an individual's symptoms, we will also use the factors set forth in 20 CFR 404.1529(c)(3) and 416.929(c)(3). These factors include:

1. Daily activities;
2. The location, duration, frequency, and intensity of pain or other symptoms;
3. Factors that precipitate and aggravate the symptoms;
4. The type, dosage, effectiveness, and side effects of any medication an individual takes or has taken to alleviate pain or other symptoms;
5. Treatment, other than medication, an individual receives or has received for relief of pain or other symptoms;

6. Any measures other than treatment an individual uses or has used to relieve pain or other symptoms (e.g., lying flat on his or her back, standing for 15 to 20 minutes every hour, or sleeping on a board); and
7. Any other factors concerning an individual's functional limitations and restrictions due to pain or other symptoms.

We will consider other evidence to evaluate only the factors that are relevant to assessing the intensity, persistence, and limiting effects of the individual's symptoms. If there is no information in the evidence of record regarding one of the factors, we will not discuss that specific factor in the determination or decision because it is not relevant to the case. We will discuss the factors pertinent to the evidence of record.

How we will determine if an individual's symptoms affect the ability to perform work-related activities for an adult, or age-appropriate activities for a child with a title XVI disability claim

If an individual's statements about the intensity, persistence, and limiting effects of symptoms are consistent with the objective medical evidence and the other evidence of record, we will determine that the individual's symptoms are more likely to reduce his or her capacities to perform work- related activities for an adult or reduce a child's ability to function independently, appropriately, and effectively in an age-appropriate manner for a child with a title XVI disability claim.[16] In contrast, if an individual's statements about the intensity, persistence, and limiting effects of symptoms are inconsistent with the objective medical evidence and the other evidence, we will determine that the individual's symptoms are less likely to reduce his or her capacities to perform work-related activities or abilities to function independently, appropriately, and effectively in an age-appropriate manner.

We may or may not find an individual's symptoms and related limitations consistent with the evidence in his or her record. We will explain which of an individual's symptoms we found consistent or inconsistent with the evidence in his or her record and how our evaluation of the individual's symptoms led to our conclusions. We will evaluate an individual's symptoms considering all the evidence in his or her record.

In determining whether an individual's symptoms will reduce his or her corresponding capacities to perform work-related activities or abilities to function independently, appropriately, and effectively in an age-appropriate manner, we will consider the consistency of the individual's own statements. To do so, we will compare statements an individual makes in connection with the individual's claim for disability benefits with any existing statements the individual made under other circumstances.

We will consider statements an individual made to us at each prior step of the administrative review process, as well as statements the individual made in any subsequent or prior disability claims under titles II and XVI. If an individual's various statements about the intensity, persistence, and limiting effects of symptoms are consistent with one another and consistent with the objective medical evidence and

other evidence in the record, we will determine that an individual's symptoms are more likely to reduce his or her capacities for work-related activities or reduce the abilities to function independently, appropriately, and effectively in an age- appropriate manner. However, inconsistencies in an individual's statements made at varying times does not necessarily mean they are inaccurate. Symptoms may vary in their intensity, persistence, and functional effects, or may worsen or improve with time. This may explain why an individual's statements vary when describing the intensity, persistence, or functional effects of symptoms.

We will consider an individual's attempts to seek medical treatment for symptoms and to follow treatment once it is prescribed when evaluating whether symptom intensity and persistence affect the ability to perform work-related activities for an adult or the ability to function independently, appropriately, and effectively in an age- appropriate manner for a child with a title XVI disability claim. Persistent attempts to obtain relief of symptoms, such as increasing dosages and changing medications, trying a variety of treatments, referrals to specialists, or changing treatment sources may be an indication that an individual's symptoms are a source of distress and may show that they are intense and persistent.[17]

In contrast, if the frequency or extent of the treatment sought by an individual is not comparable with the degree of the individual's subjective complaints, or if the individual fails to follow prescribed treatment that might improve symptoms, we may find the alleged intensity and persistence of an individual's symptoms are inconsistent with the overall evidence of record. We will not find an individual's symptoms inconsistent with the evidence in the record on this basis without considering possible reasons he or she may not comply with treatment or seek treatment consistent with the degree of his or her complaints. We may need to contact the individual regarding the lack of treatment or, at an administrative proceeding, ask why he or she has not complied with or sought treatment in a manner consistent with his or her complaints. When we consider the individual's treatment history, we may consider (but are not limited to) one or more of the following:

- An individual may have structured his or her activities to minimize symptoms to a tolerable level by avoiding physical activities or mental stressors that aggravate his or her symptoms.
- An individual may receive periodic treatment or evaluation for refills of medications because his or her symptoms have reached a plateau.
- An individual may not agree to take prescription medications because the side effects are less tolerable than the symptoms.
- An individual may not be able to afford treatment and may not have access to free or low-cost medical services.
- A medical source may have advised the individual that there is no further effective treatment to prescribe or recommend that would benefit the individual.
- An individual's symptoms may not be severe enough to prompt him or her to seek treatment, or the symptoms may be relieved with over the counter medications.

- An individual's religious beliefs may prohibit prescribed treatment.
- Due to various limitations (such as language or mental limitations), an individual may not understand the appropriate treatment for or the need for consistent treatment of his or her impairment.
- Due to a mental impairment (for example, individuals with mental impairments that affect judgment, reality testing, or orientation), an individual may not be aware that he or she has a disorder that requires treatment.
- A child may disregard the level and frequency of treatment needed to maintain or improve functioning because it interferes with his or her participation in activities typical of other children his or her age without impairments.

The above examples illustrate possible reasons an individual may not have pursued treatment. However, we will consider and address reasons for not pursuing treatment that are pertinent to an individual's case. We will review the case record to determine whether there are explanations for inconsistencies in the individual's statements about symptoms and their effects, and whether the evidence of record supports any of the individual's statements at the time he or she made them. We will explain how we considered the individual's reasons in our evaluation of the individual's symptoms.

Adjudication - How we will use our evaluation of symptoms in our five-step sequential evaluation process to determine whether an individual is disabled

In evaluating an individual's symptoms, it is not sufficient for our adjudicators to make a single, conclusory statement that "the individual's statements about his or her symptoms have been considered" or that "the statements about the individual's symptoms are (or are not) supported or consistent." It is also not enough for our adjudicators simply to recite the factors described in the regulations for evaluating symptoms. The determination or decision must contain specific reasons for the weight given to the individual's symptoms, be consistent with and supported by the evidence, and be clearly articulated so the individual and any subsequent reviewer can assess how the adjudicator evaluated the individual's symptoms.

Our adjudicators must base their findings solely on the evidence in the case record, including any testimony from the individual or other witnesses at a hearing before an administrative law judge or hearing officer. The subjective statements of the individual and witnesses obtained at a hearing should directly relate to symptoms the individual alleged. Our adjudicators are prohibited from soliciting additional non- medical evidence outside of the record on their own, except as set forth in our regulations and policies.

Adjudicators must limit their evaluation to the individual's statements about his or her symptoms and the evidence in the record that is relevant to the individual's impairments. In evaluating an individual's symptoms, our adjudicators will not assess an individual's overall character or truthfulness in the manner typically used during an adversarial court litigation. The focus of the evaluation of an individual's symptoms should not be to determine whether he or she is a truthful person. Rather, our adjudicators will focus on

whether the evidence establishes a medically determinable impairment that could reasonably be expected to produce the individual's symptoms and given the adjudicator's evaluation of the individual's symptoms, whether the intensity and persistence of the symptoms limit the individual's ability to perform work-related activities or, for a child with a title XVI disability claim, limit the child's ability to function independently, appropriately, and effectively in an age-appropriate manner.

In determining whether an individual is disabled or continues to be disabled, our adjudicators follow a sequential evaluation process.[18] The first step of our five-step sequential evaluation process considers whether an individual is performing substantial gainful activity. If the individual is performing substantial gainful activity, we find him or her not disabled. If the individual is not performing substantial gainful activity, we proceed to step 2. We do not consider symptoms at the first step of the sequential evaluation process.

At step 2 of the sequential evaluation process, we determine whether an individual has a severe medically determinable physical or mental impairment or combination of impairments that has lasted or can be expected to last for a continuous period of at least 12 months or end in death.[19] A severe impairment is one that affects an individual's ability to perform basic work-related activities for an adult or that causes more than minimal functional limitations for a child with a title XVI disability claim.[20] At this step, we will consider an individual's symptoms and functional limitations to determine whether his or her impairment(s) is severe unless the objective medical evidence alone establishes a severe medically determinable impairment or combination of impairments that meets our duration requirement.[21] If an individual does not have a severe medically determinable impairment that meets our duration requirement, we will find the individual not disabled at step 2. If the individual has a severe medically determinable impairment that has met or is expected to meet our duration requirement, we proceed to the next step.

At step 3 of the sequential evaluation process, we determine whether an individual's impairment(s) meets or medically equals the severity requirements of a listed impairment. To decide whether the impairment meets the level of severity described in a listed impairment, we will consider an individual's symptoms when a symptom(s) is one of the criteria in a listing to ensure the symptom is present in combination with the other criteria. If the symptom is not one of the criteria in a listing, we will not evaluate an individual's symptoms at this step as long as all other findings required by the specific listing are present. Unless the listing states otherwise, it is not necessary to provide information about the intensity, persistence, or limiting effects of a symptom as long as all other findings required by the specific listing are present.[22] In considering whether an individual's symptoms, signs, and laboratory findings are medically equal to the symptoms, signs, and laboratory findings of a listed impairment, we will look to see whether the symptoms, signs, and laboratory findings are at least equal in severity to the listed criteria. However, we will not substitute the individual's allegations of pain or other symptoms for a missing or deficient sign or laboratory finding to raise the severity of the impairment(s) to that of a listed impairment.[23] If an individual's impairment meets

or medically equals the severity requirements of a listing, we find him or her disabled. If an individual's impairment does not meet or medically equal a listing, we proceed to assess the individual's residual functional capacity at step 4 of the sequential evaluation process unless the individual is a child with a title XVI disability claim.

For a child with a title XVI disability claim whose impairment does not meet or medically equal the severity requirements of a listing, we consider whether his or her impairment functionally equals the listings. This means that the impairment results in “marked” limitations in two out of six domains of functioning or an “extreme” limitation in one of the six domains.[24] We will evaluate an individual's symptoms at this step when we rate how a child's impairment-related symptoms affect his or her ability to function independently, appropriately, and effectively in an age-appropriate manner in each functional domain. If a child's impairment functionally equals a listing, we find him or her disabled. If a child's impairment does not functionally equal the listings, we find him or her not disabled. For a child with a title XVI disability claim, the sequential evaluation process ends at this step.

If the individual's impairment does not meet or equal a listing, we will assess and make a finding about an individual's residual functional capacity based on all the relevant medical and other evidence in the individual's case record. An individual's residual functional capacity is the most the individual can still do despite his or her impairment-related limitations. We consider the individual's symptoms when determining his or her residual functional capacity and the extent to which the individual's impairment-related symptoms are consistent with the evidence in the record.[25]

After establishing the residual functional capacity, we determine whether an individual is able to do any past relevant work. At step 4, we compare the individual's residual functional capacity with the requirements of his or her past relevant work. If the individual's residual functional capacity is consistent with the demands of any of his or her past relevant work, either as the individual performed it or as the occupation is generally performed in the national economy, then we will find the individual not disabled. If none of the individual's past relevant work is within his or her residual functional capacity, we proceed to step 5 of the sequential evaluation process.

At step 5 of the sequential evaluation process, we determine whether the individual is able to adjust to other work that exists in significant numbers in the national economy. We consider the same residual functional capacity, together with the individual's age, education, and past work experience. If the individual is able to adjust to other work that exists in significant numbers in the national economy, we will find him or her not disabled. If the individual cannot adjust to other work that exists in significant numbers in the national economy, we find him or her disabled. At step 5 of the sequential evaluation process, we will not consider an individual's symptoms any further because we considered the individual's symptoms when we determined the individual's residual functional capacity.

EFFECTIVE DATE: This SSR is effective on March 28, 2016

CROSS-REFERENCES: SSR 96-3p, “Titles II and XVI: Considering Allegations of Pain and Other Symptoms in Determining Whether a Medically Determinable Impairment is Severe,” SSR 96-8p, “Titles II and XVI: Assessing Residual Functional Capacity in Initial Claims,” SSR 96-6p, “Titles II and XVI: Consideration of Administrative Findings of Fact by State Agency Medical and Psychological Consultants and Other Program Physicians and Psychologists at the Administrative Law Judge and Appeals Council Levels of Administrative Review; Medical Equivalence;” and Program Operations Manual System, sections DI 24515.061 and DI 24515.064.

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[1] ACUS made several recommendations in its March 12, 2015 final report, “Evaluating Subjective Symptoms in Disability Claims.” Among other things, ACUS recommended we consider amending SSR 96-7p to clarify that subjective symptom evaluation is not an examination of an individual's character, but rather is an evidence-based analysis of the administrative record to determine whether the nature, intensity, frequency, or severity of an individual's symptoms impact his or her ability to work. In any revised SSR, ACUS also recommended we more closely follow our regulatory language about symptom evaluation, which does not use the term “credibility” and instead directs adjudicators to consider medical and other evidence to evaluate the intensity and persistence of symptoms to determine how the individual's symptoms limit capacity for work if he or she is an adult, or for a child with a title XVI disability claim, how symptoms limit ability to function. ACUS further recommended when revising SSR 96-7p, we offer additional guidance to adjudicators on regulatory implementation problems that have been identified since we published SSR 96-7p.

[2] See 20 CFR 404.1528(a) and 416.928(a) for how our regulations define symptoms.

[3] See 20 CFR 404.1529 and 416.929 for how we evaluate statements of symptoms.

[4] See 20 CFR 404.1528(b) and 416.928(b) for how our regulations define signs.

[5] See 20 CFR 404.1528(c) and 416.928(c) for how our regulations define laboratory findings.

[6] See 20 CFR 404.1513(a) and 416.913(a) for a list of acceptable medical sources.

[7] See 20 CFR 404.1508 and 416.908 for what is needed to show a medically determinable impairment.

[8] By “complete medical history,” we mean the individual's complete medical history for at least the 12 months preceding the month in which he or she filed an application, unless there is a reason to believe that development of an earlier period is necessary or the individual says that his or her alleged disability began less than 12 months before he or she filed an application. 20 CFR 404.1512(d) and 416.912(d).

[9] See 20 CFR 404.1529(c)(2) and 416.929(c)(2).

[10] See 20 CFR 404.1529(c)(2) and 416.929(c)(2).

[11] See 20 CFR 404.1529 and 416.929.

[12] See 20 CFR 404.1513 and 416.913.

[13] See 20 CFR 404.1529(c)(3) and 416.929(c)(3)

[14] See 20 CFR 416.928(a).

[15] See 20 CFR 404.1527 and 416.927.

[16] See 20 CFR 404.1529(c)(4) and 416.929(c)(4).

[17] See 20 CFR 404.1529(c) and 416.929(c).

[18] See 20 CFR 404.1520 and 416.920. For continuing disability, see 404.1594, 416.994 and 416.994a.

[19] See 20 CFR 404.1520(a)(4)(ii) and 416.920(a)(4)(ii).

[20] See 20 CFR 416.924(c).

[21] See 20 CFR 416.920(c) for adults and 416.924(c) for children.

[22] See 20 CFR 404.1529(d)(2) and 416.929(d)(2).

[23] See 20 CFR 404.1529(d)(3) and 416.929(d)(3).

[24] See 20 CFR 416.926a.

[25] See 20 CFR 404.1545 and 416.945.

IV.F.3. Evaluation of Symptoms - Desk Guide

EVALUATING SYMPTOMS – DESK GUIDE

SSR 16-3p and 20 CFR 404.1529 and 416.929

Mandated TWO-STEP Process for Evaluating Symptoms		
Step	**Conclusion**	**Next Action**
STEP ONE: *Is there a medically determinable impairment (MDI) that could reasonably cause the claimant's alleged symptoms?*	**Yes**	Proceed to Step Two
	No	Do not evaluate any symptom that you cannot reasonably attribute to the claimant's MDI(s) at any step of sequential evaluation.
STEP TWO: Evaluate the intensity and persistence of those symptoms to determine the extent to which the symptoms limit the claimant's ability to perform work-related activities for an adult or to function independently, appropriately, and effectively in an age-appropriate manner for a child with a title XVI disability claim. ***Are the symptoms consistent with the objective medical evidence alone?***	**Yes**	No further symptom evaluation is necessary. If alleged symptoms and resulting limitations are consistent with the objective medical evidence, the claimant's alleged limitations incorporate the alleged symptoms and resulting limitations into the RFC.
	No	Evaluate the consistency of the claimant's alleged symptoms with all of the evidence in the case file. Consider the symptom evaluation factors that are pertinent to the claimant's case.

FACTORS CONSIDERED IN A SYMPTOMS EVALUATION
Consider all of the evidence to evaluate the intensity, persistence, and limiting effects of an individual's symptoms. Consider each of the following factors if relevant to the claim: • *Daily activities;* • *The location, duration, frequency, and intensity of pain or other symptoms;*

- *Factors that precipitate and aggravate the symptoms;*
- *The type, dosage, effectiveness, and side effects of any medication an individual takes or has taken to alleviate pain or other symptoms;*
- *Treatment, other than medication, an individual receives or has received for relief of pain or other symptoms;*
- *Any measures other than treatment an individual uses or has used to relieve pain or other symptoms (e.g., lying flat on his or her back, standing for 15 to 20 minutes every hour, or sleeping on a board): and*
- *Any other factors concerning an individual's functional limitations and restrictions due to pain or other symptoms.*

General Guidelines for Evaluating Symptoms

- A symptom evaluation may be necessary at step 2 of sequential evaluation if the claimant has an MDI, but the objective medical evidence does not support a severe impairment, while the claimant's MDI-related alleged symptoms and resulting limitations suggest his or her impairment is severe.
- A symptom evaluation may be necessary at step 3 of sequential evaluation if the listing(s) under consideration includes symptoms.
- A symptom evaluation may be necessary when assessing an RFC if the claimant's symptoms and resulting limitations can reasonably be linked to an MDI and his or her alleged symptoms and resulting limitations are NOT consistent with the objective medical evidence alone. If the claimant's MDI-related symptoms and resulting limitations are consistent with the objective medical evidence, incorporate the symptom-related limitations into the RFC.
- We will never find a claimant disabled based on his or her alleged symptoms alone.
- We will never find a claimant not disabled because his or her symptoms are not consistent with the objective medical evidence without evaluating the claimant's symptoms based on all of the evidence in the file and a consideration of the factors in 20 CFR 404.1529(c)(3) and 416.929(c)(3) that are relevant to the case.
- If any of the claimant's alleged symptoms and resulting limitations are consistent with the objective medical evidence alone, or are found consistent with all of the evidence in the case file after a symptoms evaluation, and we are assessing an RFC, the RFC will include any of the claimant's alleged limitations that are consistent with the objective medical evidence alone, or are found consistent with all of the evidence in the case file after a symptoms evaluation.
- We will consider a claimant's persistent attempts to obtain relief of symptoms such as increasing dosages and changing medications, trying a variety of treatments, referrals to specialists, or changing treatment sources to be an indication that the symptoms are a source of distress and are intense and persistent.
- If the frequency or extent of the treatment sought by a claimant is not comparable with the degree of claimant's alleged symptoms, we will not find his or her symptoms inconsistent with the evidence in file without considering possible reasons he or she may not have sought treatment in a manner consistent with his or her alleged symptoms.
- A symptom evaluation may be necessary at step 2 of sequential evaluation if the claimant has an MDI, but the objective medical evidence does not support a severe impairment, while the claimant's MDI-related alleged symptoms and resulting limitations suggest his or her impairment is severe.

- A symptom evaluation may be necessary at step 3 of sequential evaluation if the listing(s) under consideration includes symptoms.
- A symptom evaluation may be necessary when assessing an RFC if the claimant's symptoms and resulting limitations can reasonably be linked to an MDI and his or her alleged symptoms and resulting limitations are NOT consistent with the objective medical evidence alone. If the claimant's MDI-related symptoms and resulting limitations are consistent with the objective medical evidence, incorporate the symptom-related limitations into the RFC.
- We will never find a claimant disabled based on his or her alleged symptoms alone.
- We will never find a claimant not disabled because his or her symptoms are not consistent with the objective medical evidence without evaluating the claimant's symptoms based on all of the evidence in the file and a consideration of the factors in 20 CFR 404.1529(c)(3) and 416.929(c)(3) that are relevant to the case.
- If any of the claimant's alleged symptoms and resulting limitations are consistent with the objective medical evidence alone, or are found consistent with all of the evidence in the case file after a symptoms evaluation, and we are assessing an RFC, the RFC will include any of the claimant's alleged limitations that are consistent with the objective medical evidence alone, or are found consistent with all of the evidence in the case file after a symptoms evaluation.
- We will consider a claimant's persistent attempts to obtain relief of symptoms such as increasing dosages and changing medications, trying a variety of treatments, referrals to specialists, or changing treatment sources to be an indication that the symptoms are a source of distress and are intense and persistent.
- If the frequency or extent of the treatment sought by a claimant is not comparable with the degree of claimant's alleged symptoms, we will not find his or her symptoms inconsistent with the evidence in file without considering possible reasons he or she may not have sought treatment in a manner consistent with his or her alleged symptoms.

IV.F.4. Adjudication Tip #52 – Evaluating the Functional Limitations of Pain

#52

We all know that symptoms such as pain may be found to affect an individual's ability to do basic work activities if there is a medically determinable impairment that could reasonably be expected to produce the alleged symptoms. But did you know that an individual's symptoms, including pain, can cause limitations or restrictions that are classified as exertional, nonexertional, or a combination of both (see 20 CFR 404.1569a, 416.969a, and SSR 96-4p)?

For example, pain caused by a physical impairment can cause nonexertional limitations including manipulative limitations (e.g., reaching, handling) and/or mental limitations (e.g., understanding and remembering instructions). Similarly, although mental impairments usually affect only nonexertional functions, they might also limit exertional capacity. For example, a mental impairment might cause pain, fatigue or hysterical paralysis with resulting difficulty walking or standing. Therefore, symptoms including pain, are not intrinsically exertional or nonexertional; it is the functional limitations that a symptom causes that can be exertional, nonexertional, or both (SSR 96-4p).

As with other findings in the decision, the residual functional capacity (RFC) assessment must include a narrative discussion describing how the evidence supports each conclusion. While pain can lead to mental limitations, these limitations must always be clearly established by the evidence and explained thoroughly in the decision. Without this documented explanation, key findings, including the inability to perform skilled past relevant work, no transferable skills, or erosion of the occupational base, may not be supported by substantial evidence. We must look to the record for corroborating evidence (e.g., medication side effects, clinical observations, daily activities, opinion evidence, claimant's statements, third party statements, and all other relevant evidence). Ultimately, the decision must clearly articulate the rationale and make the direct link between the impairment (e.g., degenerative disc disease), the symptom (e.g., pain), and the RFC. The key is comprehensive, clear, and consistent articulation.

For additional information, see Social Security Rulings 96-3p, 96-4p, 96-7p, 96-8p, 03-01p, and 03-02p; Appeals Council Feedback Training: Symptom Evaluation, and Appeals Council Feedback Training: Evaluating Allegations of Mental Impairments.

IV.F.5. MENTAL IMPAIRMENTS

IV.F.5.a. 12.00 Mental Disorders -- Adult

https://www.ssa.gov/disability/professionals/bluebook/12.00-MentalDisorders-Adult.htm

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IV.F.5.b. 112.00 Mental Disorders -- Childhood

https://www.ssa.gov/disability/professionals/bluebook/112.00-MentalDisorders-Childhood.htm

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IV.F.5.b. Titles IIAND XVI: CAPACITY TO SO OTHER WORK – THE MEDICAL-VOCATIONAL RULES AS A FRAMEWORK FOR EVALUATING SOLELY NONEXERTIONAL IMPAIRMENTS: SSR 85-15

SSR 85-15

This supersedes Program Policy Statement No. 116 (SSR 85-7) with the same title (which superseded Program Policy Statement No. 104 (SSR 83-13) and is in accord with an order of the U.S. District Court for the District of Minnesota.

PURPOSE:

The original purpose of SSR 83-13 was to clarify how the regulations and the exertionally based numbered decisional rules in Appendix 2, Subpart P, Regulations No. 4, provide a framework for decisions concerning persons who have only a nonexertional limitation(s) of function or an environmental restriction(s). The purpose of this revision to SSR 83-13 and SSR 85-7 is to emphasize, in the sections relating to mental impairments: (1) that the potential job base for mentally ill claimants without adverse vocational factors is not necessarily large even for individuals who have no other impairments, unless their remaining mental capacities are sufficient to meet the intellectual and emotional demands of at least unskilled, competitive, remunerative work on a sustained basis; and (2) that a finding of disability can be appropriate for an individual who has a severe mental impairment which does not meet or equal the Listing of Impairments, even where he or she does not have adversities in age, education, or work experience.

CITATIONS (AUTHORITY):

Sections 223(d)(2)(A) and 1614(a)(3)(E) of the Social Security Act; Regulations No. 4, Subpart P, sections 404.1505(a), 404.1520(f)(1), 404.1521(b), 404.1545. and 404.1560 through 404.1569; Appendix 2 of Subpart P, sections 200.00(c), 200.00(e)(1), and 204.00; and Regulations No. 16, Subpart 1, sections 416.905(a), 416.920(f)(1), 416,921(b), 416.945, and 416.960 through 416.969.

PERTINENT HISTORY:

If a person has a severe medically determinable impairment which, though not meeting or equaling the criteria in the Listing of Impairments, prevents the person from doing past relevant work, it must be determined whether the person can do other work. This involves consideration of the person's RFC and the vocational factors of age, education, and work experience.

The Medical-Vocational Guidelines (Regulations No. 4, Subpart P, Appendix 2) discuss the relative adjudicative weights which are assigned to a person's age, education, and work experience. Three tables in Appendix 2 illustrate the interaction of these vocational factors with his or her RFC. RFC is expressed in terms of sedentary, light, and medium work exertion. The tables rules reflect the potential occupational base of unskilled jobs for individuals who have severe impairments which limit their exertional capacities: approximately 2,500 medium, light, and sedentary occupations; 1,600 light and sedentary occupations; and 200 sedentary occupations — each occupation representing numerous jobs in the national economy. (See the text and glossary in SSR 83-10, PPS-101, Determining Capability to Do Other Work — the Medical-Vocational Rules of Appendix 2.) Where individuals also have nonexertional limitations of function or environmental restrictions, the table rules provide a framework for consideration of how much the individual's work capability is further diminished in terms of any types of jobs within these exertional ranges with would be contraindicated by the additional limitations or restrictions. However, where a person has solely a nonexertional impairment(s), the tables rules do not direct conclusions of disabled or not disabled.

Conclusions must, instead, be based on the principles in the appropriate sections of the regulations, giving consideration to the rules for specific case situations in Appendix 2.

This PPS clarifies policies applicable in cases involving the evaluation of solely nonexertional impairments.

POLICY STATEMENT:

Given that no medically determinable impairment limits exertion, the RFC reflecting the severity of the particular nonexertional impairment(s) with its limiting effects on the broad world of work is the first issue. The individual's relative advantages or adversities in terms of age, education, and work experience is the second. Section 204.00 of Appendix 2 provides an example of one type of nonexertional impairment — environmental restrictions — and states that environmental restrictions ordinarily would not significantly affect the range of work existing in the national economy for individuals with the physical capability for heavy work (or very heavy work); i.e., with no medically determinable impairment which limits exertion. However, numerous environmental restrictions might lead to a different conclusion, as might one or more severe losses of nonexertional functional capacities. The medical and vocational factors of the individual case determine whether exclusion of particular occupation or kinds of work so reduces the person's vocational opportunity that a work adjustment could not be made.

Nonexertional Impairments Contrasted with Exertional Impairments

The term "exertional" has the same meaning in the regulations as it has in the U.S. Department of Labor's classifications of occupations by strength levels. (See SSR 83-10, PPS-101, Determining Capability to Do Other Work — The Medical-Vocational Rules of Appendix 2.) Any job requirement which is not exertional is considered to be nonexertional. A nonexertional impairment is one which is medically determinable and causes a nonexertional limitation of function or an environmental restriction. Nonexertional impairments may or may not affect a person's capacity to carry out the primary strength requirements of jobs, and they may or may not significantly narrow the range of work a person can do.

Nonexertional limitations can affect the abilities to reach; to seize, hold, grasp, or turn an object (handle); to bend the legs alone (kneel); to bend the spine alone (stoop) or bend both the spine and legs (crouch). Fine movements of small objects, such as done in much sedentary work and in certain types of more demanding work (e.g., surgery), require use of the fingers to pick, pinch, etc. Impairments of vision, speech, and hearing are nonexertional. Mental impairments are generally considered to be nonexertional, but depressions and conversion disorders may limit exertion. Although some impairments may cause both exertional limitations and environmental restriction (e.g., a respiratory impairment may limit a person to light work exertion as well as contraindicate exposure to excessive dust or fumes), other impairments may result in only environmental restrictions (e.g., skin allergies may only contraindicate contact with certain liquids).

What is a nonexertional and extremely rare factor in one range of work (e.g., crawling in sedentary work) may become an important element in arduous work like coal mining.

Where a person's exertional capacity is compromised by a nonexertional impairment(s), see SSR 83-14, PPS-105, Capability to Do Other Work — The Medical-Vocational Rules as a Framework for Evaluating a Combination of Exertional and Nonexertional Impairments.

Jobs which can possibly be performed by persons with solely nonexertional impairments are not limited to the approximately 2,500 unskilled sedentary, light and medium occupations which pertain to the table rules in Appendix 2. The occupational base cuts across exertional categories through heavy (and very heavy) work and will include occupations above the unskilled level if a person has skills transferable to skilled and semiskilled occupations within his or her RFC. (Note the examples in item 4.b of SSR 82-41, PPS-67, Work Skills and Their Transferability as Intended by the Expanded Vocational Factors Regulations effective February 26, 1979, where medical factors prevent not only the performance of past work but also the transferability of skills.)

Given no medically determinable impairment which limits exertion, the first issue is how much the person's occupational base — the entire exertional span from sedentary work through heavy (or very heavy) work — is reduced by the effects of the nonexertional impairment(s). This may range from very little to very much, depending on the nature and extent of the impairment(s). In many cases, a decisionmaker will need to consult a vocational resource.

The publications listed in sections 404.1566 and 416.966 of the regulations will be sufficient vocational resources for relatively simple issues. In more complex cases, a person or persons with specialized knowledge would be helpful. State agencies may use personnel termed vocational consultants or specialist, or they may purchase the services of vocational evaluation workshops. Vocational experts may testify for this purpose at the hearing and appeals levels. In this PPS, the term vocational specialist (VS) describes all vocational resource personnel.

The second issue is whether the person can be expected to make a vocational adjustment considering the interaction of his or her remaining occupational base with his or her age, education, and work experience. A decisionmaker must consider sections 404.1562-404.1568 and 416.962-416.968 of the regulations, section 204.00 of Appendix 2, and the table rules for specific case situations in Appendix 2. If, despite the nonexertional impairment(s), an individual has a large potential occupational base, he or she would ordinarily not be found disabled in the absence of extreme adversities in age, education, and work experience. (This principle is illustrated in rule 203.01, 203.02, and 203.10 and is set out in SSR 82-63, PPS-79, Medical-Vocational Profiles Showing an Inability to Make an Adjustment to Other Work.) The assistance of a vocational resource may be helpful. Whenever vocational resources are used and in the decision is adverse to the claimant, the determination or decision will include: (1) citations of examples of occupation/jobs the person can do functionally and vocationally, and (2) a statement of

the incidence of such work in the region in which the individual resides or in several regions of the country.

Examples of Nonexertional Impairments and Their Effects on the Occupational Base

1. *Mental Impairments*

There has been some misunderstanding in the evaluation of mental impairments. Unless the claimant or beneficiary is a widow, widower, surviving divorced spouse or a disabled child under the Supplemental Security Income program, the sequential evaluation process mandated by the regulations does not end with the finding that the impairment, though severe, does not meet or equal an impairment listed in Appendix 1 of the regulations. The process must go on to consider whether the individual can meet the mental demands of past relevant work in spite of the limiting effects of his or her impairment and, if not, whether the person can do other work, consideration his or her remaining mental capacities reflected in terms of the occupational base, age, education, and work experience. The decisionmaker must not assume that failure to meet or equal a listed mental impairment equates with capacity to do at least unskilled work. The decision requires careful consideration of the assessment of RFC.

In the world of work, losses of intellectual and emotional capacities are generally more serious when the job is complex. Mental impairments may or may not prevent the performance of a person's past jobs. They may or may not prevent an individual from transferring work skills. (See SSR 82-41, PPS-67, Work Skills and Their Transferability as Intended by the Expanded Vocational Factors Regulations effective February 26, 1979.)

Where a person's only impairment is mental, is not of listing severity, but does prevent the person from meeting the mental demands of past relevant work and prevents the transferability of acquired work skills, the final consideration is whether the person can be expected to perform unskilled work. The basic mental demands of competitive, remunerative, unskilled work include the abilities (on a sustained basis) to understand, carry out, and remember simple instructions; to respond appropriately to supervision, coworkers, and usual work situations; and to deal with changes in a routine work setting. A substantial loss of ability to meet any of these basic work-related activities would severely limit the potential occupational base. This, in turn, would justify a finding of disability because even favorable age, education, or work experience will not offset such a severely limited occupational base.

> Example 1: A person whose vocational factors of age, education, and work experience would ordinarily be considered favorable (i.e., very young age, university education, and highly skilled work experience) would have severely limited occupational base if he or she has a mental impairment which causes a substantial loss of ability to respond appropriately to supervision, coworkers, and usual work situations. A finding of disability would be appropriate.

Where there is no exertional impairment, unskilled jobs at all levels of exertion constitute the potential occupational base for persons who can meet the mental demands of unskilled work. These jobs ordinarily involve dealing primarily with objects, rather than with data or people, and they generally provide substantial vocational opportunity for person with solely mental impairments who retain the capacity to meet the intellectual and emotional demands of such jobs on a sustained basis. However, persons with this large job base may be found disabled because of adversities in age, education, and work experience. (This is illustrated in examples 2 and 3 immediately following.)

> Example 2: Someone who is of advanced age, has a limited education, has no relevant work experience, and has more than a non severe mental impairment will generally be found disabled. (See SSR 82-63, PPS-79, Medical-Vocational Profiles Showing an Inability to Make an Adjustment to Other Work.)
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> Example 3: Someone who is closely approaching retirement age, has a limited education or less, worked for 30 years in a cafeteria doing an unskilled job as a "server," almost constantly dealing with the public, and now cannot, because of a severe mental impairment, frequently deal with the public. In light of the narrowed vocational opportunity in conjunction with the person's age, education, lack of skills, and long commitment to the particular type of work, a finding of disabled would be appropriate; but the decision would not necessarily be the same for a younger, better-educated, or skilled person. (Compare sections 404.1562 and 416.962 of the regulations and rule 203.01 of Appendix 2.)

Where a person has only a mental impairment but does not have extreme adversities in age, education, and work experience, and does not lack the capacity to do basic work-related activities, the potential occupational base would be reduced by his or her inability to perform certain complexities or particular kinds of work. These limitations would affect the occupational base in various ways.

> Example 4: Someone who is of advance age, has a high school education, and did skilled work as manager of a housing project can no longer, because of a severe mental impairment, develop and implement plans and procedures, prepare budget requests, schedule repairs or otherwise deal with complexities of this level and nature. Assuming that, in this case, all types of related skilled jobs are precluded but the individual can do work which is not detailed and does not require lengthy planning, the remaining related semiskilled jobs to which skills can be transferred and varied unskilled jobs, at all levels of exertion, constitute a significant vocational opportunity. A conclusion of "not disabled" would be appropriate. (Compare rules 201.07, 202.07, and 203.13 of Appendix 2.)
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> Example 5: Someone who is of advanced age, has a limited education, and did semiskilled work as a first-aid attendant no longer has the mental capacity to work with

people who are in emergency situations and require immediate attention to cuts, burns, suffocation, etc. Although there may be very few related semiskilled occupations to which this person could transfer work skills, the large occupational base of unskilled work at all levels of exertion generally would justify a finding of not under a disability. (This is consistent with rules 203.11-203.17 of Appendix 2.)

Stress and Mental Illness — Since mental illness is defined and characterized by maladaptive behavior, it is not unusual that the mentally impaired have difficulty accommodating to the demands of work and work-like settings. Determining whether these individuals will be able to adapt to the demands or "stress" of the workplace is often extremely difficult. This section is not intended to set out any presumptive limitations for disorders, but to emphasize the importance of thoroughness in evaluation on an individualized basis.

Individuals with mental disorders often adopt a highly restricted and/or inflexible lifestyle within which they appear to function well. Good mental health services and care may enable chronic patients to function adequately in the community by lowering psychological pressures, by medication, and by support from services such as outpatient facilities, day care programs, social work programs and similar assistance.

The reaction to the demands of work (stress) is highly individualized, and mental illness is characterized by adverse responses to seemingly trivial circumstances. The mentally impaired may cease to function effectively when facing such demands as getting to work regularly, having their performance supervised, and remaining in the workplace for a full day. A person may become panicked and develop palpitations, shortness of breath, or feel faint while riding in an elevator; another may experience terror and begin to hallucinate when approached by a stranger asking a question. Thus, the mentally impaired may have difficulty meeting the requirement of even so-called "low stress" jobs.

Because response to the demands of work is highly individualized, the skill level of a position is not necessarily related to the difficulty an individual will have in meeting the demands of the job. A claimant's condition may make performance of an unskilled job as difficult as an objectively more demanding job, for example, a busboy need only clear dishes from tables. But an individual with a severe mental disorder may find unmanageable the demand of making sure that he removes all the dishes, does not drop them, and gets the table cleared promptly for the waiter or waitress. Similarly, an individual who cannot tolerate being supervised may be not able to work even in the absence of close supervision; the *knowledge* that one's work is being judged and evaluated, even when the supervision is remote or indirect, can be intolerated for some mentally impaired persons. Any impairment-related limitations created by an individual's response to demands of work, however, must be reflected in the RFC assessment.

2. Postural-Manipulative Impairments

a. Limitations in *climbing and balancing* can have varying effects on the occupational base, depending on the degree of limitation and the type of job. Usual everyday activities, both at home and at work, include ascending or descending ramps or a few stairs and maintaining body equilibrium while doing so. These activities are required more in some jobs that in others, and they may be critical in some occupations. Where a person has some limitation in climbing and balancing and it is the only limitation, it would not ordinarily have a significant impact on the broad world of work. Certain occupations, however, may be ruled out; e.g., the light occupation of construction painter, which requires climbing ladders and scaffolding, and the very heavy occupation of fire-fighter, which sometimes requires the individual to climb poles and ropes. Where the effects of a person's actual limitations of climbing and balancing on the occupational base are difficult to determine, the services of a VS may be necessary.

b. *Stooping, kneeling, crouching, and crawling*are progressively more strenuous forms of bending parts of the body, with crawling as a form of locomotion involving bending. Some stooping (bending the body downward and forward by bending the spine at the waist) is required to do almost any kind of work,, particularly when objects below the waist are involved. If a person can stoop occasionally (from very little up to one-third of the time) in order to lift objects, the sedentary and light occupational base is virtually intact. However, because of the lifting require for most medium, heavy, and very heavy jobs, a person must be able to stoop frequently (from one-third to two-thirds of the time); inability to do so would substantially affect the more strenuous portion of the occupational base. This is also true for crouching (bending the body downward and forward by bending both the legs and spine). However, crawling on hands and knees and feet is a relatively rare activity even in arduous work, and limitations on the ability to crawl would be of little significance in the broad world or work. This is also true of kneeling (bending the legs at the knees to come to rest on one or both knees).

c. *Reaching, handling, fingering, and feeling* require progressively finer usage of the upper extremities to perform work-related activities. Reaching (extending the hands and arms in any direction) and handling (seizing, holding, grasping, turning or otherwise working primarily with the whole hand or hands) are activities required in almost all jobs. Significant limitations of reaching or handling, therefore, may eliminate a large number of occupations a person could otherwise do. Varying degrees of limitations would have different effects, and the assistance of a VS may be needed to determine the effects of the limitations. "Fingering" involves picking, pinching, or otherwise working primarily with the fingers. It is needed to perform most unskilled sedentary jobs and to perform certain skilled and semiskilled jobs at all levels of exertion. As a general rule, limitations of fine manual dexterity have greater adjudicative significance — in terms of relative number of jobs in which the function is required — as the person's exertional RFC decreases. Thus, loss of fine manual dexterity narrows the sedentary and light ranges of work much more than it does the medium, heavy, and very heavy ranges of work. The varying degrees of loss which can occur may require a decisionmaker to have the assistance of a VS. However, a VS would not ordinarily be required where a

person has a loss of ability to feel the size, shape temperature, or texture of an object by the fingertips, since this is a function required in very few jobs.

3. *Hearing Impairments*

Communication is an important factor in work. The inability to hear, because it vitally affects communication, is thus of great importance. However, hearing impairments do not necessarily prevent communication, and differences in types of work may be compatible with various degrees of hearing loss. Occupations involving loud noise, such as in printing, have traditionally attracted persons with hearing impairments, whereas individuals with normal hearing have to wear ear protectors to be able to tolerate the working conditions. On the other hand, occupations such as bus driver require good hearing. There are so many possible medical variables of hearing loss that consultation of vocational reference materials or the assistance of a VS is often necessary to decide the effect on the broad world of work.

4. *Visual Impairment*

As a general rule, even if a person's visual impairment(s) were to eliminate all jobs that involve very good vision (such as working with small objects or reading small print), as long as he or she retains sufficient visual acuity to be able to handle and work with rather large objects (and has the visual fields to avoid ordinary hazards in a workplace), there would be a substantial number of jobs remaining across all exertional levels. However, a finding of disability could be appropriate in the relatively few instances in which the claimant's vocational profile is extremely adverse, e.g., closely approaching retirement age, limited education or less, unskilled or no transferable skills, and essentially a lifetime commitment to a field of work in which good vision is essential.

5. *Environmental Restriction*

A person may have the physical and mental capacity to perform certain functions in certain places, but to do so may aggravate his or her impairment(s) or subject the individual or others to the risk of bodily injury. Surroundings which an individual may need to avoid because of impairment include those involving extremes of temperature, noise, and vibration; recognized hazards such as unprotected elevations and dangerous moving machinery; and fumes, dust, and poor ventilation. A person with a seizure disorder who is restricted only from being on unprotected elevations and near dangerous moving machinery is an example of someone whose environmental restriction does not have a significant effect on work that exist at all exertional levels.

Where a person has a medical restriction to avoid excessive amounts of noise, dust, etc., the impact on the broad world of work would be minimal because most job environments do not involve great noise, amounts of dust, etc.

Where an individual can tolerate very little noise, dust, etc., the impact on the ability to work would be considerable because very few job environments are entirely free of irritants, pollutants, and other potentially damaging conditions.

Where the environmental restriction falls between very little and excessive, resolution of the issue will generally require consultation of occupational reference materials or the services of a VS.

EFFECTIVE DATE:

Final regulations providing the Medical-Vocational Guidelines were published in the *Federal Register* on November 28, 1978, at FR 55349, effective February 26, 1979. They were rewritten to make them easier to understand and were published on August 20, 1980, at 45 FR 55566. The policies in this PPS also became effective as of February 26, 1979.

CROSS-REFERENCES:

Program Operations Manual System, Part 4 (Disability Insurance State Manual Procedures) sections DI 00401.691 and 00401.694; SSR 83-10, PPS-101, Determining Capability to Do Other Work — The Medical-Vocational Rules of Appendix 2 (with a glossary); SSR 83-11, PPS-102, Capability to Do Other Work — The Exertionally Based Medical-Vocational Rules Met; SSR 83-12, PPS-103, Capability to Do Other Work — The Medical-Vocational Rules as a Framework for Evaluating Exertional Limitations Within a Range of Work or Between Ranges of Work or Between Ranges of Work; and SSR 83-14, PPS-105, Capability to Do Other Work — The Medical-Vocational Rules as a Framework for Evaluating a Combination of Exertional and Nonexertional Impairments.

IV.F.5.c. TITLES II AND XVI: RESIDUAL FUNCTIONAL CAPACITY FOR MENTAL IMPAIRMENTS: SSR 85-16

SSR 85-16

This supersedes Program Policy Statement (PPS) No. 117 (Social Security Ruling (SSR) 85-8), Titles II and XVI: Residual Functional Capacity (RFC) for Mental Impairments (which superseded PPS No. 97 (SSR 83-16) with the same title).

PURPOSE:

To state the policy and describe the issues to be considered when an individual with a mental impairment requires an assessment of the residual functional capacity (RFC) in order to determine the individual's capacity to engage in basic work-related activities.

CITATIONS (AUTHORITY):
Sections 223(d), 216(i) and 1614(a) of the Social Security Act, as amended; Regulations No. 4, Subpart P, sections 404.1545, 404.1546, and Appendix 1, Part A, section 12.00, and Regulations No. 16, Subpart I, sections 416.945, 416.946.

INTRODUCTION:
An individual whose impairment(s) meets, or is medically equivalent to, the requirements of an impairment(s) contained in the Listing of Impairments is considered unable to function adequately in work-related activities. On the other hand, an individual whose impairment is found to be not severe is considered not to be significantly restricted in the ability to engage in basic work-related activities. An individual whose impairment(s) falls between these two levels has a significant restriction in the ability to engage in some basic work-related activities. It is, therefore, necessary to determine the RFC for these individuals. This policy statement provides guides for the determination of RFC for individuals whose mental impairment(s) does not meet or equal the listing, but is more than not severe.

POLICY STATEMENT:

Importance of RFC Assessments in Mental Disorders

Medically determinable mental disorders present a variable continuum of symptoms and effects, from minor emotional problems to bizarre and dangerous behavior. However, in determining the impact of a mental disorder on an individual's capacities, essentially the same impairment-related medical and nonmedical information is considered to determine whether the mental disorder meets listing severity as is considered to determine whether the mental impairment is of lesser severity, yet diminishes the individual's RFC. For impairments of listing severity, inability to perform substantial gainful activity (SGA) is presumed from prescribed findings. However, with mental impairments of lesser severity, such inability must be demonstrated through a detailed assessment of the individual's capacity to perform and sustain mental activities which are critical to work performance. Conclusions of ability to engage in SGA are not to be inferred merely from the fact that the mental disorder is not of listing severity.

Regulations No. 4, section 404.1545(c)/416.945(c), presents the broad issues to be considered in the evaluation of RFC in mental disorders. It states that this evaluation includes consideration of the ability to understand, to carry out and remember instructions and to respond appropriately to supervision, coworkers, and customary work pressures in a work setting. Consideration of these factors, which are contained in section 12.00 of the Listing of Impairments in Appendix 1, is required for the proper evaluation of the severity of mental impairments.

The determination of mental RFC involves the consideration of evidence, such as:

- History, findings, and observations from medical sources (including psychological test results), regarding the presence, frequency, and intensity of hallucinations, delusions or

paranoid tendencies; depression or elation; confusion or disorientation; conversion symptoms or phobias; psychophysiological symptoms, withdrawn or bizarre behavior; anxiety or tension.

- Reports of the individual's activities of daily living and work activity, as well as testimony of third parties about the individual's performance and behavior.
- Reports from workshops, group homes, or similar assistive entities.

In analyzing the evidence, it is necessary to draw meaningful inferences and allow reasonable conclusions about the individual's strengths and weaknesses. Consideration should be given to factors such as:

- Quality of daily activities, both in occupational and social spheres (see Listing 12.00, Introduction), as well as of the individual's actions with respect to a medical examination.
- Ability to sustain activities, interests, and relate to others *over a period of time*. The frequency, appropriateness, and independence of the activities must also be considered (see PPS No. 96, SSR 83-15, Titles II and XVI: Evaluation of Chronic Mental Impairments).
- Level of intellectual functioning.
- Ability to function in a work-like situation.

When a case involves an individual (except disabled widow(ers) and title XVI children under 18) who has a severe impairment(s), which does not meet or equal the criteria in the Listing of Impairments, the individual's RFC must be considered in conjunction with the individual's age, education, and work experience. While some individuals will have a significant restriction of the ability to perform some work-related activities, not all such activities will be precluded by the mental impairment. However, all limits on work-related activities resulting from the mental impairment must be described in the mental RFC assessment.

It is the responsibility of the program physician or psychologist, the disability hearing officer (DHO), the administrative law judge (ALJ), or the Appeals Council (AC) member to identify the pertinent evidence from medical and nonmedical reports and to make findings as to the individual's ability to perform work-related activities (RFC). The determination of impairment severity and the resulting RFC constitute the medical evaluation of the mental disorder. The determination of "disability," however, depends upon the extent to which the individual has the vocational qualifications to perform work, in light of the restrictions described in the RFC assessment.

Evaluation of Medical and Other Evidence

Medical evidence is critical to determinations of disability. It provides medical history, test results, examination findings, and observations, as well as conclusions of medical

sources trained and knowledgeable in the diagnosis and treatment of diseases and disorders.

Reports from psychiatrists and other physicians, psychologists, and other professionals working in the field of mental health should contain the individual's medical history, mental status evaluation, psychological testing, diagnosis, treatment prescribed and response, prognosis, a description of the individual's daily activities, and a medical assessment describing ability to do work-related activities. These reports may also contain other observations and opinions or conclusions on such matters as the individual's ability to cope with stress, the ability to relate to other people, and the ability to function in a group or work situation.

Medical documentation can often give clues as to functional limitation. For example, evidence that an individual is markedly withdrawn or seclusive suggests a greatly reduced capacity for close contact and interaction with other people. The conclusion of reduced RFC in this area can then be applied to all steps of vocational assessment. For example, when the vocational assessment establishes that the claimant's past work has been limited to work requiring close contact and interaction with other people, the preceding assessment would indicate that the claimant would be unable to fulfill the requirements of his or her past work. Therefore, the determination of disability in this instance would depend on the individual's vocational capacity for other work.

Similarly, individuals with paranoid tendencies may be expected to experience moderate to moderately severe difficulties in relating to coworkers or supervisors, or in tolerating normal work pressures. The ability to respond appropriately to supervision and to coworkers under customary work pressure is a function of a number of different factors, some of which may be unique to a specific work situation.

The evaluation of intellectual functioning by a program physician, psychologist, ALJ, or AC member provides information necessary to determine the individual's ability to understand, to remember instructions, and to carry out instructions. Thus, an individual, in whom the only finding in intellectual testing is an IQ between 60 and 69, is ordinarily expected to be able to understand simple oral instructions and to be able to carry out these instructions under somewhat closer supervision than required of an individual with a higher IQ. Similarly, an individual who has an IQ between 70 and 79 should ordinarily be able to carry out these instructions under somewhat less close supervision.

Since treating medical sources often have considerable information about the development and progress of an individual's impairment, as well as information about the individual's response to treatment, evidence from treating sources should be given appropriate consideration. On occasion, the report of a current treating source may disclose other sources of medical evidence not previously report. If so, these sources should be contacted, since it is essential that the medical documentation reflect all available sources, particularly in instances of questionable severity of impairment or inconclusive RFC. When medical source notes appear to be incomplete, recontact with the source should be made to attempt to obtain more detailed information. Every

reasonable effort should be made to obtain all medical evidence from the treating source necessary to make a determination of impairment severity and RFC before obtaining evidence from any other source on a consultative basis. However, when treating medical sources cannot provide essential information, consultative examination by a treating or nontreating source may resolve the impairment or RFC issue. Similarly, when the reports from these sources appear to be incomplete, the source should be recontacted to clarify the issues.

Other evidence also may play a vital role in the determination of the effects of impairment. To arrive at an overall assessment of the effects of mental impairment, relevant, reliable information, obtained from third party sources such as social workers, previous employers, family members, and staff members of halfway houses, mental health centers, and community centers, may be valuable in assessing an individual's level of activities of daily living. Information concerning an individual's performance in any work setting (including sheltered work and volunteer or competitive work), as well as the circumstances surrounding the termination of the work effort, may be pertinent in assessing the individual's ability to function in a competitive work environment.

Reports of workshop evaluation may also be of value in assessing the individual's ability to understand, to carry out and remember instructions, and to respond appropriately to supervisors, coworkers, and customary work pressures in a work setting. Consequently, wherever the record shows that a workshop evaluation has been performed, the report should be requested from the source. If no workshop evaluation has been done, but, after complete and comprehensive documentation, genuine doubt remains as to the individual's functional capacity, consideration should be given to obtaining one. Information derived from workshop evaluations must be used in conjunction with the clinical evidence of impairment, but all conflicts between workshop evaluation and evidence and the conclusions based on objective medical findings must be resolved.

Descriptions and observations of the individual's restrictions by medical and other sources (including Social Security Administration representatives, such as district office representatives and ALJ's), in addition to those made during formal medical examinations, must also be considered in the determination of RFC. However, care must be taken not to give duplicate weight to certain findings. For example, a competent psychometric assessment of intellectual functioning provides a sample, referenced to established norms, of the individual capabilities in various areas, including those germane to a workshop situation. such a psychometric assessment, therefore, usually provides the same impairment-related information about functional capacity that might also be disclosed in the course of a workshop evaluation. Since the effects of the same underlying impairment(s) may be revealed in both assessment approaches, it would be incorrect to consider this duplicate representation of the same impairment to reflect separate and independent impairments. Such an approach would give the same impairment(s) double weight.

Observations and findings from a workshop evaluation may supplement the psychometric assessment or may raise some question concerning the accuracy of the

psychometric assessment. Whenever a significant discrepancy in conclusions between the two arises, an explanation must be given by the program physician, psychologist, ALJ, or AC member for rejecting or modifying the conclusions of the psychometric assessment or the workshop evaluation.

EFFECTIVE DATE: On publication.

CROSS-REFERENCES: Program Operations Manual System, section DI 00401.592.

IV.F.5.d. Mental Disorders Listings – Paragraph B Criteria Quick Refernce Guide

Mental Disorders Listings – Paragraph B Criteria
Quick Reference Guide

Paragraph B1 – Understand, Remember, or Apply Information	Paragraph B2 – Interact with Others	Paragraph B3 – Concentrate, Persist, or Maintain Pace	Paragraph B4 – Adapt or Manage Oneself
Examples of this area of mental functioning include:			
• Understanding and learning terms, instructions, and procedures • Following one- or two-step oral instructions to carry out a task • Describing work activity to someone else • Asking and answering questions and providing explanations • Recognizing a mistake and correcting it • Identifying and solving problems • Sequencing multi-step activities • Using reason and judgment to make work-related decisions	• Cooperating with others • Asking for help when needed • Handling conflicts with others • Stating one's own point of view • Initiating or sustaining conversation • Understanding and responding to social cues, including physical, verbal, and emotional cues • Responding to requests, suggestions, criticism, correction, and challenges • Keeping social interactions free of excessive irritability, sensitivity, argumentativeness, or suspiciousness	• Initiating and performing a task that the person understands and knows how to do • Working at an appropriate and consistent pace • Completing tasks in a timely manner • Ignoring or avoiding distractions while working • Changing activities or work settings without being disruptive • Working close to or with others without interrupting or distracting them • Sustaining an ordinary routine and regular attendance at work • Working a full day without needing more than the allotted number or length of rest periods	• Responding to demands • Adapting to changes • Managing psychologically based symptoms • Distinguishing between acceptable and unacceptable work performance • Setting realistic goals • Making plans independently of others • Maintaining personal hygiene and attire appropriate to a work setting • Being aware of normal hazards and taking appropriate precautions

Office of Disability Policy
Effective January 17, 2017

IV.F.5.e. 12.05 Intellectual disorder (see 12.00B4), satisfied by A or B:

A. Satisfied by 1, 2, and 3 (see 12.00H):
   1. Significantly subaverage general intellectual functioning evident in your cognitive inability to function at a level required to participate in standardized testing of intellectual functioning; and
   2. Significant deficits in adaptive functioning currently manifested by your dependence upon others for personal needs (for example, toileting, eating, dressing, or bathing); and

3. The evidence about your current intellectual and adaptive functioning and about the history of your disorder demonstrates or supports the conclusion that the disorder began prior to your attainment of age 22.

OR

B. Satisfied by 1, 2, and 3 (see 12.00H):
    1. Significantly subaverage general intellectual functioning evidenced by a or b:
        a. A full scale (or comparable) IQ score of 70 or below on an individually administered standardized test of general intelligence; or
        b. A full scale (or comparable) IQ score of 71-75 accompanied by a verbal or performance IQ score (or comparable part score) of 70 or below on an individually administered standardized test of general intelligence; and
    2. Significant deficits in adaptive functioning currently manifested by extreme limitation of one, or marked limitation of two, of the following areas of mental functioning:
        a. Understand, remember, or apply information (see 12.00E1); or
        b. Interact with others (see 12.00E2); or
        c. Concentrate, persist, or maintain pace (see 12.00E3); or
        d. Adapt or manage oneself (see 12.00E4); and
    3. The evidence about your current intellectual and adaptive functioning and about the history of your disorder demonstrates or supports the conclusion that the disorder began prior to your attainment of age 22.

IV.G. Failure to Follow Prescribed Treatment: SSR 82-59

IV.H. Medical Expert Testimony

IV.H.1. Testimony of a Medical Expert: HALLEX I-2-6-70

I-2-6-70. Testimony of a Medical Expert

Last Update: 6/16/16 (Transmittal I-2-175)

A. Prehearing Actions

When an administrative law judge (ALJ) determines that the testimony of a medical expert (ME) is needed at a hearing (see Hearings, Appeals and Litigation Law (HALLEX) manual I-2-5-34), the ALJ must:

- Have no substantive contact related to the merits of the case with the ME except at the hearing or in writing, and ensure that any such writing is exhibited; and
- Request that the ME examine any pertinent evidence received between the time the ME completed the case study and the time of the hearing.

For instructions on obtaining testimony or a written opinion from an ME, see HALLEX I-2-5-30 through I-2-5-45.

Assisting hearing office (HO) staff will:

- Send copies of any correspondence between the ALJ and the ME to the claimant and make the correspondence an exhibit; and
- If the ME is appearing via telephone, confirm the ME's telephone number before the hearing.
-

  NOTE 1:

  When an ME is scheduled to testify at a hearing, HO staff must notify the claimant of this appearance in the “REMARKS” section of the notice of hearing. The notice of hearing must also specify the manner in which the ME will appear.

  NOTE 2:

  An ALJ must obtain testimony from an ME in order to determine whether the claimant's impairments medically equal a medical listing. See Social Security Ruling (SSR) 86-8: *Titles II and XVI: The Sequential Evaluation Process* and SSR 17-2p: *Titles II and XVI: Evidence Needed by Adjudicators at the Hearings and Appeals Council Levels of the Administrative Review Process to Make Findings about Medical Equivalence*.

  NOTE 3:

  An ALJ is encouraged to consult with an ME when he or she must make an inference about the onset of disability. SSR 83-20: *Titles II and XVI: Onset of Disability*.

B. Conduct of the Hearing

At the hearing, the ALJ must advise the claimant of the reason for the ME's presence and explain the procedures all participants will follow.

The ME may attend the entire hearing, but this is not required. If the ME was not present to hear pertinent testimony, such as testimony regarding the claimant's current medications or sources and types of treatment, the ALJ will summarize the testimony for the ME on the record. If additional medical evidence is received at the hearing, the ALJ will provide it to the ME for review before the ME testifies.

All ME testimony must be on the record. After administering the oath or affirmation, the ALJ must:

- Ask the ME to confirm his or her impartiality, expertise, and professional qualifications;
- Verify the ME has examined all medical and other relevant evidence of record;
- Ask the claimant and the representative whether they have any objections to the ME testifying; and
- Rule on any objection(s). The ALJ may address the objection(s) on the record during the hearing, in narrative form as a separate exhibit, or in the body of his or her decision.

C. Questioning the ME

The ALJ will ask the ME questions designed to elicit clear and complete information. The claimant and the representative have the right to question the ME fully on any pertinent matter within the ME's area of expertise. However, the ALJ will determine when they may exercise this right and whether questions asked or answers given are appropriate.

The ALJ will also ensure the following during questioning of the ME:

If the ME's replies are ambiguous or overly technical, the ALJ will follow up with more specific questions in order to obtain a response that is understandable to the average person.

The ALJ will not permit the ME to respond to questions on nonmedical matters or to draw conclusions not within the ME's expertise. For example, the ME may not provide opinions regarding vocational factors or the resolution of ultimate issues of fact or law. However, the ME may respond to questions about the effects of the claimant's medical treatment on the claimant's ability to engage in work related activities.

The ALJ will not ask or allow the ME to conduct any type of physical or mental status examination of the claimant during the hearing.

If the ME bases certain testimony on an assumption, the ALJ will ask the ME to clearly describe the assumption on the record.

D. Opinion on Medical Equivalence

An ALJ will consider opinions about medical equivalence from a physician or psychologist designated by the Commissioner whenever a claimant is not engaging in substantial gainful activity and has a severe impairment(s) that does not "meet" the requirements of a listing. See 20 CFR 404.1526, 416.926, and SSR 17-2p. Medical equivalence exists when:

- Signs, symptoms, and laboratory findings are not identical to those specified in a listed impairment, but are of equivalent severity;
- Signs, symptoms, and laboratory findings are equivalent in severity to those of the most closely analogous listed impairment; or
- The combination of signs, symptoms, and laboratory findings are equivalent in severity to the criteria of a listed impairment.

An ALJ must obtain ME testimony specific to the issue of medical equivalence if he or she intends to find that the claimant equals the requirements of a listing. See SSR 86-8 and SSR 17-2p.

NOTE:

An ALJ may not ask an ME to decide whether the claimant is disabled.

When questioning an ME about medical equivalence, the ALJ will:

- Ask the ME to describe the claimant's medical impairment(s);
- Obtain testimony about which listing in the Listing of Impairments (Appendix 1 to 20 CFR Part 404 Subpart P) is the most appropriate for comparison with the claimant's impairment(s) and why;
- When applicable, ask the ME whether the claimant's impairment(s) meet the duration requirement; and
- Request an opinion from the ME about whether the claimant had or has an impairment(s) that medically equals the criteria of the listing and the reasons for the opinion.

E. Opinion Used to Determine the Claimant's Residual Functional Capacity (RFC)

An ALJ may ask an ME to provide information and an opinion(s) that will help the ALJ establish the claimant's RFC. For example, an ALJ may ask an ME to describe the impact of an impairment on the claimant's ability to concentrate or remember. However, an ALJ may not ask an ME to:

- Decide a claimant's RFC;
- Determine whether a claimant is disabled; or
- Testify about vocational aspects of a case, such as whether a claimant can work in a competitive work situation or in a particular type of employment.

IV.H.2. Sample Questions for the Medical Expert: HALLEX I-2-5-93

HALLEX I-2-5-93. Sample Questions for the Medical Expert
Last Update: 9/28/05 (Transmittal I-2-68)

To access Sample Interrogatories go to DGS and then click on the "CE and Evidence Request" tab and then click on the "Medical Interrogatories" tab.

IV.H.3. Medical Equivalence

IV.H.3.a. 404.1526

§ 404.1526. Medical equivalence.

(a) ***What is medical equivalence?*** Your impairment(s) is medically equivalent to a listed impairment in appendix 1 if it is at least equal in severity and duration to the criteria of any listed impairment.

(b) ***How do we determine medical equivalence?*** We can find medical equivalence in three ways.

(1)(i) If you have an impairment that is described in appendix 1, but —

(A) You do not exhibit one or more of the findings specified in the particular listing, or

(B) You exhibit all of the findings, but one or more of the findings is not as severe as specified in the particular listing,

(ii) We will find that your impairment is medically equivalent to that listing if you have other findings related to your impairment that are at least of equal medical significance to the required criteria.

(2) If you have an impairment(s) that is not described in appendix 1, we will compare your findings with those for closely analogous listed impairments. If the findings related to your impairment(s) are at least of equal medical significance to those of a listed impairment, we will find that your impairment(s) is medically equivalent to the analogous listing.

(3) If you have a combination of impairments, no one of which meets a listing (see § 404.1525(c)(3)), we will compare your findings with those for closely analogous listed impairments. If the findings related to your impairments are at least of equal medical significance to those of a listed impairment, we will find that your combination of impairments is medically equivalent to that listing.

(4) Section 404.1529(d)(3) explains how we consider your symptoms, such as pain, when we make findings about medical equivalence.

(c) ***What evidence do we consider when we determine if your impairment(s) medically equals a listing?*** When we determine if your impairment medically equals a listing, we consider all evidence in your case record about your impairment(s) and its effects on you that is relevant to this finding. We do not consider your vocational factors of age, education, and work experience (see, for example, § 404.1560(c)(1)). We also consider the opinion given by one or more medical or psychological consultants designated by the Commissioner. (See § 404.1616.)

(d) *Who is a designated medical or psychological consultant?* A medical or psychological consultant designated by the Commissioner includes any medical or psychological consultant employed or engaged to make medical judgments by the Social Security Administration, the Railroad Retirement Board, or a State agency authorized to make disability determinations. See § 404.1616 of this part for the necessary qualifications for medical consultants and psychological consultants and the limitations on what medical consultants who are not physicians can evaluate.

(e) *Who is responsible for determiningmedical equivalence?*

(1) In cases where the State agency or other designee of the Commissioner makes the initial or reconsideration disability determination, a State agency medical or psychological consultant or other designee of the Commissioner (see § 404.1616 of this part) has the overall responsibility for determining medical equivalence.

(2) For cases in the disability hearing process or otherwise decided by a disability hearing officer, the responsibility for determining medical equivalence rests with either the disability hearing officer or, if the disability hearing officer's reconsideration determination is changed under § 404.918 of this part, with the Associate Commissioner for Disability Policy or his or her delegate.

(3) For cases at the administrative law judge or Appeals Council level, the responsibility for deciding medical equivalence rests with the administrative law judge or Appeals Council.

IV.H.3.b. Medical Equivalence Ruling: SSR 17-2p

Social Security Ruling, SSR 17-2p:

Titles II and XVI: Evidence Needed by Adjudicators at the Hearings and Appeals Council Levels of the Administrative Review Process to Make Findings about Medical Equivalence

This Social Security Ruling (SSR) rescinds and replaces SSR 96-6p: "Titles II and XVI: Consideration of Administrative Findings of Fact by State Agency Medical and Psychological Consultants and Other Program Physicians and Psychologists at the Administrative Law Judge and Appeals Council Levels of Administrative Review; Medical Equivalence."

PURPOSE: This SSR provides guidance on how adjudicators at the hearings and Appeals Council (AC) levels of our administrative review process make findings about medical equivalence in disability claims under titles II and XVI of the Social Security Act (Act).

CITATIONS: Sections 216(i), 223(d), and 1614(a) of the Act, as amended; 20 CFR 404.1526 and 416.926.

BACKGROUND:

The Sequential Evaluation Process

We use a five-step sequential evaluation process to determine whether an adult is disabled under titles II or XVI of the Act.[1] We use a different process to decide whether a child is disabled under title XVI of the Act.[2] In both situations, if we can find an individual is disabled at a step, we make a determination or decision at that step and do not go on to the next step.[3]

At step 3 of the sequential evaluation process for determining disability in adult and child claims, we make a medical assessment to determine whether an individual's impairment(s) meets a listing in the Listing of Impairments (listings).[4] If an individual's impairment(s) meets all the criteria of any listed impairment in the listings, we will find that the individual is disabled. If an individual has an impairment(s) that does not meet all of the requirements of a listing, we then determine whether the individual's impairment(s) medically equals a listed impairment. An impairment is medically equivalent to a listed impairment if it is at least equal in severity and duration to the criteria of any listed impairment. We can find medical equivalence in three ways:

1. If an individual has an impairment that is described in the listings, but either:
    a. the individual does not exhibit one or more of the findings specified in the particular listing, or
    b. the individual exhibits all of the findings, but one or more of the findings is not as severe as specified in the particular listing,

    then we will find that his or her impairment is medically equivalent to that listing if there are other findings related to the impairment that are at least of equal medical significance to the required criteria.
2. If an individual has an impairment(s) that is not described in the listings, we will compare the findings with those for closely analogous listed impairments. If the findings related to the impairment(s) are at least of equal medical significance to those of a listed impairment, we will find that the impairment(s) is medically equivalent to the analogous listing.
3. If an individual has a combination of impairments, no one of which meets a listing, we will compare the findings with those for closely analogous listed impairments. If the findings related to the impairments are at least of equal medical significance to those of a listed impairment, we will find that the combination of impairments is medically equivalent to that listing.[5]

If we determine an individual's impairment(s) does not meet or medically equal a listed impairment, we continue evaluating the claim using the sequential evaluation process.[6]

Who decides whether an individual's impairment medically equals a listing?

At the initial and reconsideration levels of the administrative review process, Federal or State agency Medical Consultants (MC) or Psychological Consultants (PC) consider the evidence and make administrative medical findings about medical issues, including whether an individual's impairment(s) meets or medically equals a listing.[7] MCs and PCs are highly qualified medical sources who are also experts in the evaluation of medical issues in disability claims under the Act. In most situations,[8] we require adjudicators at the initial and reconsideration levels to obtain MC or PC administrative medical findings about medical equivalence.

At the hearings level of the administrative review process, administrative law judges (ALJ) and some attorney advisors[9] determine whether an individual's impairment(s) meets or

medically equals a listing at step 3 of the sequential evaluation process. To assist in evaluating this issue, adjudicators at the hearings level may ask for and consider evidence from medical experts (ME) about the individual's impairment(s), such as the nature and severity of the impairment(s).

At the AC level of the administrative review process, when the AC exercises its authority to issue a decision,[10] it determines whether an individual's impairment(s) meets or medically equals a listing. The AC may ask its medical support staff to help decide whether an individual's impairment(s) medically equals a listing.

POLICY INTERPRETATION

Evidentiary requirements

At the hearings level or at the AC level when the AC issues its own decision, the adjudicator is responsible for the finding of medical equivalence. The adjudicator must base his or her decision about whether the individual's impairment(s) medically equals a listing on the preponderance of the evidence in the record. To demonstrate the required support of a finding that an individual is disabled based on medical equivalence at step 3, the record must contain one of the following:

1. A prior administrative medical finding from an MC or PC from the initial or reconsideration adjudication levels supporting the medical equivalence finding, or
2. ME evidence, which may include testimony or written responses to interrogatories, obtained at the hearings level supporting the medical equivalence finding, or
3. A report from the AC's medical support staff supporting the medical equivalence finding.

When an MC or PC makes administrative medical findings at the initial or reconsideration levels, the findings are part of the Commissioner's determination; therefore, they are not evidence at that level of adjudication.[11] At subsequent levels of the administrative review process, the MCs' or PCs' administrative medical findings made at the initial or reconsideration levels are prior administrative medical findings, which are evidence.[12] Although adjudicators at the hearings and AC levels are not required to adopt prior administrative medical findings when issuing decisions, adjudicators must consider them and articulate how they considered them in the decision.[13]

When an adjudicator at the hearings level obtains ME testimony or written responses to interrogatories about whether an individual's impairment(s) medically equals a listing, the adjudicator cannot rely on an ME's conclusory statement that an individual's impairment(s) medically equals a listed impairment(s). Whether an impairment(s) medically equals the requirements of a listed impairment is an issue reserved to the Commissioner. If the ME states that the individual's impairment(s) medically equals a listed impairment, the adjudicator must ask the ME to identify medical evidence in the record that supports the ME's statements. Adjudicators will consider ME testimony and interrogatories using our rules for considering evidence. The adjudicator will then consider whether an individual's impairment(s) medically equals a listing using one of the three methods specified in 20 CFR 404.1526 and 416.926.

Similarly, when the AC obtains a report from its medical support staff to evaluate medical equivalence, the AC retains final responsibility for determining whether an individual's impairment(s) medically equals a listed impairment. The AC will consider the medical support staff's report and all other supporting medical evidence using our rules for considering evidence.

The AC will then consider whether an individual's impairment(s) medically equals a listing using one of the three methods specified in 20 CFR 404.1526 and 416.926.

If an adjudicator at the hearings or AC level believes that the evidence does not reasonably support a finding that the individual's impairment(s) medically equals a listed impairment, we do not require the adjudicator to obtain ME evidence or medical support staff input prior to making a step 3 finding that the individual's impairment(s) does not medically equal a listed impairment.

Articulation requirements

An adjudicator at the hearings or AC level must consider all evidence in making a finding that an individual's impairment(s) medically equals a listing. To make a finding of medical equivalence, the adjudicator must articulate how the record establishes medical equivalency using one of the three methods specified in 20 CFR 404.1526 and 416.926. An adjudicator must provide a rationale for a finding of medical equivalence in a decision that is sufficient for a subsequent reviewer or court to understand the decision. Generally, this will entail the adjudicator identifying the specific listing section involved, articulating how the record does not meet the requirements of the listed impairment(s), and how the record, including ME or medical support staff evidence, establishes an impairment of equivalent severity.

Similarly, an adjudicator at the hearings or AC level must consider all evidence in making a finding that an individual's impairment(s) does not medically equal a listing. If an adjudicator at the hearings or AC level believes that the evidence already received in the record does not reasonably support a finding that the individual's impairment(s) medically equals a listed impairment, the adjudicator is not required to articulate specific evidence supporting his or her finding that the individual's impairment(s) does not medically equal a listed impairment. Generally, a statement that the individual's impairment(s) does not medically equal a listed impairment constitutes sufficient articulation for this finding. An adjudicator's articulation of the reason(s) why the individual is or is not disabled at a later step in the sequential evaluation process will provide rationale that is sufficient for a subsequent reviewer or court to determine the basis for the finding about medical equivalence at step 3.

EFFECTIVE DATE: This SSR is effective on March 27, 2017.

CROSS-REFERENCES: 20 CFR 404.1526 and 416.926.

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[1] See 20 CFR 404.1520 and 416.920.

[2] See 20 CFR 416.924.

[3] See 20 CFR 404.1520(a)(4) and 416.920(a)(4).

[4] 20 CFR part 404, subpart P, Appendix 1.

[5] See 20 CFR 404.1526 and 416.926.

[6] In adult claims, we will determine the individual's residual functional capacity and then go to step 4 of the sequential evaluation process. See 20 CFR 404.1520 and 416.920. In a child's claim under Title XVI, we will determine whether the child's impairment(s) functionally equals the Listings at step 3. See 20 CFR 416.926a.

[7] In some States, we are testing modifications to the disability determination procedures that allow disability examiners to decide whether an individual's impairment(s) medically

equals a listing without requiring consultation with an MC or PC, although such consultation is permissible. One modification authorizes specialized State agency disability examiners called “single decisionmakers” (SDM) to make initial and reconsideration determinations without consulting an MC or PC in some types of claims. See 20 CFR 404.906(b)(2) and 416.1406(b)(2). The other modification being tested allows disability examiners to make fully favorable determinations in quick disability determinations (QDD) and compassionate allowance (CAL) claims without requiring consultation with an MC or PC because those types of claims involve the most obviously disabling impairments. See 20 CFR 404.1615(c)(3) and 416.1015(c)(3). In those States using the testing modifications, there may not be an MC or PC medical assessment in the file. Both of these testing modifications are scheduled to end by the end of calendar year 2018. See 81 FR 73027 (2016) and 81 FR 58544 (2016).

[8] As stated in the prior footnote, disability examiners are not required to obtain MC or PC input about medical equivalence in certain SDM claims and in QDD and CAL claims. In those States using the testing modifications, there may not be a MC or PC medical assessment in the file.

[9] See 20 CFR 404.942 and 416.1442.

[10] The Appeals Council issues decisions in cases after it grants a request for review or takes own motion review of a hearing decision. See 20 CFR 404.969-970 and 416.1469-1470. The Appeals Council may also make a decision after a Federal court remands a case. See 20 CFR 404.983 and 416.1483.

[11] See 20 CFR 404.1513a(a)(1) and 416.913a(a)(1).

[12] See 20 CFR 404.1513a(b)-(c) and 416.913a(b)-(c). It is possible for an MC or PC to have found that an individual's impairment(s) medically equal(s) the requirements of a listed impairment(s), but we would still not make a favorable determination. For example, we could find that the individual does not meet nonmedical requirements for eligibility.

[13] See 20 CFR 404.1513a(b)-(c), 404.1520c, 416.913a(b)-(c), and 416.920c. In States using the two testing modifications discussed in footnote 7, the record may not contain any MC or PC prior administrative medical finding about medical equivalence that an adjudicator is able to consider. In these situations, the adjudicator may find that an individual's impairment(s) medically equals a listed impairment using the second or third method, but not the first method. In these situations, the adjudicator is not required to obtain ME evidence or medical support staff input before making a finding that the claimant's impairment(s) do not medically equal a listing.

V. Residual Functional Capacity and VE Hypotheticals Tab

V. Residual Functional Capacity and VE Hypotheticals

V.A. 20 CFR 404.1545; Residual Functional Capacity

§ 404.1545. Your residual functional capacity.

(a) ***General***—(1) ***Residual functional capacity assessment.*** Your impairment(s), and any related symptoms, such as pain, may cause physical and mental limitations that affect what you can do in a work setting. Your residual functional capacity is the most you can still do despite your limitations. We will assess your residual functional capacity based on all the relevant evidence in your case record. (***See*** §§ 404.1512(d) through (e).)

(2) ***If you have more than one impairment.*** We will consider all of your medically determinable impairments of which we are aware, including your medically determinable impairments that are not "severe," as explained in §§ 404.1520(c), 404.1521, and 404.1523, when we assess your residual functional capacity. (See paragraph (e) of this section.)

(3) ***Evidence we use to assess your residual functional capacity.*** We will assess your residual functional capacity based on all of the relevant medical and other evidence. In general, you are responsible for providing the evidence we will use to make a finding about your residual functional capacity. (***See*** § 404.1512(c).) However, before we make a determination that you are not disabled, we are responsible for developing your complete medical history, including arranging for a consultative examination(s) if necessary, and making every reasonable effort to help you get medical reports from your own medical sources. (***See*** §§ 404.1512(d) through (f).) We will consider any statements about what you can still do that have been provided by medical sources, whether or not they are based on formal medical examinations. (***See*** § 404.1513.) We will also consider descriptions and observations of your limitations from your impairment(s), including limitations that result from your symptoms, such as pain, provided by you, your family, neighbors, friends, or other persons. (***See*** paragraph (e) of this section and § 404.1529.)

(4) ***What we will consider in assessing residual functional capacity.*** When we assess your residual functional capacity, we will consider your ability to meet the physical, mental, sensory, and other requirements of work, as described in paragraphs (b), (c), and (d) of this section.

(5) ***How we will use our residual functional capacity assessment.*** (i) We will first use our residual functional capacity assessment at step four of the sequential evaluation process to decide if you can do your past relevant work. (***See*** §§ 404.1520(f) and 404.1560(b).)

(ii) If we find that you cannot do your past relevant work, you do not have any past relevant work, or if we use the procedures in § 404.1520(h) and § 404.1562 does not apply, we will use the same assessment of your residual functional capacity at step five

of the sequential evaluation process to decide if you can adjust to any other work that exists in the national economy. (***See*** §§ 404.1520(g) and 404.1566.) At this step, we will not use our assessment of your residual functional capacity alone to decide if you are disabled. We will use the guidelines in §§ 404.1560 through 404.1569a, and consider our residual functional capacity assessment together with the information about your vocational background to make our disability determination or decision. For our rules on residual functional capacity assessment in deciding whether your disability continues or ends, ***see*** § 404.1594.

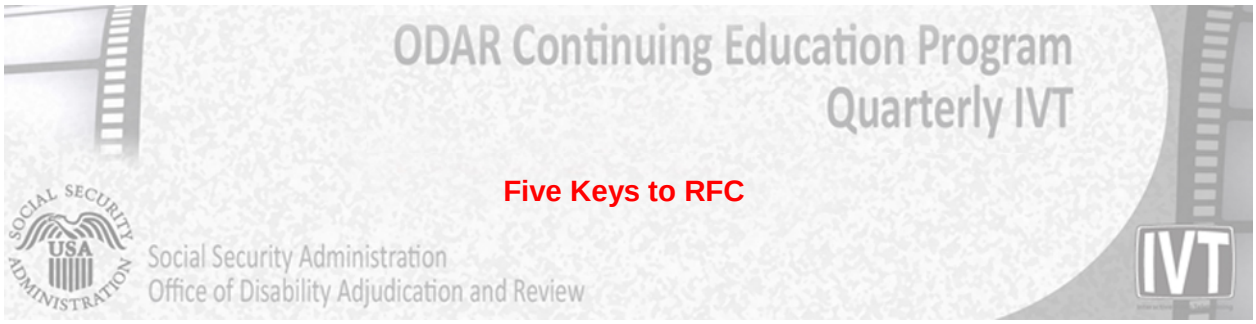
(b) ***Physical abilities.*** When we assess your physical abilities, we first assess the nature and extent of your physical limitations and then determine your residual functional capacity for work activity on a regular and continuing basis. A limited ability to perform certain physical demands of work activity, such as sitting, standing, walking, lifting, carrying, pushing, pulling, or other physical functions (including manipulative or postural functions, such as reaching, handling, stooping or crouching), may reduce your ability to do past work and other work.

(c) ***Mental abilities.*** When we assess your mental abilities, we first assess the nature and extent of your mental limitations and restrictions and then determine your residual functional capacity for work activity on a regular and continuing basis. A limited ability to carry out certain mental activities, such as limitations in understanding, remembering, and carrying out instructions, and in responding appropriately to supervision, co-workers, and work pressures in a work setting, may reduce your ability to do past work and other work.

(d) ***Other abilities affected by impairment(s).*** Some medically determinable impairment(s), such as skin impairment(s), epilepsy, impairment(s) of vision, hearing or other senses, and impairment(s) which impose environmental restrictions, may cause limitations and restrictions which affect other work-related abilities. If you have this type of impairment(s), we consider any resulting limitations and restrictions which may reduce your ability to do past work and other work in deciding your residual functional capacity.

(e) ***Total limiting effects.*** When you have a severe impairment(s), but your symptoms, signs, and laboratory findings do not meet or equal those of a listed impairment in appendix 1 of this subpart, we will consider the limiting effects of all your impairment(s), even those that are not severe, in determining your residual functional capacity. Pain or other symptoms may cause a limitation of function beyond that which can be determined on the basis of the anatomical, physiological or psychological abnormalities considered alone; e.g., someone with a low back disorder may be fully capable of the physical demands consistent with those of sustained medium work activity, but another person with the same disorder, because of pain, may not be capable of more than the physical demands consistent with those of light work activity on a sustained basis. In assessing the total limiting effects of your impairment(s) and any related symptoms, we will consider all of the medical and nonmedical evidence, including the information described in § 404.1529(c).

V.B. OCEP 01/18/12; Phrasing the RFC: Five Keys to RFC



1. Clearly articulate the rationale for every part of the residual functional capacity (RFC) finding in the written decision and include references to specific evidence in the record.

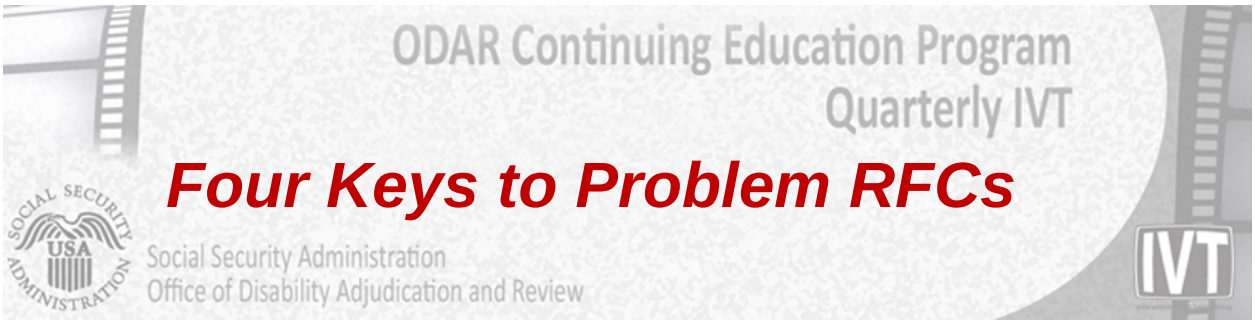
2. Do not use vague or imprecise terms such as “moderate”, “fair”, “low”, “mild”, “marked”, “reasonable”, “unreasonable”, “excessive”, and similar terms in the RFC statement.
   a. Use precise terms which mean the same to all.
   b. Use clearly defined terms from the regulations, rulings, ***Dictionary of Occupational Titles***, and ***Selected Characteristics of Occupations***, such as “occasional”, “frequent”, “never”, etc., when possible.
   c. Use quantifiable terms such as the specific amount of time in minutes, hours, days, or the percentage of a workday or workweek, when possible.

3. Ensure the RFC is the same, in the vocational expert hypothetical, in the decision rationale, and in the decision.

4. Include in the RFC at least one limitation for each impairment that is found to be “severe.”

5. RFC findings must be function-by-function statements - conclusive statements such as “less than sedentary”, “unable to sustain work activity”, “unable to work full-time”, and similar statements are not RFC Findings.

V.C. OCEP 04/23/14; Four Keys to Problem RFCs



State the most the individual can do in the RFC. A statement that the claimant is able to perform "less than sedentary work" or "cannot sustain work" is not an RFC

- Apply the ABCs for RFC: always be comprehensive, always be clear, always be consistent
- The RFC is the MOST the individual can do. An RFC that says the individual is limited to "less than sedentary work" or "cannot sustain work" does not state the most the individual can do
- Describe the claimant's abilities and limitations on a function-by-function basis for exertional (sit, stand, walk, lift, carry, push, and pull) and nonexertional (postural, manipulative, environmental, special senses, and mental) capacities

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

- These terms may be used in an RFC, but the record must support the finding
- The decision should tie the evidence directly to the finding
- Do not use either term as a shortcut to find disability not supported by the evidence

Avoid the terms "moderate," "sit/stand option," or "low stress work" in an RFC

- Use clear, quantified terms in the RFC
- As appropriate, use terms defined in the DOT and SCO such as "occasional," "frequent," and "never" to describe limitations
- Avoid vague, open-ended terms such as "at will" or "extended"

"Tell Me Why" – explain how the evidence supports the RFC

- Tie the RFC findings to the evidence in a persuasive, legally sufficient way
- Acknowledge and address evidence that conflicts with your RFC finding.

V.D. Vocational Expert Hypothetical Chart

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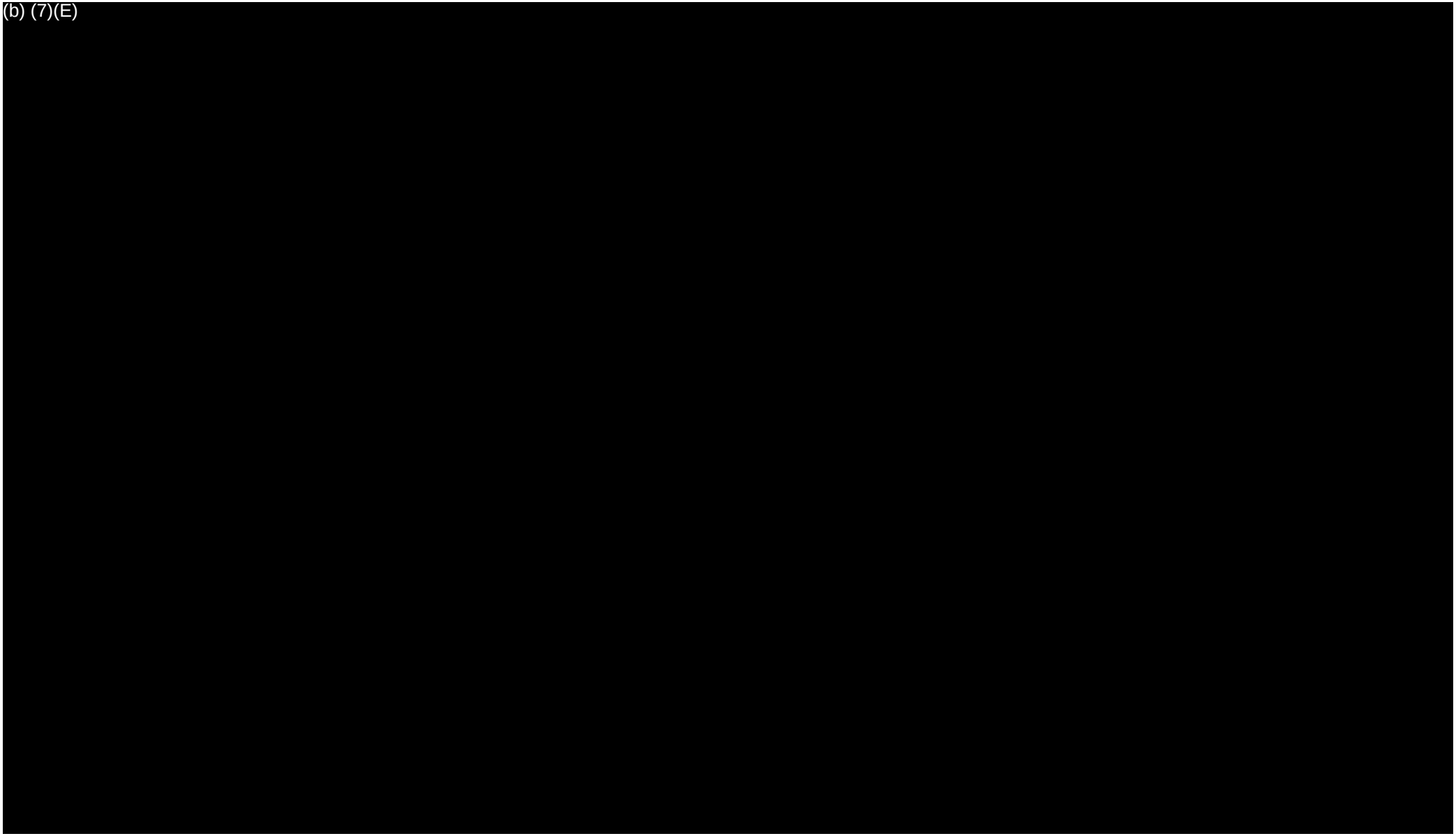
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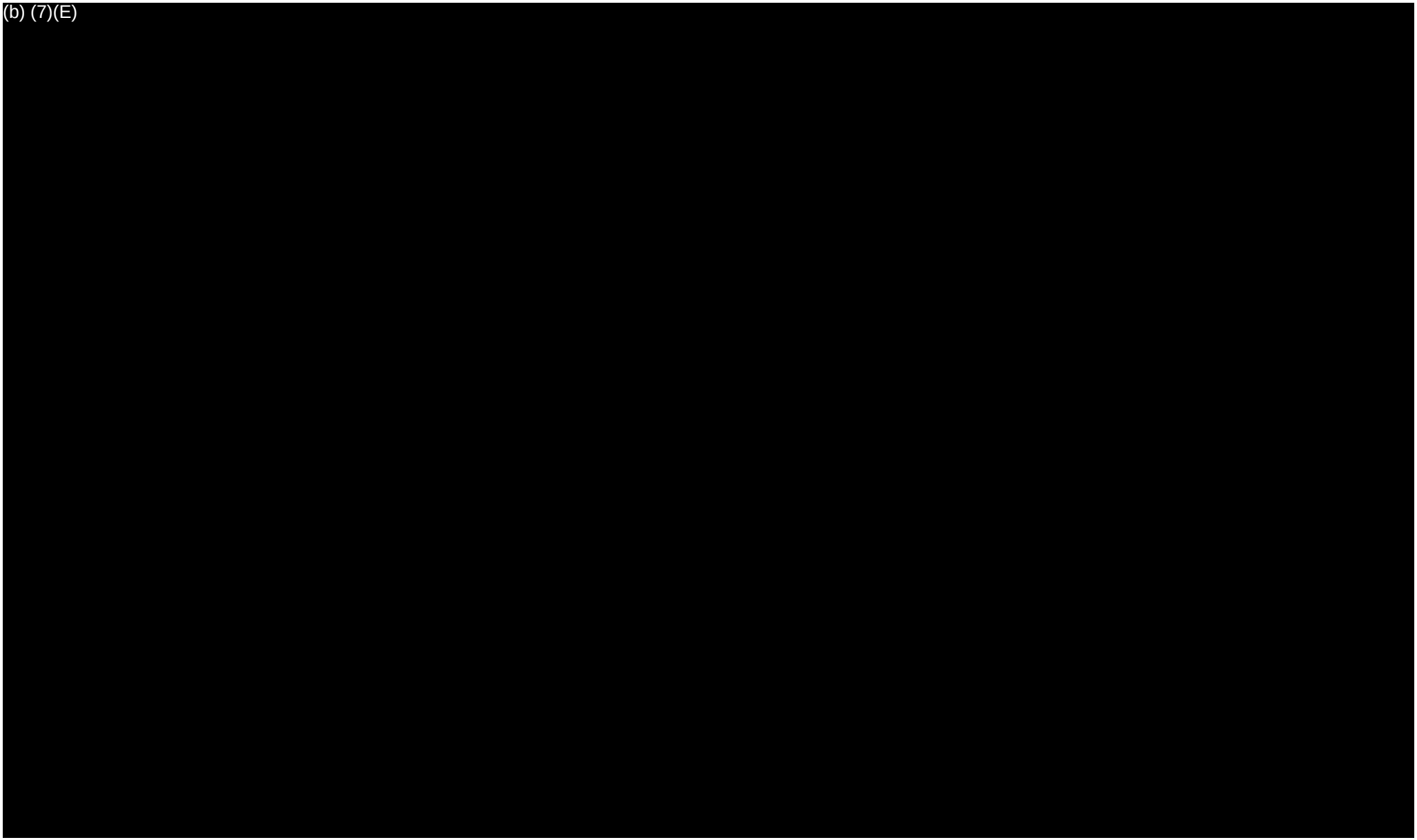

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V.E. Vocational Expert Opinion

V.E.1. SSR 00-4p: Titles II And XVI: Use of Vocational Expert and Vocational Specialist Evidence, and Other Reliable Occupational Information in Disability Decisions

SSR 00-4p: TITLES II AND XVI: USE OF VOCATIONAL EXPERT AND VOCATIONAL SPECIALIST EVIDENCE, AND OTHER RELIABLE OCCUPATIONAL INFORMATION IN DISABILITY DECISIONS

PURPOSE:

This Ruling clarifies our standards for the use of vocational experts (VEs) who provide evidence at hearings before administrative law judges (ALJs), vocational specialists (VSs) who provide evidence to disability determination services (DDS) adjudicators, and other reliable sources of occupational information in the evaluation of disability claims. In particular, this ruling emphasizes that before relying on VE or VS evidence to support a disability determination or decision, our adjudicators must:

- Identify and obtain a reasonable explanation for any conflicts between occupational evidence provided by VEs or VSs and information in the *Dictionary of Occupational Titles* (DOT), including its companion publication, the *Selected Characteristics of Occupations Defined in the Revised Dictionary of Occupational Titles* (SCO), published by the Department of Labor, and
- Explain in the determination or decision how any conflict that has been identified was resolved.

CITATIONS (AUTHORITY):

Sections 216(i), 223(d)(2)(A), and 1614(a)(3)(B) of the Social Security Act, as amended; 20 CFR Part 404, sections 404.1566-404.1569, 20 CFR Part 404, subpart P, appendix 2, § 200.00(b), and 20 CFR Part 416, sections 416.966-416.969.

PERTINENT HISTORY:

To determine whether an individual applying for disability benefits (except for a child applying for Supplement Security Income) is disabled, we follow a 5-step sequential evaluation process as follows:

1. Is the individual engaging in substantial gainful activity? If the individual is working and the work is substantial gainful activity, we find that he or she is not disabled.
2. Does the individual have an impairment or combination of impairments that is severe? If the individual does not have an impairment or combination of

impairments that is severe, we will find that he or she is not disabled. If the individual has an impairment or combination of impairments that is severe, we proceed to step 3 of the sequence.

3. Does the individual's impairment(s) meet or equal the severity of an impairment listed in appendix 1 of subpart P of part 404 of our regulations? If so, we find that he or she is disabled. If not, we proceed to step 4 of the sequence.
4. Does the individual's impairment(s) prevent him or her from doing his or her past relevant work (PRW), considering his or her residual functional capacity (RFC)? If not, we find that he or she is not disabled. If so, we proceed to step 5 of the sequence.
5. Does the individual's impairment(s) prevent him or her from performing other work that exists in the national economy, considering his or her RFC together with the "vocational factors" of age, education, and work experience? If so, we find that the individual is disabled. If not, we find that he or she is not disabled.

The regulations at 20 CFR 404.1566(d) and 416.966(d) provide that we will take administrative notice of "reliable job information" available from various publications, including the DOT. In addition, as provided in 20 CFR 404.1566(e) and 416.966(e), we use VEs and VSs as sources of occupational evidence in certain cases. Questions have arisen about how we ensure that conflicts between occupational evidence provided by a VE or a VS and information in the DOT (including its companion publication, the SCO) are resolved. Therefore, we are issuing this ruling to clarify our standards for identifying and resolving such conflicts.

POLICY INTERPRETATION:

Using Occupational Information at Steps 4 and 5

In making disability determinations, we rely primarily on the DOT (including its companion publication, the SCO) for information about the requirements of work in the national economy. We use these publications at steps 4 and 5 of the sequential evaluation process. We may also use VEs and VSs at these steps to resolve complex vocational issues.[1] We most often use VEs to provide evidence at a hearing before an ALJ. At the initial and reconsideration steps of the administrative review process, adjudicators in the DDSs may rely on VSs for additional guidance. See, for example, SSRs 82-41, 83-12, 83-14, and 85-15.

Resolving Conflicts in Occupational Information

Occupational evidence provided by a VE or VS generally should be consistent with the occupational information supplied by the DOT. When there is an apparent unresolved conflict between VE or VS evidence and the DOT, the adjudicator must elicit a reasonable explanation for the conflict before relying on the VE or VS evidence to support a determination or decision about whether the claimant is disabled. At the

hearings level, as part of the adjudicator's duty to fully develop the record, the adjudicator will inquire, on the record, as to whether or not there is such consistency.

Neither the DOT nor the VE or VS evidence automatically "trumps" when there is a conflict. The adjudicator must resolve the conflict by determining if the explanation given by the VE or VS is reasonable and provides a basis for relying on the VE or VS testimony rather than on the DOT information.

Reasonable Explanations for Conflicts (or Apparent Conflicts) in Occupational Information

Reasonable explanations for such conflicts, which may provide a basis for relying on the evidence from the VE or VS, rather than the DOT information, include, but are not limited to the following:

- Evidence from VEs or VSs can include information not listed in the DOT. The DOT contains information about most, but not all, occupations. The DOT's occupational definitions are the result of comprehensive studies of how similar jobs are performed in different workplaces. The term "occupation," as used in the DOT, refers to the collective description of those jobs. Each occupation represents numerous jobs. Information about a particular job's requirements or about occupations not listed in the DOT may be available in other reliable publications, information obtained directly from employers, or from a VE's or VS's experience in job placement or career counseling.
- The DOT lists maximum requirements of occupations as generally performed, not the range of requirements of a particular job as it is performed in specific settings. A VE, VS, or other reliable source of occupational information may be able to provide more specific information about jobs or occupations than the DOT.

Evidence That Conflicts With SSA Policy

SSA adjudicators may not rely on evidence provided by a VE, VS, or other reliable source of occupational information if that evidence is based on underlying assumptions or definitions that are inconsistent with our regulatory policies or definitions. For example:

- Exertional Level

  We classify jobs as sedentary, light, medium, heavy and very heavy (20 CFR 404.1567 and 416.967). These terms have the same meaning as they have in the exertional classifications noted in the DOT.

  Although there may be a reason for classifying the exertional demands of an occupation (as generally performed) differently than the DOT (e.g., based on other reliable occupational information), the regulatory definitions of exertional

levels are controlling. For example, if all available evidence (including VE testimony) establishes that the exertional demands of an occupation meet the regulatory definition of "medium" work (20 CFR 404.1567 and 416.967), the adjudicator may not rely on VE testimony that the occupation is "light" work.

- Skill Level

  A skill is knowledge of a work activity that requires the exercise of significant judgment that goes beyond the carrying out of simple job duties and is acquired through performance of an occupation that is above the unskilled level (requires more than 30 days to learn). (See SSR 82-41.) Skills are acquired in PRW and may also be learned in recent education that provides for direct entry into skilled work.

  The DOT lists a specific vocational preparation (SVP) time for each described occupation. Using the skill level definitions in 20 CFR 404.1568 and 416.968, unskilled work corresponds to an SVP of 1-2; semi-skilled work corresponds to an SVP of 3-4; and skilled work corresponds to an SVP of 5-9 in the DOT.

  Although there may be a reason for classifying an occupation's skill level differently than in the DOT, the regulatory definitions of skill levels are controlling. For example, VE or VS evidence may not be relied upon to establish that unskilled work involves complex duties that take many months to learn, because that is inconsistent with the regulatory definition of unskilled work. See 20 CFR 404.1568 and 416.968.

- Transferability of Skills

  Evidence from a VE, VS, or other reliable source of occupational information cannot be inconsistent with SSA policy on transferability of skills. For example, an individual does not gain skills that could potentially transfer to other work by performing unskilled work. Likewise, an individual cannot transfer skills to unskilled work or to work involving a greater level of skill than the work from which the individual acquired those skills. See SSR 82-41.

The Responsibility To Ask About Conflicts

When a VE or VS provides evidence about the requirements of a job or occupation, the adjudicator has an affirmative responsibility to ask about any possible conflict between that VE or VS evidence and information provided in the DOT. In these situations, the adjudicator will:

- Ask the VE or VS if the evidence he or she has provided conflicts with information provided in the DOT; and
- If the VE's or VS's evidence appears to conflict with the DOT, the adjudicator will obtain a reasonable explanation for the apparent conflict.

Explaining the Resolution

When vocational evidence provided by a VE or VS is not consistent with information in the DOT, the adjudicator must resolve this conflict before relying on the VE or VS evidence to support a determination or decision that the individual is or is not disabled. The adjudicator will explain in the determination or decision how he or she resolved the conflict. The adjudicator must explain the resolution of the conflict irrespective of how the conflict was identified.

EFFECTIVE DATE:

This Ruling is effective on the date of its publication in the *Federal Register*. The clarified standard stated in this ruling with respect to inquiring about possible conflicts applies on the effective date of the ruling to all claims for disability benefits in which a hearing before an ALJ has not yet been held, or that is pending a hearing before an ALJ on remand. The clarified standard on resolving identified conflicts applies to all claims for disability or blindness benefits on the effective date of the ruling.

Cross Reference:

SSR 82-41, "Titles II and XVI: Work Skills and Their Transferability as Intended by the Expanded Vocational Factors Regulations Effective February 26, 1979," SSR 82-61, "Titles II and XVI: Past Relevant Work--The Particular Job or the Occupation as Generally Performed," SSR 82-62, "Titles II and XVI: A Disability Claimant's Capacity to Do Past Relevant Work, In General," SSR 83-10, "Titles II and XVI: Determining Capability to Do Other Work--The Medical-Vocational Rules of Appendix 2," SSR 83-12, "Titles II and XVI: Capability to Do Other Work--The Medical-Vocational Rules as a Framework for Evaluating Exertional Limitations Within a Range of Work or Between Ranges of Work," SSR 83-14, "Titles II and XVI: Capability to do Other Work--The Medical-Vocational Rules as a Framework for Evaluating a Combination of Exertional and Nonexertional Impairments," and SSR 85-15, "Titles II and XVI: Capability to Do Other Work--The Medical-Vocational Rules as a Framework for Evaluating Solely Nonexertional Impairments";

AR 90-3(4), 837 F.2d 635 (4th Cir. 1987)-Use of Vocational Experts or Other Vocational Specialist in Determining Whether a Claimant Can Perform Past Relevant Work-Titles II and XVI of the Social Security Act;
Program Operations Manual System, Part 04, sections DI 25001.001, DI 25005.001, DI 25020.001-DI 25020.015, and DI 25025.001- DI 25025.005.

V.E.2. OCEP 04/17/13; Four Keys to Vocational Evidence

Most Adult Disability Cases Require Vocational Expert Evidence

- The Medical-Vocational Guidelines ("Grid Rules") direct a finding only if the claimant's vocational factors and RFC match a Grid Rule. Very few do.
- Limitations of some basic work activities cited in SSRs 83-12, 83-14, 85-15, and 96-9p have a minor effect on the occupational base. In these limited, specific situations, the SSR allows you to use the Grid Rule as a framework for the decision.
- Consider having a vocational expert testify in all adult disability hearings.

Know SSR 00-4p – Address Conflicts with the DOT

- ALJs should always ask the VE if testimony provided conflicts with the DOT.
- Explain in the decision how any conflict was resolved.

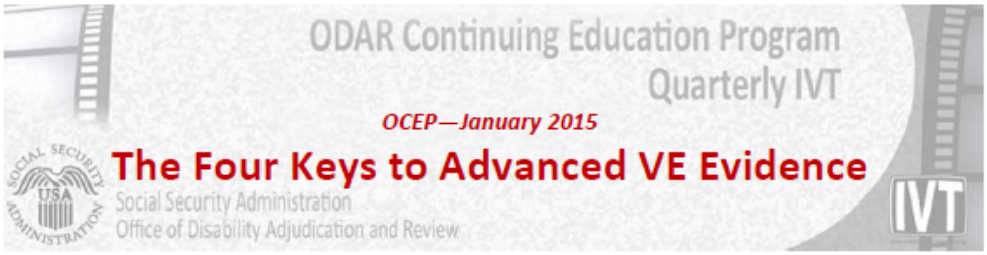
Transferable Skills Are Usually Not an Issue; Do Not Assess Unless Necessary

- Do not ask a VE to identify a claimant's transferable skills unless it is a material issue.
- With very rare exceptions, transferable skills are not a material issue for claimants under age 50.

Examination of the VE Is Limited to Pertinent Questions on Material Issues; the ALJ Should Determine the Appropriateness of Questions Asked

- The VE's estimate on the number of jobs nationally generally suffices; with rare exceptions, the number of jobs regionally is not necessary.
- Do not permit the VE to answer improperly posed questions.

V.E.3. OCEP 01/21/15; Four Keys to Advanced Topics in Vocational Expert Evidence



VE testimony should be limited to vocationally relevant evidence

- The ALJ should not permit the VE to answer an improper question. Examples include a question that:
  i. Is repetitive or cumulative or designed to intimidate, harass, or embarrass;
  ii. Asks the VE to speculate - on the effects of pain, the credibility of the claimant, or the meaning of vague terms;
  iii. Asks the VE about medical matters, the claimant's RFC, or whether the claimant is disabled.

ALJs must control the conduct of the hearing and rule on objections and subpoena requests

- The ALJ should address and separately rule on any objections to the VE qualifications or testimony.
- A subpoena should be issued only if the material sought is reasonably necessary to the full presentation of the case (20 CFR 404.950(d) and 416.1450(d)).
- A request for subpoena must be filed at least 5 days prior to hearing and state the information required by HALLEX I-2-5-78.
- Denials of subpoena requests must be in writing and exhibited in the file.

Apply the "9 Stages of Transferability of Work Skills" if transferable skills are a material issue

- In general, assess transferable skills only if the claimant is limited to sedentary work and is closely approaching advanced age or older, or is limited to light work or less and is advanced age or older.
- For claimants age 55 or older and limited to sedentary work, or age 60 or older and limited to light or sedentary work, there must also be "very little, if any, vocational adjustment required in terms of tools, work processes, work settings, or the industry."

The ALJ decides whether other work exists in significant numbers

- With very rare exceptions, an estimate of the number of jobs nationally is sufficient; the number of jobs regionally is unnecessary.
- No set number qualifies as a "significant" number. If the number seems low, ask the VE to identify other occupations consistent with the RFC.
- It is acceptable for VEs to "crosswalk" and combine information from multiple sources to estimate job numbers.

V.E.4. HALLEX I-2-5-94; Sample Questions for the Vocational Expert

I-2-5-94. Sample-Interrogatories to Vocational Expert
Last Update: 9/28/05 (Transmittal I-2-68)

To access Interrogatories go to DGS and click on the “CE and Evidence Request” tab and then click on the tab “Vocational Expert Interrogatories.”

V.E.5. Social Security Acquiescence Ruling 14-1(8)

Acquiescence Ruling 14-1(8)

V.E.6. Acceptable Electronic Occupational Resources

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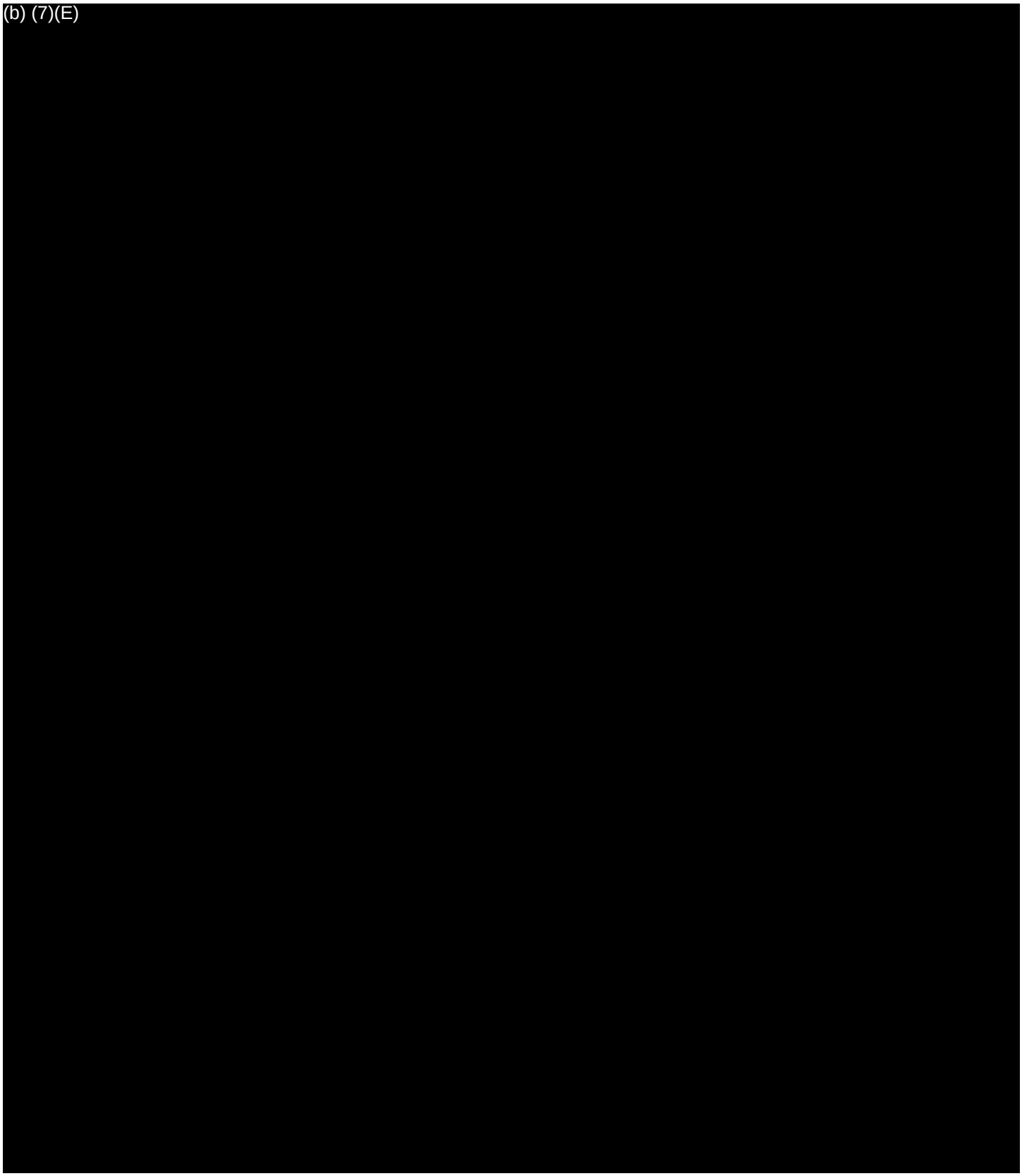

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Category: Disability Policy
Subcategory: Vocational Resources
Purpose: Policy Clarification

Posted: 09/18/2015
Answered on: 09/18/2015

Initiating Component: Other
Answered by: ODP
Responsible CO Component: ODP

Review Frequency: 12 (months)
Last Reviewed: 09/18/2015
Due for Review: 09/18/2016

Links to References:

POMS DI 25005.001
POMS DI 25015.030
POMS DI 25001.001
POMS DI 25015.015
POMS DI 25003.000

History:

09-026 - (b) (2) [redacted]
09-026 Rev 1 - (b) (2) [redacted]
(b) (2) [redacted]

V.E.7. CALJ Memo, 5/31/16; Vocation Expert Testimony---- Information and Reminder

SOCIAL SECURITY

MEMORANDUM

Date: May 31, 2016

Refer To: ACL 16-479

To: All Administrative Law Judges
All Decision Writers

From: Debra Bice **/s/**
Chief Administrative Law Judge

Subject: Vocational Expert Testimony — **INFORMATION AND REMINDER**

This memorandum provides guidance on our policy, best practices, and recent court trends regarding vocational expert (VE) evidence. In conjunction with our colleagues in the Office of the General Counsel, we have prepared this memorandum to assist Administrative Law Judges (ALJs) and decision writers (DWs) when considering VE evidence. While sections of this memorandum address certain federal circuits, we encourage all ALJs and DWs to read the entire memorandum, as the information may be useful regardless of one's location.

General

Under our regulations, a VE "may offer relevant evidence within his or her expertise or knowledge concerning the physical and mental demands of a claimant's past relevant work, either as the claimant actually performed it or as generally performed in the national economy." 20 C.F.R. §§ 404.1560(b)(2) and 416.960(b)(2). Further, we use VEs to determine "whether [a claimant's] work skills can be used in other work and the specific occupations in which they can be used." 20 C.F.R. §§ 404.1566(e) and 416.966(e); *see also* Social Security Ruling (SSR) 00-

4p. However, a "VE's opinion is not binding on the ALJ. The ALJ must weigh a VE's opinion along with all other evidence." HALLEX I-2-5-48. Moreover, an ALJ must allow the claimant or representative to question the VE on any pertinent matter within the VE's area of expertise, including the number of jobs available, the sources the VE is relying on, and how the VE is using the sources. HALLEX I-2-6-74 C, I-2-5-55.

SSR 00-4p provides in part that occupational evidence provided by a VE "generally should be consistent with the occupational information supplied by" the *Dictionary of Occupational Titles* (DOT). "When there is an apparent unresolved conflict between VE or VS [vocational specialist] evidence and the DOT, the adjudicator must elicit a reasonable explanation for the conflict before relying on the VE or VS evidence to support a determination or decision about whether the claimant is disabled." *Id*. The SSR further states that, "as part of the adjudicator's duty to fully develop the record, the adjudicator will inquire, on the record, as to whether or not there is such consistency." Finally, the SSR explains, "[n]either the DOT nor the VE or VS evidence automatically 'trumps' when there is a conflict. The adjudicator must resolve the conflict by determining if the explanation given by the VE or VS is reasonable and provides a basis for relying on the VE or VS testimony rather than on the DOT information."

In light of the above, and when responding to representatives' objections relating to VE testimony, consider the following:

- *If the representative submits an objection to the VE's qualifications to testify as an expert*, ensure that ALJs clearly state the VE's qualifications on the record or in the decision. Keep in mind that VE testimony, including testimony as to VE qualifications, is evidence like all other evidence and must be weighed (see HALLEX I-2-5-48).

- *If the representative objects to the substance of the VE's testimony*, keep in mind that the VE may be relying on publications of which the agency has taken administrative notice (see 20 C.F.R. §§ 404.1566(d) and 416.966(d)). However, the VE may also rely on his or her professional judgment, and/or other vocational publications as long as they are reliable. Representatives and ALJs may ask the VE why he or she considers such publications to be reliable sources. If a representative requests that the ALJ issue a subpoena to obtain the VE's sources, the ALJ must evaluate the request under 20 C.F.R. §§ 404.950(d) and 416.1450(d) and follow the procedures listed in HALLEX I-2-5-78.

- *If the representative argues that the VE did not provide reliable job numbers*, ask the VE what sources, methodology, calculations, and other information he or she relied upon in presenting the job numbers, noting where he or she relied on a publication of which the agency has taken administrative notice. Ask the VE whether the occupation identified was a "representative occupation" from a broader category of occupations. If so, ask how he or she calculated the numbers, since not all occupations in the broader category may fit within the hypothetical limitations.

- *If the representative asserts that he or she obtained job numbers from another source*, ask how he or she obtained such numbers, and ask the VE for an opinion on the accuracy and reliability of the representative's numbers. Address and resolve any conflicts between the VE's numbers and the representative's numbers in the decision.

- *If the representative objects to any reliance on the DOT* (perhaps asserting that another job source is more appropriate), remember that the DOT is one of the publications of which the agency has taken administrative notice under the regulations. Further, SSR 00-4p only requires ALJs to determine whether VE testimony conflicts with the DOT. It does not require ALJs to ask whether there are conflicts between the DOT and other job source publications. Nevertheless, it is proper for a representative (or ALJ) to inquire into whether specific information in the DOT remains accurate.

- *In order to avoid remands, and to identify and properly resolve conflicts with the DOT*, ask the VE whether his or her testimony conflicts with the DOT. If the VE says the testimony conflicts with the DOT, ask the VE to provide a reasonable explanation for the conflict. If the VE says the testimony does not conflict with the DOT, still be on the lookout for *apparent* conflicts (see discussion in the next section of this memorandum, regarding a Fourth Circuit case, *Pearson v. Colvin*). Or, consider asking more specific questions to further explore whether there may be conflicts. If the representative states that there are, or may be, conflicts, ask the VE to address the issue. Keep in mind whether the VE's testimony was based on the VE's professional experience and/or contained more specific information about the job than the DOT provides; whether the representative's allegation of a conflict with the DOT is based on mere speculation about how the job is performed; and whether the job has evolved such that VE testimony is critical. Address and resolve any conflicts in the decision writer instructions and the written decision.

- *Request that any objections be specific*. Either rule on them at the hearing, or take them under advisement. Address them in the decision writer instructions and the written decision, providing a clear explanation and resolution.

<u>Fourth Circuit (West Virginia, Virginia, Maryland, North Carolina, and South Carolina)</u>

The following guidance may be particularly helpful to ALJs and DWs assigned cases in and from the Fourth Circuit. In *Pearson v. Colvin*, 810 F.3d 204 (4th Cir. 2015), the United States Court of Appeals for the Fourth Circuit held that ALJs had an affirmative duty to identify conflicts separate and apart from the testimony of a VE. Specifically, the Court held that "[t]he ALJ independently must identify conflicts between the expert's testimony and the *Dictionary*." *Id.* at 209.

The Court further held that an ALJ has a duty to identify "apparent" conflicts with the DOT. In defining "apparent," the Court concluded that an "apparent" conflict is one that seems "'real or true, but [is] not necessarily so.'" *Id*. In so holding, the Fourth Circuit explained that a VE's

"testimony that apparently conflicts with the *Dictionary* can only provide substantial evidence if the ALJ has received this explanation from the expert and determined that the explanation is reasonable and provides a basis for relying on the testimony rather than the *Dictionary*." *Id.* at 209–10. Put another way, and as the Court observed, an ALJ must identify where the expert's testimony seems to, but does not necessarily, conflict with the DOT. *See id*. at 209. In many cases, VE testimony may only appear to conflict with the DOT, and the VE may be able to explain that, in fact, no conflict exists. However, if the ALJ does not elicit this explanation, then the expert's testimony cannot provide substantial evidence to support the ALJ's decision. *Id.*

In light of *Pearson* and similar holdings, the following guidance may be helpful. Rather than making only a "blanket" request of the VE to alert the ALJ if there are any conflicts between his or her testimony and the DOT, after the VE identifies occupations based on the claimant's vocational criteria and the RFC, an ALJ might ask the VE questions such as:

1. Ms./Mr. VE, please review the occupations you have identified in response to my hypothetical and compare their DOT requirements with the limitations in the hypothetical. Are there any conflicts – apparent or otherwise - between the DOT's requirements and the hypothetical's limitations?
2. [If there are conflicts] For each of the conflicts you just listed, please explain why a person with the limitations described in the hypothetical could still perform the occupations you identified? What is the basis for your conclusion(s)?
3. Do you need to revise the number of jobs you have identified within each occupation to account for this identified conflict(s)? If yes, please do so and provide the revised numbers to us.
4. Are there any other matters covered in your testimony that are not addressed in the DOT?
5. If so, what is the basis for your testimony regarding such matters?

The decision should include the VE's explanation(s) and should resolve any conflicts.

<u>Seventh Circuit (Wisconsin, Illinois, Indiana)</u>

The United States Court of Appeals for the Seventh Circuit has issued several opinions in recent years addressing VE issues. The Court's approach has varied somewhat based on case-specific circumstances, but, among other things, the Court has questioned the source and accuracy of the job numbers cited by VEs and emphasized that claimants are entitled to the data and reasoning supporting the VE's testimony. Given these decisions, the following guidance may be particularly helpful to ALJs and DWs in cases from Wisconsin, Illinois, and Indiana:

1. An ALJ must evaluate VE testimony.

- HALLEX I-2-5-48: "The VE's opinion is not binding on the ALJ. The ALJ must weigh a VE's opinion along with all other evidence." (20 C.F.R. §§ 404.1560(b)(2), 404.1566(e), 416.960(b)(2), and 416.966(e))

- HALLEX I-2-5-55: "If a claimant raises an objection about a VE's opinion, the ALJ must rule on the objections and discuss any ruling in the decision."

2. An ALJ must allow the claimant or representative to fully question the VE on pertinent matters.

- HALLEX I-2-6-74: "The claimant and the representative have the right to question the VE fully on any pertinent matter within the VE's area of expertise. However, the ALJ will determine when they may exercise this right and whether questions asked or answers given are appropriate."

3. Questions about sources the VE is relying on and how the VE is using those sources concern "pertinent matter[s] within the VE's area of expertise." They are, therefore, appropriate questions. *See* HALLEX I-2-6-74.

4. ALJs should evaluate any subpoena request for materials from a VE under the standards in the regulations and HALLEX (20 C.F.R. §§ 404.950(d) and 416.1450(d); HALLEX I-2-5-78), and grant or deny the subpoena as appropriate. It is a best practice to encourage VEs to bring to the hearing source materials and/or citations to those materials that the VE anticipates he or she may rely on. The VE must be able to identify the source materials he or she has relied on with specificity.

5. If a VE says he or she is relying on source materials that he or she has at the hearing, the ALJ should generally allow the claimant or representative to inspect the materials if they ask to do so.

6. If a VE says he or she is relying on source materials that he or she does not have at the hearing, the claimant or representative is entitled to inquire as to how the VE knows what the sources say.

7. If the claimant or representative asks the VE to provide additional materials after the hearing, the ALJ should evaluate whether the VE has already provided sufficient data supporting her testimony or whether additional data is necessary to determine whether the testimony was reliable.

- If the VE provides citations to publicly available sources, this material may not need to be produced for a full presentation of the case.

- If the VE relies on sources that are not publicly available, the ALJ should generally require the VE to provide the materials after the hearing if the claimant or representative asks to review them. Voluminous materials may be made available for review in the hearing office.

8. If the claimant argues that VE testimony is not reliable, but the ALJ disagrees, the ALJ should address the issue in the decision. HALLEX I-2-5-55.

Hearing office staff should contact the Regional Office with questions. The staff contact for Regional inquiries is (b) (6), who may be reached at (b) (6).

cc: Regional Chief Administrative Law Judges
Regional Office Management Teams
Hearing Office Management Teams

V.F. Transferability of Work Skills Analysis 9 Stages of Transferability of Work Skills Analysis

[404.1568, 416.968, SSR 82-41]

1. The first stage is to determine whether transferable work skills are even required. (Appendix 2, Subpart P, Regulations No. 4; SSR 82-63; SSR 85-15) If transferable work skills are not required for a legally sufficient decision, the transferability of work skills analysis should be ended. If transferable work skills are required, proceed with the following analysis.

2. The work activity from which the "skills" were acquired must meet the 3-part "past relevant work" (PRW) test (recency, duration, and substantial gainful activity) and must be semi-skilled or skilled, ***not unskilled.***

3. The specific transferable work skills (not aptitudes or traits) and the PRW (i.e., not hobbies, life experiences, etc.) from which the skills were acquired must be identified.

4. The occupations to which the work skills are transferable must be semi-skilled or skilled, ***not unskilled.***

5. The specific occupations to which the work skills are transferable must be identified.

6. The occupations to which the work skills are transferable must be within the claimant's residual functional capacity (RFC).

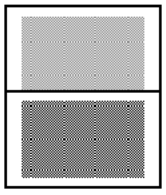
7. The occupations to which the work skills are transferable must require the transferable work skills, but no additional work skills.

8. If the claimant is age 55 or older and limited to sedentary work or age 60 or older and limited to light or sedentary work, for the work skills to be transferable there must be "very little, if any, vocational adjustment required in terms of tools, work processes, work settings, or the industry." (Sections 201.00 (f) & 202.00(f), Appendix 2, Subpart P, Regulations No. 4)

9. The decision must include rationale and "Finding" for each stage of the above analysis as appropriate.

TRANSFERABILITY OF SKILLS

	Younger Individual 18-49	Closely Approaching Advanced Age 50-54	Advanced Age 55-59	Closely Approaching Retirement Age 60-64
Sedentary				
Light				
Medium				
Heavy				



= Transferability of skills material

= Transferability of skills material, with very little, if any, vocational adjustment

V.G. Dictionary of Occupational Titles *APPENDICES*

(4th Ed., Rev. 1991)

V.H. Selected Characteristics of Occupations Appendices *(link)*

VI. HALLEX I-2-6-78; Closing the Hearing Tab

VI. HALLEX I-2-6-78; Closing the Hearing

I-2-6-78. Closing the Hearing

Last Update: 5/1/17 (Transmittal I-2-199)

Before closing the hearing, the administrative law judge (ALJ) will remind the claimant that he or she must inform the ALJ about or submit all evidence known to him or her that relates to whether he or she is blind or disabled. See 20 CFR 404.1512 and 416.912. The ALJ will remind the representative of the duty to help the claimant obtain the necessary information. See 20 CFR 404.1512, 404.1740, 416.912, and 416.1540.

The ALJ will ask the claimant and the representative if they are aware of any additional evidence that relates to whether the claimant is blind or disabled.

> **NOTE:**
> Evidence generally does not include a representative's analysis of the claim or oral or written communications between a claimant and his or her representative that are subject to the attorney-client privilege, or that would be subject to the attorney-client privilege if a non-attorney representative was an attorney. See 20 CFR 404.1513(b) and 416.913(b).

If the claimant and the representative have no additional evidence to submit or to disclose to the ALJ, and the ALJ determines that no additional evidence is needed, the ALJ will state on the record that the hearing and record are closed. In addition, the ALJ will advise the claimant and the representative that he or she will issue a written decision setting forth the findings of fact and the conclusions of law.

If the claimant or representative has additional evidence to submit, the ALJ will consider whether to grant an extension of time to submit the evidence using the procedures in Hearings, Appeals and Litigation Law (HALLEX) manual I-2-7-20 A. When the ALJ determines that additional evidence is needed (for example, a consultative examination or an updated medical report), the ALJ will inform the claimant and representative (if any) that the record will remain open after the hearing to allow time to submit or obtain the additional evidence. If the claimant and representative intend to submit additional evidence, the ALJ will decide how long to leave the record open. If the ALJ intends to obtain additional evidence, the ALJ will advise the claimant and the representative that, before the ALJ issues a decision, the ALJ will give them an opportunity to examine the evidence, provide comments, object to the evidence, refute the evidence by submitting other evidence, or request a supplemental hearing, if necessary. For specific proffer instructions, see HALLEX I-2-7-1. The claimant or representative may knowingly and voluntarily waive the right to examine the evidence. If they knowingly and voluntarily waives this right, the ALJ will indicate such waiver on the record. For more information about the waiver, see HALLEX I-2-7-15.

VII. Post Hearing Tab

VII. Post Hearing

VII.A. Post Hearing Development

VII.A.1. HALLEX I-2-7-20; Claimant Requests Additional Time to Submit Evidence After the Hearing

I-2-7-20.Claimant Requests Additional Time to Submit Evidence After the Hearing

Last Update: 5/1/17 (Transmittal I-2-200)

A. Setting a Time Limit for Submitting Posthearing Evidence

Generally, an administrative law judge (ALJ) may decline to consider or obtain evidence that a claimant did not inform the Social Security Administration (SSA) about or submit at least five business days before the date of the scheduled hearing, unless the circumstances in 20 CFR 404.935(b) and 416.1435(b) apply (see Hearings, Appeals and Litigation Law (HALLEX) manual I-2-6-58 and I-2-6-59). For the definition of business day, see HALLEX I-2-5-1 NOTE 3.

When a claimant or appointed representative misses the five-day deadline and requests additional time to submit evidence after the hearing, the ALJ generally will evaluate whether the circumstances in 20 CFR 404.935(b) and 416.1435(b) apply using the procedures in HALLEX I-2-6-59.

> **NOTE:**
> In title XVI cases other than those based on an application for benefits (e.g., age 18 redeterminations, continuing disability reviews, and terminations), the ALJ will accept any evidence submitted on or before the date of the hearing decision. See 20 CFR 416.1435(c).

If the ALJ grants a claimant's or representative's request for additional time to submit evidence after the hearing, the ALJ will:

- Set a time limit for submitting the evidence; and
- Inform the claimant and appointed representative (if any) that if the ALJ does not receive the evidence within the set time limit, the ALJ will issue a decision without considering the evidence (absent a showing that the circumstances in 20 CFR 404.935(b) and 416.1435(b) apply).

Hearing office (HO) staff will diary the case for the time limit set by the ALJ.

B. Evidence Not Submitted

The ALJ will issue a decision without the additional evidence when:

- The ALJ notified the claimant and appointed representative (if any), of the deadline for submitting the evidence as set forth in HALLEX I-2-7-20 A above; and

- The claimant or appointed representative (if any) does not submit the evidence or show that the circumstances in 20 CFR 404.935(b) or 416.1435(b) apply (see HALLEX I-2-6-58 and I-2-6-59).

When these criteria are met, it is not necessary for the ALJ or designated HO staff to recontact the claimant or appointed representative (if any) before the ALJ issues the decision.

> **NOTE:**
> However, to document all attempts to fully and fairly develop the record, the ALJ will explain in the decision any actions taken relating to good cause statements, extensions of the time limit, and non-receipt of evidence. Documentation of attempt(s) to obtain evidence such as a letter from a medical provider that the information is not available should be entered into the claim(s) file.

If the ALJ does not receive the evidence by the set time limit, but the claimant requires additional time because the circumstances in 20 CFR 404.935(b) or 416.1435(b) apply, the ALJ will:

- Set another time limit by which the evidence must be received;

- Inform the claimant and appointed representative (if any) of the revised time limit;

- Remind the claimant and appointed representative (if any) that if the material is not received by that time, he or she will issue a decision without considering the evidence;

- Tell the claimant and appointed representative (if any) that he or she will not grant any additional extensions unless the circumstances in 20 CFR 404.935(b) or 416.1435(b) apply; and

- Document the revised time limit in the record.

The ALJ will use the same instructions above when a claimant or appointed representative (if any) submits subsequent requests for extensions to the time limit.

C. Receipt of Evidence

1. No Other Parties to the Hearing

When a claimant or appointed representative (if any) submits posthearing evidence and there is no other party to the hearing (as defined in HALLEX I-2-1-45), the ALJ, or HO staff under the ALJ's direction, will:

- Mark the evidence as an exhibit;
- Add the exhibit to the List of Exhibits under the heading “RECEIVED FROM THE CLAIMANT/REPRESENTATIVE SUBSEQUENT TO THE HEARING”; and
- Place the exhibit in the claim(s) file.

2. Multiple Parties to the Hearing

If there are multiple parties to a hearing (as defined in HALLEX I-2-1-45) and evidence is submitted by one party, all other parties to the hearing have the right to review the evidence. On receipt of the information, the ALJ must proffer the evidence to the other parties to the hearing, unless the other parties have waived the right to review the evidence. See HALLEX I-2-7-1.

VII.A.2. Medical Expert Evidence

VII.A.2.a. HALLEX 1-2-5-42; Obtaining Medical Expert Opinion through Expert Interrogatories

I-2-5-42. Obtaining Medical Expert Opinion Through Interrogatories

Last Update: 4/1/16 (Transmittal I-2-170)

A. General

Usually, an administrative law judge (ALJ) will obtain medical expert (ME) testimony in person, by video teleconferencing, or by telephone at a hearing. These methods provide the ALJ, claimant, or appointed representative, if any, the opportunity to question the ME at the time testimony is given. However, an ALJ can also obtain ME testimony through written interrogatories.

Interrogatories are often used when an ALJ receives posthearing evidence that requires further review because it appears the additional evidence may affect the outcome of the case. However, an ALJ can use interrogatories at any time in the hearing process. The ALJ may obtain interrogatories at the request of the claimant or representative, or on his or her own initiative.

NOTE:
Under the direction of management, certain attorney adjudicators or designated hearing office (HO) staff may also request written interrogatories on their own initiative when a case has not yet been assigned to an ALJ. See Hearings, Appeals and Litigation Law (HALLEX) manual I-2-5-29 for more information about proffering prehearing interrogatories.

B. Preparing Interrogatories

When preparing interrogatories, the ALJ will:

- Phrase questions in a way that does not direct or suggest a specific conclusion;
- Ask questions that will elicit a clear and complete response that will, as much as possible, be expressed in terms the claimant will understand (see HALLEX I-2-5-93 for instructions on how to access sample interrogatories); and
- Leave sufficient space between the questions for the ME to answer the questions.

C. Sending the Interrogatories to the ME

1. Information to Send With Initial Interrogatories

Assisting HO staff will send the interrogatories to the ME along with a letter explaining the request and the requested method of response. For instructions on how to access a sample letter, see HALLEX I-2-5-95. The letter must clearly identify the claimant and indicate that the ME should respond within 10 calendar days. Staff will also add a copy of the letter to the E section of the claim(s) file and exhibit the letter.

Additionally, assisting HO staff will send the following with the letter:

- For an electronic claim(s) file, a compact disc (CD) of the exhibit list, or, for a paper claim(s) file, a copy of the exhibit list;
- CD copies or photocopies of the pertinent evidence, arranged in chronological order;
- A copy of the ME's professional qualifications for verification;
- A transcript or summary of pertinent testimony provided at a hearing (if applicable);
- A statement of the issues in the case;
- A contractor's invoice for signature by the ME, or, if the Office of Disability Adjudication and Review does not have a blanket purchase agreement with the ME, optional Form 347 (Order for Supplies or Services);
- The name and telephone number of an HO contact person; and
- A self-addressed, postage paid envelope large enough for the ME to return all enclosures and responses to the interrogatories.

2. Response to Interrogatories

When the ME responds, the ALJ must proffer the response to the claimant and representative, if any. For instructions, see HALLEX I-2-5-44. HALLEX I-2-5-44 also includes instructions if additional evidence is received after receipt of a response to interrogatories.

VII.A.2.b. HALLEX 1-2-5-44; Action When ALJ Receives Medical Expert's Responses to Interrogatories

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VII.A.3. Obtaining Vocational Evidence After the Hearing

VII.A.3.a. Obtaining VE Testimony After the hearing

I-2-5-56.Obtaining Vocational Expert Testimony After the Hearing

Last Update: 8/29/14 (Transmittal I-2-118)

An administrative law judge (ALJ) may determine vocational expert (VE) evidence is needed during or after a hearing. For example:

- The claimant may establish the existence of another severe impairment that requires VE testimony to evaluate step 5 of the sequential evaluation process.
- Evidence submitted after the hearing indicates that the claimant's functional limitations differ from the hypothetical questions presented to the VE at the hearing.

When VE testimony is needed after the hearing has been held, the ALJ will determine whether the testimony will be obtained in a supplemental hearing or in written interrogatories. In deciding how to obtain the testimony, the ALJ must carefully balance administrative efficiency with the claimant's rights with respect to post-hearing evidence. See Hearings, Appeals and Litigation Law manual I-2-5-30. The ALJ may consider:

- Whether and when a VE would be available to testify at a supplemental hearing;
- The feasibility of scheduling a hearing at a remote hearing site; and
- The potential for delays if a supplemental hearing is scheduled.

If the ALJ determines a supplemental hearing is needed, the ALJ will direct the expert to appear by video teleconferencing (VTC) or telephone when:

- VTC or telephone equipment is available;
- Use of VTC or telephone equipment would be more efficient than conducting an examination of a witness in person; and
- There is no other reason VTC or telephone should not be used.

> **NOTE:**
> Regardless of the method used to obtain VE evidence, or whether the claimant is represented, the ALJ must question the VE in lay terms and elicit responses in terms that the claimant can understand (to the extent possible).

VII.A.3.b. HALLEX I-2-5-57; Obtaining Vocational Expert Opinion through Interrogatories

I-2-5-57. Obtaining Vocational Expert Opinion Through Interrogatories

Last Update: 8/29/14 (Transmittal I-2-118)

A. General

As noted in Hearings, Appeals and Litigation Law (HALLEX) manual I-2-5-30, it is generally preferred that an administrative law judge (ALJ) obtain vocational expert (VE) opinion at a hearing because live testimony provides the opportunity to ask the VE any questions material to the issues, including questions that arise for the first time during the hearing. However, there are circumstances in which it is more appropriate to obtain a VE opinion through written interrogatories.

An ALJ can use written interrogatories at any point in the adjudication process. A claimant or appointed representative may ask the ALJ to obtain interrogatories, or the ALJ may decide to use them on his or her own initiative.

> **NOTE:**
> When the ALJ receives new evidence after the VE provides an opinion, see HALLEX I-2-5-60.

B. Preparing Interrogatories

When preparing interrogatories, the ALJ will:

- Phrase each interrogatory in a way that will not suggest any specific conclusion but will elicit a clear and complete response that can ultimately be expressed (to the extent possible) in lay terms. (See sample interrogatories in the Document Generation System (DGS));
- Ensure each interrogatory is case specific and tailored to the facts of the individual case at issue;

- Include any interrogatory needed to identify or address possible conflicts in the record regarding vocational issues. (See Social Security Ruling (SSR) 00-4p: Titles II and XVI: Use of Vocational Expert and Vocational Specialist Evidence, and Other Reliable Occupational Information in Disability Decisions);
- If applicable, include any interrogatory that is appropriate for a VE response to assist the ALJ in evaluating the effects of mental impairments on a claimant's ability to work. (See SSR 85-15: Titles II and XVI: Capability To Do Other Work-The Medical-Vocational Rules as a Framework for Evaluating Solely Nonexertional Impairments);
- Leave sufficient space between the questions for the answers.

C. Information to Send With Interrogatories

1. Document Generation System (DGS) Letter
The ALJ will send the interrogatories to the VE with a letter explaining the request and the requested method of response. A template for the letter can be found in DGS, as noted in HALLEX I-2-5-95. The letter will include all identifying information and request a response within 10 days. A copy of the letter must be associated with the claim(s) file and exhibited.

2. Copy of Exhibit List and Pertinent Evidence From the File
The ALJ will send the VE the following information:
- A copy of the exhibit list;
- Any evidence pertinent to vocational issues from the claim(s) file;
- A transcript or summary of any pertinent testimony provided in an earlier hearing;
- A statement of the issues in the case; and
- A copy of the VE's professional qualifications (for verification).

> **NOTE:**
> Do not include the professional qualifications of any other sources.

If the claim(s) file is electronic, the ALJ will send the information on a compact disc. If the claim(s) file is paper, the ALJ will send photocopies of the information. For more information, see also hearing office electronic business process (eBP) sections 3.3 and 5.1.

3. Invoice
The ALJ will send a copy of the expert call order for signature by the VE. See also eBP sections 2.3, 3.3, and 5.1 for additional guidance on preparing expert call orders.

4. Contact Information
The ALJ, or designated staff, will provide the VE the name and telephone number of a hearing office contact if the VE has any questions.
Additionally, the ALJ or designated staff must provide the VE with a self-addressed, postage paid envelope large enough for the VE to return all enclosures.

VII.A.3.c. HALLEX I-2-5-58; Action When ALJ Receives VE's Responses to Interrogatories

VII.B. Proffer

VII.B.1. HALLEX I-2-7-1; Post-Hearing Evidence – When Proffer is Required

I-2-7-1. Posthearing Evidence – When Proffer Is Required

Last Update: 4/1/16 (Transmittal I-2-171)

A. Definition of Proffer

Generally, to "proffer" means to offer or present for consideration. In the context of evidence development, to "proffer" means to provide an opportunity for a claimant (and appointed representative, if any) to review additional evidence that has not previously been seen and that an adjudicator proposes to make part of the record. Proffering evidence allows a claimant to:

- Comment on, object to, or refute the evidence by submitting other evidence; or
- If required for a full and true disclosure of the facts, cross-examine the author(s) of the evidence.

B. When Proffer Is Required

When an administrative law judge (ALJ) receives additional evidence after the hearing from a source other than the claimant or the appointed representative, if any, and the ALJ proposes to admit the evidence into the record, he or she will proffer the evidence to the claimant and appointed representative, if any. For a description of information an ALJ will exhibit, see Hearings, Appeals and Litigation Law (HALLEX) manual I-2-1-15. When proffer is required, the ALJ will usually offer the claimant an opportunity for a supplemental hearing. See subsection C below.

> **NOTE:**
>
> An ALJ must always proffer interrogatory responses from a medical or vocational expert, or posthearing consultative examination reports. Proffer is required even if interrogatory responses were obtained prehearing. (For prehearing proffer procedures, see HALLEX I-2-5-29).

An ALJ will not proffer posthearing evidence when:

- The evidence was submitted by the claimant or the appointed representative, if any, and there is no other party to the hearing (see HALLEX I-2-7-20). (For more information about who is a party to the hearing, see HALLEX I-2-1-45);

- The claimant has knowingly waived his or her right to examine the evidence (see HALLEX I-2-7-15); or
- The ALJ issues a fully favorable decision.

For more information about specific proffer procedures, see HALLEX I-2-7-30. Additionally, when there are multiple parties to a hearing, the ALJ must proffer additional evidence from one of the parties to all parties to the hearing. For an explanation of who is a party to a hearing, see HALLEX I-2-1-45.

C. When Offering a Supplemental Hearing With Proffered Evidence Is Required

In addition to proffering posthearing evidence, an ALJ will offer the claimant the opportunity for a supplemental hearing unless:

- The ALJ admits non-opinion evidence into the record but does not cite to or otherwise rely on the additional evidence when making a finding; or
- The evidence is of a nature that it has no significant impact on the outcome or processing of the claim (e.g., medical treatment for a common ailment that the ALJ reasonably finds is unrelated to the claimant's impairment(s)).

> **NOTE:**
> Offering a supplemental hearing is required if the proffered evidence includes any opinion evidence or a medical examination report requested by the ALJ (e.g., a consultative examination report).

If a claimant requests a hearing on proffered evidence when the ALJ appropriately did not offer a supplemental hearing (i.e., the criteria above is met), the ALJ has discretion to decide whether to grant the request. However, if the ALJ offered the right to a hearing on the proffered evidence, even in error, the ALJ must grant any request for a supplemental hearing.

VIII. Decisions Tab

VIII Decisions

VIII.A.1. Erosion of Occupational Base 02/02/17 BI-WEEKLY POLICY

Scope: All Regions
Tracking Number: 17-001 Rev 1
Status: Active
Brief Question
When do amounts lifted affect the "medium occupational base"?

Detailed Question:
Is the "medium occupational base" significantly eroded if an individual can lift at least 25 pounds frequently, but cannot lift 50 pounds occasionally?

Answer:
In general an individual must be capable of lifting 25 pounds frequently and 50 pounds occasionally to do the full range of medium work. SSR 83-10 states that it is much more critical that an individual be capable of lifting 25 pounds frequently than that they be able to lift up to 50 pounds. Therefore, if the claimant can lift 25 pounds frequently he or she may be capable of performing most medium work. If, however, the claimant is not capable of lifting 25 pounds frequently, in most instances, we would expect the medium occupational base to be significantly eroded. Please contact a Vocational Specialist for an analysis of each case's specific facts.

Category:	Disability Policy	Posted:02/01/2017
Subcategory:	Policy	Answered on:02/01/2017
Purpose:	Policy Clarification	
Initiating Component:	CO	Review Frequency:12 (months)
Answered by:	ODP	Last Reviewed:02/01/2017
Responsible CO Component:	ODP	Due for Review:02/01/2018

Links to References: POMS DI 25025.015

History: 17-001 - (b) (2)
17-001 Rev 1 - (b) (2)

VIII.A.2. Citing a Social Security Ruling (SSR) at Step 5 POMS DI 25025.001C

Use this desk guide to help identify appropriate rulings that explain the impact of specific non-exertional limitations on the occupational base. Adjudicators may cite these rulings in lieu of citing 3 occupations that a claimant can perform when denying a claim using a vocational rule as framework for the decision. See DI 25025.001C.	
SSR 83-10	• Many unskilled light jobs are performed primarily in one location, with the ability to stand being more critical than the ability to walk. • Sedentary work requires no significant stooping. • Weight lifted in light jobs may be very little but a good deal of standing/walking is the primary difference between sedentary and most light jobs. • For medium work, ability to lift 25 pounds frequently is more critical than being able to lift up to 50 pounds occasionally. • Medium work generally requires frequent but not constant stooping and crouching. • Light and medium jobs generally do not require the use of the fingers for fine activities to the extent required in much sedentary work.
SSR 83-12	• An individual with an amputation below the elbow has an occupational base for a little more than sedentary work. • Typically, at professional and managerial jobs an individual can sit or stand with a degree of choice. • Unskilled jobs are usually not structured so that an individual can sit or stand at will; however, individuals who can adjust to any need to vary sitting and standing by doing so at breaks, lunch periods would not have substantial erosion of the occupational base.
SSR 83-14	• Limitations on ability to ascend or descend scaffolding poles and ropes, inability to crawl, and inability to use fingertips to sense temperature or texture do not significantly affect the unskilled medium, light or sedentary occupational base. • Light and sedentary work requires only occasional stooping. Very few jobs in the national economy require ascending or descending ladders or scaffolding. • Very few jobs in the national economy require ascending or descending ladders or scaffolding.

SSR 85-15	• An individual who can meet the mental demands of unskilled work will have an unrestricted unskilled occupational base. • Unskilled work primarily requires working with things rather than people. • A limitation in climbing and balancing with no other limitation has no impact on occupational base. • Crawling and kneeling are relatively rare even in arduous work. • An individual who retains sufficient visual acuity to be able to handle and work with rather large objects and has the visual fields to avoid hazards in the workplace would have a substantial remaining occupational base. • Restriction from excessive environmental exposures has very little impact on occupational base.
SSR 96-9p	• If a claimant can perform all of the following activities, the sedentary, unskilled occupational base is not eroded: understand, remember, and carry out simple instructions; make judgments that are commensurate with the functions of unskilled work; respond appropriately to supervision, co-workers and usual work situations; deal with changes in a routine work setting. • Ability to lift /carry slightly less than 10 pounds -- unskilled sedentary occupational base not significantly eroded. • Ability to stand/walk slightly less than 2 hours per day – unskilled sedentary occupational base not significantly eroded. • Very few unskilled sedentary occupations require exposure to hazards, extreme cold, heat, wetness, humidity, or vibration. • Assistive device used when only one extremity is affected , when assistive device is needed only for prolonged ambulation, walking on uneven terrain, ascending or descending slopes, or can occasionally lift small items with the free hand, the sedentary occupational base not significantly limited. • Limited in balancing on narrow, slippery erratically moving surfaces would not result in significant erosion of the sedentary occupational base.

VIII.B. Policy Compliance

VIII.B.1. CALJ Memo, 01/11/13, #11-1460; Compliance with Agency Policy

SOCIAL SECURITY

MEMORANDUM

Date: January 11, 2013

Refer To: 11-1460

To: All Administrative Law Judges
All Senior Attorneys

From: Debra Bice ***/s/***
Chief Administrative Law Judge

Subje c Compliance with Agency Policy – **INFORMATION**

This Memorandum is a reminder to all Administrative Law Judges (ALJs) and Senior Attorney Adjudicators (SAAs) to follow agency policy, including policies contained in Emergency Messages (EM), Administrative Messages (AM), and the Hearings, Appeals and Litigation Law Manual (HALLEX). EMs, AMs, and HALLEX changes are distributed at the time of issuance through Daily PolicyNet postings. We have ensured all ODAR staff now receive Daily PolicyNet postings via e-mail and agency policy is also accessible via PolicyNet.

Sections 205(a) and (b) and 1631(c) and (d) of the Social Security Act (Act) grant the Commissioner of Social Security (Commissioner) the power and authority to make rules and regulations and establish procedures which are necessary or appropriate to carry out the provisions of the Act, as well as to make findings of fact and decisions as to the right of any individual applying for payment under the Act. Under the Commissioner's delegated authority to implement the provisions of the Act, the agency may, from time to time, issue instructions, through EMs, AMs, or HALLEX, that explain the agency's policies, regulations, rulings, or procedures. The ALJs and SAAs who decide cases under the authority delegated to them by the Commissioner are required to follow such instructions because they represent the agency's considered policy about the interpretation of the statute and the Commissioner's regulations.

The Office of the General Counsel has advised that ALJs and SAAs are subordinate to the agency on matters of law and policy. As a result, agency adjudicators, including ALJs and SAAs, do not have the authority to disregard or decline to follow agency policy, including policy contained in EMs, AMs, or HALLEX. Congress delegated the authority to interpret the statute, and to make policy based on that interpretation, to the Commissioner as the highest official of the agency, not to individual adjudicators. Because the agency has not delegated to any ALJ or SAA the authority to determine agency policy, no ALJ or SAA has the authority to decline to follow agency policy, even if that policy is stated in documents such as an EM, AM, or HALLEX.

Except in rare cases in which the district court has ordered us to apply its holding to other claims, as in a class action, the agency does not consider district court decisions to be precedential. Typically, an ALJ or SAA should not consider any district court decisions except when one of his or her own decisions has been remanded by the district court. The agency has articulated a policy regarding the application of Circuit Court decisions.

Social Security Ruling (SSR) 96-1p states in pertinent part:

> To clarify longstanding policy that, unless and until a Social Security Acquiescence Ruling (AR) is issued determining that a final circuit court holding conflicts with the Agency's interpretation of the Social Security Act or regulations and explaining how SSA will apply such a holding, SSA decisionmakers continue to be bound by SSA's nationwide policy, rather than the court's holding, in adjudicating other claims within that circuit court's jurisdiction. This Ruling does not in any way modify SSA's acquiescence policy to which the Agency continues to remain firmly committed, but instead serves to emphasize consistent adjudication in the programs SSA administers. This Ruling is also issued to clarify longstanding Agency policy that, despite a district court decision which may conflict with SSA's interpretation of the Social Security Act or regulations, SSA adjudicators will continue to apply SSA's nationwide policy when adjudicating other claims within that district court's jurisdiction unless the court directs otherwise.

As explained in SSR 96-1p, court decisions are no exception to the agency's longstanding policy that ALJs and SAAs are required to follow the instructions the Commissioner provides to them. The agency has issued regulations and Social Security Ruling (SSR) 96-1p directing how and when its adjudicators are to consider and apply court decisions. Therefore, an ALJ or SAA may not decline to follow a policy based on his or her own reading of a court decision that he or she interprets as being contrary to agency policy.

Hearing office staff should raise questions through their management chain to their regional office. Regional Office staff may refer questions or unresolved issues to their Headquarters contacts in my office.

cc:
Regional Chief Administrative Law Judges
Regional Office Management Teams
Hearing Office Management Teams

VIII.B.2. CALJ Memo, 3/27/2017: Drafting Succinct Fully Favorable Decisions

SOCIAL SECURITY

MEMORANDUM

Date: March 27, 2017 Refer To:

To: All Administrative Law Judges
All Decision Writers

From: Patrick Nagle /s/
Chief Administrative Law Judge

Subject: Drafting Succinct Fully Favorable Decisions — **INFORMATION AND REMINDER**

Ensuring that a fully favorable decision is accurate and policy-compliant is crucial both for program integrity, and because it may be the comparison point decision for a future continuing disability review. In February 2012, Judge Bice provided guidance regarding expectations for legally sufficient decisions. With those considerations in mind, however, I am sending the following suggestions for drafting fully favorable decisions that are both legally sufficient and succinct.

General Considerations

- Focus on articulating necessary policy compliant findings and include a strong rationale with citations to evidence that supports those findings.

- Wholesale, untargeted summary of the medical evidence requires time and effort, yet does not increase the overall supportability of the decision. Instead, focus on the most relevant medical evidence that best supports or challenges the findings.
- Only briefly summarize evidence that does not strongly support or detract from the findings.
- Articulate a clear, legally sufficient, and succinct rationale as to why the longitudinal record supports the findings.

Step 1: Substantial Gainful Activity (SGA)

- If there is no evidence of SGA in the record, simply state the record shows no SGA and move on to Step 2.
- If post-onset earnings in the record do not rise to the level of SGA, a simple statement to this effect is sufficient.

Step 2: Severe Impairments

- At Step 2, identify the severe medically determinable impairments and include a general statement indicating why these impairments are severe.
- Briefly list non-severe impairments and include a general statement that these impairments either do not satisfy the durational requirement or do not more than minimally impact the claimant's vocational functioning.

Step 3: Listings

- If finding the claimant disabled at Step 3, explain how the record "meets" each of the required elements of the listing or, alternatively, refer to specific evidence that "medically equals" the requirement(s) of the listing.
- If finding that the claimant "medically equals" the requirements of a listing, be sure to concisely discuss the supporting evidence and testimony. While you cannot simply rely on the medical expert's (ME) conclusory statement, you can target your discussion on the most supportive medical evidence.
- In considering non-mental impairments in a Step 5 decision, simply identify the listings considered at Step 3, and then state that the claimant fails to meet or equal the listing(s) at issue.
- If finding a mental impairment meets or equals a listing, the decision must address the relevant "B" (or "C") criteria. See this desk guide for examples of the four areas of mental functioning and types of evidence that support each area of functioning.

Residual Functional Capacity (RFC):

- The RFC assessment should be well articulated and fully supported by both rationale and evidence. However, focus on impairments and limitations that are material to the finding of disability. For example, it is unnecessary to articulate extensively on a limitation (such as a frequent

limitation in a postural activity) that does not significantly impact the claimant's ability to perform past work or significantly erode the remaining occupational base. Spend the bulk of your time and energy supporting those findings material to the outcome.

- Identify the medical opinions in the record, grouping similar medical opinions and/or opinions from the same source. Assign appropriate weight in accordance with our regulations and SSRs, but focus on the medical opinion upon which you are relying.
- Briefly assess the extent to which the claimant's allegations are consistent with, and supported by, the evidence of record. A detailed subjective allegation analysis is only required when an SSR 16-3p factor(s) is particularly important to the RFC conclusions.

Step 4: Past Relevant Work (PRW)

- The most important parts of the Step 4 discussion in a fully favorable decision are explaining whether the claimant has PRW and, if so, why the claimant cannot perform that PRW given the RFC.
- To establish whether the claimant can perform PRW, compare the claimant's function-by-function RFC with the demands of the PRW, both as actually performed by the claimant, and as the work is generally performed in the national economy. Typically, a brief statement is sufficient.

Step 5: Other Work

- If the ALJ bases the favorable decision on **direct application** of the grid rules, the Step 5 analysis ends without the need for further discussion.
- If the ALJ relies on the **framework** of a grid rule, explain whether a vocational expert (VE) testified at the hearing and discuss briefly the VE's testimony that no jobs remain. If no VE testified, or if section 204.00 applies, cite any appropriate SSRs and discuss how they preclude other work.

Hearing office staff should contact the Regional Office with questions. The staff contact for Regional inquiries is Attorney-Advisor (b) (6), who may be reached at (b) (6).

cc: Regional Chief Administrative Law Judges
Regional Office Management Teams
Hearing Office Management Teams

VIII.C. DECISIONAL INSTRUCTIONS

VIII.C.1. CALJ Memo 7/10/13, "Expectations for Instructions to Decision Writers—INFORMATION"

SOCIAL SECURITY

MEMORANDUM

Date: July 10, 2013 Refer To: ACL 13-203

To: Administrative Law Judges

From: Debra Bice ***/s/***
Chief Administrative Law Judge

Subject: Expectations for Instructions to Decision Writers -- **INFORMATION**

Last year, I shared some expectations for legally sufficient decisions. Legally sufficient decisions are decisions that are supported by substantial evidence and are reached through the application of the correct legal standard. As expressed in that memorandum, our goal is to provide timely decisions that are consistent with laws, regulations, rulings, and agency policy. To achieve that goal, it is important that the Administrative Law Judge (ALJ) and the decision writer work as a team to produce high quality decisions in a timely manner. The process for legally sufficient decisions begins with the issuance of clear and complete decision-writing instructions.

As expressed in HALLEX I-2-8-20, "the ALJ is responsible for providing clear directions on the rationale supporting the resolution of each issue necessary to reach the ultimate conclusion." Therefore, each ALJ should ensure that his or her instructions to the decision writer are complete, clear, and policy-compliant before releasing a case for decision writing.
In writing your instructions, you should attempt to communicate sufficient accurate information so that the decision writer fully understands the particulars of what you want in the decision and why you made that decision. Tell the decision writer the key evidence that led to your decision, and if applicable, why you did not find the claimant's statements regarding his or her limitations to be credible or supported by the evidence. Where there are conflicts in the evidence, explain how you want the

conflict resolved so that the decision writer does not have to guess. If your instructions are free of ambiguities, the decision writer will be better able to follow your instructions quickly.

The following are some things to keep in mind when preparing decision-writing instructions:

GENERAL

- Provide directions for each step of the sequential evaluation process, and clearly identify the step at which the claim is being allowed or denied. When appropriate, use the "B" and "C" criteria to rate the severity of mental impairments at steps two and three of the sequential evaluation process.
- Identify the major exhibits or testimony that provides support for your specific findings and the ultimate conclusion.
- If appropriate, indicate to the decision writer whether drug addiction and alcoholism is a contributing factor material to the determination that the claimant is disabled, and provide the rationale for the materiality finding. *See* 20 CFR 404.1535, 416.935 and SSR 13-2p.
- To ensure consistency in the form and format of the instructions and to ensure policy compliance, consider using available tools such as Electronic Bench Book and Findings Integrated Templates (FIT) or enhanced FIT instructions.
- Although we recommend that you do not use handwritten instructions, if you elect to do so, you must ensure that your handwriting is legible. Consider typing your instructions or using DRAGON software rather than handwriting the instructions.
- Avoid abbreviations that are not widely known.
- Make the instructions brief but clear. You can cover the necessary points in most cases in a few pages.

HEARING TESTIMONY

- Include the key points from relevant testimony in your instructions.
- Do not routinely instruct the decision writer to listen to the hearing recording unless there are circumstances that require the writer to listen to a particular segment. In such instances, clearly direct the writer to where the relevant testimony can be found on the recording, such as "claimant's testimony at 35:00 to 38:00."

RESIDUAL FUNCTIONAL CAPACITY (RFC)

- Specify the function by function limitations. Avoid general phrases, such as "less than sedentary" or "unable to sustain full time work," that do not phrase the RFC in functional terms.
- Use precise terms that mean the same to all. Avoid use of ambiguous terms like "moderate" in the RFC.
- Ensure that the limitation(s) for each severe impairment is included in the RFC.
- Ensure that the RFC finding in the decision is identical to the vocational expert (VE) hypothetical used during the hearing.

MEDICAL EVIDENCE AND OPINIONS

- Assign appropriate weight to all relevant opinions.
- Articulate the reasons for the weight given in clear, concise, and accurate language.
- Cite the supporting evidence.

CREDIBILITY

- Discuss the credibility of the individual's complaints of pain and other symptoms.
- Identify specific exhibits, page numbers, and testimony that support the credibility determination.

WORK HISTORY AND OTHER WORK

- When relevant, specify in the instructions your conclusion as to the claimant's past relevant work. Do not include just a recitation of the claimant's work history. See 20 CFR 404.1560 and 416.960.
- If making a step five decision, specify the other work identified by the VE. Do not instruct the decision writer to listen to the hearing recording for the work identified.

The issuance of clear and complete decision-writing instructions is a significant part of our effort to continue providing timely, legally sufficient, and accurate decisions. Although the process of preparing quality decisions may take longer, investing the time to produce a quality decision means there will be fewer remands, resulting in a reduction of the cases we must rework and the delivery of better public service.

Please contact your regional office with questions. The staff contact for regional inquiries is (b) (6), who can be reached at (b) (6).

cc: Associate Chief Administrative Law Judges
Regional Chief Administrative Law Judges
Regional Office Management Teams
Hearing Office Management Teams

VIII.C.2. CALJ Memo 06/08/16, "Expectations for Instructions to Decision Writers—CLARIFICATION"

SOCIAL SECURITY

MEMORANDUM

Date: June 8, 2016 Refer To: ACL 16-125

To: All Administrative Law Judges

From: Debra Bice */s/*
Chief Administrative Law Judge

Subject: Expectations for Instructions to Decision Writers – **CLARIFICATION**

In light of our current service crisis, with over 1 million cases pending, it is import
Judges (ALJs) may be able to be more efficient is in providing concise decision w
My memo of July 10, 2013 and the recent HALLEX I-2-8-20 revision include mar
Administrative Law Judges, and I recently discussed decision writing instructions
pending, I want to clarify the elements of decision writing instructions that are ES
ALL decision writing instructions MUST:

- Identify the step of the sequential evaluation process at which the claim is
- Identify the medically determinable impairment(s) and indicate the impairr
- Include a function-by-function residual functional capacity (RFC) assessm
- Include rationale regarding symptoms and limitations associated with thos
- Articulate the reasons for the weight given to all relevant opinion evidence
- Explain how any conflicts in the record were resolved.
- If appropriate, provide policy compliant rationale for a later onset date or c
  that the claimant is disabled. *See* 20 CFR 404.1535 and 416.935, and SSR

For those of you who would like further guidance, we posted examples of decisior
instructions at Judicial Training this summer.

I welcome your input on other ways to improve our processes so that we can provide bet

Please contact your HOCALJs if you have any questions. HOCALJs can relay inquiries (b) (6) .

cc: Associate Chief Administrative Law Judges
Regional Chief Administrative Law Judges
Regional Office Management Teams
Hearing Office Management Teams
NTEU
AFGE
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VIII.C.3. HALLEX Instructions to Decision Writers

I-2-8-20 Instructions to Decision Writers

Last Update: 3/10/16 (Transmittal I-2-167)

A. General

The administrative law judge (ALJ) adjudicating the case is responsible for providing an assisting decision writer (DW) with complete, clear, and policy compliant directions. Most importantly, the ALJ needs to include rationale supporting the findings that impact the ultimate conclusion. A DW must have enough information to specifically understand what an ALJ wants to include in the decision and why the ALJ wants that information included.

B. Specific Information to Include in Instructions

As applicable, an ALJ's decision writing instructions will generally:

- Cite to the pertinent evidence or testimony on which the ALJ relies (specifically noting the exhibits or testimony that support findings and the ultimate conclusion);
- Provide directions for each step of the sequential evaluation process, identifying the step at which the claim is being allowed or denied;
- Include instructions relating to the “B” and “C” criteria for mental impairments at steps two and three of the sequential evaluation process;
- Include any pertinent observations or comments regarding symptoms and why the symptoms are or are not supported by the evidence of record;
- Explain how the ALJ resolved any conflicts in the record;
- State the weight given to opinion evidence;
- Include a function by function residual functional capacity (RFC) assessment;
- Ensure the limitations for each medically-determinable impairment are accounted for in the RFC, especially those that are determined to be “severe”;

- Ensure the RFC in the instructions matches the RFC given to the vocational expert (VE) at the hearing;
- Make a finding(s) on applicable issue(s) relating to the claimant's past relevant work and not merely recite the claimant's work history;
- State the occupations and numbers of jobs as identified by the VE for a step 5 evaluation; and
- When applicable, include information and rationale about whether drug addiction or alcoholism is a contributing factor material to disability. (For applicability and other requirements, see Social Security Ruling 13-2p: Titles II and XVI: Evaluating Cases Involving Drug Addiction and Alcoholism (DAA)).

To help ALJs prepare policy compliant instructions, and to assist with consistency in form and format, ALJs are encouraged to use available tools to draft instructions, such as the Electronic Bench Book (eBB), Findings Integrated Templates (FIT), or enhanced FIT instructions.

C. Things to Avoid When Providing Instructions

An ALJ should avoid:

- Using abbreviations, especially those that are not commonly used;
- Using ambiguous terms like “moderate” in the RFC;
- Routinely instructing the DW to listen to the entire hearing recording (but when appropriate, ALJs may direct the DW to where the relevant testimony can be found on the hearing recording);
- Instructing the DW to listen to the VE's testimony rather than stating the occupations and corresponding number of jobs in the instructions; or
- Issuing handwritten instructions.

> **NOTE:**
> Although ALJs may use legible handwritten instructions, the practice is not optimal because DWs often have difficulty deciphering the instructions and the instructions need to be manually scanned (unlike eBB or FIT instructions).

VIII.D. Quality Decisions

VIII.D.1. CALJ Memo 2/27/12, Expectations for Legally Sufficient Decisions

SOCIAL SECURITY

MEMORANDUM

Date: February 27, 2012 Refer To: 11-1517, 11-1700

To: All Administrative Law Judges, Attorney Adjudicators, and Decision Writers

From: Debra Bice */s/*
Chief Administrative Law Judge

Subject: Expectations for Legally Sufficient Decisions – **INFORMATION**

Our mission is to provide timely and legally sufficient hearings and decisions. It is important not only that we issue decisions in a timely manner, but also that we make sure these decisions are consistent with laws, regulations, rulings, and agency policy.

Claimants who think the decision in their case is incorrect may file a request for review with the Office of Appellate Operations (OAO). If the ALJ decision is supported by "substantial evidence," OAO will deny the request for review. When the OAO issues its own decision, it bases its decision on a preponderance of the evidence. OAO's most frequent remands are due to deficiencies in the decisions when addressing medical opinions, credibility, and the residual functional capacity (RFC).

The Office of Quality Performance (OQP) recently issued two reports: the Disability Case Review of Administrative Law Judge Hearing Decisions report and the Quality Review Assessment Report of Senior Attorney Advisor Disability Decisions. The agreement rate with 299 ALJ allowance decisions issued for the period October 2009 through March 2010 was 85 percent, a decrease from earlier agreement rates. The agreement rate with 301 ALJ denial decisions for the same period was 92 percent. OQP's agreement rate for 987 senior attorney decisions issued in Fiscal Year (FY) 2010 was 94 percent, which is a statistically significant drop from a 98 percent agreement rate in FY 2008. In FY 2011, OAO's Division of Quality reviewed a larger sample of fully favorable decisions by judges and attorney adjudicators pre-

effectuation, and identified a higher percentage of adjudicative deficiencies. For more details on OAO's findings, see the recently released report: OAO Executive Director's Broadcast, Volume 3, Special Edition – Quality Review.

In light of these findings, it is important to review our expectations for all decisions, but particularly fully favorable decisions.

MEDICAL OPINIONS

While all evidence need not be recited and discussed in the decision, adjudicators do need to identify and discuss medical opinions, especially those that conflict with the established RFC. The adjudicator must provide rationale in the decision explaining the weight given to these opinions and why a specific opinion(s) is found more persuasive than others. Paragraph (d)(2) of 20 CFR 404.1527 and 416.927, and SSR 96-2p set forth the criteria used in evaluating medical opinions.

CREDIBILITY

In assessing an individual's credibility, it is insufficient for a decision to be limited to only a single, conclusory statement such as "the individual's allegations have been considered" or that "the allegations are (or are not) fully credible." Further, it is inappropriate to establish an RFC or determine an individual's credibility based solely on the individual's subjective statements. Rather, the decision must contain specific reasons for the finding on credibility, including a discussion of how "other evidence" was considered, as required in 20 CFR 404.1529(c)(3) and 416.929(c)(3). The finding must be supported by the evidence in the case record, and must be sufficiently specific so that a claimant or any subsequent reviewers can determine whether the claimant's statements were found to be credible or not credible, as well as the *reasons* for the finding.

A credibility analysis is required under the regulations whether the decision is fully favorable, partially favorable, or unfavorable. While an unfavorable decision may include a much longer discussion of these factors, every decision should include a discussion of: the longitudinal medical record; the consistency of the claimant's statements with medical signs and laboratory findings; the medical history and treatment; and prior statements to treating and other medical sources, SSA at previous steps of the administrative review process, or in connection with claims for other types of disability benefits (*see* SSR 96-7p).

RESIDUAL FUNCTIONAL CAPACITY

The RFC assessment should be well-articulated and fully supported, both by rationale and evidence. While the narrative discussion of the RFC assessment is critical in unfavorable decisions, it is just as important in fully favorable decisions that proceed past step 3. But even in fully favorable decisions, the RFC must be established based on the medical evidence of record, and the RFC assessment should include a function-by-function assessment of an individual's ability to perform work-related activities and it should describe the maximum amount of each work-related activity the individual can perform based on the evidence of record. See 20 CFR 404.1545 and 404.1569a, 416.945 and 416.969a, as well as Social Security Rulings (SSRs) 96-8p and 96-9p. This is crucial to establish a comparison point RFC in a future Continuing

Disability Review. Unsupported, generalized statements that the claimant is unable to work on a full-time basis or is limited to less than sedentary work are not legally sufficient RFCs.

Additional training on developing and articulating an RFC is available via the Office of Learning's website at learning.ba.ssa.gov/OL/. Suggested Videos on Demand (VOD's) include:

- Sequential Evaluation – Residual Functional Capacity;
- RFC for Less Than a Full Range of Sedentary;
- Mental Residual Functional Capacity;
- Physical RFC;
- Remands and How to Avoid Them;
- Supplemental Decision Writer Training – Residual Functional Capacity;
- Supplemental Decision Writer Training – Tying the Analysis Back to the RFC.

The Interactive Video Training (IVT) introduced on January 18, 2012, is the first installment of the new ODAR Continuing Education Program, a series on substantive disability topics for hearing office personnel. This IVT was mandatory for Administrative Law Judges, attorney adjudicators, and decision writers, and is now available as a VOD.

OPINIONS FROM NON-MEDICAL SOURCES

The case record should reflect the consideration of opinions from medical sources who are not acceptable medical sources and from non-medical sources who have seen the claimant in their professional capacity. The adjudicator generally should explain the weight given to opinions from these other sources, or otherwise ensure that the discussion of the evidence in the decision allows a claimant or subsequent reviewer to follow the adjudicator's reasoning, when such opinions may have an effect on the outcome of the case. Please refer to SSR 06-03p for information about considering opinions from other sources.

EARNINGS

When a claimant's records indicate earnings after the alleged onset date (AOD), the earnings should be addressed, even if they do not amount to substantial gainful activity (SGA). It is not sufficient to state the claimant has not performed SGA in such a situation. Rather, the adjudicator should acknowledge the post-AOD earnings and include a brief discussion as to why these earnings do not constitute SGA. Also, when writing the decision, the decision-writer should be sure to select the appropriate options presented by the FIT template for the Step 1 analysis. Please refer to 20 CFR 404.1574 and 416.974, as well as SSR 83-33, SSR 83-34, and SSR 05-02 for more guidance on SGA issues.

DECISION

For all decisions, adjudicators are to follow the guidelines for writing decisions set forth in HALLEX I-2-8-25. The decision must be written so the claimant can understand it, and it must be carefully proofread. The decision must also follow the sequential evaluation process and clearly state the rationale for the decisionmaker's findings on the relevant issues and the ultimate

conclusion. The FIT template guides the writer through all of these requirements. Attached is an excerpt from a well written fully favorable decision.

While we strive to accomplish the agency's number one strategic goal of eliminating the hearings backlog, we must not sacrifice the quality of our decisions. By stating a function-by-function RFC clearly, addressing conflicts in the evidence, identifying supporting evidence, and providing adequate rationale, we can meet our mission of providing both timely and legally sufficient decisions.

Hearing office staff should contact their regional office with questions. The staff contact for regional inquiries is (b) (6), who can be reached at (b) (6).

cc: Associate Chief Administrative Law Judges
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Attachment: Decision Excerpt

VIII.D.2. CALJ Memo 3/27/17, Drafting Succinct Fully Favorable Decisions ---INFORMATION AND REMINDER

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Chief Administrative Law Judge

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- In considering non-mental impairments in a Step 5 decision, simply identify the listings considered at Step 3, and then state that the claimant fails to meet or equal the listing(s) at issue.
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- Identify the medical opinions in the record, grouping similar medical opinions and/or opinions from the same source. Assign appropriate weight in accordance with our regulations and SSRs, but focus on the medical opinion upon which you are relying.
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- To establish whether the claimant can perform PRW, compare the claimant's function-by-function RFC with the demands of the PRW, both as actually performed by the claimant, and as the work is generally performed in the national economy. Typically, a brief statement is sufficient.

Step 5: Other Work

- If the ALJ bases the favorable decision on **direct application** of the grid rules, the Step 5 analysis ends without the need for further discussion.
- If the ALJ relies on the **framework** of a grid rule, explain whether a vocational expert (VE) testified at the hearing and discuss briefly the VE's testimony that no jobs remain. If no VE testified, or if section 204.00 applies, cite any appropriate SSRs and discuss how they preclude other work.

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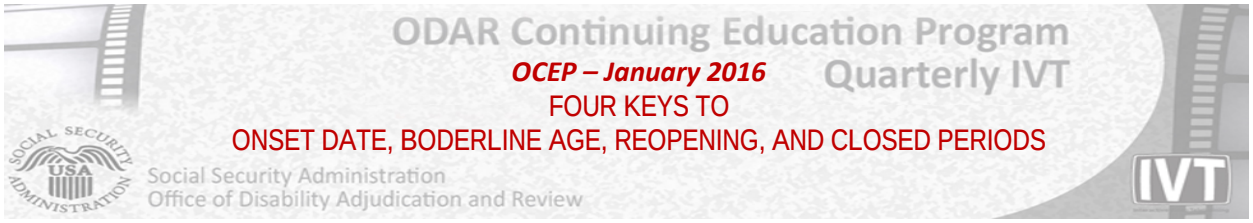
VIII.E. Borderline Age Rule

VIII.E.1. OCEP 1/13/16: Four Keys to Onset Date, Borderline Age, Reopening, and Closed Periods



Determine the Established Onset Date by considering the individual's allegations, work history, and medical and other evidence

- The medical evidence is the primary factor used to determine onset date
- Medical expert evidence is necessary to infer a disability onset date before the earliest available medical evidence

In Borderline Age situations, apply the medical-vocational guidelines non-mechanically only if supported by the overall impact of all case factors (20 C.F.R. §§ 404.1563, 416.963)

- Borderline Age is a two-part test:
  - The individual must be within a few days to a few months of reaching an older age category, and
  - Use of the older age category would result in a finding of disability
- Use the higher age category if supported by the case factors of the individual's RFC not captured by the broad classifications within the medical-vocational guidelines.

In limited situations, you may reopen and revise a prior determination or decision that is administratively final (20 C.F.R. §§ 404.987-.989, 416.1487-.1489)

- You may reopen a prior administratively final determination or decision:
  - Within 1 year of the initial determination notice date for any reason
  - Within 2 years in Title XVI and 4 years in Title II cases, for good cause
  - At any time, for fraud or similar fault
- The time limits do not apply if mental incapacity prevented a timely request for review (SSR 91-5p)

A Closed Period of Disability generally requires a change in medical condition so the claimant is able to engage in substantial gainful activity following the period of disability

- Determine medical improvement for a closed period by applying the continuing disability review 8-step sequential evaluation process
- Return to work alone does not establish medical improvement

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VIII.E.2. HALLEX I-2-2-42 Borderline Age

I-2-2-42 Borderline Age

Last Update: 3/25/16 (Transmittal I-2-168)

A. General

When determining disability, the Social Security Administration (SSA) will use each of the age categories applicable to a claimant during the period for which SSA is determining whether the claimant is disabled. SSA will not apply the age categories mechanically in a borderline age situation. If a claimant is within a few days to a few months of reaching an older age category (hereinafter “higher age category”), and using the higher age category would result in a determination of decision that the claimant is disabled, SSA will consider whether to use the higher age category after evaluating the overall impact of all the factors of the case. See 20 CFR 404.1563 and 416.963.

> **NOTE:**
> If using the claimant's chronological age will result in a favorable decision, an administrative law judge (ALJ) will not use the higher age category solely because it will result in a more favorable onset date, determination, or decision for the claimant.

B. Identifying a Borderline Age Situation

If application of a claimant's chronological age results in a decision that the claimant is not disabled, an ALJ will identify whether the claim may involve a borderline age situation by applying a two-part test:

- Is the claimant's age within a few days or a few months of the next higher age category?
- Will the higher age category result in a decision of “disabled” instead of “not disabled”?

If the answer to one or both parts of the test is “no,” a borderline age situation either does not exist or would not affect the outcome of the decision. The ALJ will then use the claimant's chronological age.

If the answer to both parts of the test is “yes,” a borderline age situation exists, and the ALJ must decide whether it is more appropriate to use the claimant's chronological age or the higher age category.

1. Is the Claimant's Age Within a Few Days or Months of the Next Higher Age Category?

SSA does not have a precise programmatic definition for the phrase “within a few days to a few months.” The word “few” should be defined using its ordinary meaning, e.g., a small number. Generally, SSA considers a few days to a few months to mean a period not to exceed six months.

To decide the first part of the test, ALJs will assess whether the claimant reaches or will reach the next higher age category within a few days to a few months after the:

- Date of adjudication;
- Date last insured;
- End of disabled widow(er)'s benefit prescribed period;
- End of child disability re-entitlement period; or
- Date of cessation of disability.

2. Will the Higher Age Category Result in a Decision of "Disabled" Instead of "Not Disabled"?

As previously stated, if using the higher age category does not affect the outcome of the decision, a borderline age situation does not exist, and the ALJ will use the claimant's chronological age to adjudicate the case. However, if the other criteria is met and using the higher age category does affect the outcome of the decision, a borderline age situation does exist, and the ALJ will use the procedures outlined in HALLEX I-2-2-42 C below.

C. Deciding Whether to Apply a Higher Age Category in a Borderline Age Situation

ALJs will not use the higher age category automatically in a borderline age situation. ALJs will consider whether to use the higher age category after evaluating the overall impact of all the factors on the claimant's ability to adjust to doing other work (e.g., residual functional capacity combined with age, education, and work experience as explained in 20 CFR 404.1563, 416.963, and Part 404, Subpart P, Appendix 2). For additional information and examples, see also Program Operations Manual System (POMS) DI 25015.006.

When deciding whether to apply a higher age category in a borderline age situation, the ALJ will:

1. Determine the Time Period Under Review.

The ALJ will first determine the time period under review. For example, under a particular fact scenario, the time under review may be a "few days to a few months" between the date of adjudication and the date the claimant attains age 55 and would be found disabled under a direct application of the medical-vocational rules. The closer in time the claimant is to the next higher age category, the more disadvantageous the claimant's age.

2. Analyze the Other Factor(s) of the Case.

The ALJ will consider all other factor(s) relevant to the case (e.g., residual functional capacity combined with age, education, and work experience as explained in 20 CFR

404.1563, 416.963, and Part 404, Subpart P, Appendix 2) for each of the medical-vocational rules for chronological age and the higher age category. The ALJ will consider whether an adjudicative factor(s) is relatively more adverse under the criteria of each rule, or whether there is an additional element(s) present that seriously affects a claimant's ability to adjust to other work. Examples of situations where certain factors may impact the case can be found in POMS DI 25015.006E.

ALJs must be careful not to double-weigh a factor if the medical-vocational rule for the higher age category already incorporates the factor. For example, if the applicable medical-vocational rule for the higher age category already considers illiteracy (such as a younger individual age 44 years and 9 months who has a reduced sedentary residual functional capacity, and the adjudicator is considering applying the higher age category (45-49) medical-vocational rule 201.17), then there would need to be factors other than illiteracy to justify application of the higher age category.

3. Determine Whether the Overall Impact of the Factor(s) Justifies Using the Higher Age Category to Find the Claimant "Disabled."

The ALJ will take a "sliding scale" approach when determining which age category to use. To support the use of the higher age category, the claimant must show that the factor(s) have a progressively more adverse impact on his or her ability to adjust to other work as the period between the claimant's actual age and attainment of the next higher age category lengthens.

4. Determine Onset.

If all of the factors support using the higher age category, the ALJ will find the claimant disabled with an established onset date corresponding to the:

- Date of adjudication;
- Date last insured;
- End of disabled widow(er)'s benefit prescribed period;
- End of child disability re-entitlement period; or
- Date of cessation of disability.

If there is no support for the use of the higher age category (e.g., the factors present do not negatively affect or have a more adverse impact on the case), ALJs will use the claimant's chronological age, even when the period under consideration is only a few days.

5. Include in the Decision an Explanation that the Borderline Age Situation Was Considered.

The ALJ will explain in the decision that he or she considered the borderline age situation, state whether he or she applied the higher age category or the chronological age, and note the specific factor(s) he or she considered.

NOTE:
Even when the ALJ is using the higher age category to issue a favorable decision, the ALJ must identify the specific factors that support the use of the higher age category.

VIII.E.3. ADJUDICATION TIP #60

#60 – Borderline Age (Replaces Tip #27)
Have you ever wondered when an ALJ should consider using a higher age category when evaluating a grid rule? Under the new HALLEX section I-2-2-42, if application of a claimant's chronological age results in a decision that the claimant is not disabled, an ALJ will identify whether the claim may involve a borderline age situation by applying the following two-part test:

A claimant's age is within a few days or a few months (a period not to exceed six months) of the next higher age category; and

The use of the higher age category would result in a decision of "disabled" instead of "not disabled."

Once an ALJ identifies that a borderline age situation exists, application of the higher age category is not automatic. Rather, the ALJ will consider using the higher age category after evaluating the overall impact of all the factors on the claimant's ability to adjust to other work.
What are these factors? One of them is the time period under review. The closer in time the claimant is to the next higher age category, the more adverse the claimant's age becomes. For example, we are more likely to apply the higher age category for a claimant who is a few days from the next higher age category than for a claimant who is 5 months away.
Other factors are residual functional capacity combined with age, education, and work experience. When assessing the overall impact of the factors, the ALJ will use a sliding scale. The longer the time to the next higher age category, the more adverse the additional factors must be. See POMS DI 25015.006(E) for examples.
Reminders

1. Where applicable, explain that the ALJ considered the borderline age situation, state whether the ALJ applied the higher age category or the category for the chronological age, and note the specific factor(s) considered.
2. Do not double-weigh a factor if the medical-vocational rule for the higher age category already incorporates the factor. For example, if the rule for the higher age category considers illiteracy, there would need to be an adverse factor ***other*** than illiteracy to justify application of the higher age category.
3. To decide the first part of the test, assess whether the claimant reaches or will reach the next higher age category within a few days to a few months after the date of adjudication, date last insured, end of the disabled widow or widower's benefit prescribed period, end of child disability re-entitlement period, or date of cessation of disability.
4. Do not apply the higher age category solely because it will result in a ***more*** favorable onset date if using the claimant's chronological age already will result in a favorable decision, even if the decision is partially favorable. This is not a borderline age situation because the claim is not being denied when applying the age categories mechanically.

For further guidance on handling borderline age situations refer to 20 CFR 404.1563 and 416.963; HALLEX I-2-2-42; HALLEX I-3-3-25; SSR 83-10; POMS DI 25015.006; OCEP Program January 2016

VIII.F. WRITING TIPS

VIII.F.1. OCEP 10/17/12; Tips on Persuasive Writing.

Tips in persuasive writing can be found by reviewing the OCEP Broadcast of October 17, 2012, and as part of the Persuasive Writing Keys.

VIII.F.2. Good Writing Document

EXAMPLES OF USING TESTIMONY IN DECISIONS

Please note that the examples below depict one possible way to handle the evidence. It is not intended to show the perfect way or the best way, but it shows one acceptable way to proceed. These examples are provided only to illustrate the underlying principles.

Opening and procedural matters

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(b) (7)(E)

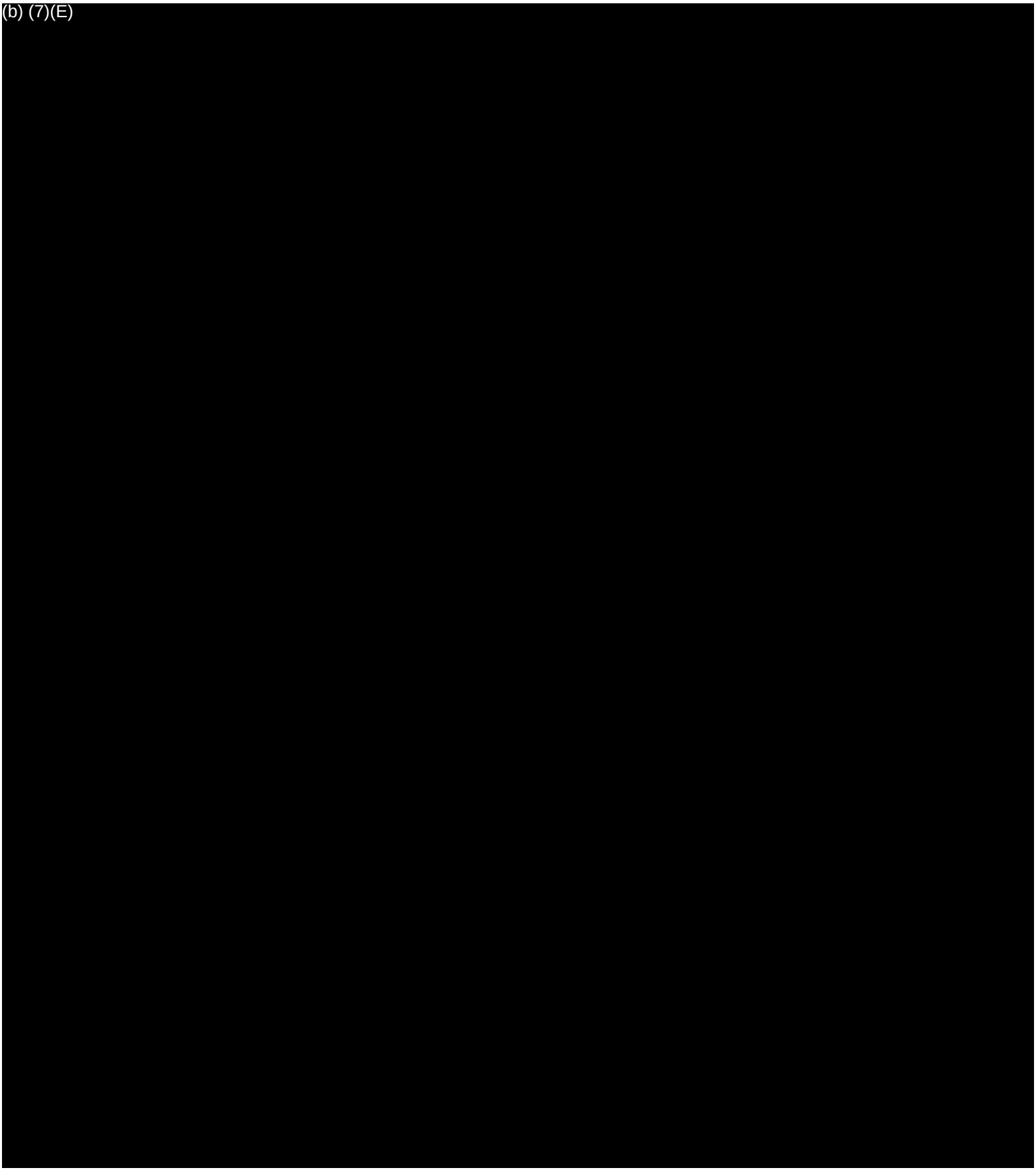
[redacted]

Questioning the Claimant

(b) (7)(E)

[redacted]

(b) (7)(E)



VIII.G. ORAL (BENCH) DECISIONS

I-2-8-19.Oral Decisions on the Record (Bench Decisions)

Last Update: 11/7/16 (Transmittal I-2-194)

A. General Policy

1. Regulatory Requirements

Under 20 CFR 404.953(b) and 416.1453(b), an administrative law judge (ALJ) may enter a fully favorable oral decision based on the preponderance of the evidence into the record of the hearing proceedings, and thereafter issue a written decision that incorporates the oral decision by reference. However, the regulations also state that an ALJ may use these procedures only when:

> The case was identified by the Social Security Administration (SSA) in advance as appropriate for an oral decision (see Hearings, Appeals and Litigation Law (HALLEX) manual I-2-8-19 A.2. below); and
>
> No changes are required in the findings of fact or the reasons for the decision as stated at the hearing.

If a fully favorable decision is entered into the record at the hearing, the regulations require that the ALJ include as an exhibit, a document that sets forth the key data, findings of fact, and narrative rationale for the decision (see HALLEX I-2-8-19 B.2. below).

The regulations also require that if the decision incorporates by reference the findings and the reasons stated in an oral decision at the hearing, a party may submit a written request for a record of the oral decision. On request, SSA must provide the party with a copy of the oral decision (see HALLEX I-2-8-19 B.3. below).

2. When an ALJ May Issue an Oral Decision

Unless an exception below applies, ALJs may issue fully favorable oral decisions in the following cases:

- An initial adult disability claim under title II, title XVI, or both titles;
- A claim for disability benefits as a disabled widow, widower, or surviving divorced spouse under title II; or
- A claim for benefits by a child under age 18 under title XVI.

ALJs may not issue oral decisions in:

- Disabled adult child claims under title II;
- “Age-18 redetermination” claims under title XVI;
- Continuing disability reviews;
- Claims involving a closed period of disability;
- Claims involving drug addiction or alcoholism issues;

- Claims where there is reason to believe that fraud or similar fault was involved in providing the evidence; and
- Non-disability claims.

B. Procedures

1. Prior to the Hearing

When an ALJ believes an oral decision may be appropriate, the ALJ will generate an oral decision checksheet from the Document Generation System. As needed, the ALJ may choose to complete certain portions of or the entire checksheet prior to the hearing.

2. At the Hearing

a. Announcing an Oral Decision

When announcing an oral decision into the record of a hearing, the ALJ will explain on the record that:

- The claimant will receive a decision in writing;
- After entering the fully favorable oral decision into the record of hearing, the ALJ's written decision will typically incorporate the oral decision by reference;
- However, if any of the oral findings or reasons for the decision entered into the record at the hearing require change, or if the ALJ decides that incorporation-by-reference procedures should not be used, the ALJ will issue a written decision that sets forth the findings of fact and the reasons for the decision, including any changes in the findings and reasons stated at the hearing; and
- If any contemplated changes will make the written decision less favorable than announced during the hearing, the ALJ will proffer the changes and the supporting exhibits of record to the claimant and appointed representative, if any, and provide an opportunity to comment on the possible changes. For proffer procedures, see HALLEX I-2-7-30.

b. Stating the Oral Decision

When stating the oral decision, the ALJ will clearly delineate the decision from the rest of the hearing proceedings. The ALJ must speak clearly and enunciate so that the decision is audible and understandable by the claimant or other reviewing component. The ALJ must use terms that the claimant can understand and should avoid the oral equivalent of boilerplate in the rationale.
An oral decision has three required parts:

i. Procedural History

As part of the procedural history, the ALJ will:

- Explain why the case is before the ALJ for a hearing and provide other relevant background information;

- Note whether the claimant is represented at the hearing and, if so, the name of the appointed representative;
- Note whether an interpreter is present and identify all witnesses and experts; and
- State the issue(s) to be resolved, framed as specifically as possible with appropriate reference to the applicable statute(s) and regulation(s).

ii. Findings and Rationale

The ALJ will provide findings that outline the relevant issues and explain his or her rationale for the ultimate conclusion, including the following (as applicable):

- Findings on any pertinent threshold issues (e.g., insured status, age, literacy, dependency relationship);
- Findings on the alleged onset date and established onset date;
- Reasons for reopening any prior determination(s) or decision(s);
- An assessment of the case under the sequential evaluation process, including an explanation of the findings on each issue including the ultimate conclusion;
- An evaluation of the intensity and persistence of symptoms and the extent to which the symptoms limit the functional abilities of the claimant;
- A discussion of the opinion evidence pursuant to applicable regulations and sub-regulatory policies;
- A recitation of the following or equivalent statement if the case is decided at step 5 of the sequential evaluation process:
- Although the claimant generally continues to have the burden of proving disability at step five, in order to support a finding that an individual is not disabled at this step, the Social Security Administration is responsible for demonstrating that there is other work that the claimant can do that exists in significant numbers in the national economy, given the claimant's residual functional capacity, age, education, and work experience.
- The basis for finding the claimant disabled (e.g., direct or framework application of a Medical-Vocational Rule);
- A statement clearly articulating the relevant testimony from an expert witness(es) if the ALJ is relying on the testimony of (or interrogatories from) a medical or vocational expert;
- The ALJ's ruling(s) on any objection(s) made by the claimant and/or his or her appointed representative, if any;
- A recommendation for a representative payee, if applicable;
- A statement relating to medical reexamination, if recommended;
- A notation if there is evidence of a workers' compensation claim or payment; and
- Findings on any other issue(s) required by statute or regulation.

iii. Conclusion

The ALJ must give a brief and succinct summary of his or her ultimate conclusion in the case.

c. Exhibit Checksheet

After issuing an oral decision on the record during the hearing, the ALJ will add the completed checksheet as an exhibit to the record.

NOTE:

If the ALJ later decides to amend the oral decision or not to use the incorporation-by-reference procedures, the ALJ must leave the completed checksheet as an exhibit in the record.

3. After the Hearing

After a hearing in which the ALJ issued an oral decision, the ALJ will usually issue a written notice of the oral decision that incorporates by reference the findings of fact and the reasons stated orally at the hearing.

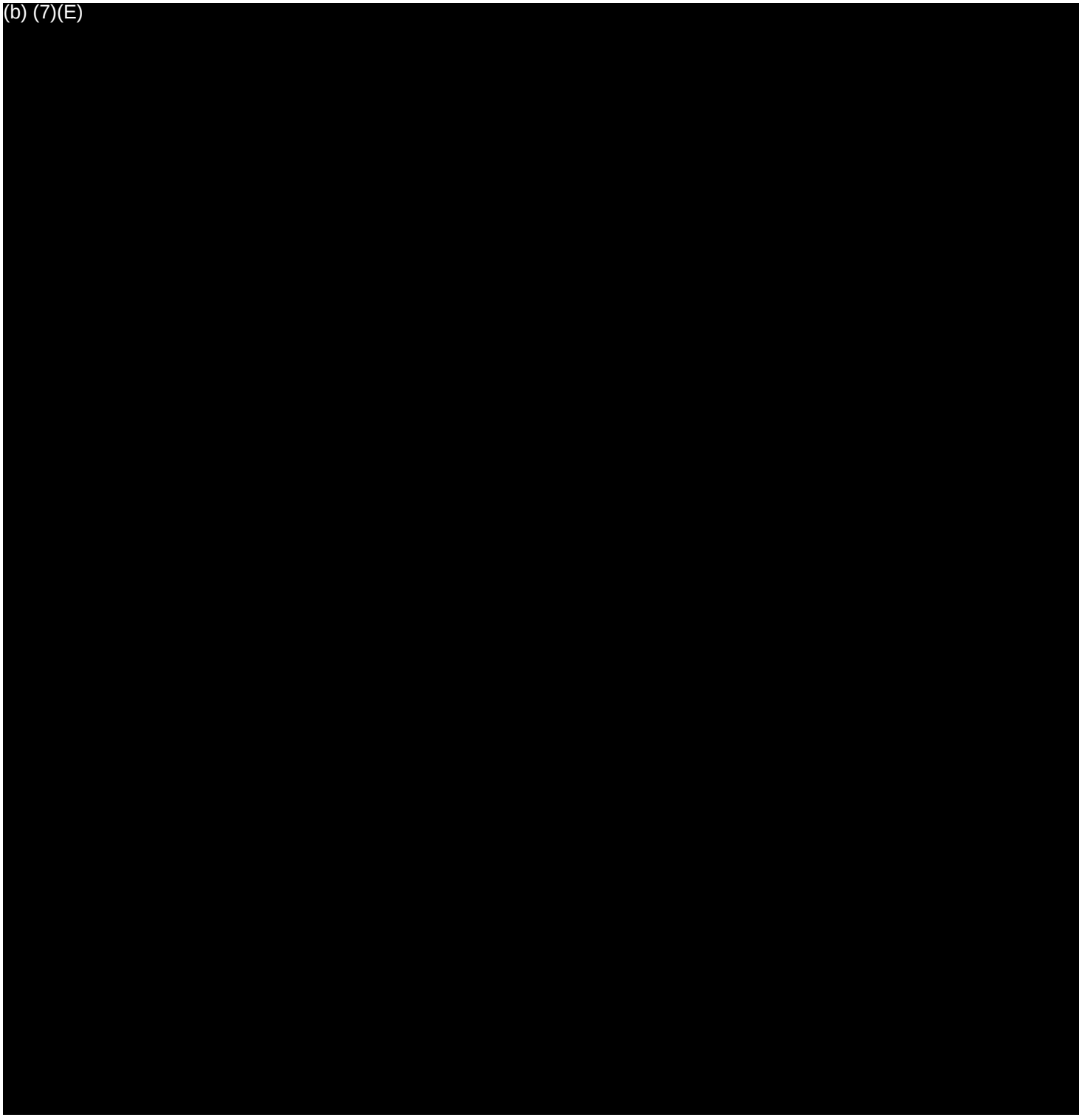
However, an ALJ cannot use the incorporation-by-reference procedure if he or she determines after the hearing that any of the findings of fact or reasons for the decision entered into the record at the hearing have changed. In that situation, the ALJ will:

- Proffer the changes and the supporting exhibits of record to the claimant and appointed representative, if any, if the contemplated changes make the written decision less favorable than announced during the hearing (see HALLEX I-2-7-30 for proffer procedures); and
- Issue a written decision that sets forth the findings of fact and the reasons for the decision, including any changes in the findings and reasons stated at the hearing.

If a claimant or appointed representative requests a copy of the ALJ's oral decision, the hearing office will provide a compact disc of the digital recording, or, when technology permits and it is consistent with SSA disclosure rules, an electronically propagated digital recording.

(b) (7)(E), (b) (5)

(b) (7)(E)



VIII.H. Earnings

VIII.H.1 PRW AFTER THE ALLEGED ONSET DATE: Adjudication Tip 62

#62 - Past Relevant Work after the Alleged Onset Date

In Adjudication Tip #30, we explained why work performed after the alleged onset date (AOD) is generally not considered past relevant work (PRW). However, did you know that in certain instances, work performed after the AOD may constitute PRW?

When evaluating whether work activity constitutes PRW, we must first confirm whether the work activity in question is work that the claimant has "already been able to do." 20 CFR 404.1565(a) and 416.965(a). That is, we can only consider work activity to be PRW, if that work was performed in the "past." Second, the work activity must also be performed within the past 15 years (recency), last long enough for the claimant to learn how to do it (duration), and be performed at substantial gainful activity (SGA). If these two conditions are met, then the work may constitute PRW, even if it was performed after the AOD. See 20 CFR 404.1560 and 416.960; Social Security Ruling 82-62; and POMS DI 25005.015.

Consider these tips when deciding whether work activity at SGA after the AOD can be considered PRW:

1. If less than 12 months have elapsed between the AOD and the start of the work at issue (subject work), a period of disability does not exist for that period because there is no continuous period of 12 months in which the claimant did not engage in SGA. However, for any period starting after that work ends, the subject work may be PRW, as long as the other requirements are met (remember to consider whether an exception to SGA applies such as unsuccessful work attempt or a trial work period).
2. If 12 months or more have elapsed between the AOD and the start of the subject work, there is a continuous period of at least 12 months in which the claimant did not engage in SGA. Thus, we must determine whether the claimant is disabled for that period without considering the subject work as PRW. The subject work cannot be considered PRW since it was not performed prior to the period at issue. If the evidence demonstrates that the claimant is not disabled, use the sequential evaluation process for the period after the work ended, considering the subject work as PRW.

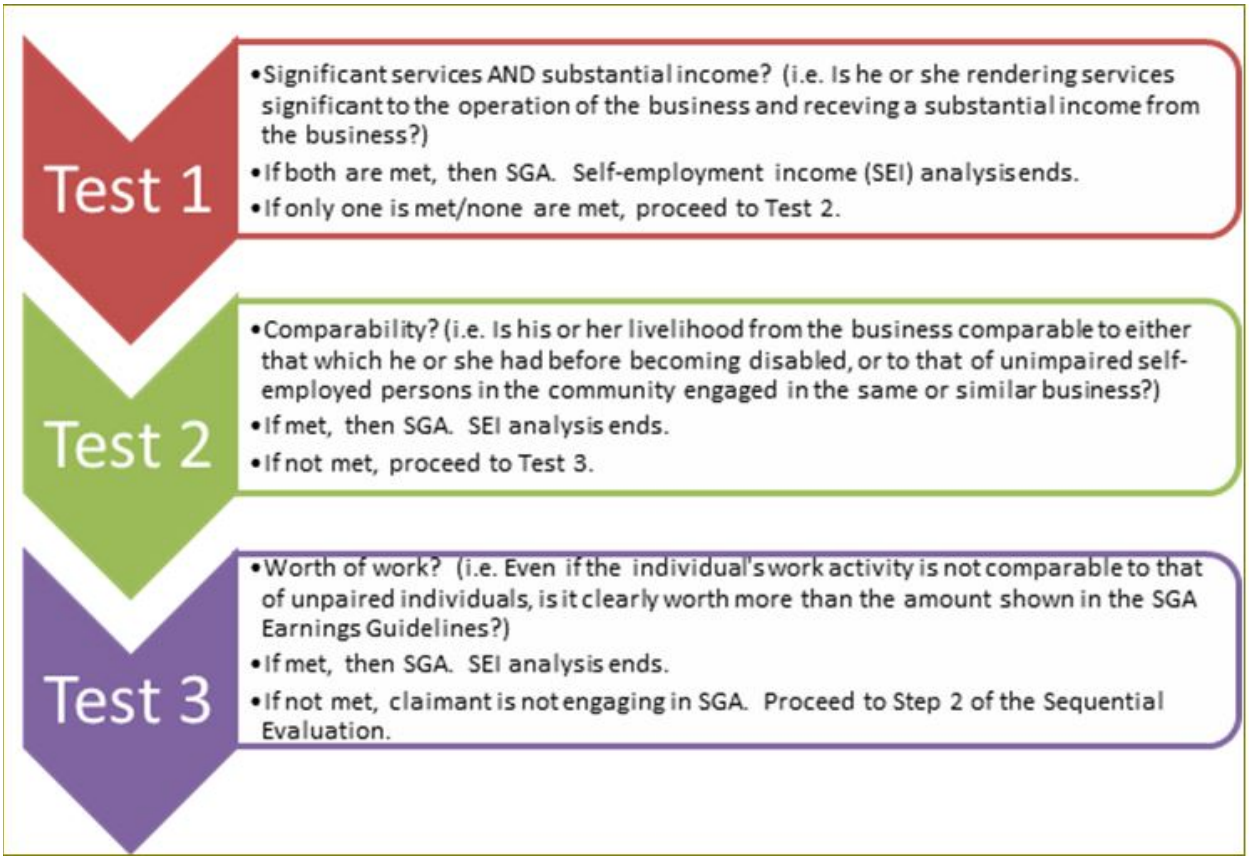
Please note, if the evidence demonstrates that the claimant is disabled for the period from the AOD to the start of the subject work, we must determine whether disability continues or ends on or after the start date of the subject work. See 20 CFR 404.1588 et seq., and 416.988 et seq.

In addition to Adjudication Tip 30, Adjudication Tips 9, 10, 11, 12, 20, and 49 include information and references generally related to this topic.

VIII.H.2 SELF EMPLOYMENT INCOME AS SUBSTANTIAL GAINFUL ACTIVITY: Adjudication Tip 63

#63 - Self-Employment Income as Substantial Gainful Activity

As you know, substantial gainful activity (SGA) determinations for the self-employed are based on either the "general evaluation criteria" or the "countable income test." The "countable income test" is used in limited situations with a title II-only disability beneficiary. 20 CFR 404.1575(e)(3). In all other cases, adjudicators should use the three tests under the "general evaluation criteria." This tip addresses those three tests as well as points to consider and questions to ask when a claimant testifies he or she works or worked in a self-employed capacity.



(Chart adapted from the October 2015 OCEP on Work Activity's QuickNotes Answers.)

Points to Consider:

To compare income, obtain tax returns for 5 years prior to the AOD through the post-AOD activity. If there is no significant difference in the work activity before and after AOD, the income is substantial, even if the amount is small
Since each factor must be described in detail, ask for specifics: How does the claimant get business and what skills does he or she allege in advertising? What services does the claimant offer? Does the claimant have references, suppliers, or long-term customers?
To compare unimpaired individuals, look to well established same-or-similar businesses in the community. The District Office may have done some research or have knowledge of the job documented in the file. Additional sources of information include Vocational Experts and online resources such as the U.S. Bureau of Labor Statistics and U.S. Census Bureau.

For further guidance on handling self-employment situations refer to 20 CFR 404.1575 and 20 CFR 416.975; Social Security Ruling 83-34; OCEP on Work Activity; and POMS DI 10510.010, POMS DI 10510.015, and POMS DI 10510.020.

VIII.H.3. UNSUCCESSFUL WORK ATTEMPTS

20 CFR 404.1574 (c)(1), (c)(4), and (c)(5)

(c) *The unsuccessful work attempt*—(1) *General.* Ordinarily, work you have done will not show that you are able to do substantial gainful activity if, after working for a period of 6 months or less, your impairment forced you to stop working or to reduce the amount of work you do so that your earnings from such work fall below the substantial gainful activity earnings level in paragraph (b)(2) of this section, and you meet the conditions described in paragraphs (c)(2), (3), (4), and (5), of this section. We will use the provisions of this paragraph when we make an initial determination on your application for disability benefits and throughout any appeal you may request. Except as set forth in § 404.1592a(a), we will also apply the provisions of this paragraph if you are already entitled to disability benefits, when you work and we consider whether the work you are doing is substantial gainful activity or demonstrates the ability to do substantial gainful activity.

(3) *If you worked 3 months or less.* We will consider work of 3 months or less to be an unsuccessful work attempt if you stopped working, or you reduced your work and earnings below the substantial gainful activity earnings level, because of your impairment or because of the removal of special conditions which took into account your impairment and permitted you to work.

See also 20 CFR 404.1573(d)

VIII.H.4. SGA TABLES

IX. Special Issues

IX. Special Issues

IX.A. ALJ Conduct

IX.A.1. OCEP, 7/15/15; Judicial Demeanor – Avoiding Bias and Misconduct Complaints

ZAHM:
Let's briefly review the legal authority governing our conduct as judges.

Various statutes and regulations establish the general duty of fairness and impartiality for judges.

The Administrative Procedure Act (APA) at 5 USC Section 556 **says administrative law judges must exercise their authority in an impartial manner. The Standards of Ethical Conduct for Executive Branch Employees at** 5 CFR Part 2635 **also require ALJs to act impartially.**

Social Security regulations (20 CFR 404.940 **and** 416.1440**)** prohibit a judge from adjudicating a claim if the judge is prejudiced or partial with respect to any party or has any interest in the matter to be decided. Recusal is appropriate, for instance, when the judge learns that the representative or claimant is a family member or a close friend.

COSTELLO:
Judges should be courteous to those who appear before them. The American Bar Association Model Code of Judicial Conduct says "a judge shall be patient, dignified, and courteous" to those with whom the judge deals in an official capacity.

Social Security Ruling (SSR) 13-1p outlines the procedure for filing a complaint of bias or misconduct against a judge. Complaints may be filed with the Agency through a telephone call or letter or with the Appeals Council through an appeal of a hearing decision. Most complaints go to the Division of Quality Services (DQS). You will be notified if a complaint is filed. You should immediately secure your notes or recollections of the incident. If an investigation is undertaken, you'll be so advised and asked to provide a written response to the complaint. Make sure you do so.

Do not try to avoid complaints by abdicating your responsibility to insure a full and complete record or by failing to ask the hard questions at a

hearing. This is your responsibility as a judge. And, it is possible to do this while conducting yourself in a professional manner.

ZAHM:
Our broadcast today will focus on what we call the Four Principles of Judicial Conduct. Now, you will not find these four principles spelled out in a treatise or book on the judiciary. They're not identified specifically in the Code of Federal Regulations, the ABA code, or the Standards of Ethical Conduct for Employees of the Executive Branch. But, they are consistent with the spirit and intent of all these codes – that is, to promote the integrity and impartiality of ALJ decision-making and ensure judgments are made without bias or prejudice, or the appearance of bias or prejudice.

The Four Principles of Judicial Conduct are:
1 -- Be Cool, Calm, and Collected
2 -- Be Courteous, Not Chummy
3 -- Be Non-Confrontational, and
4 -- Be in Control of the Hearing

IX.A.2. HALLEX I-2-1-60. RECUSAL

I-2-1-60.Disqualification of an Administrative Law Judge Assigned to a Case

Last Update: 7/27/16 (Transmittal I-2-179)

A. General

Under 20 CFR 404.940 and 416.1440, an administrative law judge (ALJ) must disqualify or recuse himself or herself from adjudicating a case if the ALJ is prejudiced or partial with respect to any party or has any interest in the matter pending for decision.

However, disqualification is not a matter of personal preference or reluctance to handle a particular case. An ALJ must have reasonable and proper grounds for disqualifying himself or herself. For example, an ALJ may withdraw from the case if:

- The ALJ shares an acquaintance with, but does not know, the claimant or any other party;
- The ALJ has particular knowledge about the claimant or any other party from an extrajudicial source; or
- The ALJ believes his or her participation in the case would give an appearance of impropriety.

NOTE:

ALJs may not submit blanket recusals on multiple cases, regardless of the reason. ALJs will make recusal decisions on a case-by-case basis and with regard to the ALJ's ability to provide a fair hearing to the claimant.

B. ALJ Voluntarily Disqualified

1. Notice Not Required

If the ALJ disqualifies himself or herself from a case on his or her own initiative, and the hearing office has not sent the notice of hearing to the claimant, the ALJ need not send notice of the disqualification to the claimant.

2. Notice Required

If the hearing office has sent the notice of hearing to the claimant and the ALJ is later disqualified, the claimant must be notified of the disqualification. This notice requirement applies regardless of whether the disqualification is before, during, or after a hearing. The ALJ is not required to provide the claimant with the specific reason(s) for the disqualification, but may voluntarily choose to do so.

a. Before the Scheduled Hearing

If the ALJ knows before the hearing of a reason for disqualification, the ALJ must disqualify himself or herself before the date of the hearing. If the ALJ disqualifies himself or herself either as a result of an objection received from a claimant, or on his or her own initiative after the notice of hearing is sent to the claimant, the ALJ must notify the claimant of the disqualification in writing, informing the claimant that:

- The date set for the hearing has been cancelled (if cancellation is necessary); and
- The claimant will receive an amended notice of hearing when another ALJ is assigned to conduct the hearing.

b. At the Hearing

Under some circumstances, an ALJ may not be aware of the need to disqualify himself or herself until the time of the hearing.

If the ALJ needs to disqualify himself or herself at the hearing, the ALJ's oral statement on the record is sufficient notice to the claimant. After verbal notice of disqualification, the ALJ will inform the claimant that another ALJ will be assigned to the case and the hearing will be rescheduled.

c. After the Hearing

If the reason for disqualification comes to the ALJ's attention after a hearing, the ALJ will notify the claimant of the disqualification in writing and associate the writing with the record. The writing must inform the claimant that:

- The ALJ is disqualifying himself or herself;
- Another ALJ will be assigned to decide the case;
- The newly assigned ALJ will determine whether a supplemental hearing is necessary and will provide notice to the claimant if another hearing is needed; and
- The newly assigned ALJ will issue the decision in the case.

C. Claimant Objects to ALJ Assigned to Case

If a claimant objects to the ALJ assigned to his or her case, he or she must do so at the earliest opportunity. The ALJ will consider the objection and determine whether to proceed or withdraw.

If the ALJ decides disqualification is appropriate, the procedures in B above apply.

When sufficient time and facts allow an ALJ to decide before the hearing that the claimant's reasons for objecting do not warrant disqualification, the ALJ will set forth the reasons in writing, send the writing to the claimant and appointed representative (if any), associate the writing with the record, and reiterate the decision in the opening statement at the hearing. If there is insufficient time before the hearing for the ALJ to respond or obtain information necessary to decide the issue, the ALJ may obtain any needed information at the hearing and set forth the reasons for his or her decision on the record during the hearing.

If the claimant objects at the hearing, and the ALJ refuses at the hearing to disqualify himself or herself, the ALJ will set forth the reasons for his or her decision on the record during the hearing.

If the claimant objects after the hearing, and the ALJ decides that the claimant's reasons for objecting do not warrant disqualification, the ALJ will set forth the reasons for his or her decision in the jurisdiction and procedural history section of the decision.

NOTE:

If the ALJ does not withdraw and the claimant objects to the ALJ's decision, the claimant may use non-disqualification as a basis for appeal to the Appeals Council (AC). See 20 CFR 404.940 and 416.1440. The AC will process any issues of bias or unfair treatment raised with the claimant's request for review pursuant to Hearings, Appeals and Litigation Law (HALLEX) manual I-3-3-2 and I-3-2-25. See also 20 CFR 404.970 and 416.1470, and Social Security Ruling 13-1p: *Titles II and XVI: Agency Processes For Addressing Allegations of Unfairness, Prejudice, Partiality, Bias, Misconduct, or Discrimination by Administrative Law Judges (ALJs)*.

D. Special Considerations for Newly Assigned ALJ

When an ALJ is assigned to conduct a hearing in a case in which another ALJ has disqualified himself or herself, and the claimant is aware of the disqualification of the first ALJ, the newly assigned ALJ should mention the disqualification as part of the procedural history in his or her opening statement at the hearing. However, the ALJ need not discuss the reasons for the disqualification.

IX.B.1. OCEP 7/16/14: DAA

IX.B.1.a. The Four Keys to DAA

You must determine if DAA is a medically determinable severe impairment.

- Evidence of drug or alcohol use alone does not establish DAA as a medically determinable severe impairment. Evidence from an acceptable medical source is necessary.
- DAA is a "substance use disorder" defined as a "maladaptive pattern of substance use that leads to clinically significant impairment or distress."

If you find the claimant disabled considering all impairments, including DAA, use the six-step evaluation process under SSR 13-2p to determine if DAA is material.

- If the claimant is not disabled considering all impairments, including DAA, your evaluation is finished. DAA materiality is not an issue.
- If the claimant is disabled considering all impairments, including DAA, you must conduct a second sequential evaluation considering all impairments except DAA to determine if DAA is material.
- The claimant has the burden of proving disability throughout the sequential evaluation process.

Recognize and avoid common DAA errors.

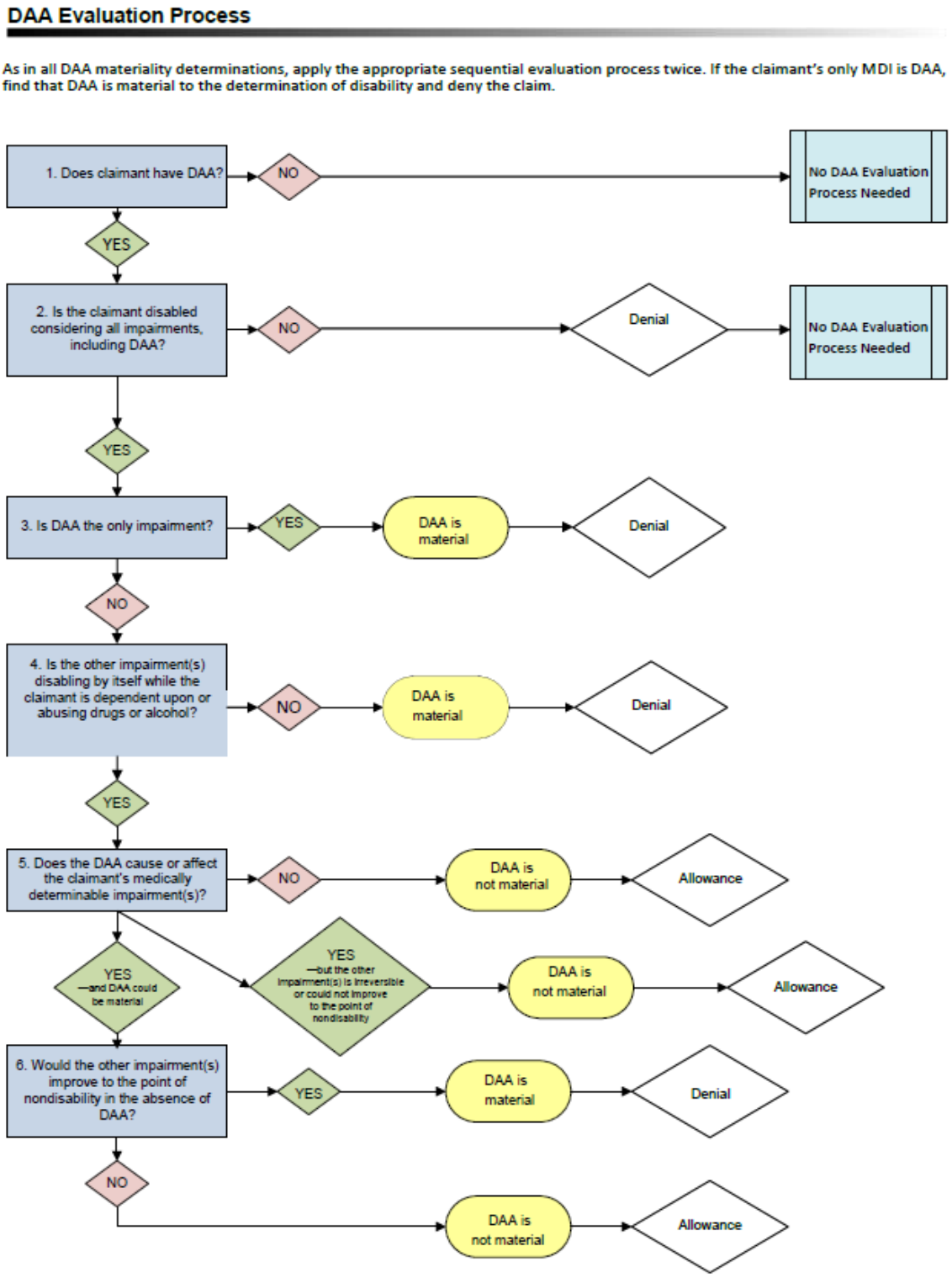
- Failure to cite specific evidence to support a finding that DAA is material to the finding of disability;
- Failure to explain the "B" criteria findings;
- Finding the claimant disabled only during a period of abstinence; and,
- Failure to evaluate DAA when it is a severe impairment.

Decision instructions and drafts must identify specific evidence showing whether DAA is material.

- A statement in the decision that DAA is, or is not, material to the determination is insufficient. The decision must cite evidence in support of this finding.

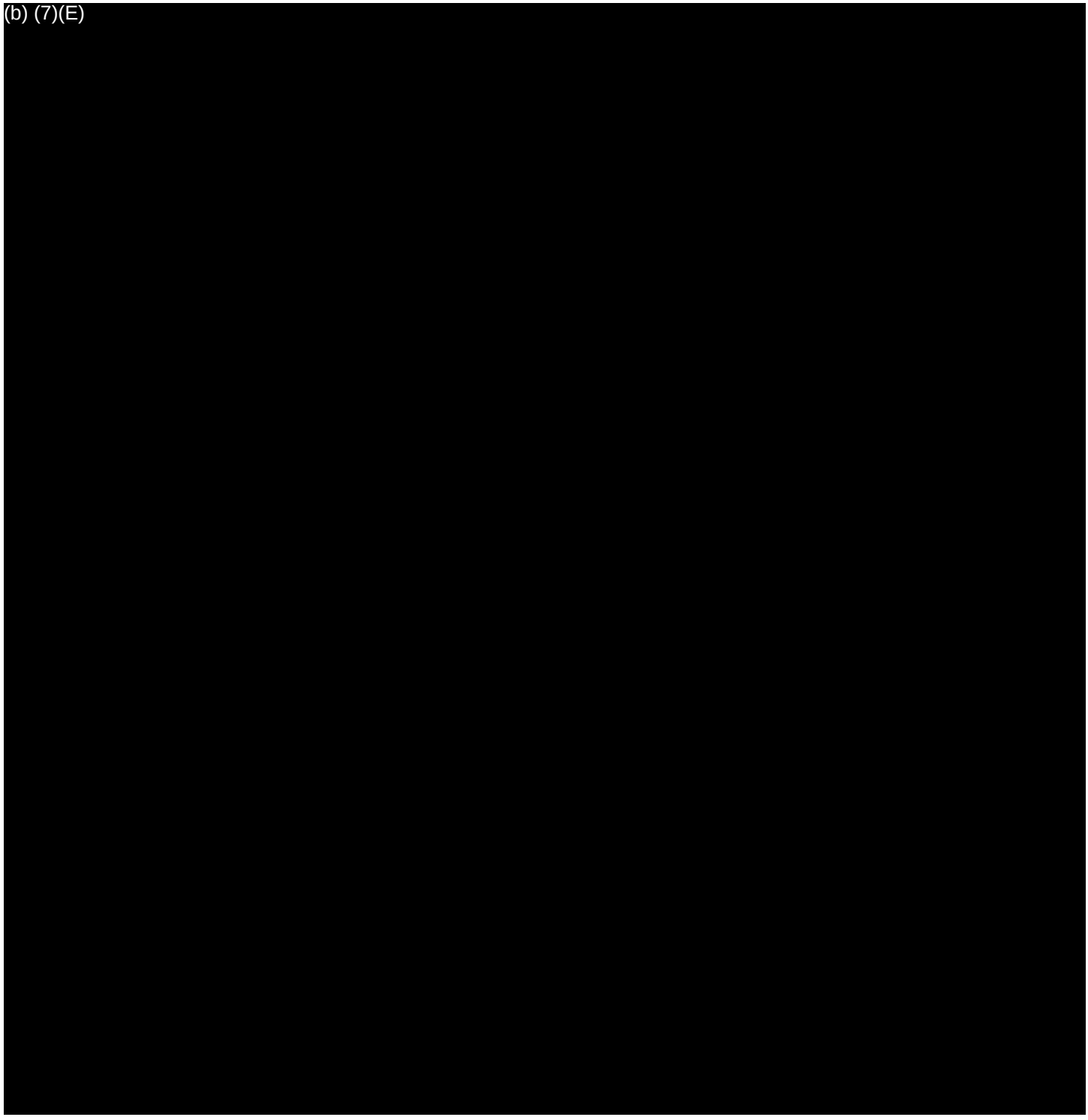
IX.B.2. Evaluating Cases Involving Drug Addition and Alcoholism (DAA): SSR 13-2p

IX.B.3. DAA Evaluation Flow Chart, aka DAA Evaluation Process



IX.B.4. Points to Remember When Adjudicating DA&A cases

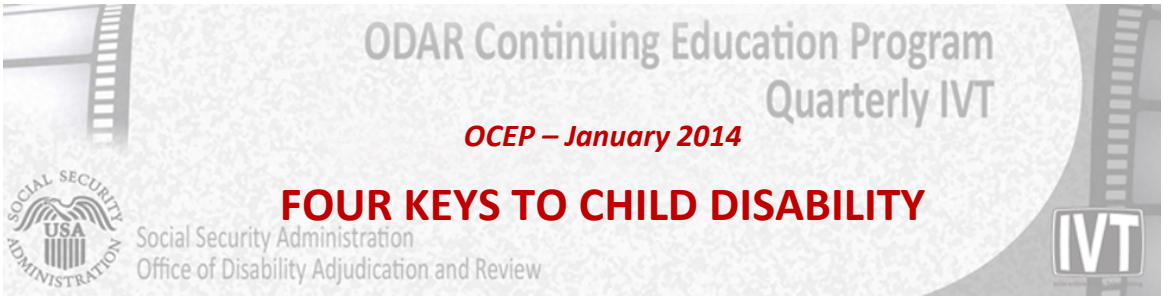
(b) (7)(E)



(b) (7)(E)

IX.C. SSI Childhood Disability

IX.C.1. OCEP 01/15/14; Child Disability Four Keys



Determining Child Disability is a three-step sequential evaluation process.

- Step 1: Is the child engaged in Substantial Gainful Activity? If so, the child is not disabled.
- Step 2: Is there a severe impairment(s)? Severe means the impairment must cause more than minimal functional limitations
- Step 3: Do the impairments satisfy the one-year durational requirement and meet, equal, or functionally equal the Listing of Impairments?
- To functionally equal the Listings a child must have "marked" limitations in two functional domains or an "extreme" limitation in one.
    - "Marked" means the impairment "interferes seriously" with the ability to independently initiate, sustain, or complete activities; or, is more than moderate but less than extreme; or, on standardized testing is at least two but less than three standard deviations below the mean.
    - "Extreme" means the impairment interferes "very seriously" with the ability to independently initiate, sustain, or complete activities; or, is more than marked; or, on standardized testing is at least three standard deviations below the mean.

Use the "Whole Child" approach in determining functional equivalence, (20 CFR 416.926a(c); SSR 09-1p).

- An impairment may have effects in more than one domain. Evaluate the limitations from the child's impairments in all affected domain(s).

Use the Age Group Descriptors and examples in the Regulations when assessing functional equivalence, 20 CFR 416.926a (g)-(l)

- Consider the correct Age Group descriptor, which may involve more than one age group.

Understand standardized testing and how it is used in assessing child functioning.

- Do not automatically assign standardized test scores to one domain. Use the whole child approach and consider all domains affected.

IX.C.2. Standardized Tests for Evaluating Child Disability

Test	Purpose	Target Age	Most Likely Application/Domains*
Clinical Evaluation of Language Fundamentals and Comprehensive Assessment of Spoken Language	Tests receptive and expressive language competence		Acquiring and Using Information; Interacting and Relating to Others.
Wechsler Intelligence Scales for Children – 4th Edition (WISC-IV)	Verbal Comprehension Perceptual Reasoning Full Scale	6-16	Verbal Comprehension Index; Perceptual Reasoning Index; Full-Scale IQ.
Wide Range Achievement Test 4 (WRAT4)	Measures academic skills Complements WISC scales		
Wechsler Individual Achievement Test, Third Edition (WIAT3)	Academic achievement and expressive and receptive language	4 & older	Can be used with WISC-IV to compare aptitude and achievement.
Stanford- Binet Intelligence Scale, Fifth Edition (SB-5)	Used for educational placement; determines child's ability to acquire and use information.	2 & older	Acquire and Use Information.
Vineland Adaptive Behavior Scales – 2nd Edition (Vineland-II)	Assesses adaptive behavior in communication, daily living skills, socialization and motor skills; provides composite scores that summarize performance in all of above.		Caring for Self; Interacting and Relating with Others; Moving About and Manipulating Objects.
Peabody Individual Achievement Test – Revised (PIAT-R)	Assesses Reading, Math, Written Expression and Spelling skills. Ideal for assessing low- functioning or those with limited expressive abilities.	5-22	Acquire and Use Information; Attending and Completing Tasks; Interacting and Relating with Others.
Peabody Developmental Motor Scales, 2nd Edition (PDMS-2)	Assesses motor skills	Birth – 5	Move About and Manipulate Objects.

Woodcock Johnson Tests of Achievement –III (WJ-III)	Measures both achievement and predicted achievement based on cognitive ability levels.	2 & older	Helps to identify skill deficits and determining eligibility for special education programs.
Woodcock Johnson III Normative Update (NU) Tests of Cognitive Abilities.	Identify strengths and weaknesses in cognitive abilities and processes.		Used to diagnose learning disabilities and plan IEP's. Acquiring and Using Information; Attending and Completing Tasks.

*Please note that any disorder may cause limitations in any domain. This chart is a general guide only and should not be interpreted to exclude any domain from consideration.

IX.C.3. SSI Child Teacher Questionnaire, Forms SSA-5665-BK and SSA-5666-BK

IX.C.4. SSR 09-1p:Title XVI: Determining Childhood Disability Under the Functional Equivalence Rule — The "Whole Child" Approach

Purpose: This SSR provides policy interpretations and consolidates information from our regulations, training materials, and question-and-answer documents about our "whole child" approach for determining whether a child's impairment(s) functionally equals the listings.
Citations:

Sections 1614(a)(3), 1614(a)(4), and 1614(c) of the Social Security Act, as amended; Regulations No. 4, subpart P, appendix 1; and Regulations No. 16, subpart I, sections 416.902, 416.906, 416.909, 416.923, 416.924, 416.924a, 416.924b, 416.925, 416.926, 416.926a, and 416.994a.

Introduction: A child[1] who applies for Supplemental Security Income (SSI)[2] is "disabled" if the child is not engaged in substantial gainful activity and has a medically determinable physical or mental impairment or combination of impairments[3] that results in "marked and severe functional limitations."[4] 20 CFR 416.906. This means that the impairment(s) must *meet or medically equal* a listing in the Listing of Impairments (the listings),[5] or *functionally equal* the listings (also referred to as "functional equivalence"). 20 CFR 416.924 and 416.926a.

To functionally equal the listings, an impairment(s) must be of listing-level severity; that is, it must result in “marked” limitations in two domains of functioning or an “extreme” limitation in one domain.[6] 20 CFR 416.926a(a). Domains are broad areas of functioning intended to capture all of what a child can or cannot do. We use the following six domains:

(1) Acquiring and using information,

(2) Attending and completing tasks,

(3) Interacting and relating with others,

(4) Moving about and manipulating objects,

(5) Caring for yourself, and

(6) Health and physical well-being.

20 CFR 416.926a(b)(1) .[7]

Our rules provide that we start our evaluation of functional equivalence by considering the child's functioning without considering the domains or individual impairments. They provide that “[w]hen we evaluate your functioning and decide which domains may be affected by your impairment(s), we will look first at your activities and limitations and restrictions.”[8] 20 CFR 416.926a(c) (emphasis added). Our rules also provide that we:

look at the information we have in your case record about how your functioning is affected *during all of your activities* when we decide whether your impairment or combination of impairments functionally equals the listings. Your activities are *everything you do at home, at school, and in your community.*

20 CFR 416.926a(b) (emphasis added).

After we identify which of a child's activities are limited, we determine which domains are involved in those activities. We then determine whether the child's impairment(s) could affect those domains and account for the limitations. This is because:

[a]ny given activity may involve the integrated use of many abilities and skills; therefore, any single limitation may be the result of the interactive and cumulative effects of one or more impairments. And any given impairment may have effects in more than one domain; therefore, we will evaluate the limitations from your impairment(s) in any affected domain(s).

20 CFR 416.926a(c). We then rate the severity of the limitations in each affected domain.

This technique" for determining functional equivalence accounts for all of the effects of a child's impairments singly and in combination—the interactive and cumulative effects of the impairments—because it starts with a consideration of actual functioning in all settings. We have long called this technique our “whole child” approach.

Policy Interpretation
I. General

We always evaluate the “whole child” when we make a finding regarding functional equivalence, unless we can make a fully favorable determination or decision without having to do so. The functional equivalence rules require us to begin by considering how the child functions every day and in all settings compared to other children the same age who do not have impairments. After we determine how the child functions in all settings, we use the domains to create a picture of how, and the extent to which, the child is limited by identifying the abilities that are used to do each activity, and assigning each activity to any and all of the domains involved in doing it. We then determine whether the child's medically determinable impairment(s) accounts for the limitations we have identified. Finally, we rate the overall severity of limitation in each domain to determine whether the child is “disabled” as defined in the Act.

More specifically, we consider the following questions.

1. *How does the child function?* “Functioning” refers to a child's activities; that is, everything a child does throughout the day at home, at school, and in the community, such as getting dressed for school, cooperating with caregivers, playing with friends, and doing class assignments. We consider:
    - What activities the child is able to perform,
    - What activities the child is not able to perform,
    - Which of the child's activities are limited or restricted,
    - Where the child has difficulty with activities—at home, in childcare, at school, or in the community,
    - Whether the child has difficulty independently initiating, sustaining, or completing activities,
    - The kind of help, and how much help the child needs to do activities, and how often the child needs it, and
    - Whether the child needs a structured or supportive setting, what type of structure or support the child needs, and how often the child needs it.

    20 CFR 416.926a(b)(2).
2. *Which domains are involved in performing the activities?* We assign each activity to any and all of the domains involved in performing it. Many activities require more than one of the abilities described by the first five domains and may also be affected by problems that we evaluate in the sixth domain.

3. *Could the child's medically determinable impairment(s) account for limitations in the child's activities?* If it could, and there is no evidence to the contrary, we conclude that the impairment(s) causes the activity limitations we have identified in each domain.
4. *To what degree does the impairment(s) limit the child's ability to function age-appropriately in each domain?* We consider how well the child can initiate, sustain, and complete activities, including the kind, extent, and frequency of help or adaptations the child needs, the effects of structured or supportive settings on the child's functioning, where the child has difficulties (at home, at school, and in the community), and all other factors that are relevant to the determination of the degree of limitation. 20 CFR 416.924a.

This technique of looking first at the child's actual functioning in all activities and settings and considering all domains that are involved in doing those activities, accounts for the interactive and cumulative effects of the child's impairment(s), including any impairments that are not “severe.” This is because limitations in a child's activities will generally be the manifestation of any difficulties that result from the impairments both individually and in combination.[9]

In sections II, III, and IV, we provide more detail about the technique for determining functional equivalence. However, we do not require our adjudicators to discuss all of the considerations in the sections below in their determinations and decisions, only to provide sufficient detail so that any subsequent reviewers can understand how they made their findings.

II. Determining which domains are involved in doing activities.
A. General.

The “whole child” approach recognizes that many activities require the use of more than one of the abilities described in the first five domains, and that they may also be affected by a problem that we consider in the sixth domain. A single impairment, as well as a combination of impairments, may result in limitations that require evaluation in more than one domain.[10] Conversely, a combination of impairments, as well as a single impairment, may result in limitations that we rate in only one domain.

Therefore, it is incorrect to assume that the effects of a particular medical impairment must be rated in only one domain or that a combination of impairments must always be rated in several. Rather, adjudicators must consider the particular effects of a child's impairment(s) on the child's activities in any and all of the domains that the child uses to do those activities, based on the evidence in the case record.[11]

In the sections that follow, we provide examples to illustrate how we apply these principles. These examples do not indicate whether a child is disabled, only how we assign limitations in a child's activities to a domain or domains. The rating of severity—determining whether the child is disabled—comes later. See sections III and IV below.

B. Examples of activities that typically require two or more abilities.

1. *Tying shoes.* Tying shoes typically requires abilities in at least four domains:
    - Learning and remembering the sequence for tying (Acquiring and using information),
    - Focusing on the task (Attending and completing tasks),
    - Using the fingers and hands to do the task (Moving about and manipulating objects), and
    - Taking responsibility for dressing and appearance (Caring for yourself).

    Therefore, depending on the nature and effects of the impairment(s), a child who has difficulty tying his shoes may have limitations in one, two, three, or even all of these domains. For example, if a child has a deformity of the hands and fingers that affects only manipulation, the only domain that might be affected is "Moving about and manipulating objects." However, if the child has pain or other symptoms, there might also be a problem in concentration, which we would also evaluate in the domain of "Attending and completing tasks." There might also be limitations in other domains.[12]
2. *Riding a public bus.* Taking a public bus independently typically requires the abilities in the first five domains:
    - Knowing how, where, and when to catch the bus, which bus to ride, the amount of the fare and how to pay it, and how and where to get off, as well as properly accomplishing these tasks (Acquiring and using information, Attending and completing tasks).
    - Relating appropriately to the driver and other passengers (Interacting and relating with others),
    - Being physically able to get on and off the bus (Moving about and manipulating objects), and
    - Following safety rules (Caring for yourself).

Again, depending on the nature and particular effects of the impairment(s), a child who has difficulty riding a public bus may have limitations in any one, two, several, or even all of these domains.

C. Example of a child with a single impairment that is rated in more than one domain.

A boy in elementary school with attention-deficit/hyperactivity disorder (AD/HD) has trouble with all of the following activities.

1. *Reading class assignments.* The child repeatedly misreads words by impulsively guessing what they are based on the first letters or the shapes of the words, and he is not keeping up with the rest of his class. His ability to learn and think about

information in school is at least partly dependent on how well he can read. These difficulties indicate a limitation in the domain of “Acquiring and using information.”

2. *Following classroom instructions.* The child generally carries out only the first part of three-part instructions. Being unable to sustain focus, he quickly goes on to unrelated activities. He also makes mistakes in carrying out the instructions on which he does try to focus. He needs controlled, directed attention to carry out instructions correctly. These difficulties indicate a limitation in the domain of “Attending and completing tasks.”
3. *Playing with others.* The child will typically approach a group of children, interrupt whoever is talking, and begin telling his own story, leading to conflicts with the other children. To successfully interact and relate with peers, the child must understand the social situation and use appropriate behaviors to approach other children. These difficulties indicate a limitation in the domain of “Interacting and relating with others.”
4. *Avoiding danger.* The child often impulsively dashes out into the street without looking for cars and considering his safety. Being responsible for his own safety requires the child to stop moving and to be cautious before stepping into the street. These difficulties in self-related activities indicate a limitation in the domain of “Caring for yourself.”

Therefore, even though attentional difficulties and hyperactivity are hallmarks of AD/HD, in this case it would be incorrect to assume that this child's AD/HD causes limitations only in the domain of “Attending and completing tasks.” This child's activities demonstrate that his single impairment causes limitations that we must rate in four domains.

D. Example of a child with a combination of impairments that is rated in only one domain.

A girl in middle school has a mild hearing disorder that affects both her hearing and speech. She also has a repaired complete cleft lip and palate that affects her speech as well as her appearance. She has difficulty hearing other children, especially on the playground during games, and they have difficulty understanding what she says. The other children do not approach her, and they also make fun of her because of her appearance and speech difficulties. Consequently, she has difficulty forming friendships with her classmates. She tends to stay to herself during recess and lunchtime and plays alone when at home.[13]

However, she does not have any difficulty learning. She completes all her schoolwork and chores on time, appropriately, and without unusual assistance, is well-behaved and otherwise cares for herself age-appropriately. She also has no motor difficulties.

In this example, the evidence shows that the child has only social limitations at school and in her neighborhood, and that the limitations in her activities are the result of her

difficulty communicating effectively with other children because of her hearing and speech problems and appearance. Therefore, the combination of this child's two impairments causes limitations only in the domain of “Interacting and relating with others.”

It is unnecessary to evaluate the effects of each of the child's impairments separately and then to determine their combined effects. Since we start by evaluating her functioning (in this case, her social limitations), the limitations in interacting and relating with others established by the evidence in the case record reflect the combined effects of her impairments.

E. Example of a child with a combination of impairments that is rated in more than one domain.

An adolescent has a diagnosis of borderline intellectual functioning (BIF) and has been a “slow learner” throughout school. She also has recently been diagnosed with depression. She has received special education services throughout her school years and is now in the 11th grade. She has attended special classes for all of her academic subjects, but has been mainstreamed for some elective courses and extracurricular activities. Her teacher reports that she performed satisfactorily in most of her classes in previous years, but for the past two semesters has become inattentive in class, has failed three academic subjects because of inattention and failure to complete her assignments, and has frequently refused to go to school. Her mother reports that at home the child cries a lot, sleeps as long as 12 hours every night, eats irregularly, complains of headaches, and is irritable, uncooperative, and angry more often than not. Despite many attempts, the parent has been unable to engage her daughter in talking about what is wrong and how she might help.

The student's difficulty with activities at school and at home involves three, and possibly four, domains:

1. Her many years of placement in special education classes for all academic work indicate a limitation that we would rate in the domain of “Acquiring and using information.”
2. Her inattention in class and current failure in three academic subjects as a consequence indicate that there is also a limitation in the domain of “Attending and completing tasks.”
3. Her mother's description of some of the child's difficulties at home (for example, crying, oversleeping, physical complaints, and irritability) and the child's avoidance of dealing with them indicate a limitation in the domain of “Caring for yourself.”
4. In addition, if her refusal to talk with her mother and her anger and uncooperativeness exceed what would be expected of adolescents of the same

age who do not have an impairments, this would indicate a limitation in the domain of “Interacting and relating with others.”

III. Rating severity

A. General.

Once we have determined which of a child's activities are limited, which domain or domains are involved, and that the limitations are the result of a medically determinable impairment(s), we rate the severity of the limitations and determine whether the impairment(s) functionally equals the listings. We consider all relevant evidence in the case record, including objective medical and other evidence, and all of the relevant factors discussed in 20 CFR 416.924a.[14]

It is important to determine the extent to which an impairment(s) compromises a child's ability to independently initiate, sustain, and complete activities. To do so, we consider the kinds of help or support the child needs in order to function. *See* 20 CFR 416.924a(b). In general, if a child needs a person, medication, treatment, device, or structured, supportive setting to make his functioning possible or to improve the functioning, the child will not be as independent as same-age peers who do not have impairments. Such a child will have a limitation, even if he is functioning well with the help or support.

The more help or support of any kind that a child receives beyond what would be expected for children the same age without impairments, the less independent the child is in functioning, and the more severe we will find the limitation to be. For example:

- A 10-year-old child who is dressed appropriately may appear not to be limited in this activity. However, if the evidence in the case record shows that the child needs significant help from her parents with the basics of dressing every day (for example, putting on and buttoning shirts), the child will have a limitation of that activity.[15]
- A 14-year-old child who has a serious emotional disturbance may be given “wrap-around services” that include the services of an adult who supervises the child at school. With these services, the child attends school, participates in activities with other children, and does not take any actions that endanger himself or others. However, the degree of “extra help”[16] the child needs to function demonstrates a limitation in at least the domains of “Interacting and relating with others” and “Caring for yourself.”

B. Rating the severity of limitations in the domains.

When we determine the degree to which the child's impairment(s) limits each affected domain, we use the definitions of “marked” or “extreme” in our regulations.

See 20 CFR 416.926a(e). The following discussion provides further guidance about how to apply those definitions.

To determine whether there is a “marked” or an “extreme” limitation in a domain, we use a picture constructed of the child's functioning in each domain. This last step in the “whole child” approach summarizes everything we know about a child's limited activities. The rating of limitation in a domain is then based on the answers to these questions:

1. How many of the child's activities in the domain are limited (for example, one, few, several, many, or all)?
2. How important are the limited activities to the child's age-appropriate functioning (for example, basic, marginally important, or essential)?
3. How frequently do the activities occur and how frequently are they limited (for example, daily, once a week, or only occasionally)?
4. Where do the limitations occur (for example, only at home or in all settings)?
5. What factors are involved in the limited activities (for example, does the child receive support from a person, medication, treatment, device, or structured/supportive setting)?

There is no set formula for applying these considerations in each case. A child's day-to-day functioning may be seriously or very seriously limited whether an impairment(s) limits only one activity or whether it limits several. See 20 CFR 416.926a(e)(2) and (e)(3). Also, we may find that a child has a “marked” or “extreme” limitation of a domain even though the child does not have serious or very serious limitations every day. As in any case, we must consider the effects of the impairment(s) longitudinally (that is, over time) when we evaluate the severity of the child's limitations.[17] The judgment about whether there is a “marked” or “extreme” limitation of a domain depends on the importance and frequency of the limited activities and the relative weight of the other considerations described above.

Adjudicators must also be alert to the possibility that limitation of several seemingly minor activities may point to a larger problem that requires further evaluation. For example, a young child may have serious difficulty with common childhood activities such as scribbling, using scissors, or copying shapes, which in themselves may not appear to be important to age-appropriate functioning. It would be unlikely, however, that a young child would have *serious* difficulty with those common activities but have no trouble with other activities, such as buttoning a shirt or printing letters, that also involve fine motor or perceptual-motor ability. Such additional difficulties would indicate that the child has more significant problems with age-appropriate functioning than just scribbling, using scissors, or copying shapes alone might suggest.

Finally, the rating of limitation of a domain is not an “average” of what activities the child can and cannot do. When evaluating whether a child's functioning is age-appropriate, adjudicators must consider evidence about all of the child's activities. We do not

“average” all of the findings in the evidence about a child's activities to come up with a rating for the domain as a whole. The fact that a child can do a particular activity or set of activities relatively well does not negate the difficulties the child has in doing other activities.

IV. Example of a functional equivalence analysis

In this section, we provide an example of how we would consider a child's activities at the functional equivalence step. In this example, we provide only partial evidence to illustrate how we consider activities and sort them into the domains. We do not rate the severity of the limitations because we are not providing complete evidence and because rating severity based on a specific set of case facts would not be useful in other cases.

Example: A parent files a claim on behalf of her 8-year-old son, alleging that anxiety keeps him from living normally, going to school regularly, and playing with other children. The evidence establishes that the child has a generalized anxiety disorder (GAD) that is “severe” but that does not meet or medically equal listing 112.06.

A. How does the child function?

The child says that he cannot sleep because he is afraid of the dark and the noises he hears outside, and that he needs to be awake and keep his eyes open as long as possible in case anything happens. His mother reports that he refuses to go to bed, must be coaxed into his room, frequently will not stay there, and gets up and watches television until he falls asleep in front of it. He does not sleep well at night and in the daytime is often irritable. Sometimes, he is combative. He cries when he has to leave for school, and his mother must sometimes ride with him on the school bus. His teacher reports a reduction in his energy and attention in school, that he has trouble focusing in class and does little work at school or at home, and that he may not be promoted at the end of the year because he has fallen behind in his learning. She also reports that he sometimes refuses to leave the classroom for recess or activities anywhere else in the school building or playground, and that an aide must stay with him when he does. She says that the child seems suspicious of other children in his class because he frequently reports things they do and say that worry and frighten him.

The child is seen regularly by a clinical psychologist. Results of formal evaluation, including an anxiety scale and a depression inventory, contribute to a profile of GAD. His pediatrician prescribed two kinds of medications, but both had unacceptable side effects, so the child does not take them. He is in play therapy.

B. Which domains are involved in the child's limited activities?

The following chart[18] provides a picture of the child's functioning, including information about several factors that are relevant to determining the severity of his limitations; for example, help from a parent and school aide, medications, and play therapy. As shown

in the chart, the descriptions from the evidence about how the child functions must be specific, not general. For example, “the child is anxious” is a general conclusion, while the notes in the chart below state specifically what the child does and how he does it, based on his own words and the observations of the medical sources and adults who know him and spend the most time with him.

Acquiring & Using Information	Attending & Completing Tasks	Interacting & Relating with Others	Moving About & Manipulating Objects	Caring for Yourself	Health & Physical Well-being
Does little work in class or at home and has fallen behind; may not be promoted to next grade in school.	Attention at school is reduced; has trouble focusing in class; does little work in class or at home.	Despite orders from mother, refuses to go to bed; mother must coax him into bedroom; will not stay in bed; gets up and watches TV until falls asleep. May be combative at home. Sometimes refuses to leave classroom for recess and activities elsewhere; in that case, an aide must stay with him. Frequently reports other children's actions and conversations; seems suspicious of them.	(No limitations.)	Difficulty sleeping; afraid of dark and outside noises; needs to stay awake and keep eyes open (be vigilant). Parent must coax him into bedroom. Will not stay in bed; watches TV until falls asleep. Is irritable because of lack of sleep. Cries when has to leave for school; mother may have to ride bus with him to school. Anxiety scale shows GAD. Child	Pediatrician has tried short-term Valium; child complained of stomach cramps and headache; tried short-term Ativan; side effects were dizziness and daytime sleepiness.

Acquiring & Using Information	Attending & Completing Tasks	Interacting & Relating with Others	Moving About & Manipulating Objects	Caring for Yourself	Health & Physical Well-being
				is in play therapy.	

C. Could the child's medically determinable impairment(s) limit any of his activities?

In the example described above, the medically determinable impairment of GAD clearly accounts for the child's problems, and there is no evidence to the contrary.[19] Therefore, it is appropriate to conclude that the child's GAD results in limitations that are evaluated in five of the six domains, as indicated in the chart above.

V. Responsibility for determining functional equivalence

The responsibility for making functional equivalence determinations depends on the level of the administrative review process.

- For initial and reconsideration determinations, the State agency medical or psychological consultant has the overall responsibility for determining functional equivalence.
- When an SSI recipient has requested a hearing before a disability hearing officer at the reconsideration level, the disability hearing officer determines functional equivalence.
- For cases at the Administrative Law Judge (ALJ) and Appeals Council (AC) levels (when the AC makes a decision), the ALJ or AC determines functional equivalence. 20 CFR 416.926a(n).

While SSR 96-6p[20] requires that an ALJ or the AC must obtain an updated medical expert opinion before making a decision of disability based on medical equivalence, there is no such requirement for decisions of disability based on functional equivalence. Therefore, ALJs and the AC (when the AC makes a decision) are not required to obtain updated medical expert opinions when they determine that a child's impairment(s) functionally equals the listings.[21]

Effective date:

This SSR is effective on March 19, 2009.

Cross-References:

SSR 09-2p, Title: 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 09-5p, Title XVI: Determining Childhood Disability — “Interacting and Relating with Others”; SSR 09-6p, Title XVI: Determining Childhood Disability — The Functional Equivalence Domain of “Moving About and Manipulating Objects”; SSR 09-7p, Title XVI: Determining Childhood Disability — The Functional Equivalence Domain of “Caring for Yourself”; SSR 09-8p, Title XVI: Determining Childhood Disability — The Functional Equivalence Domain of “Health and Physical Well-Being”; SSR 98-1p, Title XVI: Determining Medical Equivalence in Childhood Disability Claims When a Child Has Marked Limitations in Cognition and Speech; SSR 96-6p, Titles II and XVI: Consideration of Administrative Findings of Fact by State Agency Medical and Psychological Consultants and Other Program Physicians and Psychologists at the Administrative Law Judge and Appeals Council Levels of Administrative Review; Medical Equivalence; and Program Operations Manual System (POMS) DI 25225.030, DI 25225.035, DI 25225.040, DI 25225.045, DI 25225.050, and DI 25225.055.

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[1] The definition of disability in section 1614(a)(3)(C) of the Social Security Act (the Act) applies to any “individual” who has not attained age 18. In this SSR, we use the word "child" to refer to any such person, regardless of whether the person is considered a "child" for purposes of the SSI program under section 1614(c) of the Act.

[2] For simplicity, we refer in this SSR only to initial claims for benefits. However, the policy interpretations in this SSR also apply to continuing disability reviews of children under section 1614(a)(4) of the Act and 20 CFR 416.994a.

[3] We use the term “impairment(s)” in this SSR to refer to an “impairment or a combination of impairments.”

[4] The impairment(s) must also satisfy the duration requirement in section 1614(a)(3)(A) of the Act; that is, it must be expected to result in death, or must have lasted or be expected to last for a continuous period of not less than 12 months.

[5] For each major body system, the listings describe impairments we consider severe enough to cause “marked and severe functional limitations.” 20 CFR 416.925(a); 20 CFR part 404, subpart P, appendix 1.

[6] See 20 CFR 416.926a(e) for definitions of the terms “marked” and “extreme.”

[7] For the first five domains, we describe typical development and functioning using five age categories: Newborns and young infants (birth to attainment of age 1); older infants

and toddlers (age 1 to attainment of age 3); preschool children (age 3 to attainment of age 6); school-age children (age 6 to attainment of age 12); and adolescents (age 12 to attainment of age 18). We do not use age categories in the sixth domain because that domain does not address typical development and functioning, as we explain in SSR 09-8p Title XVI: Determining Childhood Disability — The Functional Equivalence Domain of “Health and Physical Well-Being.”

[8] In the preamble to the final childhood disability regulations we published in 2000, we noted that this approach assumes that at this step in the sequential evaluation process for children we have already established the existence of at least one medically determinable impairment that is “severe.” Therefore, * * * we are looking primarily at the extent of the limitation of the child's functioning. We look at all of the child's activities to determine the child's limitations or restrictions and then decide which domains to use. 65 FR 54747, 54757 (2000).

[9] As noted in question no. 3 above, we would not make this assumption if there is evidence indicating that a child's limitations are not attributable to a medically determinable impairment(s). However, in most cases, limitations that are of listing-level severity will be associated with underlying physical or mental impairments.

[10] Rating the limitations caused by a child's impairment(s) in each and every domain that is affected is not “double-weighting” of either the impairment(s) or its effects. Rather, it recognizes the particular effects of the child's impairment(s) in all domains involved in the child's limited activities.

[11] By the time we reach the functional equivalence step, we will have already determined that the child has at least one medically determinable impairment that is “severe”; that is, it that causes more than minimal functional limitations. 20 CFR 416.924. Therefore, the child must have a limitation in at least one domain.

[12] Children who have mental disorders will often have limitations that are rated in more than one domain, but as we explain in the domain-specific SSRs referenced at the end of this SSR, physical impairments can also have effects that must be assigned to more than one domain.

[13] Even though this child's underlying ability to socialize may not be affected, there is a limitation in her ability to interact and relate with other children because of indirect effects of her impairments that limit her opportunity to use the ability.

[14] As provided in 20 CFR 416.924a(b), we consider these factors whenever we evaluate functioning at any step of the sequential evaluation process for children. We also use these factors to determine *whether* a child has a limitation, not just the severity of the limitations.

[15] The domain or domains in which we would rate the limitation would depend on the reason(s) that the child needs the help. For example, the child may have motor difficulties (Moving about and manipulating objects), difficulties learning or remembering how to dress appropriately (Acquiring and using information), difficulties with attention or impulsivity (Attending and completing tasks), or a combination of some or all of these problems. There may be limitations we would evaluate in other domains as well.

[16] *See* 20 CFR 416.924a(b)(5).

[17] For example, in 20 CFR 416.924a(b)(8), we provide: "If you have a chronic impairment(s) that is characterized by episodes of exacerbation (worsening) and remission (improvement), we will consider the frequency and severity of your episodes of exacerbation as factors that may be limiting your functioning. Your level of functioning may vary considerably over time. Proper evaluation of your ability to function in any domain requires us to take into account any variations in your level of functioning to determine the impact of your chronic illness on your ability to function over time." When we published this rule in 2000, we explained that, while we adopted the language from section 12.00D of the adult mental disorders listings, "[t]his principle is equally applicable to children and adults, and to both physical and mental impairments." *See* 65 FR at 54754.

[18] This chart is for illustration only. We do not require our adjudicators to develop or use such a chart.

[19] With other facts, additional development might be needed. For example, if the evidence in this case showed that the child performed poorly in sports (which we mention as a typical activity of children without impairments), we would note that GAD would not be expected to affect the child's physical ability to move about and manipulate objects. Therefore, poor performance in sports in a child with GAD might be attributable to something other than the mental disorder. There may not be a medical reason at all: the child might do poorly because he does not like to play any sport, is not good at sports, or is not interested in them. On the other hand, there might be another impairment not yet documented by evidence from an acceptable medical source that would limit motor functioning and interfere with the child's day-to-day activities; in such instances, additional development might be needed to complete the evaluation of the child's functioning.

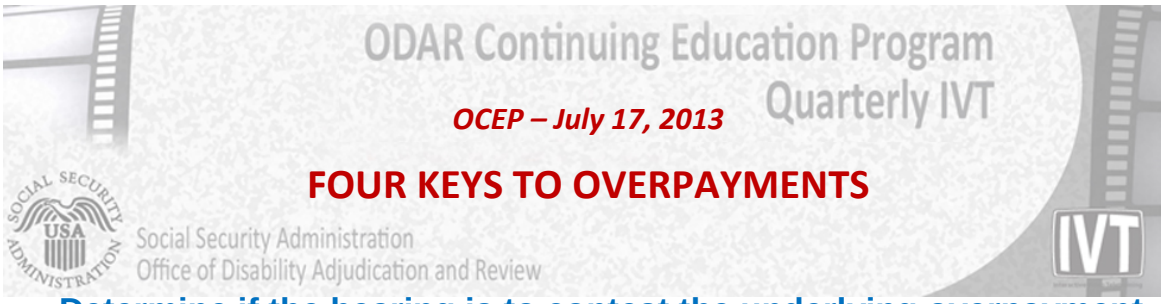
[20] *See* SSR 96-6p, Titles II and XVI: Consideration of Administrative Findings of Fact by State Agency Medical and Psychological Consultants and Other Program Physicians and Psychologists at the Administrative Law Judge and Appeals Council Levels of Administrative Review; Medical Equivalence, 61 FR 34466 (1996), available at: http://www.socialsecurity.gov/OP_Home/rulings/di/01/SSR96-06-di-01.html.

[21] For cases pending at the ALJ and AC levels from States in the Ninth Circuit (Alaska, Arizona, California, Guam, Hawaii, Idaho, Montana, Nevada, Northern Mariana Islands,

Oregon, and Washington) at the time of the ALJ or AC decision, see Acquiescence Ruling 04-1(9), *Howard on behalf of Wolff v. Barnhart*, 341 F.3d 1006 (9th Cir. 2003)—Applicability of the Statutory Requirement for Pediatrician Review in Childhood Disability Cases to the Hearings and Appeals Levels of the Administrative Review Process—Title XVI of the Social Security Act, 69 FR 22578 (2004), available at: http://www.socialsecurity.gov/OP_Home/rulings/ar/09/AR2004-01-ar-09.html.

IX.D. Overpayments

IX.D.1. OCEP 07/17/13: Four Keys to Overpayments



Determine if the hearing is to contest the underlying overpayment, request waiver of overpayment recovery, or both.

- An individual who contests the fact or amount of the overpayment may request a hearing before an ALJ from a reconsideration determination.
- An individual seeking waiver of overpayment recovery must be *without fault* and recovery must *defeat the purpose of the Act* or *be against equity and good conscience*.

When the issue is waiver of overpayment recovery, first determine if the claimant is without fault.

- Waiver of recovery cannot be granted if the claimant was at fault in causing or accepting the overpayment.
- Consider all pertinent circumstances, including the age, intelligence, and any physical, mental, educational or linguistic limitation of the individual.
- *Fault* is defined at 20 CFR 404.507 and 416.552. Did the overpaid individual:
  - Make an incorrect statement which he knew or should have known was incorrect; or,
  - Fail to provide information that he knew or should have known was material; or,
  - Accept a payment that he knew or could have been expected to know was incorrect?

"Defeat the purpose" generally means to deprive the individual of ordinary and necessary living expenses.

- If the individual needs substantially all current income, including monthly social security benefits, to meet current ordinary and necessary living expenses, recovery defeats the purpose.
- Consider all current household income, resources and expenses in making this determination.

"Against equity and good conscience" does not involve financial considerations. It invokes principles of equitable estoppel.

- This concept generally applies when an individual *detrimentally relied* upon the payments and spent the money believing that the payments were correct.

- It also applies if the individual never received financial benefit from the payments and has little connection to the actual recipient.
- 20 CFR 404.509 and 416.554 have examples of recovery that are against equity and good conscience.

IX.D.2. Desk Guide – Determining Issues for Overpayments

OVERPAYMENTS DESK GUIDE – DETERMINING ISSUE FOR OVERPAYMENTS TITLE II AND TITLE XVI

References: 20 CFR 404.501-526, 20 CFR 416.535-571, and LA Module on Special Issues for Hearing Notice

Make sure there is an initial and reconsideration determination (or personal conference) on the issue being appealed at the hearing level. What is claimant disputing-(1) amount of overpayment or calculations of benefits, (2) fault, (3) waiver determination? Request for hearing may deal with any or all of these issues.

Read the initial and reconsideration determinations to define the issue of the claim:

WHO	has been overpaid benefits
WHAT	caused the overpayment
WHEN	did the overpayment take place (timeframe)
AMOUNT	of the overpayment

FAULT **20 CFR 404.510, 416.550**

- Did the claimant fail to report information timely to SSA?
- Did claimant know or could reasonably have been expected to know there was an overpayment? (consider age, education, mental status, language limitations)
- Did claimant accept incorrect payment in good faith?
- Did claimant exercise a high degree of care in preventing the overpayment?
- It does not matter if SSA was at fault.

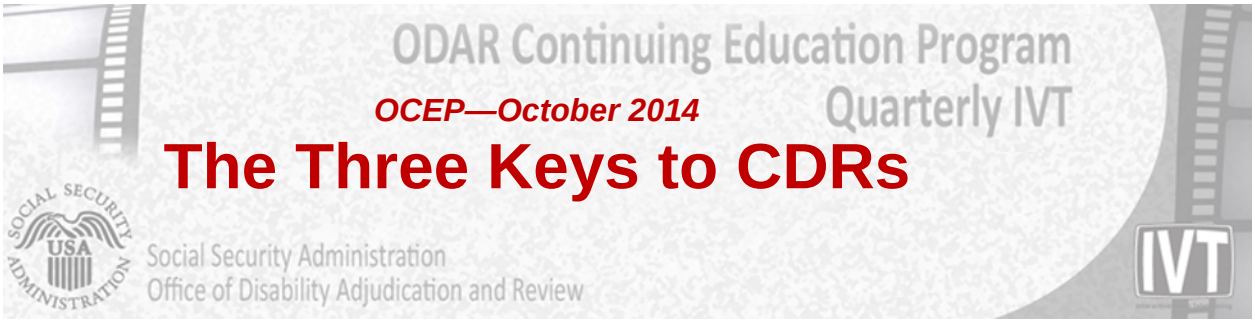
WAIVER **20 CFR 404.508-404.527, 416.552-416.556**

- If the claimant is found "without fault", would collection of the overpayment leave him/her without funds necessary for ordinary living expenses?
- We need form SSA-632, “Request for Waiver of Overpayment Recovery Statement of Income”, no more than 6 months old at time of ALJ hearing (SCT will have to send this form to claimant).
- If the claimant is found "without fault", would recovery of the overpayment be against equity and good conscience? Would it change claimant's financial position for the worse or cause them to relinquish a valuable right? (see 20 CFR 404.509 for examples)

August 2009

IX.E. Continuing Disability Reviews (CDRs)

IX.E.1. OCEP 10/22/14 Keys to CDRs



An Adult Continuing Disability Review (CDR) is an 8 Step Sequential Evaluation Process (20 CFR 404.1594; 416.994).

- Is the person engaged in Substantial Gainful Activity? If the answer is yes, disability ends. This step applies only to benefits under Title II of the Social Security Act.
- Do the impairments currently meet or equal a current Listing of Impairments? If the answer is yes, disability continues.
- Has there been medical improvement?
- Does the medical improvement relate to the person's ability to work?
- Does a Group I or Group II exception to medical improvement apply?
- Does the person have a severe impairment?
- Can the person perform past relevant work?
- Can the person perform other work?

A Disabled Child Continuing Disability Review (CDR) is a 3 Step Sequential Evaluation Process (20 CFR 416.994a(b)).

- Has there been medical improvement in any CPD impairment?
- Do the CPD impairments now meet, equal, or functionally equal the severity of a CPD listing? And,
- Is the child currently disabled, considering all the impairments?

Adapt decision writing instructions and decision drafts to reflect the special considerations in CDRs.

IX.E.2. SSR 13-3p: Title II: Appeal of an Initial Medical Disability Cessation Determination or Decision

Policy Interpretation Ruling

SSR 13-3p: *Title II*: Appeal of an Initial Medical Disability Cessation Determination or Decision

Purpose: This SSR explains how we will review an initial medical cessation determination or decision when we receive a timely request for administrative review of the cessation determination or decision. In this SSR, we are adopting as our nationwide policy the holding in ***Difford v. Secretary of Health and Human Services***, 910 F.2d 1316 (6th Cir. 1990). We have applied the holding in that decision under Acquiescence Ruling (AR) 92-2(6) to cases involving beneficiaries residing in States within the Sixth Circuit (Kentucky, Michigan, Ohio, Tennessee). Because this SSR addresses the issue decided by the ***Difford*** court, in this issue of the **Federal Register**, we are also publishing a notice rescinding AR 92-2(6) as obsolete in accordance with our acquiescence regulations, 20 CFR 404.985(e)(4).[1]

Citations: Sections 223(f) of the Social Security Act, as amended; Regulations No. 4, Subpart D, section 404.316; Subpart J, sections 404.902, 404.905; and Subpart P, sections 404.1579, 404.1589, 404.1590, 404.1593, and 404.1594.

Pertinent History: Section 223(f) of the Social Security Act (Act) sets forth the standard of review for determining whether an individual's disability has medically ceased. This provision provides, in relevant part, as follows:

" (f) A recipient of benefits under this title or title XVIII based on the disability of any individual may be determined not to be entitled to such benefits on the basis of a finding that the physical or mental impairment on the basis of which such benefits are provided has ceased, does not exist, or is not disabling only if such finding is supported by—

(1) substantial evidence which demonstrates that—

(A) there has been any medical improvement in the individual's impairment or combination of impairments (other than medical improvement which is not related to the individual's ability to work), and

(B) the individual is now able to engage in substantial gainful activity; or

(2) substantial evidence which—

(A) consists of new medical evidence and a new assessment of the individual's residual functional capacity, and demonstrates that—

(i) although the individual has not improved medically, he or she is nonetheless a beneficiary of advances in medical or vocational therapy or technology (related to the individual's ability to work), and

(ii) the individual is now able to engage in substantial gainful activity, or

(B) demonstrates that—

(i) although the individual has not improved medically, he or she has undergone vocational therapy (related to the individual's ability to work), and

(ii) the individual is now able to engage in substantial gainful activity; or

(3) substantial evidence which demonstrates that, as determined on the basis of new or improved diagnostic techniques or evaluations, the individual's impairment or combination of impairments is not as disabling as it was considered to be at the time of the most recent prior decision that he or she was under a disability or continued to be under a disability, and that therefore the individual is able to engage in substantial gainful activity; or

(4) substantial evidence (which may be evidence on the record at the time any prior determination of the entitlement to benefits based on disability was made, or newly obtained evidence which relates to that determination) which demonstrates that a prior determination was in error.

* * * * *

Any determination under this section shall be made on the basis of all the evidence available in the individual's case file, including new evidence concerning the individual's prior or current condition, which is presented by the individual or secured by the Commissioner of Social Security. Any determination made under this section shall be made on the basis of the weight of the evidence and on a neutral basis with regard to the individual's condition, without any initial inference as to the presence or absence of disability being drawn from the fact that the individual has previously been determined to be disabled."

Introduction

Since Congress enacted section 223(f) of the Act in 1984, we have interpreted the words "now" and "current" in that section of the Act to mean that, generally, when deciding the appeal of a medical cessation, an adjudicator would consider what the beneficiary's condition was at the time of the initial cessation determination. The adjudicator would not consider the beneficiary's condition at the time of the reconsideration or disability hearing officer's determination, the administrative law judge's (ALJ) decision, or the Appeals Council's (AC) decision. If the adjudicator determined that the medical cessation date was appropriate, but evidence also showed that the beneficiary had again become disabled at any time through the date of his or her determination or decision, as a result of a worsening of an existing impairment or by the onset of a new impairment, the adjudicator would solicit a new application for title II disability benefits. In title XVI cases, a new application is not required if a recipient of supplemental security income payments again becomes disabled while an appeal is pending (20 CFR 416.305(b)).

In *Difford*, the United States Court of Appeals for the Sixth Circuit interpreted the references to "now" and "current" in section 223(f) of the Act to require that when we review a medical disability cessation determination or decision, we must consider whether the beneficiary was disabled at any time through the date of the adjudicator(s)'s final determination or decision. Under ***Difford***, as applied in AR 92-2(6), when we

review a determination or decision that disability has medically ceased, the adjudicator must consider the individual's disability through the date of his or her determination or decision, rather than determining only whether the individual's disability had ceased at the time of the initial cessation determination. We are now revising our interpretation of section 223(f) of the Act to adopt the policy contained in Difford AR as our nationwide policy.

In this SSR, we use the term “final decision” to differentiate between the initial cessation determination and the subsequent determination or decision on appeal that becomes administratively final. As used in this Ruling, “final decision” refers to the administrative determination or decision that becomes final because the beneficiary does not request further administrative review, or when the AC issues a decision. “Final decision” does not refer to cases where the AC denies a request for review or issues remand or dismissal order. At the time an adjudicator makes a determination or decision at the reconsideration or hearing level, the adjudicator does not know if the beneficiary will request an appeal. Therefore, the adjudicator cannot know whether the determination or decision will become the final determination or decision. In implementing this Ruling, we refer to a determination or decision made at any administrative review level as though it will become a final determination or decision.

Policy Interpretation: This SSR revises our policy to provide that we will use the same timeframe for determinations or decision we make in both title II and title XVI medical disability cessation cases reviewed at the reconsideration and hearings level(s) of our administrative review process. Under the policy we are adopting in this Ruling, the adjudicator reviewing the medical cessation determination or decision will decide whether the beneficiary is under a disability through the date of the adjudicator's determination or decision.

When the AC receives a request for review of a hearing decision, the AC generally considers evidence that relates to the period on or before the date of the ALJ's decision. When deciding whether to grant a request for review of an ALJ's decision in a medical cessation case, the AC will not consider evidence that does not relate to the period on or before the date of the ALJ's decision. If the ALJ correctly applied this Ruling and there is no basis for review on any other issue, the AC will deny the request for review. If the AC grants the request for review, vacates the ALJ's decision and remands the medical cessation case to the ALJ for further proceedings, on remand, the ALJ will apply the provisions of this Ruling. However, in a medical cessation case when the AC grants review and exercises its authority to issue a decision, then it will determine the beneficiary's disability through the date of the AC decision, which will be our final decision.

In addition, a timely request for administrative review of a disability cessation determination or decision, including cases where we find good cause for late filing, constitutes a protective filing of an application permitting a determination of disability through the date of the final determination or decision on appeal.

Adjudicators use the date of the initial request for review of the disability cessation determination as the filing date for a new period of disability. We establish a new period of disability if the beneficiary again became disabled as a result of a worsening of an existing impairment or by the onset of a new impairment before the date of the determination or decision on appeal, and if all other requirements for establishing a period of disability, including the duration and insured status requirements in title II cases, have been met. If cessation of a prior period of disability is confirmed, a beneficiary will not be found eligible for a subsequent period of disability if he or she did not become disabled again until after the date last insured (as determined after taking account of all prior periods of disability and updates to a claimant's earnings record).

Since this Ruling revises how we consider the title II appeal (or in concurrent cases, the title II portion) of a medical disability cessation case, it eliminates the need for a new claim for reentitlement in title II cases. The adjudicator will evaluate disability through the date of the appeal determination or decision regarding the beneficiary's medical cessation and possible reentitlement, thereby eliminating the need for filing a new application for reentitlement in title II cases.

Adjudicators will consider the following in administrative review of determinations or decisions that a beneficiary's disability has medically ceased:

- If the adjudicator determines the initial medical cessation determination was correct, he or she will then determine whether the beneficiary has again become disabled at any time through the date of his or her determination or decision because of a worsening of an existing impairment or the onset of a new impairment, if all other requirements for establishing a period of disability, including the duration and insured status requirements are met.
- If the adjudicator determines that the initial disability cessation determination was not correct, he or she will determine if the evidence establishes medical improvement as a basis for cessation of disability at any time through the date of final determination or decision.
- In every case where we find that that the beneficiary was not continuously disabled through the date of the appeal determination or decision, the adjudicator must fully explain the basis for the conclusion reached in the determination or decision. The adjudicator will state the month the beneficiary's disability ended, and, if applicable, the month in which a new period of disability began and any intervening months during which there was no disability.
- If the beneficiary's disability has medically ceased, the determination or decision must specifically address the initial cessation determination and the beneficiary's eligibility (or ineligibility) for a new a period of disability through the date on which the appeal determination or decision is being made, or, if earlier, through the date last insured.

Effective Date: This Ruling is effective upon publication in the **Federal Register**.

[1] This SSR applies only to determinations or decisions finding that a beneficiary is no longer entitled to benefits because the physical or mental impairment on the basis of which the benefits have been paid has ceased, does not exist, or is no longer disabling. We call this type of finding a medical cessation determination or decision. This SSR does not apply to disability cessations based on substantial gainful activity.

IX.E.3. Adjudication Tip #54 – Section 301

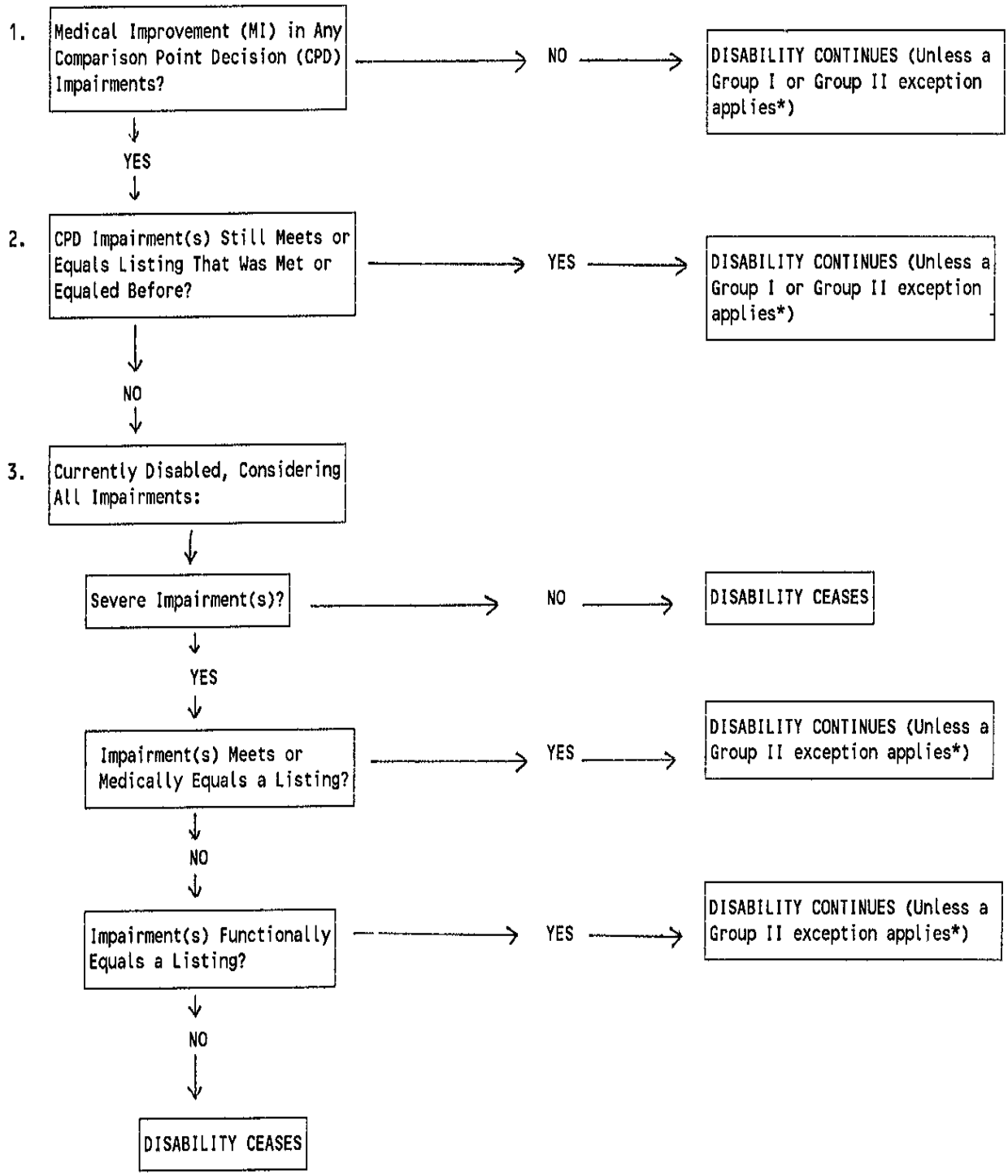
#54 - "Section 301" Cases

We all know that disability benefits end after a claimant's impairment is no longer disabling, but have you ever been asked by a claimant or representative to continue benefits because of the claimant's participation in a qualified "Section 301" program? Under our policy, an individual whose disability has ceased may still be entitled to continuing disability benefits if he or she is participating in a qualified vocational rehabilitation program (20 CFR 404.316(c)(1)(i) and 416.1338), also known as a "Section 301" program. A qualified vocational rehabilitation program may include Ticket to Work programs; State vocational rehabilitation programs; Veterans Administration rehabilitation programs; and individualized education programs for individuals between the ages of 18 and 21 (20 CFR 404.327 and 416.1338(c) and (d)). See also POMS DI 14505.005.

The issue of Section 301 eligibility usually arises during a continuing disability review (CDR) or age 18 redetermination case. When the issue of Section 301 eligibility is raised, the administrative law judge (ALJ) must first determine whether he or she is adjudicating the medical cessation of a CDR or age 18 redetermination, or whether he or she is adjudicating an appeal of Section 301 eligibility.
If the ALJ is adjudicating a medical cessation issue, the ALJ does not have jurisdiction over the Section 301 issue. When an ALJ is deciding a medical cessation issue, the field office will hold the request for hearing on the Section 301 issue pending the medical cessation appeal outcome because a finding of continuing disability would render the Section 301 issue moot (POMS DI 14510.035(B)(3); see also POMS DI 14510.003).

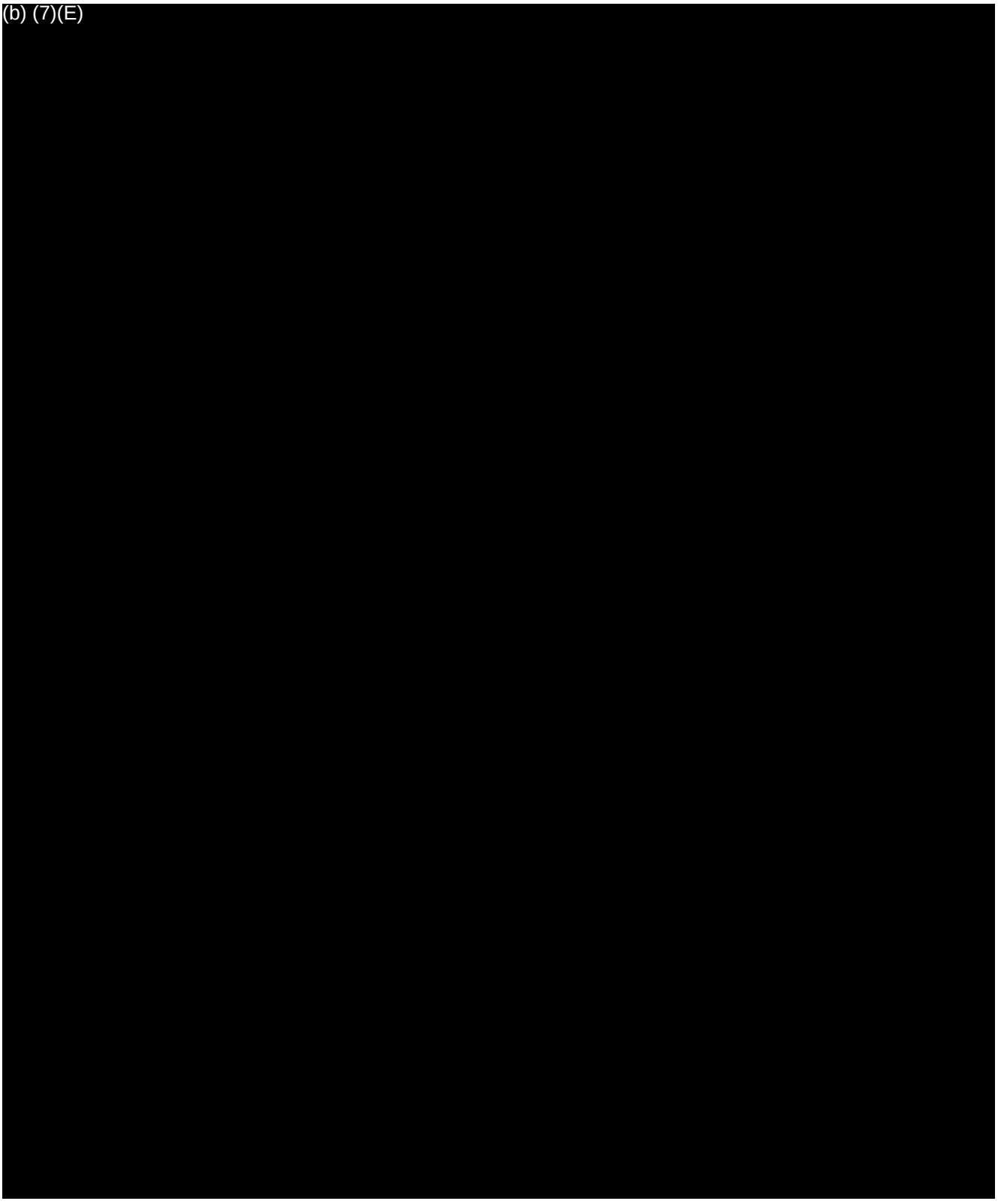
Additionally, it is important to be aware that the Office of Disability Operations (ODO) makes the initial determination on Section 301 eligibility. In some cases, ODO may be considering the Section 301 eligibility at the same time the ALJ is considering a request for hearing on the medical cessation issue.

IX.E.3.b. Childhood SSI CDR Flow Chart I-5-4-30-C.



IX.E.3.c. Adult CDR Flow Chart

(b) (7)(E)



IX.F. Application of National Uniformity Rules to CDRs

The rule requiring submission of evidence five days before the hearing applies to Title II CDRs, but does not apply to Title XVI CDRs and Age-18 Redeterminations. *See* 20 CFR 416.935(c)

IX.F.1. 20 CFR 416.35(c)

(c) *Claims Not Based on an Application For Benefits.* Notwithstanding the requirements in paragraphs (a)-(b) of this section, for claims that are not based on an application for benefits, the evidentiary requirement to inform us about or submit evidence no later than 5 business days before the date of the scheduled hearing will not apply if our other regulations allow you to submit evidence after the date of an administrative law judge decision.

Evaluating Medical Evidence –Overview and Relevant Dates

New Approach to Evaluating Medical Evidence:
The Agency revised the rules on evaluation of medical evidence effective March 27, 2017. The revisions redefined several key terms related to evidence, revise rules about acceptable medical sources (AMS); revised how the Agency considers and articulates consideration of medical opinions and prior administrative medical findings; revised rules about medical consultants (MC) and psychological consultants (PC); revised rules about treating sources, and reorganized the evidence regulations for ease of use.

- Five new categories of evidence are: objective medical evidence, medical opinion, other medical evidence, evidence from nonmedical sources, and prior administrative medical finding.

- For claims filed on or after March 27, 2017, a Medical Opinion for an adult is defined as statement from a medical source about what an individual can still do despite his or her impairments and whether the individual has one or more impairment-related limitations or restrictions in one or more specified demands of work and adapt to environmental conditions.

- For claims filed on or after March 27, 2017, AMSs includes Advanced Practice Registered Nurse (APRN) for impairments within their licensed scope of practice, including: certified nurse midwives, nurse practitioner, certified registered nurse anesthetists, and clinical nurse specialists; Physician Assistants (PAs); and Audiologists.

- Both the prior rules and the revised rules require an adjudicator to consider all evidence in a claim, including decisions by other governmental agencies and nongovernmental entities. See 20 CFR 404.1520b and 416.920b. For claims filed on or after March 27, 2017, though written analysis is not required on decisions by other governmental and nongovernmental entities, we must always consider all of the supporting evidence underlying the other agency or entity's decision that we receive in a claim. The underlying evidence may require a written analysis (See 20 CFR 404.1504 and 416.904 noting that ". . .we will not provide any analysis in our determination or decision about a decision made by any other governmental agency or a nongovernmental entity about whether you are disabled, blind, employable, or entitled to any benefits.").

- In claim(s) filed on or after March 27, 2017, do not defer to or give specific weight to any medical opinion or prior administrative medical finding. Articulate the persuasiveness of the opinions or prior administrative medical findings by considering supportability, consistency, relationship with the claimant, specialization, and other factors. The most important factors are supportability and consistently, and we must provide articulation on these factors for every medical opinion in all decisions.

Topic	"Prior Rule" Citation Regulations that apply to claims filed prior to March 27, 2017	"Current Rule" Citation Regulations that apply to cases filed on or after March 27, 2017.
Acceptable Medical Sources	20 CFR 404.1502(a)(1)-(5) and 416.902(a)(1)-(5)	20 CFR 404.1502(a)(1)-(8) and 416.902(a)(1)-(8)
Medical Opinion Definition	20 CFR 404.1527(a)(1) and 416.927(a)(1)	20 CFR 404.1513(a)(2) and 416.913(a)(2)
Other Medical Evidence Definition	20 CFR 404.1513(a)(3) and 416.913(a)(3)	20 CFR 404.1513(a)(3) and 416.913(a)(3)
Consideration and Articulation of Opinion Evidence and Prior Administrative Medical Findings	20 CFR 404.1513a, 404.1527, 416.913a and 416.927	20 CFR 404.1513a, 404.1520c, 416.913a, and 416.920c
Statements on Issues Reserved to the Commissioner	20 CFR 404.1527(d) and 416.927(d)	20 CFR 1520b(c)(3) and 416.920b(c)(3)
Decisions by other Governmental and Nongovernmental Entities	20 CFR 404.1504 and 416.904	20 CFR 404.1504, 404.1520b(c)(1), 416.904, and 416.920b(c)(1)

Resources:

- Chief Judge Resources: Revisions to Rules Regarding the Evaluation of Medical Evidence
- Chief Judge Memo - Revised Rules for Evaluating Medical Evidence
- ALJ/DW Training Course Module 8: Evaluation of Medical Opinion Evidence
- Judicial Training 2017 Session on Evaluation of Medical Evidence

ALJ Supplemental Training (Phase IV) -- August 2018

Table of Contents

Administrative Law Judge (ALJ) Online Resources

	Resource & Link	What this resource covers
1	**ALJ Dashboard**	Homepage for ALJs in Case Processing Management System (CPMS).
2	**Office of the Chief Administrative Law Judge (OCALJ) - Homepage**	Site contains useful resources including mission statement, regional website access, staff listings, Adjudications Tips, employee information, transfer information and benchmarks for case processing.
3	**Adjudications Tips** ***- within OCALJ home page above***	Site contains adjudication tips that have not been affected by recent regulatory and policy changes.
4	**ALJ Digital Library**	Library contains helpful medical and legal resources for ALJs, including a medical encyclopedia, access to Lexis* and Westlaw, and vocational hyperlinks, including OccuBrowse, Job Browser Pro and O*Net. The broader SSA Digital Library provides an A-Z list of research databases on a wide variety of topics.
5	**Body Mass Index (BMI) Calculator***	Calculator is available on the ALJ CPMS Homepage. Allows you to quickly calculate BMI after entering height and weight.
6	**Chief Judge Resources**	Quick reference to resources listed by topic, including Bi-Weekly Hearing Level Policy Updates, Fee Petition and Fee Agreement training, a library of OCALJ Memoranda, OHO Continuing Education Program (OCEP)* information with links to prior broadcasts, and recent policy changes.
7	***HALLEX****	The Hearings, Appeals and Litigation Law Manual (HALLEX) provides official guidance on interpreting and applying Social Security policy.
8	**Hearings and Decisions Reference Library**	(Presently under revision) Arranged alphabetically by topic, this resource provides a comprehensive library of reference materials on topics related to holding hearings and issuing decisions.
9	**Job Browser Pro**	Tool provides the ability to search jobs by the Dictionary of Occupational Titles (DOT) number and name. It gives a detailed description of the job from the DOT and tabs within the listing provide additional information on DOT job characteristics (e.g. education requirements, physical demands, aptitudes and temperaments).

	Resource & Link	What this resource covers
10	**Policy Net**	Database that allows you to access a broad range of valuable online policy resources, including the POMS* and SSRs.
11	**OHO Continuing Education Program (OCEP)** ***- within OCALJ page above***	Quarterly IVT broadcasts that discuss and clarify Hearing Level issues.
12	**Office of Disability Policy A-Z Disability Index**	Site contains hyperlinks to a wide variety of disability policy training materials, including Videos on Demand (VODs), PowerPoint presentations, electronic desk guides, and case studies. All materials are arranged alphabetically by topic for ease of use.
13	**Online Code of Federal Regulation (CFR)*** - **The Grids*** - **The Adult and Childhood Listings***	Site provides online access to the most recently published Code of Federal Regulations, Title 20, Chapter III, Parts 400-499 (the Social Security Regulations). A.K.A. the Medical-Vocational Guidelines (Appendix 2 to Subpart P of 20 CFR Part 404.). Electronic version of the most current Listing of Adult and Childhood Impairments.
14	**SGA***	An up to date table of SGA amounts for approximately the last 30 years.
15	**TWP Amounts**	An up to date table of earnings that constitute "service months" in evaluation of Trial Work Periods.
16	**Work History Assistant Tool (WHAT)**	Tool retrieves Detail Earnings Query (DEQY) data and displays it in an easy to read format. It also allows you to run an up to date NDNH query.

**Link currently available on the ALJ CPMS Homepage.*

ERE (Electronic Records Express)

What is ERE?

ERE allows online access to the claimant's electronic folder of certain individuals. Use of ERE eliminates the need to burn multiple CDs for the representative and experts associated with a claim. Documents submitted by ERE are automatically associated with a claimant's disability claim folder.

Who may use ERE?

Only registered users may use ERE. Registered users may include:

- **Appointed Representatives** - Appointed representatives have access to all parts of the eFile except for the Private Section. Appointed representatives can also upload evidence to the eFile, track evidence submissions and send messages to OHO.

- **Vocational Experts (VEs)** - VEs have access only to the parts of the eFile relevant to their testimony (A, E and F sections only). They may also upload documents to the file and view or download the Hearing Office Status Report. The Hearing Office Status Report provides experts the key information for assigned cases. This information includes the full SSN of claimant's, hearing office scheduled information and interrogatory due dates.

- **Medical Experts (MEs)** - MEs have access to only the parts of the eFile relevant to their testimony (A, E and F sections only). They may also upload documents to the file and view or download the Hearing Office Status Report.

- **Consultative Examinations (CE) Providers** – CE providers may use ERE to submit CE reports and other documents. CE providers may also use ERE to submit invoices for payment.

- **Claimants, Medical Providers and Teachers** - Claimants, medical providers and teachers can use ERE to submit requested evidence. Providers may also use ERE to submit invoices for payment.

Interested in how ERE works? Visit the ERE Demo Page.

Updates Since New ALJ Training

Policy References -- General

New Regulations (Code of Federal Regulations (CFR))

- **Evaluation of Medical Evidence – Overview** (Resources – Evaluation of Medical Evidence and Medical Evidence Regulation Inquiry Session – Questions and Answers)
    - 20 CFR 404.1502 and 20 CFR 416.902
    - 3/27/17 and after application date
    - **Training Day – Day 2**

- **Program Uniformity – Overview** (Resources – Ensuring Program Uniformity)
    - 20 CFR 404.935 and 20 CFR 416.1435; Hearings, Appeals, and Litigation Law Manual (HALLEX) I-2-5-13
    - **Training Day – Day 1**

- **Mental Disorders – Overview** (Mental Disorders Listings Training and Resources)
    - Regulations effective 1/17/17
    - Revisions to listing titles/paragraphs. A diagnostic criteria based on Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5)
    - Revisions to "Paragraph B" categories/definitions for 5 pt. rating scale and "Paragraph C"
    - 12.05 reorganized and simplified
    - Additional listings – Neurodevelopmental Disorders (12.11/112.11); Eating Disorders (12.13/112.13); Trauma and Stressor-Related Disorders (12.15/112.15); Infant/Toddler Developmental Disorders (112.14)
    - Removed listing – 12.09
    - **Training Day – Throughout training**

- **Rules of Conduct and Standards of Responsibility for Appointed Representatives** (Rules of Conduct and Standards of Responsibility for Appointed Representatives)
    - Regulation effective 8/1/18
    - Outlines representative responsibilities to client and agency
    - Establishes that withdrawal of representation may only occur at a time and manner that does not disrupt processing or adjudication of claim, allows the claimant adequate time to find a replacement representative, and should not occur after the time and place of the hearing is set, absent extraordinary circumstances

Listings (20 CFR Part 404, Subpart P, Appendix 1 - Listing of Impairments)

- Listings and Status Information

- Revised since November 2016
    - Mental Disorders 12.00
        - Office of Disability Policy (ODP) Mental Disorders

        - Summary of Major Changes
    - Immune System Disorders 14.00
        - Side by Side prior/current listings 14.00 – Adult and Child
        - HIV Summary of Changes

New Social Security Rulings (SSRs) and Acquiescence Rulings (ARs)

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

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

- **SSR 17-3p:** Titles II and XVI: Evaluating Cases Involving Sickle Cell Disease (SCD).

- **SSR 17-4p:** Titles II and XVI: Responsibility for Developing Written Evidence.

Rescinded SSRs and ARs

- SSR 93-2p (Rescission effective 3/15/2017). See 82 FR 13914 **SSR 93-2p Rescission of Social Security Ruling (SSR) 93-2p: Policy Interpretation Ruling; Titles II and XVI: Evaluation of Human Immunodeficiency Virus (HIV) Infection -** When originally published, SSR 93-2p, medical outcomes for individuals infected with HIV were sufficiently unfavorable. Due to medical advances and the resulting updates to the criteria in the listings, this is no longer a proper assumption for us to make.

- SSR 87-6 (Rescission effective 3/03/2017). See 82 FR 12485 **SSR 87-6; Rescission of SSR 87-6: Policy Interpretation Ruling; Titles II and XVI: The Role of Prescribed Treatment in the Evaluation of Epilepsy. Revised Medical Criteria for Evaluating Neurological Disorders -** Incorporated portions of SSR 87-6 that continue to be relevant to the treatment of epilepsy.

- SSR 91-3p (Rescission effective 5/30/17). See 82 FR 24769 **Rescission of Social Security Ruling (SSR) 91-3p: Policy Interpretation Ruling Title II: Determining Entitlement to Disability Benefits for Months Prior to January 1991 for Widows, Widowers and Surviving Divorced Spouses Claims** - Gives notice of rescission as obsolete.

- SSR 96-3p (Rescission effective 6/14/18). See 83 FR 27816 **Rescission of Social Security Ruling (SSR) 96-3p and 96-4p; Policy Interpretation Ruling; Titles II and XVI: Considering Allegations of Pain and Other Symptoms in Determining Whether a Medically Determinable Impairment Is Severe**.

- **SSR 96-4p** (Rescission effective 6/14/18). See 83 FR 27816 **Rescission of Social Security Ruling (SSR) 96-3p and 96-4p; Policy Interpretation Ruling; Titles II and XVI: Symptoms, Medically Determinable Physical and Mental Impairments, and Exertional and Nonexertional Limitations**.

- **SSR 16-3p** (announced 11/01/17; republished 10/25/17; effective 3/28/16). **Titles II and XVI: Evaluation of Symptoms in Disability Claims** - Republishes SSR 16-3p and provides a revision changing terminology from "effective date" to "applicable date" based on guidance from the Office of the Federal Register. See 82 Federal Register (FR) 49462.

- **SSR 05-2** (Rescission effective 5/14/18). See 83 FR 22308 **Rescission of Social Security Ruling 05-02; Titles II and CVI: Determination of Substantial Gainful Activity if Substantial Work Activity Is Discontinued or Reduced – Unsuccessful Work Attempt.**

HALLEX -- Check HALLEX Transmittals for list of updates/changes, notably:

- **HALLEX I-2-8-30** (issued 8/04/17) **Issuing a Disability Decision When a Claim is Appealed on a Non-Disability Issue** - Updates information and adds processing instructions for cases when a claim is appealed on a non-disability issue to the hearing level and the ALJ denies the claim based on a non-disability factor.

Other Policy Guidance/Updates

- **CJB 13-01 REV** (July 6, 2017) Modifications to Unfavorable Title II Medical Cessation Decisions.
- **09-026 REV 2** (posted 9/21/17) Questions and Answers (Q&A) **What acceptable electronic occupational resources are currently available for use?** - Explains three acceptable electronic resources, including SkillTRAN and Job Browser Pro, as well as updates and expands the information regarding OccuBrowse.
- **ARCHIVED: CALJ Memo dated 7/12/12 –** CALJ Bice on **Proper Procedures for Exhibiting Queries – Reminder**. See Section 3.2 (L) of the Electronic Business Process (eBP) for Updated Instructions.

Tools/Technology

- Decision Writer Instructions (DWI)/Hearing and Appeals Case Processing System (HACPS) – Overview
    - DWI Instructions User Guide
    - DWI Enhancements and HACPS Frequently Asked Questions
    - HACPS One Pager

- Fully Favorable (FF) Template
    - Differences Between Regular and Updated FF – Chart
    - SAMPLE Updated FF Decision
    - FF Training Presentation
- **Training Day – Day 2**

Dismissals Desk Guide

A quick reference guide to the three most common types of dismissals.

OAO – Appeals Council Training 2017

Dismissal Due to Failure to Appear

(HALLEX I-2-4-25)

The ALJ may dismiss a request for hearing if neither the claimant nor the appointed representative, if any, appears at the time and place of a scheduled hearing, and neither shows good cause for the absence. The ALJ will determine whether good cause exists for the failure to appear and provide rationale for any finding that good cause is not established. All attempts by the hearing office to develop good cause, and any responses received, must be associated with the B section of the claim(s) folder.

Regardless of a failure to appear, if the evidence of record supports a fully favorable decision, the ALJ will consider whether it is appropriate to issue a fully favorable decision instead of dismissing the request for hearing (HALLEX I-2-4-25 C.1.a.).

Dismissal NOT Appropriate	
• **Representative appears without the claimant**	• If the representative appears at the scheduled hearing without the claimant and continues to represent the claimant during the hearing, dismissal is never appropriate. The ALJ may continue with the hearing, including taking testimony from any expert witness. The ALJ may determine that the claimant has constructively waived his/her right to appear under the procedures in HALLEX I-2-4-25 D.2.a., and then issue a decision. If the ALJ finds the claimant has not constructively waived the right to appear, the ALJ may choose to proceed with the hearing, but will also attempt to develop good cause for the claimant's failure to appear. If the claimant establishes good cause for failure to appear, the ALJ will offer the claimant a supplemental hearing.
• **Claimant waived right to oral hearing**	• The request for hearing may not be dismissed for failure to appear if the claimant waives the right to appear and a hearing is still scheduled. The ALJ must decide the case based on the evidence of record.
• **Incarceration**	• A request for hearing may not be dismissed due to a claimant's incarceration. A hearing may be held at the incarceration site or via teleconference. If the claimant presents a knowing and valid waiver of a right to oral hearing, then an on-the-record decision may be issued (20 CFR 404.948, 416.1488).
• **Sentence 6**	• An ALJ may not issue a dismissal for any reason after a sentence six court remand (HALLEX I-2-4-37).
• **Failure to attend a consultative examination**	• Failure to attend a CE is a different issue than failure to attend a scheduled hearing. Failure to appear or refusal to take part in a CE is not a regulatory basis to dismiss a request for hearing (20

(CE)	CFR 404.957, 416.1457). If no good reason for such failure or refusal exists, an unfavorable decision may result (20 CFR 404.1518, 416.918).

Good Cause

"Good cause" refers to a reasonable explanation for failing to comply with a requirement. The ALJ must consider any physical, mental, educational, or linguistic limitations that may have prevented the claimant from appearing at the hearing (20 CFR 404.911, 416.1411, and SSR 91-5p). All attempts by the hearing office to develop good cause, and any responses received, must be associated with the B section of the claim(s) folder (HALLEX I-2-4-25 A.).

• **Circumstances that generally establish good cause**	• There are no set criteria for determining what constitutes good cause; however, good cause generally exists in one of the following three circumstances (HALLEX I-2-4-25 C.): 1. No proper notification of the scheduled hearing (20 CFR 404.938, 416.1438; HALLEX I-2-3-20); 2. Unforeseeable event prevented the claimant from requesting a postponement; or 3. Withdrawal of representation without sufficient notice.
• **Proper notification procedures**	• If the acknowledgement form was not returned and there is no evidence it was received by the claimant or representative: o The record must contain documentation of an attempt to contact the claimant and his/her representative prior to the date of the hearing. Contact may be by letter or phone call. All attempts to contact the claimant and/or representative must be in the record (HALLEX I-2-3-20 B.). o Automated courtesy calls or leaving messages on an answering machine or with anyone other than the claimant or representative do not satisfy the regulatory contact requirements. o A show cause order cannot be used as an alternative to establishing receipt of the notice of hearing or attempting to contact the claimant.
• **Procedures to develop good cause**	• To develop good cause, the hearing office will send a Request to Show Cause for Failure to Appear (Form HA-L90) to the claimant and appointed representative, if any, and allow 15 days for a response (HALLEX I-2-4-25 C.2.).

• **Developing good cause is <u>not</u> necessary**	• If neither the claimant nor the appointed representative appears at the scheduled hearing, the ALJ may dismiss the request for hearing without developing good cause in the following circumstances: o Record shows the claimant received the Notice of Hearing and the claimant does not have a physical, mental, educational, or linguistic limitation that may affect his/her ability to understand the Notice; or o The claimant did not return the acknowledgement form sent with the Notice of Hearing, contact procedures were followed (20 CFR 404.938, 416.1438), and there is no indication of good cause for failure to appear; or o The claimant's whereabouts are unknown, and the necessary steps were taken to locate him or her, with the search documented in the record (HALLEX I-2-4-25 C.3.c.).
• **Request for new time or place**	• If the claimant requests a new time or place for hearing, the ALJ will determine whether good cause exists for the request. If there is good cause, the request should be granted. If there is not good cause, the ALJ will notify the claimant and any representative of his/her finding. If, after proper notification of the rescheduled hearing, neither the claimant nor representative appears at the rescheduled hearing, the ALJ may issue a dismissal of the request for hearing (HALLEX I-2-4-25 E.).
• **Tardiness**	• If an unrepresented claimant, or the claimant and his/her representative fail to appear on time for a scheduled hearing, the ALJ may dismiss the request for hearing; however, the ALJ must first develop whether there is good cause for the tardiness (HALLEX I-2-4-25 A.2.).

Dismissal at the Claimant's Request

(HALLEX I-2-4-20)

A request for hearing may be dismissed at the request of the claimant who filed the request for hearing, provided that the necessary elements are present. All written documents, phone calls, or other evidence related the claimant's request to withdraw must be documented in the claim(s) file.	
• **Documentation of request**	An ALJ may dismiss a request for hearing at the claimant's request if all of the following requirements are met: • The claimant or representative must submit a written request to withdraw the request for hearing, or make the request orally on the record at the hearing (20 CFR 404.957(a), 416.1457(a)).

• **Knowing**	• The record must show the claimant understands the effects of withdrawal, including possible loss of benefits and res judicata implications.
• **Other parties**	• No other claimant who may be adversely affected by the dismissal objects to the request after the ALJ provides notice of the request to withdraw (HALLEX I-2-1-45, I-2-4-20 B.).
• **Not sentence six court remand**	• Under a sentence six court remand, the ALJ may not dismiss a request for hearing, even if the claimant expressly states that he/she wants to withdraw the request for hearing. The ALJ must issue a decision, specifically addressing the particular issue that would normally be the basis for the dismissal action (HALLEX I-2-4-37 C.).
• **Appropriate**	• The ALJ determines that dismissal is appropriate.

Hearing Request Not Timely Filed

(HALLEX I-2-4-15)

If a hearing office receives an untimely filed request for hearing, an administrative law judge must determine whether the claimant had good cause for the untimely filing. If the ALJ decides that the claimant did not have good cause, the ALJ must dismiss the request for hearing.

Factors to be considered in determining whether good cause exists include (20 CFR 404.911, 416.1411; SSR 91-5p; HALLEX I-2-0-60):

- All circumstances that delayed the request;
- Whether SSA's action misled the claimant;
- Whether the claimant understood the requirements of the Act resulting from amendments to the Act, other legislation, or court decisions;
- Whether the claimant had any physical, mental, educational, or linguistic limitations that prevented a timely request;
- Whether the claimant relied on a representative to file the request, and the representative failed to do so; or
- Other circumstances, including but not limited to the following: illness; death or serious illness in the claimant's family; records destroyed; attempts to find information to support claim; requested explanation or determination being appealed; SSA gave incorrect/incomplete information; non-receipt of determination; good faith submission to another agency; unusual or unavoidable circumstances; or evidence that the claimant did not know of the need to file timely.

• **Development**	• Where there is insufficient evidence to rule on the issue of good cause, the ALJ may develop the necessary evidence or information needed to make a determination or elect to obtain evidence on the issue of good cause at a hearing.
• **Documentation**	• All documents used to make the good cause determination must be included in the claim file. Such documents may include the envelope used by the claimant or his/her representative to mail the request for hearing, letters, and medical records.
• **Rationale**	• The dismissal order must include a complete rationale explaining why the ALJ has found the claimant has not shown good cause. The rationale must include more than a statement that the claimant's good cause explanation was considered. For example, if the claimant alleges good cause for missing the hearing due to illness, but fails to provide medical documentation to support the allegation, the ALJ should note this in the rationale.

Dismissals Due to No Right to Hearing and Res Judicata

Dismissal Due to No Right to a Hearing

An Administrative Law Judge (ALJ) may dismiss a request for hearing if the claimant has no right to a hearing (20 CFR § 404.930 and § 416.1430). Generally, a claimant has a right to file a request for hearing if he or she received an unfavorable initial determination followed by an unfavorable consideration determination.

- Regulations at 20 CFR § 404.902 and § 416.1402 identify those administrative actions that are considered initial determinations and when revised determinations have the same effect as a reconsideration determination (i.e., entitlement or continuing entitlement to benefits, the amount of those benefits, and overpayments).

- Regulations at 20 CFR § 404.903 and § 416.1403 identify those administrative actions that are not initial determinations and, therefore, are not subject to administrative review (e.g., denial of a request to be made for a representative payee).

- Examples of cases where a claimant can file request for hearing after only one prior adverse disability determination include a determination that a claimant's disability has ceased, and where disability is determined in Prototype States where there is no reconsideration determination after an initial determination by Disability Determination Services (DDS).

Dismissal Due to Res Judicata

An ALJ may dismiss a request for hearing when SSA has previously issued a determination or decision which has become final by either administrative or judicial action and which involves the rights of the **same parties** under the **same law** on the **same facts** and the **same issues** (20 CFR § 404.957(c)(1) and § 416.1457(c)(1)).

The issue of res judicata arises when a claimant files a subsequent application alleging a date of disability onset that is within a period previously adjudicated. When all the requisite conditions for application of res judicata are met, the ALJ should dismiss the request for hearing (HALLEX I-2-4-40).

If all other requirements are met, a request for hearing on a Title II application may be dismissed in its entirety when the prior unfavorable determination or decision was issued after the claimant's date last insured (DLI). If the prior determination or decision was issued before the DLI or if there is a Title XVI application involved, there will be an adjudicated period after the prior determination or decision which must be addressed by a decision on the merits.

If there still is a period after the prior denial determination or decision during which the claimant continues to meet the insured status requirements, or if there is a Title XVI application involved, the

ALJ must still address the adjudicated period in a decision on the merits. The ALJ also cannot dismiss that part of the request for hearing.

Adjudicators must ensure that no aspect of the previous determination of disability has changed since the prior determination or decision and that the facts and issues remain the same.

- **Same Facts**: If new evidence is submitted with the subsequent claim, a dismissal order must set forth a description of new evidence and a rationale explaining why any new evidence is not material (i.e., the new evidence is duplicative, cumulative or refers to an impairment that did not exist in the relevant time period) (HALLEX I-2-4-40).

  Also, if the hearing office is not able to obtain the prior claim file or a copy of the prior determination or decision, or if the information available is not sufficient to determine the applicability of res judicata, the ALJ should offer the claimant the opportunity for a hearing and a new decision.

- **Same Issues**: Issues may change because of a change in a statute, regulation, ruling, legal precedent or policy interpretation, which the ALJ applied in reaching the final determination or decision of the prior application (HALLEX I-2-4-40 (F)). You can find a list of changes in adjudicatory standard that preclude the application of res judicata at HALLEX I-3-3-9 and POMS DI 27516.010)). An example of such a change is the revision of the musculoskeletal listings effective February 19, 2002.

Exceptions to the Application of Res Judicata

Mental Incapacity:

When there is prima facie evidence that a claimant, who was unrepresented when the prior application was adjudicated, lacked the mental capacity to pursue an administrative appeal, the ALJ must determine whether there was good cause for the failure to file a timely request for administrative review before issuing a res judicata dismissal (SSR 91-5p).

Note: See also AR 90-4(4): Culbertson v. Secretary of Health and Human Services, 859 F.2d 319 (4th Cir. 1988); Young v. Bowen, 858 F.2d 951 (4th Cir. 1988) for cases in the Fourth Circuit (Maryland, North Carolina, South Carolina, Virginia, and West Virginia).

Misleading Information:

Where the claimant received an initial or reconsideration notice dated prior to July 1, 1991, which did not state that filing a new application instead of requesting administrative review could result in the loss of benefits, the ALJ can find good cause for late filing of a request for review if the claimant demonstrates he or she did not appeal as a result of the notice (SSR 95-1p).

Regarding determinations made on or after July 1, 1991, the Act has been amended to provide that failure to timely request review of an adverse initial or reconsideration determination shall not serve as a basis for denying a subsequent application, if the claimant acted in good faith reliance upon incorrect, incomplete or misleading information provided by SSA or DDS relating to the consequences of reapplying for benefits in lieu of seeking administrative review (Sections § 205(b)(3)(A) and §1631(c)(1)(B)(i) of the Act).

Processing Dismissals: *Withdrawal of Request for Hearing*

(b) (7)(E)

[redacted]

20 CFR §§ 404.957(a) and 416.1457(a)

HALLEX I-2-4-20

- **20 CFR §§ 404.936 and 404.938**

Processing Dismissals: *Failure to Appear*

(b) (7)(E)

Processing Dismissals: Untimely Filing

- **20 CFR §§ 404.901, 404.911, 404.933, and**

(b) (7)(E)

[redacted]

- **20 CFR §§ 404.503 and 404.957(c)(4)**

Processing Dismissals: Death of Claimant

(b) (7)(E)

[redacted]

Last Revised: July 2018

Earnings Refresher

Substantial Gainful Activity (SGA)

Policies/Guidance: Code of Federal Regulations (CFR), Social Security Rulings (SSRs), and Program Operations Manual System (POMS)

- **CFR 404.1571 – 404.1576 and 416.971 – 416.976** – Addresses SGA, work performed under special conditions, calculation of earnings, self- employment earnings, and impairment related work expenses (IRWEs)
- **SSR 83-33** – Determining SGA (See **SGA Chart**)
- **SSR 83-35** – Seasonal Work
- **SSR 82-52** – SGA in the Sequential Evaluation Process
- **SSR 82-62** – Evaluation of Sporadic Work
- **POMS DI 25005.020C** – Evaluating work in a foreign country
- **Adjudication Tip #11** – Determining SGA
- **Adjudication Tip #20** – Consideration of Part-Time Work
- **OHO Continuing Education Program (OCEP) Broadcast** – 10/21/15 on Work Activity
- **OHO Continuing Education Program (OCEP) Broadcast** – 7/18/18 Trial Work Period and Period of Eligibility

Reminders:

- SGA for employees is based primarily on countable monthly earnings (gross earnings minus **IRWEs and subsidies**) – See also **POMS DI 10505.010**.
- Some payments, which may appear to be wages made by employers to employees, are **not** considered wages under the Social Security Act (e.g. investments, gifts, inheritances, unemployment compensation, retirement benefits, workers' compensation payments, short-term and long-term disability payments, and payout of accrued sick leave).
- SGA is considered in the sequential evaluation process at Step 1 and, as part of the determination of past relevant work at Step 4.
- Part time work may be SGA (work on a regular and continuing basis (i.e. 8 hours per day, 5 days per week) not required at steps 1 and 4 of the Sequential Evaluation Process) (see **SSR 96-8p)**.
- Illegal work can be SGA at Step 1 , but not at Step 4 (see **SSR 94-1c**).

Where to Find Evidence of SGA:

- In the D section (exhibited queries) and in the unexhibited queries section of the electronic file (see ***Useful Queries*** section below).
- In the E section of the electronic file which may contain development related to earnings (pay stubs, wage verification from employers) and claimant's self-reports of work history and earning after onset.

Chief Administrative Law Judge (CALJ) Memo 8/28/15 – CALJ Bice – Earned Income Tax Credit (EITC) Fraud- Revised Information – Discusses how to handle suspected Earned Income Tax Credit fraud discovered in reviewing earnings information.

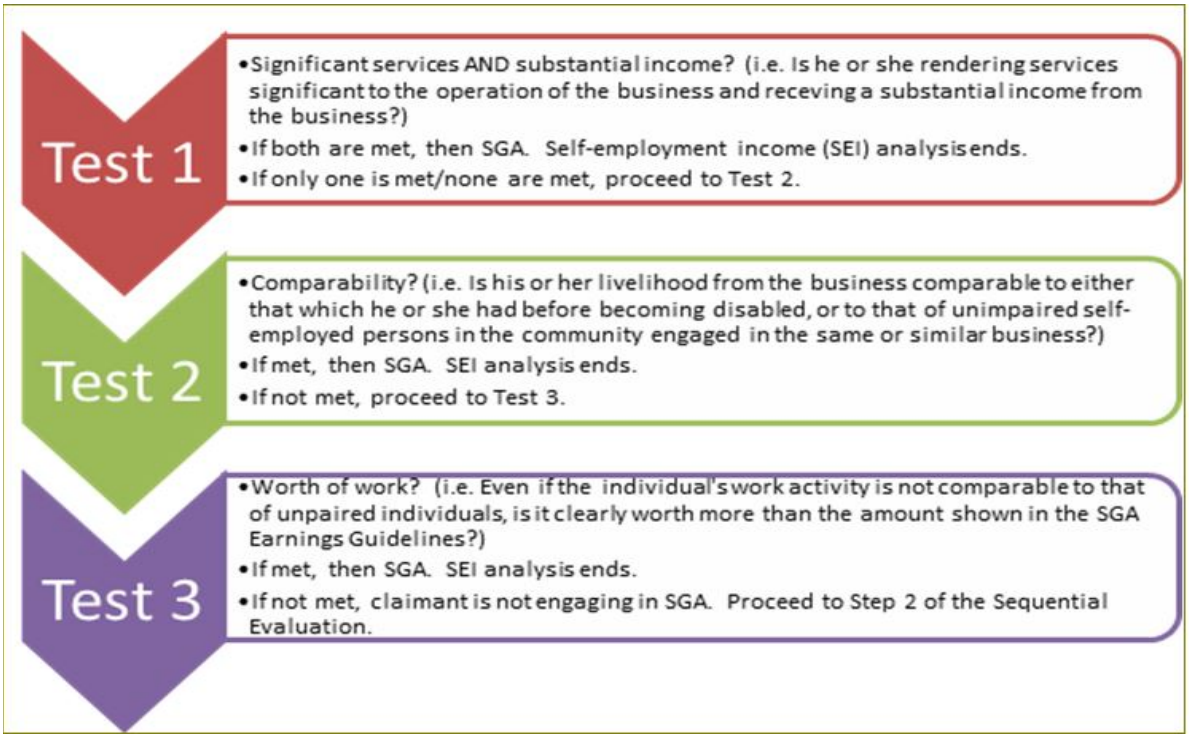
Self-Employment

Policies/Guidance:

- **SSR 83-34** – Used when determining if self-employment is SGA
- **POMS** DI 10510.010 – SGA Criteria in Self-Employment
- **POMS** DI 10510.015 – Test One of General Evaluation Criteria: Significant Services and Substantial Income
- **POMS** DI 10510.020 – Tests Two and Three of General Evaluation Criteria: Comparability of Work and Worth of Work Test
- **Adjudication Tip #63** – Self-Employment Income as SGA – Addresses the three tests for determining if Self-Employment Income is SGA

Self Employment Income (SEI) Decision Tree:

http://sharepoint.ba.ssa.gov/dco/at/ado/NFL/Pages/SEIDecisionTree/SEITree.aspx – Designed to assist field offices in determining the appropriate action to take in self-employment determinations concerning significant service and substantial income.



(Chart adapted from the October 2015 OCEP on Work Activity's QuickNotes Answers.)

Past Relevant Work (PRW)

Policies:

- 20 CFR 404.1520 and 20 CFR 416.920 – (Evaluation of Disability)
- 20 CFR 404.1560 and 416.960 – (Evaluation of PRW)
- 20 CFR 404.1565(a) and 416.965(a) – (Work Experience as a Vocational Factor)
- 20 CFR 404.1568 and 416.968 – (Skill Requirements of Jobs)
- 20 CFR 404.1566(c) and 416.966(c) – (Inability to Find Work is Not Relevant)
- SSR 82-61 and SSR 82-62 – (Capacity to Do PRW; Composite Jobs)
- SSR 96-8p – (Work on a Regular and Continuing Basis Defined)
- SSR 82-40 – (Vocational Relevance of Past Work in a Foreign Country)
- POMS DI 25005.015 and DI 25005.001 – (Evaluating Capacity to Perform Past Relevant Work)
- POMS DI 25005.020 – (Determining if Claimant Can Do PRW as Actually Performed)

Guidance:

- **Adjudication Tip #30** – Work after the AOD is generally not considered PRW
- **Adjudication Tips #9** – Discussing calculation of the 15 year relevant period
- **Adjudication Tip #10** – Discussing SVP level and duration
- **Adjudication Tip #49** – Discussing composite job as PRW
- **Adjudication Tip #62** – Discussing PRW after the AOD
- **Adjudication Tip #12** – Discussing PRW

PRW requires a review of three factors:

- SGA
- Recency (15 year period)
- Duration (Specific Vocational Preparation (SVP) is met)

An ALJ must do a **function-by-function comparison** between PRW and the Residual Functional Capacity (RFC) and look at the jobs as actually and generally performed.

Special Considerations:

- Composite jobs
- Did the claimant perform the job despite current impairments?
- An unsuccessful work attempt (UWA) cannot be PRW at Step 4
- Work with no counterpart in the Dictionary of Occupational Titles (DOT)
- Whether job exists in significant numbers is not relevant at Step 4

Work After Onset

- **CALJ Memo dated 9/1/17** – CALJ Nagle on SGA issues in Favorable Decisions – Stressing the importance of evaluating earnings in determining the proper disability onset date.

- **Average Earnings:** **SSR 83-35** and **SSR 85-5c** (Averaging Earnings)

- **Lag Earnings:** Lag Earnings are earnings that are paid in the "lag period" and that are not yet posted. The lag period is the period for which earnings may not yet be posted on the earnings record (ER) because wage reports are not due yet or have not yet processed. Use questioning at hearing to determine if Lag Earnings are an issue.

Unsuccessful Work Attempt (UWA)

Policies:

- **20 CFR 404.1573(c)** – Addresses work under special conditions
- **20 CFR 404.1574(c)** and **404.1575(d)** and **20 CFR 416.974(c)** and **416.975(d)** – Addresses UWAs, comparability, and worth of work
- **20 CFR 404.1575(d)** – Evaluating self-employment performed after disability onset
- **POMS DI 24005.001D**
    - A UWA is work that was discontinued or reduced to the non-SGA level after a short time (6 months or less) due to the person's impairment or the removal of special conditions related to the impairment that were essential to performance of the work.
    - The ALJ cannot treat PRW as a UWA.

Trial Work Period (TWP) and Extended Period of Eligibility (EPE)

A TWP allows Title II beneficiaries to test the ability to work without losing benefits. It ends with the completion of nine service months within a rolling sixty consecutive month period. TWP is not relevant to Title XVI claims.

The EPE is a 36-month re-entitlement period for Title II beneficiaries who complete the TWP and remain disabled.

Training:

- **OHO Continuing Education Program (OCEP) Broadcast** – 7/18/18 Trial Work Period and Period of Eligibility
    - Four Keys TWP and EPE
    - TWP Service Month Tracking Chart

TWP Policies:

- **20 CFR 404.1592** – Defines a TWP
- **20 CFR 416.2209** and **416.2210** – Discusses rules for TWPs for Social Security Insurance (SSI) recipients
- **POMS DI 13010.060** – Discusses the evaluation of TWP service months

EPE Policies:

- **CFR 404.1592a**
- **POMS DI 13010.210**

The concepts of trial work period (TWP) and extended period of Eligibility (EPE) apply only to Title 2 disability claims.

- In Title 2 claims, the ALJ should evaluate whether post-AOD earnings are indicative of medical improvement or whether the claimant is simply testing the ability to work under the TWP and EPE provisions.
- The TWP and EPE work incentive does not apply to Title 16 claims. Thus, in Title 16 claims, issues of income post-filing date must be addressed under substantial gainful activity (SGA) provisions.
- In a concurrent Title 2 and Title 16 claim, the TWP and EPE cannot apply to the Title 16 claim.

A TWP is normally determined by analyzing whether a claimant has engaged in services *AND* has actual earnings over the yearly TWP threshold for nine months during a rolling but consecutive 60-month period.

- The term of art, "services," is based on actual earnings or work where we would expect the claimant to be paid.
- If the claimant performs SGA within the first 12 months disability is established, the claimant is NOT eligible for a TWP.
- Unsuccessful work attempts (UWAs) and impairment related work expenses (IRWEs) do not apply to the TWP.

The first 36 months following the TWP is a special portion of the EPE called the re-entitlement period.

- During this re-entitlement period, be aware of the "grace period" in which the claimant can be paid for the first month he or she engaged in SGA and two additional months.
- If the claimant ceases to engage in SGA prior to the completion of the re-entitlement period, benefits continue.

***AFTER* the 36-month re-entitlement period, the EPE ends if any one of these three conditions occur:**

- The claimant engages in SGA
- Medical improvement is found
- A non-disability terminating event occurs, such as death or attainment of full retirement age.

Useful Queries

(b) (7)(E)

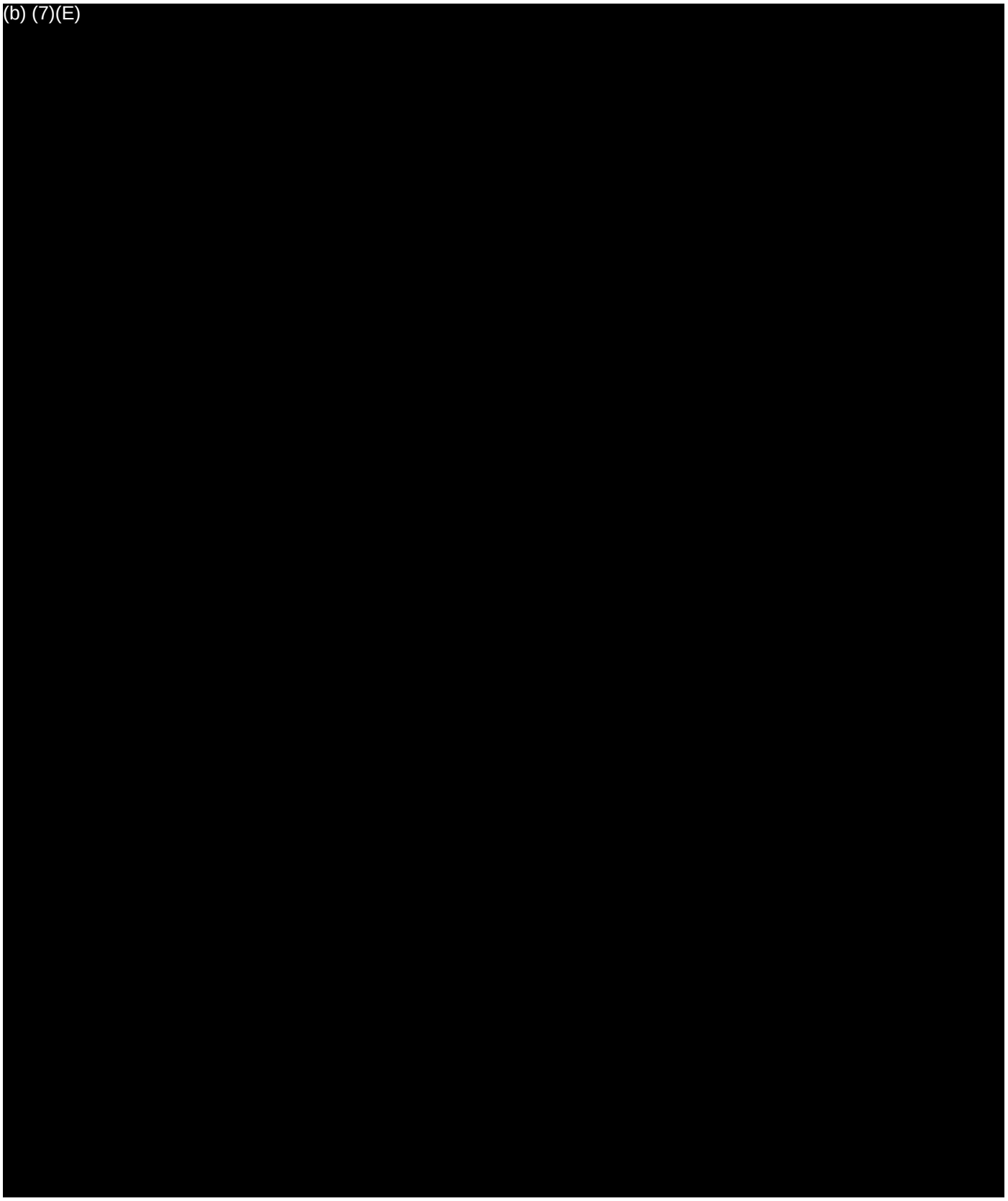
Closed Periods of Disability

Policies: 20 CFR 404.1594, 404.1591, 416.994, 416.994a, and 416.991

- A closed period of disability generally requires a change in medical condition such that the claimant is able to engage in SGA following a period of disability.
- Findings of a closed period of disability may be the result of a request by the claimant or as directed based on the facts of the case.
- To evaluate the cessation of the period of disability, use the same sequential evaluation process as is used for Continuing Disability Reviews (CDRs).
- Even if a claimant stipulates to a closed period, a finding of Medical improvement must be made unless the claimant is working at SGA and a TWP does not apply.

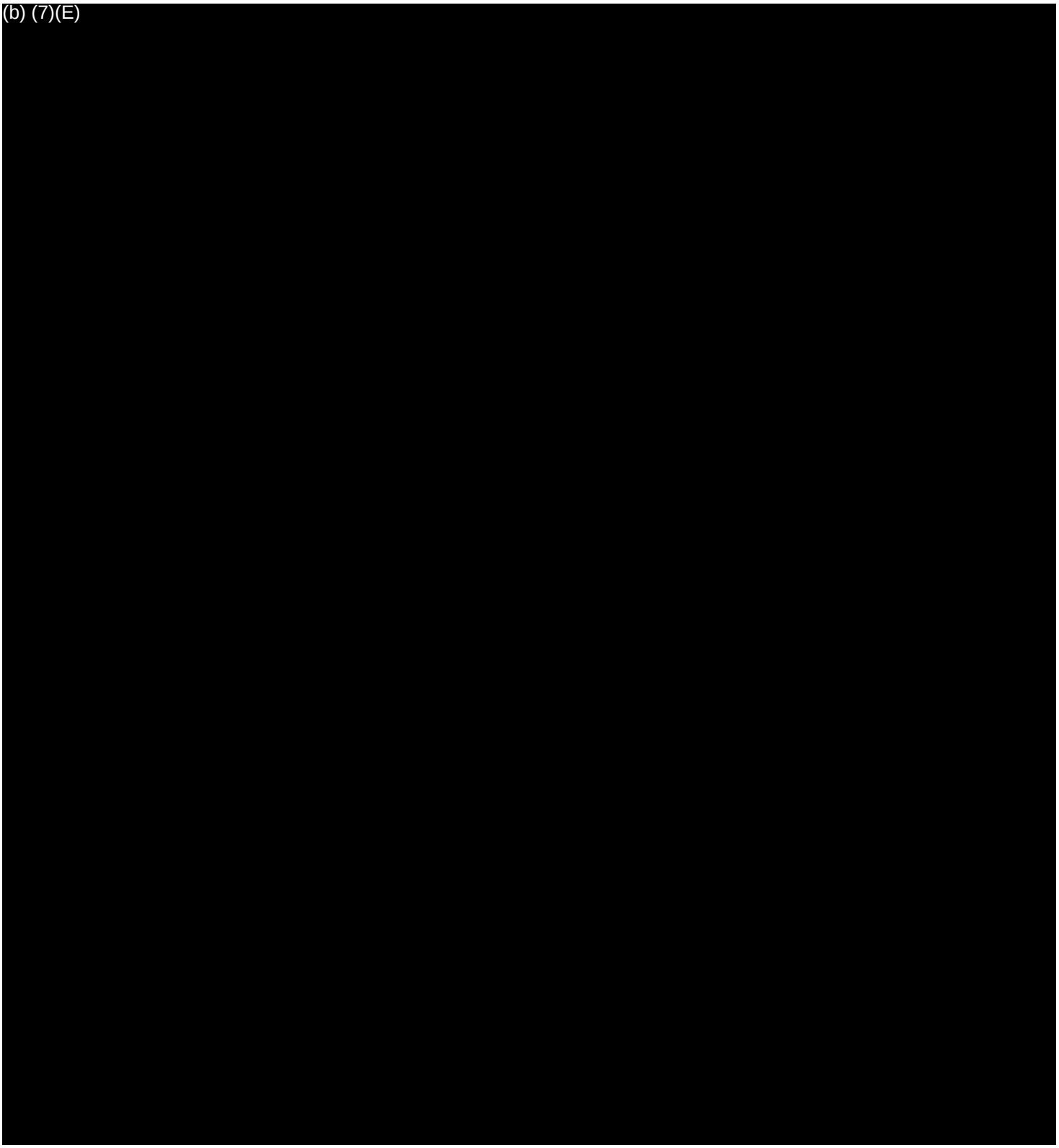
Income/Earnings Exercise

(b) (7)(E)



Last Revised: July 2018

(b) (7)(E)



File Review and File Review Efficiencies

Resources

- File Review Resources Guide: Currently on the Student Virtual Training (VT) site
- Prior Files: Hearings, Appeals and Litigation Law Manual (HALLEX) I-2-1-13 and Adjudication Tip #58

Preparing for the Hearing

- **Case Preparation Efficiencies:**
  - How far ahead; Approach to case preparation
  - Use of Standing Orders:
    - Use and office differences
    - **Standing Order Sample from Electronic Business Process Materials**

- **Preparing Residual Functional Capacity (RFC) Pre Hearing**
  - **Resouces for legally sufficient RFC language on Supplemental ALJ VT Materials site:**
    - **VE RFC/Hypo Chart**
    - **Legally Sufficient Lanauage for RFCs + Quick Reference Chart**
  - **Other resources for development of RFC:**
    - **Citing a Social Security Ruling (SSR) at Step 5**
    - **Limitations that do not Significantly Erode Occupational Base**
    - **Rulings and Acquiescence Rulings (ARs) Medical Vocational Policy**
    - **SkillTran Pocket Guide**
    - **Judge's Guide to Dictionary of Occupational Titles (DOT)**
    - **The Revised Handbook for Analyzing Jobs**

Decision Writing Intructions (DWI) and Hearings and Appeals Case Processing System (HACPS) for file review -- Resources for use of DWI/HACPS during file review in Supplemental ALJ VT Materials site:

- **DW Instructions Users Guide**
- **DWI FAQs**
- **DWI Enhancement FAQs**
- **HACPS One Page Guide**

I-2-5-85.Use of Prehearing Questionnaires (HALLEX Transmittal I-2-162)

An administrative law judge (ALJ) may find a prehearing questionnaire useful to develop the record prior to conducting a hearing or to resolve issues that may result in issuing a favorable decision without the need for a hearing. An ALJ may use a prehearing questionnaire to narrow the issues that he or she will decide at the hearing. In limited circumstances, a prehearing questionnaire may be useful to obtain information needed to schedule and conduct a hearing.

When an ALJ uses a prehearing questionnaire, he or she will ensure that a copy of the questionnaire and any response is associated with the claim(s) file. When the questionnaire (and associated response) is material to the issues in a case, the ALJ will exhibit the document(s). See HALLEX I-2-1-15.

NOTE: In some instances, an ALJ may find a prehearing questionnaire useful in conjunction with a prehearing conference (see HALLEX I-2-1-75).

The following are examples of when an ALJ may want to use a prehearing questionnaire:

- The ALJ wants to obtain evidence, including information from the claimant or an appointed representative, that may help determine whether the claimant's impairment(s) meets or equals a listing in 20 CFR Part 404, Subpart P, Appendix 1;
- The ALJ needs to clarify an issue(s) that would result in a favorable decision or might require development before the hearing (e.g., to obtain an explanation of earnings);
- The claimant's application includes a significant number of impairments, and it would be helpful for the ALJ to know which impairment(s) the claimant alleges meets the criteria for a severe impairment, meets or medically equals a listing, or results in functional limitations (NOTE: While collecting this information may help an ALJ focus on the issue(s) at hearing, the ALJ may not limit the claimant's testimony at hearing based on the claimant's response to this type of question in a prehearing questionnaire);
- The ALJ needs to obtain a list of witnesses from the claimant to determine the subject and scope of testimony (see HALLEX I-2-6-60) and to schedule the hearing with sufficient time; and
- The ALJ needs to obtain a stipulation.

An ALJ may not impose penalties, threaten sanctions, reduce an appointed representative's fee, suggest the request for hearing may be dismissed, or otherwise indicate the ALJ may take an adverse action if the claimant or appointed representative fail to complete and submit responses to the prehearing questionnaire.

(b) (2) [redacted]

Setting and Preparing for the Hearing

Dockets: Discussion - schedule by day; length; number of hearings

- See 20 CFR 404.936 and 416.1436 on scheduling
- See Hearings, Appeals and Litigation Law Manual (HALLEX) I-2-3-10
- Use of Pre hearing questionnaires - HALLEX I-2-5-85

Case Preparation Efficiencies:

- How far ahead; Approach to case preparation

- Use of Standing Orders:
  - Uses and office differences
  - **Standing Order Sample from Electronic Business Process Materials**

- Use of Scripts and Checklists (**New Administrative Law Judge (ALJ) Sample Script**)

- Preparing RFCs Pre Hearing: (**VE Hypo Chart**)

Use of Interpreters:

- **Use of Foreign Language Interpreters - Chief Judge Memo (March 5, 2014)**

- **Foreign Language Interpreters - HALLEX I-2-1-70**

- **Hearing Procedures Foreign Language Interpreters - HALLEX 1-2-6-10**

SOCIAL SECURITY

MEMORANDUM

Date: March 5, 2014 Refer To: ACL 14-238

To: All Administrative Law Judges

From: Debra Bice */s/ John R. Allen* for
Chief Administrative Law Judge

Subject: Use of Foreign Language Interpreters – INFORMATION AND REMINDER

This memorandum is a reminder of prior guidance provided in the August 7, 2009 Memorandum, "Consideration of a Claimants Ability to Communicate in English – Information and Reminder," that you must comply with agency policy with respect to the use of foreign language interpreters during hearings. Specifically, HALLEX I-2-6-10 provides, in part, that "SSA will provide an interpreter **free of charge**, to any individual requesting language assistance, or when it is evident that such assistance is necessary to ensure that the individual is not disadvantaged" (emphasis in original). Thus, when a claimant affirmatively requests an interpreter, the agency must provide one.

There also may be situations when SSA must provide an interpreter although the claimant has not specifically requested language assistance. HALLEX I-2-6-10 also provides, in part that "[i]f a claimant has difficulty understanding or communicating in English, the ALJ will ensure that an interpreter, fluent in both English and a language in which the claimant is proficient, is present throughout the hearing." HALLEX I-2-1-70 similarly

instructs hearing office staff, at the direction of the ALJ, to arrange for a qualified interpreter to assist the claimant and the ALJ at the hearing "[w]hen a claimant has limited proficiency in English."

HALLEX I-2-1-70.A. indicates that a review of CPMS, and specific forms in the claimant's case file (such as Form HA-501, Request for Hearing, and SSA-3368, Disability Report), can help determine whether an interpreter is needed. Reports of contact or other statements in the claimant's case file also may indicate the need for an interpreter.

Therefore, if a claimant requests language assistance, or when it is evident that such assistance is necessary to ensure that the claimant is not disadvantaged, the ALJ must ensure that an interpreter is present throughout the hearing. HALLEX I-2-6-10. The use of an interpreter serves to assist both the claimant and the ALJ at the hearing, and can safeguard the claimant's due process rights in the processing of his or her claim(s).

Please share this information with your hearing offices. The staff contact for regional inquiries is (b) (6), Attorney Advisor, who can be reached at (b) (6)

Claimant's Symptoms

Law: Code of Federal Regulations (CFRs)

20 CFR 404.1529 and 416.929 - How we evaluate symptoms, including pain

- Factors at (c)(3) in each section
- Objective medical evidence determines medically determinable impairment (MDI)
- Affect on basic work activities
- Consideration of other evidence and longitudinal history
- Has a Listing been met? Possibility of Equals - need a medical expert (ME)? Residual Functional Capacity (RFC) limitations for each impairment?

Policies: Social Security Rulings (SSRs)

SSR 16-3p - Titles II and XVI: Evaluation of Symptoms in Disability Claims

- Supersedes SSR 96-7p
- Effective March 28, 2016
- Eliminates credibility assessment

Training:

- New ALJ Training Module 4 - Severity
- New ALJ Training Module 6 - Mental Impairments
- New ALJ Training Module 9 - Developing Subjective Complaints/SSR 16-3p
- Mental Disorder Videos on Demand (VODs): Effective date January 17, 2017- Five Keys to each of the four VODs
- Judicial Training 2013:
    - Training Materials tab
    - PowerPoint on Functional Limiting Effects of Pain

Guidance:

- Evaluating Symptoms Desk Guide
- Adjudication Tips – Chief Judge Resources
    - Adjudication Tip #52 - Evaluating the Functional Limitations of Pain
    - Adjudication Tip #57 - Credibility No More – Focus on consistency and use of SSR 16-3p
- Subjective Complaints Worksheet
- **Program Operations Manual System (POMS)**
    - DI 24501.020 - Establishing a Medically Determinable Impairment
    - DI 24505.005 - Evaluation of Medical Impairments that are Not Severe
    - DI 24501.021 - Evaluating Symptoms

Subjective Complaints Worksheet

(b) (7)(E)

National Uniformity

On December 16, 2016, the Agency published a Final Rule in the Federal Register titled "Ensuring Program Uniformity at the Hearing and Appeals Council Levels of the Administrative Review Process." The National Uniformity regulations became effective on January 17, 2017, and compliance began May 1, 2017. *Federal Register* at 81 FR 90987. See also the "Ensuring Program Uniformity at the Hearing and Appeals Council Levels of the Administrative Review Process" page posted under Chief Judge Resources on the Office of the Chief Administrative Law Judge website, which includes training materials, Office of Hearings (OHO) Continuing Education Program (OCEP) and National Uniformity Frequently Asked Questions (FAQs).

Overview of the National Uniformity Procedures

- We must provide notice of hearing 75 days in advance, unless the claimant or representative submits a written waiver of advanced notice. Code of Federal Regulations (CFRs) - 20 CFR 404.938 and 416.1438; Hearings, Appeal, and Litigation Law Manual (HALLEX) I-2-3-25

- Claimants and representatives must inform us about or submit all written evidence, objections to issues, and pre-hearing written statements no later than 5 business days before the hearing and must submit subpoena requests no later than 10 business days prior to the hearing. 20 CFR 404.935 and 416.1435; 20 CFR 404.939 and 416.1439; 20 CFR 404.949 and 416.1449; 20 CFR 404.950 and 416.1450; HALLEX I-2-5-1.

- The Administrative Law Judge (ALJ) may decline to obtain or consider late submissions of evidence, objections, written statements or subpoena requests unless the claimant meets one of the circumstances in 20 CFR 404.935(b) and 416.1435(b).

    - Some action by the Agency misled the claimant;
    - The claimant had a physical, mental, education, or linguistic limitation that prevented him or her from informing the Agency about or submitting the evidence earlier; or
    - Some other unusual, unexpected, or unavoidable circumstance beyond the claimant's control prevented him or her from informing the Agency about or submitting the evidence earlier. Examples include, but are not limited to: 1) a serious illness that prevented the claimant from contacting the Agency in writing, in person or through another person; 2) a death or serious illness in the claimant's immediate family; 3) a showing that the claimant or his or her representative "actively and diligently sought evidence from a source and the evidence was not received or was received less than five business days prior to the hearing."

- The ALJ will articulate in the decision if the information or evidence is excluded. For objections to the issues, the ALJ will make a decision on the objections either at the hearing or in writing prior to the hearing.

- The 5-day requirement does not apply to Title XVI continuing disability reviews (CDRs) and Age 18 redeterminations, and it does not apply to concurrent claims where the Title XVI portion is one of these two types of claims (20 CFR 416.1435(c)).

- The Appeals Council (AC) will only review a case based on additional evidence if it is new, material, related to the period on or before the hearing decision, and there is a reasonable probability the evidence would change the outcome of the decision. 20 CFR 404.970 and 416.1470. The AC will only consider such evidence if the claimant shows good cause for not informing us about or submitting the evidence at least 5 business days before the date of the hearing. This is the same standard used by the ALJ for any late submission of evidence (20 CFR 404.970(b) and 416.1470(b)).

Admitting Evidence Submitted At least Five Business Days Before the Hearing

HALLEX I-2-6-58 -- Admitting Evidence Submitted At Least Five Business Days Before the Hearing

- Subject to the limitations for accepting evidence in 20 CFR 404.935 and 416.1435, an ALJ will generally admit any evidence into the record that he or she determines is material to the issues in the case. Evidence is material if it is relevant, i.e., involves or is directly related to issues being adjudicated.

- When the claimant or appointed representative submits evidence, hearing office (HO) staff will place the evidence in the claim(s) file. While HO staff initially marks and lists proposed exhibits (see HALLEX I-2-1-15 and I-2-1-20), the ALJ makes the final decision on the information admitted into the record. The ALJ may admit information into the record, even if it would not be admissible in court under the rules of evidence.

- In Title XVI cases, other than those based on an application for benefits (e.g., age 18 redeterminations, continuing disability reviews, and terminations), an ALJ will accept any evidence submitted on or before the date of the hearing decision. See 20 CFR 416.1435(c). For all other Title XVI cases, an ALJ will use the procedures referenced in this section to admit evidence into the record.

- If there was a prior ALJ decision, the ALJ must associate the prior ALJ decision with the current claim(s) file. For information about how an ALJ determines what evidence to include from a prior file and whether to exhibit the information. See HALLEX I-2-1-13.

- Subject to the limitations for accepting evidence in 20 CFR 404.935 and 416.1435, an ALJ will generally admit into the record any information that he or she determines is material to the issues in the case.

- Before taking testimony, the ALJ will make the proposed exhibits a part of the record by:
  - Asking the claimant (or appointed representative, if any) whether he or she had an opportunity to examine the proposed exhibits;
  - Asking the claimant (or appointed representative, if any) if there are any objections to admitting the proposed exhibits into the record; and
  - Ruling on any objections to the proposed exhibits. See HALLEX I-2-6-34.

Admitting Evidence Submitted Less Than Five Days Before the Hearing

HALLEX I-2-6-59 -- Admitting Evidence Submitted Less Than Five Business Days Before the Hearing or At or After the Hearing

- Subject to 20 CFR 404.935(b) and 416.1435(b), an ALJ may admit additional evidence into the record during the hearing. However, before admitting any proposed exhibit into the record, the ALJ will identify the proposed exhibit and offer the claimant the opportunity to inspect the proposed exhibit and offer any objections or comments.

- Subject to 20 CFR 404.935(b) and 416.1435(b), an ALJ may also admit additional evidence into the record after the hearing. If the ALJ plans to admit additional evidence into the record after the hearing, see generally the instructions regarding proffer in HALLEX I-2-7.

- Generally, if a claimant informs the Agency about or submits evidence less than five business days before the date of the scheduled hearing, at, or after the hearing, the ALJ may decline to obtain or consider the evidence, unless the circumstances in 20 CFR 404.935(b) and 416.1435(b) apply.

- If the claimant submits evidence after the ALJ issues a hearing decision and the claimant requests review of the decision, the ALJ will forward the information to the AC for review of the decision. If the claimant has not requested review by the AC, the ALJ may either consider revising his or her decision using the appropriate procedures in HALLEX I-2-9; or return the evidence to the claimant, noting in writing that the record is closed, but the claimant may request review by the AC.

Additional Program Uniformity Resources

- **Chief ALJ (CALJ) Memo December 30, 2016**
- **OCEP Broadcast - 4/2017 - Keys to Program Uniformity**
- **National Uniformity FAQs Part I and Part II**
- **Adjudication Tip #50 - Submission of Evidence**
- **OCEP Broadcast - 4/22/2015 - Submission of Evidence** - Video, Script, and FAQs
- **Bi-Weekly Hearing Level Policy Updates 5/17/17 (**Denotes many HALLEX changes related to the Uniformity Rules)
- **Five-Day Business Calculator for Determining Five-day Submission Compliance**

Development of Evidence - Responsibility and Procedures

Social Security Ruling (SSR) 17-4p (Effective 10/04/17) Titles II and XVI: Responsibility for Developing Written Evidence - Clarifies our responsibilities and the responsibilities of the claimant and representative to develop evidence and other information in disability and blindness claims. See also, Federal Register (FR) notice, 82 FR 46339 (Published 10/04/2017).

20 C.F.R. §§ 404.1512(b)(1) and 416.912(b)(1) -- "Before we make a determination that you are not disabled, we will develop your complete medical history for at least the 12 months preceding the month in which you file your application unless there is a reason to believe that development of an earlier period is necessary, or unless you say that your disability began less than 12 months before you filed your application. We will make every reasonable effort to help you get medical reports from your own medical sources when you give us permission to request the reports."

HALLEX I-2-5-1 -- Evidence — General (Last Update: 5/1/17)

- A claimant must inform the Social Security Administration (SSA) about or submit to SSA all evidence, in its entirety, known to him or her that relates to whether or not he or she is blind or disabled. See 20 CFR 404.1512 and 416.912. For represented claimants, the representative must help the claimant obtain information or evidence that the claimant must submit. See 20 CFR 404.1740(b)(1) and 416.1540(b)(1). We will assist claimants in developing the record when appropriate. See 20 CFR 404.1512(b) and 416.912(b).

- Evidence generally does not include a representative's analysis of the claim or oral or written communications between a claimant and his or her representative that are subject to the attorney-client privilege, or that would be subject to the attorney-client privilege if a non-attorney representative was an attorney. 20 CFR 404.1513(b) and 416.913(b).

- If a representative has a pattern of not submitting evidence that relates to the claim, or if the claimants of a particular representative develop a pattern of not submitting evidence or not informing us about evidence, an ALJ will consider whether circumstances warrant a referral to the Office of the General Counsel (OGC) as a possible violation of our rules. See HALLEX I-1-1-50 for instructions on making referrals to OGC.

- An ALJ may also decide that he or she needs additional medical or non-medical evidence to make a proper decision in a case. In this circumstance, the ALJ will make reasonable attempts to fully and fairly develop the record. The ALJ or Hearing Office (HO) staff will add to the record and exhibit documentation of all attempts to obtain evidence.

- In addition, an ALJ may decide that witnesses are needed to fully and fairly evaluate the issues in a case. The ALJ or HO staff will schedule appropriate witnesses for the hearing or solicit interrogatories from sources, experts, or other relevant persons. The ALJ may issue a subpoena if a witness indicates he or she will not appear voluntarily or if the witness refuses to produce requested evidence, and the witness's testimony or evidence is reasonably necessary for the full presentation of the case. See 20 CFR 404.950(d) and 416.1450(d). See also HALLEX I-2-5-78 and I-2-5-80.

HALLEX I-2-5-13 -- Claimant Informs Hearing Office of Additional Evidence

- A representative may inform SSA about evidence that relates to whether or not the claimant is blind or disabled (20 CFR 404.935 and 416.1435). However, a representative also has an affirmative duty to act with reasonable promptness to help obtain information or evidence that the claimant must submit under the regulations, and forward the information or evidence to SSA for consideration as soon as practicable (20 CFR 404.1740(b)(1) and 416.1540(b)(1)). If a representative has a pattern of informing SSA about evidence that relates to the claim instead of acting with reasonable promptness to help obtain and forward the evidence to SSA, an ALJ will consider whether circumstances warrant a referral to the Office of the General Counsel (OGC) as a possible violation of our rules. See HALLEX I-1-1-50 for instructions on making OGC referrals.

- If after the hearing a claimant or representative requests additional time to submit evidence, the ALJ will evaluate the request using procedures in HALLEX I-2-7-20.

- When a claimant informs an ALJ or HO staff about additional evidence but does not submit the evidence, the ALJ or HO staff will make every reasonable effort to obtain the evidence using the appropriate procedures if the claimant informed SSA about the evidence no later than five business days before the date of the scheduled hearing; the ALJ finds that the claimant missed the five-day deadline but the circumstances in 20 CFR 404.935(b) and 416.1435(b) apply (see HALLEX I-2-6-58 and I-2-6-59); or the case involves a Title XVI claim that is not based on an application for benefits (e.g., age 18 redeterminations, continuing disability reviews, and terminations).

- To make every reasonable effort to obtain evidence, the ALJ or HO staff will request that the claimant or representative submit the evidence. If necessary, the ALJ or HO staff will provide the claimant or representative with form SSA-827, Authorization To Disclose Information To The SSA, to facilitate obtaining the evidence. See HALLEX I-2-5-14 A.

HALLEX I-2-5-28 -- Action Following Receipt of Requested Evidence

- If the requested evidence is material (See HALLEX I-2-6-58), relevant to the issues of the case, complete, and responsive, hearing office (HO) staff will mark the new evidence as a proposed exhibit (see HALLEX I-2-1-15); prepare and mark the professional qualifications of each source as an exhibit (see HALLEX I-2-1-30); and review the total record for sufficiency of the evidence and any material conflicts.

- When HO staff requested the evidence through a State agency and the evidence is incomplete or unresponsive, HO staff will follow the procedures in HALLEX I-2-5-14 D.3. When staff requested the evidence directly from a treating or other source and the evidence is incomplete or unresponsive, staff will contact the source again to determine if additional evidence is available. HO staff can contact the source directly or contact the source through the claimant or the representative, if any. HO staff may request assistance from the State agency if necessary, using the procedures in HALLEX I-2-5-14 D.

- If the new evidence contains information that may be detrimental to the claimant's health (such as a serious illness of which the claimant and the treating source may not be aware), the ALJ will exercise appropriate discretion to avoid adversely affecting the claimant's medical situation, while proceeding with the actions necessary to protect the claimant's right to due process. See generally HALLEX I-2-7-30 B.

- If an ALJ receives new evidence after the hearing from a source other than the claimant or representative, if any, and the ALJ proposes to enter the evidence into the record as an exhibit, the ALJ will follow the proffer procedures in HALLEX I-2-7-1, I-2-7-30 and I-2-7-35. See also HALLEX I-2-5-91, I-2-5-92, and I-2-6-99.

Other Development of Evidence Resources

- **OCEP Broadcast - 4/22/15 - Submission of Evidence in Disability Claims**
- **2014 CALJ Memorandum - "Making 'Every Reasonable Effort' to Obtain All Evidence and Documenting Those Efforts – REMINDER"**
- **Adjudication Tip #50 - Submission of Evidence** (under "Evidence Issues")

Prehearing Proffer of Evidence

HALLEX I-2-5-29 -- Prehearing Proffer of Evidence

- In the context of evidence development, "proffer" means to provide an opportunity for a claimant (and appointed representative, if any) to review additional evidence that he

or she has not previously seen and that an adjudicator proposes to make part of the record. Proffering evidence allows a claimant to comment on, object to, or refute the evidence by submitting other evidence; or, if required for a full and true disclosure of the facts, cross-examine the author(s) of the evidence.

- Under most circumstances, proffer is not necessary when an ALJ receives additional evidence before the hearing from a source other than the claimant or representative, if any. Proffer is not usually required because other hearing procedures require that an ALJ provide the claimant or representative an opportunity to review any information in the claim(s) file before the hearing. HALLEX I-2-1-35.

- However, if an ALJ agrees to take certain actions during a prehearing conference, the ALJ must summarize the actions to be taken in writing and proffer the writing to the claimant and representative. HALLEX I-2-1-75 E. Additionally, if the ALJ (or assisting staff) requested interrogatories from a medical or vocational expert, and the received responses would not result in a fully favorable decision, the ALJ (or assisting staff) is required to proffer the evidence to the claimant and appointed representative, if any.

- When proffering the evidence, the ALJ will use the same general procedures for proffering post-hearing evidence, as set forth in HALLEX I-2-7-30.

Use of Subpoenas

20 CFR 404.950(d) and 416.1450(d) - When it is reasonably necessary for the full presentation of a case, an administrative law judge (ALJ) may issue a subpoena on his or her own initiative or at the request of a claimant or appointed representative.

HALLEX I-2-5-78 -- Use of Subpoenas - General

- An ALJ may issue a subpoena for the appearance and testimony of a witness(es), and for the production of books, records, correspondence, papers, or other documents that are material to an issue at the hearing. (In the Fifth Circuit, if a claimant requests a subpoena to cross-examine an examining physician and makes the request prior to the closing of the record, the ALJ must issue the subpoena. See Acquiescence Ruling 91-1(5), *Lidy v. Sullivan*, 911 F.2d 1075 (5th Cir. 1990) – Right to Subpoena an Examining Physician for Cross-examination Purposes – Titles II and XVI of the Social Security Act).

- Claimants have a right to request that an ALJ issue a subpoena, but they must make the request in writing at least 10 business days before the hearing date. See 20 CFR 404.950(d)(2) and 416.1450(d)(2). If a claimant does not submit the request at least 10 business days before the hearing date, the ALJ may deny the request at his or her discretion, unless the circumstances in 20 CFR 404.935(b) and 416.1435(b) apply (see

HALLEX I-2-6-58 and I-2-6-59). An ALJ will follow the procedures in HALLEX I-2-6-59 B to determine whether the circumstances are met.

- A claimant's request for a subpoena must give the name(s) of the witness(es) or document(s) to be produced; describe the address or location of the witness(es) or document(s) with sufficient detail to find them; state the important fact(s) that the witness(es) or document(s) is expected to prove; and indicate why the fact(s) could not be proven without issuing a subpoena.

- If a claimant submits a subpoena request at least ten business days before the hearing date or an ALJ finds that the circumstances in 20 CFR 404.935(b) and 416.1435(b) apply, the ALJ will evaluate the request. When all other means of obtaining the information or testimony have been exhausted, an ALJ will issue a subpoena if: the claimant or ALJ cannot obtain the information or testimony without the subpoena; and the evidence or testimony is reasonably necessary for the full presentation of the case.

- If an ALJ denies a claimant's request for a subpoena, the ALJ must notify the claimant of the denial, either in writing or on the record at the hearing. In either situation, the ALJ will enter the request into the record as an exhibit. If the denial is in writing, the ALJ will also enter the denial notice into the record as an exhibit. Whether on the record or in writing, the ALJ will explain why the ALJ declined to issue a subpoena.

From: (b) (2)
Sent: Friday, December 30, 2016 10:27 AM
Subject: Impact of the National Uniformity Regulations on the Hearing Operation

E-MAIL TO ALL HEARING OFFICE PERSONNEL

Subject:

Impact of the National Uniformity Regulations on the Hearing Operation

ACL 17-200

On December 16, 2016, the Agency published a Final rule in the Federal Register entitled "Ensuring Program Uniformity at the Hearing and Appeals Council Levels of the Administrative Review Process." The final rule revises and finalizes changes to regulations in 20 CFR Chapter III, parts 404, 405, and 416. These changes were first proposed in a Notice of Proposed Rulemaking published on July 12, 2016. The revisions will affect hearing level procedures in several areas. The most significant changes will affect the timeframe for notifying claimants of a hearing date; the information we provide in our hearing notices; and the period in which we require claimants to inform us about or submit written evidence, statements, objections to the issues, and subpoena requests.

While the final rule will be effective on January 17, 2017, compliance will not be required until May 1, 2017, based upon direction of the Office of Management and Budget. Additionally, systems updates scheduled for April 29, 2017 are required to bring our notices into compliance. We will provide further guidance on scheduling hearings to ensure that we are in compliance with the regulatory requirements as of May 1.

The most significant changes affecting the hearing operation are the timeframe in which claimants must inform us about or submit evidence, statements, objections, or subpoena requests and the timeframe in which we provide claimants with notice of the hearing.

The revised regulations will require the claimant to inform us about or submit any written evidence no later than five business days before the date of the scheduled hearing, in contrast to the current regulations, which allow claimants to submit evidence up to and on the date of the hearing, or after a hearing. Under the revised regulations, administrative law judges (ALJs) may decline to consider or obtain the additional evidence if the claimant does not adhere to this timeline unless certain good cause exceptions apply, which are enumerated in the revised regulations.

Additionally, the claimant must notify the ALJ about any objections to the issues and submit any pre-hearing written statements no later than five business days prior to the hearing, subject to the same good cause exceptions for additional evidence. This differs from the current regulations, which specify that the claimant must submit objections at "the earliest possible opportunity."

PLEASE NOTE: The provisions of the new regulation regarding submission of evidence should not be utilized until notification is received from OCALJ. Until then, claimants may continue to submit evidence under the current process (up to and on the date of the hearing, or after a hearing).

Another significant change is that the revised regulations will require us to provide claimants with a Notice of Hearing at least 75 days in advance, in contrast to the current regulations, which require us to provide notice at least 20 days in advance. The Notice of Hearing will also inform claimants and representatives about the five-day requirement to inform us about or submit evidence.

Finally, the revised regulations will affect the timeframe for submitting a subpoena request. Parties to the hearing must now file a written request for issuance of a subpoena with the ALJ at least 10 business days prior to the hearing, subject to the same regulatory good cause exceptions. Conversely, the current regulations contain a time limit of five days prior to the hearing for submission of subpoena requests. Again, continue with the current process until you receive notification from OCALJ to apply the provisions of the new regulation.

Additional revisions affect the manner in which the Appeals Council considers additional evidence but do not directly affect hearing level case processing.

The final rule will incorporate into 20 CFR parts 404 and 416 the majority of the case processing variances that have existed in Region I since 2006 under the part 405 regulations, ensuring nationwide consistency in our administrative review process. Therefore, 20 CFR part 405 will be removed in its entirety upon implementation of this final rule.

Please refer any questions through your hearing office and regional management chains. The staff contact for regional inquiries is (b) (6), who may be reached at (b) (6).

/s/

Debra Bice

Chief Administrative Law Judge

Cc: Regional Office Management Teams

Hearing Office Managers

Frequently Asked Questions Regarding the "National Uniformity" Final Rule

Question 1: Are we going to be able to dismiss cases where the claimant fails to appear but did not receive 75-day notice?

(b) (5)

[redacted]

Question 2: With the change in the rules for subpoenas, is Acquiescence Ruling 91-1(5) still valid? Is there still the absolute right to have a subpoena issued for an examining physician with no obligation to provide any reasons?

(b) (5)

[redacted]

Question 3: How is an ALJ to handle a request to reopen a prior decision when the representative submits evidence with the new application that was not timely submitted with the prior application? Example: The representative did not timely submit evidence, and the ALJ keeps it out. The ALJ issues a decision of "not disabled." No request is filed with the Appeals Council. A new application is filed, and this evidence is timely

submitted. The representative now wants the ALJ to reopen the prior decision. "New and material" as defined in HALLEX I-2-9-40 would direct that the ALJ must consider this.

(b) (5)

Question 4: Will OCALJ be providing additional guidance on the rollout of the revised regulations?

(b) (5)

Question 5: What are the consequences if an HO fails to provide written notice of hearing within 75 days? Does this mean the record "closes" after the full 75 days or does it mean that the ALJ cannot enforce the uniformity rules at all (in order to "close the record")?

(b) (5)

Question 6: If a waiver is required for a case to be scheduled under 75 days, must the scheduler have a signed waiver form from the Document Generation System (DGS)? Can we obtain permission to waive advance notice verbally over the phone when calling to schedule a hearing less than 75 days in advance?

(b) (5)

(b) (5)

Question 7: Will DGS be updated so we can click a box to include the waiver of advanced notice form with the Notice of Hearing? This will allow us to central print that waiver form and thus save time.

(b) (5)

Question 8: Does the new policy regarding the 75-day notice period apply to supplemental hearings in addition to initial hearings?

(b) (5)

Frequently Asked Questions Regarding the "National Uniformity" Final Rule-PART II[1]

Question 9: If a claimant or representative submits a letter "informing" us about additional evidence close to or on the 5-day deadline, may we require a showing of "good cause" regarding why we were not informed of the evidence earlier prior to admitting it?

(b) (5)

[redacted]

Question 10: Are waivers of advance notice of hearing specifically authorized under the national uniformity regulations? If so, may hearing office (HO) management seek waiver on behalf of an ALJ and may ALJs establish guidelines regarding waivers of advance notice in standing orders?

(b) (5)

[redacted]

[1] These FAQs supplement the original FAQs issued on March 24, 2017.

(b) (5)

[redacted]

Question 11: If the claimant or representative agrees in writing to waive advance notice of hearing, do we need to comply with the other provisions of the national uniformity regulations, such as the 5-day requirement to inform us about or submit evidence?

(b) (5)

[redacted]

Question 12: If it becomes necessary to change the time or place of the hearing after we have already sent a notice of hearing, are we required to send an amended notice at least 75 days in advance?

(b) (5)

[redacted]

(b) (5)

Question 13: What about situations where the time or place of the hearing does not change, but it becomes necessary to schedule an expert witness, change the manner of appearance at the hearing, or update the names of witnesses or the assigned ALJ after the notice has already been sent out?

(b) (5)

Question 14: Can a waiver of the 75-day advance notice of hearing be obtained on the day of the hearing with a claimant who is appearing remotely (i.e. via VTC or telephonically), particularly for an incarcerated claimant?

(b) (5)

Question 15: Do the national uniformity regulations preclude claimants or representatives from submitting post-hearing written statements absent a showing that they have satisfied one of the conditions described in 20 CFR 404.935(b) and 416.1435(b)?

(b) (5)

(b) (5)

[redacted]

Question 16: 20 CFR 404.935(a) and 416.1435(a) provide that claimants and representatives must inform us about or submit any written evidence "no later than 5 business days before the date of the scheduled hearing." How do we calculate the 5 business day period for purposes of applying this rule? If a claimant or representative submits evidence after normal business hours on the 5th day prior to the hearing, is it considered timely?

(b) (5)

[redacted]

Efficient Hearing Techniques

Opening Statement (Hearings and Appeals Litigation Law Manual (HALLEX) I-2-6-52 Opening Statement)

- The administrative law judge (ALJ) will open the hearing with a brief statement explaining how he or she will conduct the hearing, the procedural history of the case, and the issues involved. In supplemental hearings, the ALJ need only identify the case, state the purpose of the supplemental hearing, and describe the issue(s) to be decided.
- If the claimant is unrepresented, the ALJ will ensure on the record that the claimant has been properly advised of the right to representation and that the claimant is capable of making an informed choice about representation.
- If the claimant asks to postpone the hearing to obtain a representative and it is the first request, the ALJ will typically grant the requested postponement.
- The ALJ will rule on the record regarding any prehearing requests or motions of the claimant or representative (*i.e.*, requests for postponement (Code of Federal Regulations (CFR) - 20 CFR 404.936 and 416.1436), disqualification of the ALJ (20 CFR 404.940 and 416.1440), subpoenas (20 CFR 404.950(d) and 416.1450(d)), and evidence submitted less than five days before the hearing 20 CFR 404.935(b) and 416.1435(b)).

Testimony of Claimants and Witnesses (HALLEX I-2-6-60; Testimony of Claimants and Witnesses)

- The ALJ determines the subject and scope of testimony from a claimant and any witness(es), as well as how and when the person testifies at the hearing.
- If a claimant or witness requests to testify in a particular way, or asks to testify at a particular time during the hearing, the ALJ will consider whether there is a good reason for the request. Additionally, if a claimant or witness objects to the presence of any other individual during his or her testimony, the ALJ will consider whether there is a good reason for the objection.
- The claimant and an appointed representative, if any, have the right to question witnesses to inquire fully into the matters at issue. Generally, the ALJ will provide a claimant or representative broad latitude in questioning witnesses. However, the ALJ is not required to permit testimony that is repetitive or cumulative, or allow questioning that has the effect of intimidating, harassing, or embarrassing the witness.
- The ALJ determines when the claimant or representative may question a witness. The ALJ will usually provide a claimant or representative the opportunity to question a witness after the ALJ completes his or her initial questioning of the witness. If necessary, the ALJ may recall a witness for further questioning.

- An ALJ may choose to exclude a witness from the hearing while others are testifying.
- The claimant and appointed representative, if any, generally have the right to be present during the entire hearing. However, the ALJ may excuse the claimant from the hearing in circumstances such as the following:

    - The claimant requests that the ALJ proceed without his or her attendance, the ALJ has fully advised the claimant of the right to be present and participate in the hearing, and the record demonstrates that the claimant understands the right to be present and the consequences if he or she is not present.
    - The appointed representative asks that the claimant is excused for the remainder of the hearing, the claimant agrees to be excused on the record, and the representative will be present throughout the remainder of the hearing.
    - The claimant is a minor, the claimant's attendance is no longer needed, a guardian or appointed representative will be present through the remainder of the hearing, and a responsible person who is not an agency employee can wait with the minor while the hearing continues.

- If the claimant is disruptive during the hearing, and continues the behavior after the ALJ fully advises the claimant on the record that the conduct is disrupting the proceedings, the ALJ will take one of the following actions:

    - If the claimant is represented and the representative is unable to address the behavior (either during the proceedings or after a short recess), the ALJ will discuss with the representative whether to proceed with the hearing only in the presence of the representative. If the representative agrees to continue without the claimant present, the ALJ may proceed with the hearing, allowing the representative to question any witness(es). If the ALJ reschedules the hearing and the claimant is again disruptive at the supplemental hearing, the ALJ will excuse the claimant and inform the representative that the hearing will proceed only in the presence of the representative.
    - If the claimant is not represented, the ALJ will take a short recess to provide the claimant time to compose himself or herself. When the ALJ goes back on the record, the ALJ will explain what behavior is disruptive. The ALJ will also explain that the claimant has the right to be present throughout the remainder of the hearing and to question witness(es), but that if the disruptive behavior continues, the claimant will be indicating that he or she waives the right to be present during the hearing and the ALJ will issue a decision on the record. If the disruptive behavior continues, the ALJ will adjourn the hearing and issue a decision on the record.

- If the disruptive behavior is threatening, alternative service policies may apply. 20 CFR 404.937, 416.1437, and 422.901 *et seq*. See applicable procedures in HALLEX I-1-9.

- If an appointed representative causes a disruption before or during hearing proceedings that significantly impacts the ALJ's ability to effectively conduct the hearing, there may be circumstances when it is appropriate for the ALJ to excuse or exclude the representative from the hearing. If the disruption occurs during the hearing, the ALJ will only excuse the representative after fully advising the representative, on the record, that the conduct is disrupting the proceedings.
- If the ALJ removes or excludes an appointed representative from the hearing, the ALJ may not question or continue to question the claimant or any other witness(es). Rather, the ALJ will explain to the claimant, on the record: the reasons the representative was removed or excluded from the hearing; note the hearing cannot continue at this time; and that the hearing will be rescheduled.
- When there is more than one party to a hearing, the ALJ will obtain testimony from all parties at one hearing whenever possible. For more information on who is a party to the hearing and what notice is required, see HALLEX I-2-1-45. See also HALLEX I-2-3-10 for issues relating to determining the manner of appearance at a hearing and handling a claimant's objections to how another person will appear at a hearing.

Four Keys to Effective Questioning and Effective Writing (OCEP 10/17/12)

PREPARE: Review the File and Identify the Issues to Be Developed at the Hearing

- Effective file review leads to a comprehensive hearing and decision.
- There are many ways to review a file but any review should focus on understanding the evidence and identifying ambiguities or inconsistencies.

LISTEN: Do Not Question By Rote from a Hearing Script

- An effective file review prepares you to recognize testimony that is ambiguous or inconsistent with documentary evidence.
- Be alert to ambiguities and inconsistencies in answers given. Fully developing these issues leads to a more complete decision.

FOLLOW-UP: Follow Where The Answers Lead. Ask Questions to Clarify New, Ambiguous or Inconsistent Evidence

- Be aware of tone; use open-ended questions; use the 5-Ws (who, what, when, where, and why) to frame questions; use techniques such as polite interruption to redirect or focus the claimant.
- Remember the authority governing hearings and decision writing (20 CFR §§404.944, 416.1444, and HALLEX I-2-6-60 to 74).

Best Questioning (OCEP 10/17/12)

"CLAIMANT TESTIMONY GUIDE" FROM NEW ALJ TRAINING MODULE 21

Questioning of Experts

- Ask the representative to stipulate to the expert's qualifications.
- Ask the vocational expert (VE) if his or her testimony is consistent with the information found in the Dictionary of Occupational Titles (DOT).

Residual Functional Capacity (RFC) and Vocational Expert (VE) Hypotheticals

Policies: Code of Federal Regulations (CFR); Social Security Rulings (SSRs); and Hearings, Appeals and Litigation Law Manual (HALLEX)

20 CFR 404.1545

- The RFC is the most you can still do despite your limitations
- All medically determinable impairments (MDIs) considered, including MDIs that are not severe, in assessing RFC; total limiting effects of all MDIs even if not severe, to determine claimant's RFC
- Consider ability to meet the physical, mental, sensory, and other requirements of work
- RFC used at Steps 4 and 5 of Sequential Evaluation Process

SSR 85-15 Titles II and XVI: Capacity to do Other Work – The Medical-Vocational Rules as a Framework for Evaluating Solely Nonexertional Impairments

SSR 85-16 Titles II and XVI: RFC for Mental Impairments

SSR 00-4p Titles II and XVI: Use of Vocational Expert (VE) and Vocational Specialist (VS) Evidence, and Other Reliable Occupational Information in Disability Decisions

Before Relying on VE/VS evidence to support disability determination/decision, administrative law judges (ALJs) must:

- Identify and obtain reasonable explanation for conflicts between occupational evidence by VE/VS and information found in the Dictionary of Occupational Titles (DOT).
- Explain in Decision how the identified conflict has been resolved.

HALLEX I-2-5-48 "The VE's testimony is not binding on the ALJ. The ALJ must consider a VE's testimony along with all other evidence." (20 CFR 404.1560(b)(2), 404.1566(e), 416.960(b)(2), and 416.966(e))

HALLEX I-2-5-55 "When an administrative law judge (ALJ) obtains vocational expert (VE) testimony during a hearing, the ALJ will generally explain why the VEi is present before his or her opening statement."

HALLEX I-2-6-74 "The claimant and the representative have the right to question the VE fully on any pertinent matter within the VE's area of expertise. However, the ALJ will determine when they may exercise this right and whether questions asked or answers given are appropriate."

CALJ Memo 5/31/16 Vocational Expert Testimony – Information and Reminder

- Provides guidance on policy, best practices, and recent court trends regarding vocational expert (VE) evidence.

CALJ Memo 11/3/2017 Use of Electronic Occupational References – Update

Training

Office of Hearings Operations (OHO) Continuing Education Program (OCEP) Broadcast - 1/18/12 - Phrasing the RFC: Five Keys to RFC

OCEP Broadcast - 4/17/13 - Four Keys to Vocational Evidence

OCEP Broadcast - 4/23/14 - Four Keys to Problem RFCs

OCEP Broadcast - 1/21/15 - Four Keys to Advanced Topics in Vocational Expert Evidence

Helpful Resources/Guidance

Limitations That Do Not Significantly Erode the Occupational Base

Citing a Social Security Ruling (SSR) at Step 5

SSRs and Acquiescence Rulings (ARs) Medical Vocational Policy

Quick Reference Chart for RFCs -- See Page 10 (below) in "Legally-Sufficient Language for the Hypothetical to the VE and the RFC" Office of Appellate Operations (OAO) - Appeals Council Training

Chief ALJ Memo - 11/3/2017 - Use of Electronic Occupational References – Update

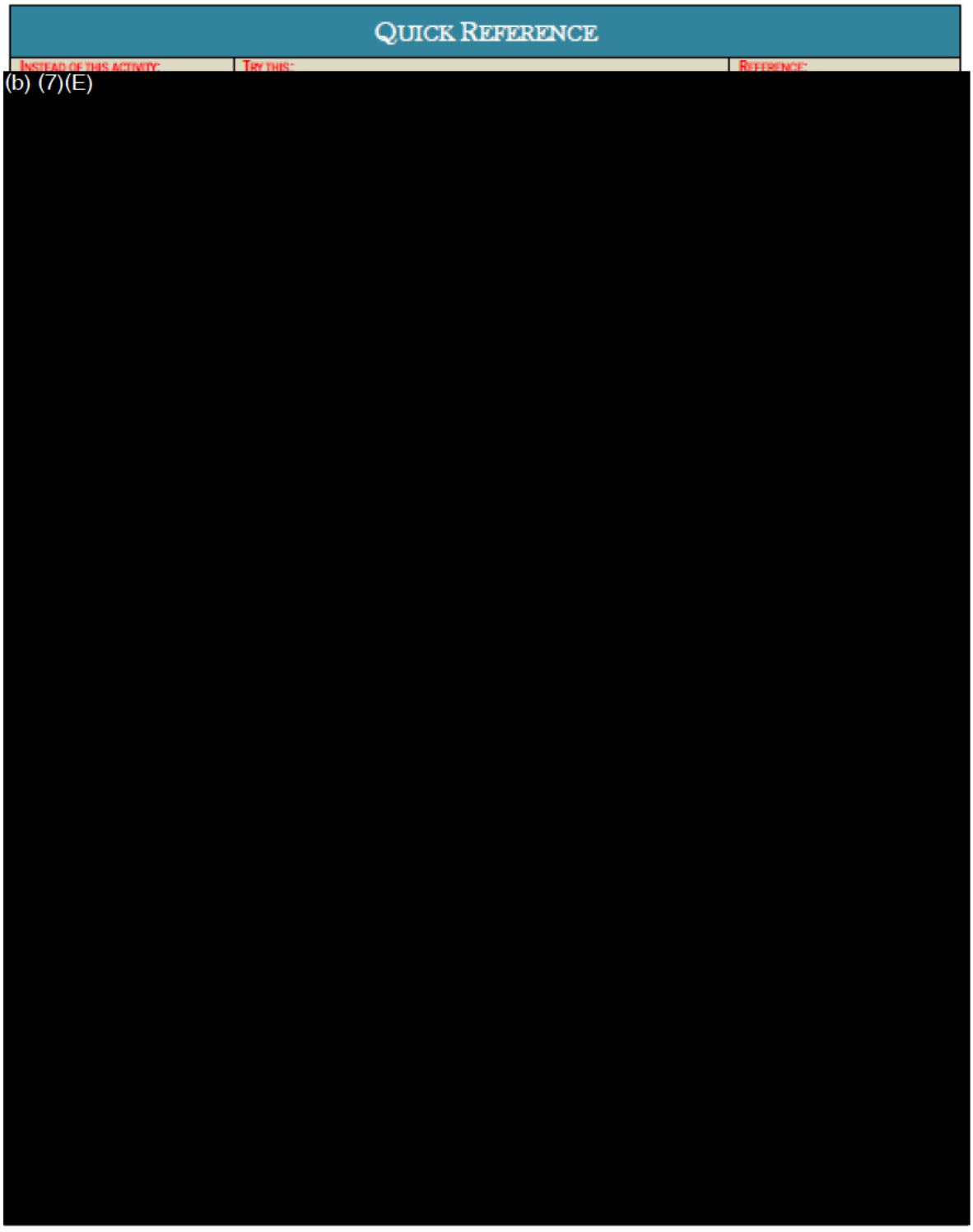
(b) (7)(E)

DOT - Appendices

Selected Characteristics of Occupations – Appendices

VE Sample Interrogatories – See DGS/CE and Evidence Request/Vocational Expert Interrogatories

Quick Reference Chart for RFCs



Transferability of Work Skills

Policies

- CFR 404.1568 and 416.968
- SSR 82-41

Guidance

- "Nine Stages of Transferability of Work Skills Analysis"
- "Transferability of Work Skills - Chart"

Transferability of Skills --Chart

	Younger Individual 18-49	Closely Approaching Advanced Age 50-54	Advanced Age 55-59	Closely Approaching Retirement Age 60-64
Sedentary				
Light				
Medium				
Heavy				

= = Transferability of skills material

= Transferability of skills material, with very little, if any, vocational adjustment

Nine Stages of Transferability of Work Skills Analysis

(CFR 404.1568, 416.968, and SSR 82-41)

STAGE 1	Determine whether transferable work skills are even required (Appendix 2, Subpart P, Regulations No. 4 and SSRs 82-63 and 85-15). If transferable skills are not required for a legally sufficient decision, the transferability of work skills analysis should be ended. If transferable work skills are required, proceed with the following analysis.
STAGE 2	The work activity from which the "skills" were acquired must meet the three-part "past relevant work (PRW)" test (recency, duration and substantial gainful activity) and must be semi-skilled or skilled, **not unskilled.**
STAGE 3	The specific transferable work skills (not aptitudes or traits) and the PRW (i.e., not hobbies, life experiences, etc.) from which the skills were acquired must be identified**.**
STAGE 4	The occupations to which the work skills are transferable must be semi-skilled or skilled, **not unskilled.**
STAGE 5	The specific occupations to which the work skills are transferable must be identified.
STAGE 6	The occupations to which the work skills are transferable must be within the claimant's residual functional capacity (RFC).
STAGE 7	The occupations to which the work skills are transferable must require the transferable work skills, but no additional work skills.
STAGE 8	If the claimant is age 55 or older (advanced age) and limited to sedentary work, or age 60 or older (close to retirement age) and limited to light or sedentary work, for the work skills to be transferable there must be a "very little, if any, vocational adjustment required in terms of tools, work processes, work settings, or the industry" (Sections 201.00(f) & 202.00(f), Appendix 2, Subpart P, Regulations No. 4).
STAGE 9	The decision must include rationale and "Finding" for each stage of the above analysis as appropriate.

Use of Medical and Vocational Experts

- **Medical Experts (MEs) – General:** Hearings, Appeals, and Litigational Law Manual (HALLEX) I-2-5-32
    - MEs are physicians, mental health professionals, and other medical professionals who provide impartial expert opinions at the hearing level on claims under Title II and Title XVI of the Social Security Act (Act).
    - Primary Use: MEs help administrative law judges (ALJs) evaluate medical evidence in a case.

- **Vocational Experts (VEs) – General:** HALLEX I-2-5-48
    - VEs are vocational professionals who provide impartial expert testimony during the hearing process on claims under Title II and Title XVI of the Act.
    - Primary Use: VEs help ALJs evaluate vocational issues at Step 4 and Step 5.

- **Regulatory Authority for Use of MEs and VEs:**
    - 20 CFR 404.936(c)(2) – The ALJ will determine whether a ME or a VE will appear at the hearing.
    - 20 CFR 404.1566(e) - VE – We will decide whether to use a VE or other specialist.

- **Manner of Appearance -** 20 CFR 404.936(c)(2) -- MEs and VEs may appear at the hearing in person, by video teleconferencing, or by telephone.

- **When Use of an ME and/or VE Is Not Necessary:**

  MEs - SSR 17-2p: ME is not needed at Step 3 if a finding of no medical equivalence is made.

  VEs - Step 5: 20 CFR 404.1569 and 20 CFR 404.1569(a)(b) – When the claimant's impairment(s) and related symptoms only impose exertional limitations and his/her specific vocational preparation (SVP) is listed in the Medical-Vocational Guidelines, we will directly apply that rule to decide whether the claimant is disabled.

- **When May You Use an ME and/or VE:**

  MEs:
    - 20 CFR 404.1529(b) and SSR 16-3p Title II and XVI: Evaluation of Symptoms in Disability Claims.
    - Step 2 – The ALJ may ask for and consider opinion of a medical or psychological expert concerning whether the claimant's impairments could reasonably be expected to produce his/her alleged symptoms.

- Step 3 – To assist in determining whether a claimant's impairment(s) meets a listed impairment(s).
- See HALLEX I-2-5-34 for a list of other situations when an ME may be necessary.

VEs

- Step 4: 20 CFR 404.1560
- The ALJ may use the services of a vocational expert to classify the claimant's past relevant work (PRW). (Please note however that only the ALJ can determine which past work constitute PRW.)
- The ALJ may use the services of a VE to assist in determining whether the claimant could perform his/her PRW as actually performed or generally performed in the national economy.

- **When Must/Should You Use an ME and/or VE:**

MEs

- HALLEX I-2-5-34 – ALJ must use ME if ordered by Appeals Council (AC) or court.
- HALLEX I-2-5-34 – ALJ must use an ME when there is a question about accuracy of reported medical test results requiring evaluation of background test data.
- SSR 17-2p Title II and XVI: Evidence Needed by Adjudicators at the Hearings and Appeals Council Levels of Administrative Review Process to Make Findings about Medical Equivalence.
- Step 3: An ME must be used to support a finding of medical equivalence at the hearing level (unless there was as prior administrative medical finding from an MC/PC from the initial or reconsideration adjudication levels supporting the medical equivalence finding, or report from the AC's medical support staff supporting the medical equivalence finding).

VEs

- HALLEX I-2-5-50 -- An ALJ must use a VE when directed by the AC or a court.
- An ALJ must obtain a VE in the Third Circuit and Eighth Circuit under AR 01-1(3) and AR 14-1(8), respectively.
- Step 5: 20 CFR 404.1569 and 20 CFR 404.1569a
- Consider using a VE when claimant has nonexertional limitations (unless, considering only the exertional limitations and vocational profile, the claimant would be considered disabled under GRID rules).
- Transferability at Step 5: 20 CFR 404.1568, 20 CFR 404.1566e, and SSR 82-41: Title II and XVI: Work Skills and Their Transferability -- When an analysis of transferability of skills is required, consider using a vocational expert to assist in determining whether the claimant has any transferable skills from his/her PRW (See Nine Stages of Transferability of Work Skills Analysis).

- **When to Use a ME and VE during the Hearing Process**
  - HALLEX I-2-5-48 – The ALJ may use a VE before, during, or after the hearing.
  - Pre-Hearing – A ME and VE may be used before a hearing to resolve issues that could lead to an on-the-record (OTR) finding of disability.
  - Interrogatories may be sent to MEs or VEs pre-hearing.
  - HALLEX I-2-5-94: Sample Interrogatories to VEs
  - HALLEX I-2-5-29: Pre-hearing proffering may be necessary.

- **Manner of Appearance at a Hearing** (20 CFR 404.936 and HALLEX I-2-5-32) -- In person, by video, or by telephone

- **Resources Relevant the MEs and VEs**
  - HALLEX I-2-6-70: Testimony of a Medical Expert
  - HALLEX I-2-5-93: Sample Questions for the Medical Expert
  - Office of Hearings Operations (OHO) Continuing Education Program (OCEP) Broadcast - (04/17/2013): The Four Keys to Vocational Evidence
  - Examinations of the VE is limited to pertinent questions on material issues; the ALJ should determine the appropriateness of questions asked.
  - The VE's estimate on the number of jobs nationally generally suffices; with rare exceptions, the number of jobs regionally is not necessary.
  - Address conflicts with the Dictionary of Occupational Titles (DOT) (Social Security Ruling (SSR) 00-4p) -- Do not assess transferability of skills unless necessary (usually, transferability of skills is not an issue).
  - OCEP (01/21/2015): The Four Keys to Advanced VE Evidence
  - Do not permit the VE to answer improperly posed questions.
  - VE should be limited to vocationally relevant evidence.
  - ALJs must control the conduct of the hearing and rule on objections and subpoena requests.
  - The ALJ decides whether other work exists in significant numbers.

- **Post-Hearing** – A ME and VE may be used after a hearing.
  - HALLEX I-2-5-42 and HALLEX I-2-5-56 – Post-hearing interrogatories may be sent to MEs and VEs.
  - Reason for need of an ME post-hearing -- Evidence submitted indicates new issues which require assistance from an ME.
  - Reasons for need of a VE post-hearing:
    - Claimant may establish the existence of another severe impairment.
    - Evidence submitted indicates that the claimant's functional limitations differ from the hypothetical questions presented to the VE at the hearing.
  - HALLEX I-2-5-44 – Actions when ALJ receives medical expert's responses to interrogatories

- HALLEX I-2-7-1 – Proffer responses from such interrogatories unless a fully favorable decision can be issued

- **Special Considerations**
  - **SSR 00-4p** Titles II and XVI: Use of Vocational Expert (VE) and Vocational Specialist (VS) Evidence, and Other Reliable Occupational Information in Disability Decisions
  - Before Relying on VE/VS evidence to support disability determination/decision, the ALJs must complete the following tasks:
    - Identify and obtain reasonable explanation for conflicts between occupational evidence by VE and information found in the DOT.
    - Explain in decision how the identified conflict has been resolved.

- **Dealing with Objections to the VEs**
  - Quick Reference Guide - Addressing Objections To VE Testimony
  - HALLEX I-2-6-74 Testimony of a Vocational Expert "The ALJ may address objection(s) on the record during the hearing, in narrative form as a parate exhibit, or in the body of his or her decision"

- **Guidance and Training Resources for MEs and VEs**
  - **Chief ALJ Memo (CALJ) - 5/31/16: VE Testimony – Information and Reminder:** Provides guidance on policy, best practices, and recent court trends regarding vocational expert (VE) evidence.
  - **CALJ Memo - 11/3/2017 - Use of Electronic Occupational References – UPDATE**
  - **OCEP Broadcast - 4/17/13: Four Keys to Vocational Evidence**
  - **OCEP Broadcast - 1/21/15: Four Keys to Advanced Topics in VE Evidence**

Evaluating Medical Evidence – Overview and Relevant Dates

New Approach to Evaluating Medical Evidence:
The Agency revised the rules on evaluation of medical evidence, effective March 27, 2017. The revisions redefined several key terms related to evidence, revised rules about acceptable medical sources (AMS); revised how the Agency considers and articulates consideration of medical opinions and prior administrative medical findings; revised rules about medical consultants (MC) and psychological consultants (PC); revised rules about treating sources; and reorganized the evidence regulations for ease of use.

- The five new categories of evidence are objective medical evidence, medical opinion, other medical evidence, evidence from nonmedical sources, and prior administrative medical finding.

- For claims filed on or after March 27, 2017, a medical opinion for an adult is defined as a statement from a medical source about what an individual can still do despite his or her impairments, whether the individual has one or more impairment-related limitations or restrictions in one or more specified demands of work, and his or her ability to adapt to environmental conditions.

- For claims filed on or after March 27, 2017, AMSs includes advanced practice registered nurses (APRN) for impairments within their licensed scope of practice, including certified nurse midwives, nurse practitioners, certified registered nurse anesthetists, and clinical nurse specialists; physician assistants (PAs); and audiologists.

- Both the prior rules and the revised rules require an adjudicator to consider all evidence in a claim, including decisions by other governmental agencies and nongovernmental entities. See 20 CFR 404.1520b and 416.920b. For claims filed on or after March 27, 2017, though written analysis is not required on decisions by other governmental and nongovernmental entities, we must always consider all of the supporting evidence underlying the other agency or entity's decision that we receive in a claim. The underlying evidence may require a written analysis (See 20 CFR 404.1504 and 416.904 noting that ". . .we will not provide any analysis in our determination or decision about a decision made by any other governmental agency or a nongovernmental entity about whether you are disabled, blind, employable, or entitled to any benefits.").

- In claim(s) filed on or after March 27, 2017, do not defer to or give specific weight to any medical opinion or prior administrative medical finding. Articulate the persuasiveness of the opinions or prior administrative medical findings by considering supportability, consistency, relationship with the claimant, specialization, and other factors. The most important factors are supportability and consistently, and we must provide articulation on these factors for every medical opinion in all decisions.

Topic	"Prior Rule" Citation Regulations that apply to claims filed prior to March 27, 2017	"Current Rule" Citation Regulations that apply to cases filed on or after March 27, 2017.
Acceptable Medical Sources (AMS)	20 CFR 404.1502(a)(1)-(5) and 416.902(a)(1)-(5)	20 CFR 404.1502(a)(1)-(8) and 416.902(a)(1)-(8)
Medical Opinion Definition	20 CFR 404.1527(a)(1) and 416.927(a)(1)	20 CFR 404.1513(a)(2) and 416.913(a)(2)
Other Medical Evidence Definition	20 CFR 404.1513(a)(3) and 416.913(a)(3)	20 CFR 404.1513(a)(3) and 416.913(a)(3)
Consideration and Articulation of Opinion Evidence and Prior Administrative Medical Findings	20 CFR 404.1513a, 404.1527, 416.913a and 416.927	20 CFR 404.1513a, 404.1520c, 416.913a, and 416.920c
Statements on Issues Reserved to the Commissioner	20 CFR 404.1527(d) and 416.927(d)	20 CFR 1520b(c)(3) and 416.920b(c)(3)
Decisions by other Governmental and Nongovernmental Entities	20 CFR 404.1504 and 416.904	20 CFR 404.1504, 404.1520b(c)(1), 416.904, and 416.920b(c)(1)

Resources:

- Chief Judge Resources: Revisions to Rules Regarding the Evaluation of Medical Evidence
- Chief Judge Memo - Revised Rules for Evaluating Medical Evidence
- ALJ/DW Training Course Module 8: Evaluation of Medical Opinion Evidence
- Judicial Training 2017 Session on Evaluation of Medical Evidence

Childhood Disability Claims

Social Security Insurance (SSI) Childhood Disability Three Step Process (20 CFR 416.924):

Step 1: Is the child engaged in substantial gainful activity (SGA)? If so, the child is not disabled.

Step 2: Is there a severe impairment(s)? Severe means the impairment must cause more than minimal functional limitations.

Step 3: Do the impairments satisfy the one-year durational requirement and meet, equal, or functionally equal the Listing of Impairments?

Meeting a Listing and Medical Equivalency (20 CFR 416.925 and 416.926):

- Consider Part B of the listings first. If the Part B criteria do not apply, then you may use Part A, if appropriate.
- Medical Expert evidence is required to find that an impairment equals a listing.

Functional Equivalence and Whole Child Approach (20 CFR 416.926a and SSR 09-01p):

- **Whole Child Approach (SSR 09-01p):**
  First, consider the child's functioning without considering the domains or individual impairments. This assessment includes everything done at home, in school or in the community. Consider how the child functions compared to other children of the same age who do not have impairments. Next, determine which domains are involved in those activities.

- **Functional Domains:**
  - Acquiring and Using Information (SSR 09-03p)
  - Attending and Completing Tasks (SSR 09-04p)
  - Interacting and Relating with Others (SSR 09-05p)
  - Moving About and Manipulating Objects (SSR 09-06p)
  - Caring for Yourself (SSR 09-07p)
  - Health and Physical Well-Being (SSR 09-08p)

Functional Equivalence -- "Marked" limitations in at least two functional domains or an "Extreme" limitation in one functional domain (20 CFR 416.926a(d-e)):

- **Marked Limitation:**
  - Marked means the impairments interfere "seriously" with the ability to independently initiate, sustain, or complete activities.

- Marked also means a limitation that is “more than moderate” but “less than extreme.”
- Marked is the equivalent of functioning that we would expect to find on standardized testing with scores of at least two, but less than three, standard deviations below the mean.

- **Extreme Limitation:**
  - Extreme means the impairments interfere “very seriously” with the ability to independently initiate, sustain, or complete activities.
  - Extreme also means a limitation that is “more than marked.”
  - The equivalent of functioning we would expect to find on standardized test scores of at least three standard deviations below mean.

Five Age Groups for Evaluating Childhood Disability (20 CFR 416.926a(g) through (l)):

- Newborns and Infants (birth to attainment of age 1)
- Older Infants and Toddlers (age 1 to attainment of age 3)
- Preschool Children (age 3 to attainment of age 6)
- School-Age Children (age 6 to attainment of age 12)
- Adolescents (Age 12 to attainment of age 18)

Standardized Tests - Testing Commonly Used in Assessing Child Functioning: Standardized Tests for Evaluating Child Disability chart in Office of Hearings Operations (OHO) Continuing Education Program (OCEP) materials

Resources and Forms:

- Supplemental Administrative Law Judge (ALJ) Training Notebook (page 304)
- OCEP Broadcast on Child Disability from January 2014
- Four Keys to Child Disability
- Adjudication Tip #21
- New ALJ Module 17
- Appeals Council Feedback Training
- Decision Writer Instructions (DWI) for Child Cases
- Childhood Disability Evaluation form SSA-538-F6
- Social Security Insurance (SSI) Child Teacher Questionnaire forms SSA-5665-BK and SSA-5666-BK

Drug Addiction & Alcohol Cases (DAA)

Analyzing DAA Cases:

1. **DAA must be a medically determinable severe impairment for DAA analysis to be relevant**
    a. **Must be diagnosed by an acceptable medial resource** - A reference in the records to drug and/or alcohol use is not enough to establish it as a severe impairment.
    b. **Substance abuse disorder is no longer considered a mental impairment** under the revised mental listings.
    c. **DAA disorder severity** -- Information from "other" sources may be helpful in documenting the severity of DAA because it supplements the medical evidence of record.
        i. Opinions from "other" sources can assist in evaluating whether DAA is material to a finding of disability because it can document how well the claimant performs activities of daily living in the presence of a comorbid impairment.
        ii. Often, evidence from "other" sources may be the most important information in the case record for these documentation issues.

2. **If DAA Disorder diagnosis?** Is the claimant disabled, considering *ALL* impairments?
    a. NO (not disabled) - DAA is not material and no analysis required.
    b. YES (disabled)- DAA may be material, and DAA analysis required.
        i. **Considering *ALL* impairments except DAA disorder -** Apply the sequential evaluation.
            1. Is claimant still disabled?
                a. YES - DAA is not material.
                b. NO - DAA is material.
        ii. **Burden of Proof** - The claimant has the burden of proving disability throughout the DAA materiality analysis.

DA&A Points to Remember:

- **Consider the relevance of DAA** if you find it to be a severe impairment.
- **Cite to specific evidence** in the record to support a finding that DAA is material/not material. If you find DAA material, there must be evidence in the record showing that, if the claimant stopped drinking/taking drugs, his condition would improve to the point that he would not be disabled.
- **For DAA Material finding, your decision must reflect** the following information:
    - The **step in the sequential evaluation** where the claimant is **found disabled**; and
    - The **step in the sequential evaluation** where the claimant is **found not disabled** if the claimant stopped using drugs or alcohol.

- **Specifically, explain "B" Criteria ratings.**
- **DAA analysis** – Focus on if the claimant would be disabled even if the claimant stopped using drugs or alcohol (not whether claimant disabled while using DAA).
- A finding that claimant **is disabled during a period of abstinence is inconsistent** with a finding that DAA is material.
- **If DAA is the only severe impairment and claimant is disabled? DAA is material.**
- **In redetermination cases**, DAA is adjudicated in the same manner as an initial case, since the appeal of the termination is treated as a new application for benefits.

Resources:

- 20 C.F.R. §§ 404.1535 and 416.935
- Social Security Ruling (SSR) 13-2p: *Titles II and XVI: Evaluating Cases Involving Drug Addiction and Alcoholism (DAA)*
- Appeals Council Feedback Training - Drug Addiction and Alcoholism
- New Administrative Law Judge (ALJ)/Decision Writer (DW) Training Module 14 ("DA and A")
- Office of Hearings Operations (OHO) Continuing Education Program (OCEP) 7/16/14: DAA - *Drug Addiction and Alcoholism (DAA) (VOD)*
- *OCEP 4 Keys to DAA*
- Disability Analysis Flow Chart: DA&A Evaluation Process Flow Chart

The Four Keys to DAA

You must determine if DAA is a medically determinable severe impairment.

- Evidence of drug or alcohol use alone does not establish DAA as a medically determinable severe impairment. Evidence from an acceptable medical source is necessary.
- DAA is a "substance use disorder" defined as a "maladaptive pattern of substance use that leads to clinically significant impairment or distress."

If you find the claimant disabled considering all impairments, including DAA, use the six-step evaluation process under SSR 13-2p to determine if DAA is material.

- If the claimant <u>is not</u> disabled considering all impairments, including DAA, your evaluation is finished. DAA materiality is not an issue.
- If the claimant <u>is</u> disabled considering all impairments, including DAA, you must conduct a second sequential evaluation considering all impairments <u>except</u> DAA to determine if DAA is material.
- The claimant has the burden of proving disability throughout the sequential evaluation process.

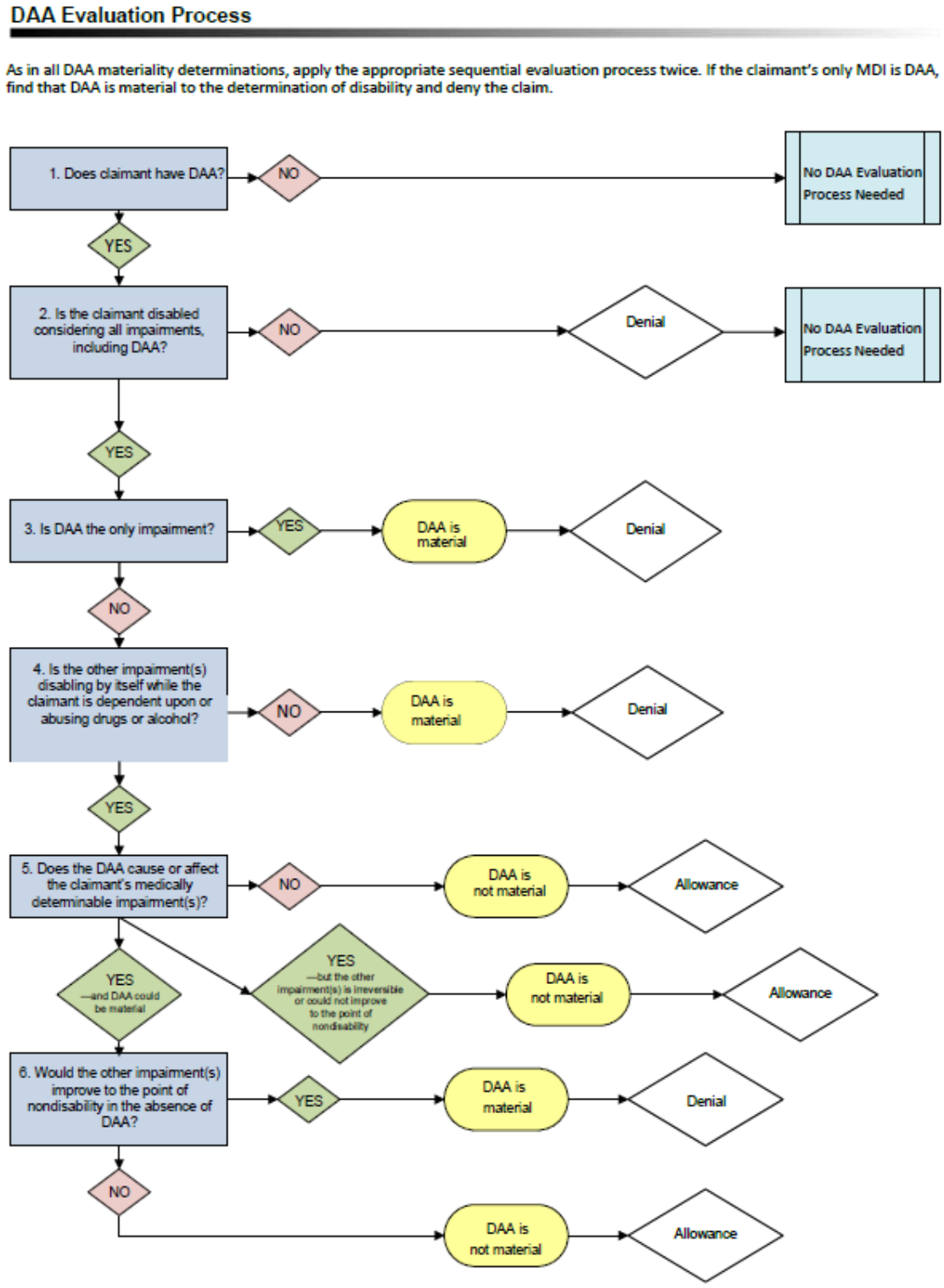
Recognize and avoid common DAA errors.

- Failure to cite specific evidence to support a finding that DAA is material to the finding of disability;
- Failure to explain the "B" criteria findings;
- Finding the claimant disabled only during a period of abstinence; and,
- Failure to evaluate DAA when it is a severe impairment.

Decision instructions and drafts must identify specific evidence showing whether DAA is material.

- A statement in the decision that DAA is, or is not, material to the determination is insufficient. The decision must cite evidence in support of this finding.

DAA Evaluation Process – Flow Chart



Efficient Drafting/Editing Techniques

POST Hearing Draft Instructions -- When and What to Include?

- Instructions to Decision Writers (Hearings, Appeals, and Litigation Law Manual (HALLEX) I-2-8-20)
- Chief Judge Memo: Expectations for Instructions to Decision Writers – Clarification June 7 2016
- Chief Judge Memo: Expectations for Instructions to Decision Writers July 10, 2013
- Using available resources: Decision Writer Instructions (DWI)/Hearing and Appeals Case Process System (HACPS), FIT, FIT Enhanced

Fully Favorable Decisions/Dismissals -- Who writes? What is the Focus?

- Decision Writing Policy Guidance Part I: Fully Favorable Decisions – INFORMATION AND REMINDER
- Regular and Updated Fully Favorable – Comparison Chart
- SAMPLE Updated Fully Favorable Decision
- Fully Favorable Training Presentation

Draft Expectations, Approach to Edit Reviews, Legally Sufficient Decisions

- HALLEX 1-2-8-25: Writing the Decision
- The Good Decision Writing document from Office of Hearings Operations (OHO) Continuing Education Program (OCEP)

Bench Decisions – When and How?

- Bench Decision HALLEX I-2-8-19; 20 CFR 404.953(b) and 416.1453(b)
- FIT Bench Decision form (Document Generation System (DGS))

Reopening Refresher

Administrative Finality:

- An administrative law judge (ALJ) may only reopen a prior determination or decision that is administratively final.
- If the decision in a prior application is pending appeal at the Appeals Council (AC) or federal court, the decision is not administratively final. The ALJ cannot reopen.
- If the AC issued a decision on a prior application, the AC decision becomes the final decision of the Commissioner. The ALJ cannot reopen it. The first possible date of disability on a subsequent application is the day after the AC decision. 20 CFR 404.987 and 416.1487
- A denial of a request for review by the AC is not a final decision of the Commissioner, and "Reopening Timeframes" (below) apply.

Reopening Timeframes:

You may reopen a determination, revised determination, decision, or revised decision:

- Within 12 months of the date of notice of the initial determination, for any reason. Reopening within 12 months is not automatic. There must be a reason.
- Within 2 years of the date of notice of the initial determination in Title XVI and within 4 years of the date of notice of the initial determination in Title II claims, for good cause.
- At any time, for fraud or similar fault, or to correct error on the face of the evidence in a prior unfavorable determination or decision. 20 CFR 404.988 and 416.1488

Exception - Social Security Ruling (SSR) 91-5p: If mental incapacity prevented a timely request for review of the prior adverse determination or decision, you may reopen no matter how much time has passed. Consider these factors, as they existed at the time of the prior administrative action:

- Inability to read or write
- Lack of facility with the English language
- Limited education
- Any mental or physical condition that limits the claimant's ability to do things for himself or herself

Types of Reopening: Implied or Express, and ALJ-Initiated Requests - 20 CFR 404.987, 404.988, 416.1487, and 416.1488; HALLEX I-2-9-10, HALLEX I-2-9-30, HALLEX I-2-9-40, and HALLEX I-2-9-60

- An implied request for reopening usually occurs when a claimant alleges an onset date that falls within the period adjudicated in a prior application; or after the ALJ issues a decision, the claimant sends the ALJ new and material evidence that relates to the earlier period at issue.
- An express request for reopening occurs when a claimant or representative asks the ALJ to reopen a determination or decision issued in a prior application.
- On own initiative, an ALJ may reopen a determination or decision issued in a prior application when the the conditions and timeframes for reopening are met, the ALJ has jurisdiction over the issues, and the facts and evidence of the particular case warrant reopening.

Calculations:
Calculate the time for reopening from the initial notice date of the determination or decision you seek to reopen as follows:

- For implied requests to reopen – to the date of the current application.
- For expressed requests to reopen – to the date of the request to Reopen.
- For ALJ initiated reopening – to the date the ALJ identified the reopening issue. HALLEX I-2-9-20.

Good Cause:
Reopening on the basis of good cause exists if:

- New and material evidence is furnished;
- A clerical error in the computation or re-computation of benefits was made; or
- The evidence considered in making the prior determination or decision clearly shows error on its face. 20 CFR 404.989 and 416.1489. HALLEX I-2-9-40

New and Material:
HALLEX I-2-9-40 provides information about the new and material evidence requirements. In general, "new" means the adjudicator, who made the prior determination, did not consider it. "Material" means the evidence, alone or in combination with other evidence, "would have resulted in a different conclusion as to eligibility, entitlement, or benefit amount…."

- If a claimant has two or more prior applications, an ALJ may not use the most recently denied application as a "stepping stone" to reach and reopen an even earlier application. (No "leap frogging" as it is commonly called.)
- An ALJ may find a claimant to be disabled within a previously adjudicated period without reopening the determination or decision issued in the prior application.

Reopening Exercises

(b) (7)(E)

(b) (7)(E)

Post Hearing Development

Post Hearing Medical Evidence of Record: The Program Uniformity (Five Day) Rule includes direction on the submission and admission of post hearing evidence.

- Code of Federal Regulations (CFR) - 20 CFR 404.935(b) and 416.1435(b).
- Hearings, Appeals, and Litigation Law Manual (HALLEX) I-2-7-20. Claimant Requests Additional Time to Submit Evidence After the Hearing.
- Exceptions - 20 CFR 416.1435(c). (Title XVI – age 18 redeterminations, CDR, terminations)
- Video on Demand (VOD) – Ensuring Program Uniformity.

Expert Interrogatories: HALLEX I-2-5-30 - Medical or Vocational Expert Opinion

Medical Experts:

- HALLEX I-2-5-42. Obtaining Medical Expert Opinion Through Interrogatories.
- HALLEX I-2-5-44. Action When Administrative Law Judge (ALJ) Receives Medical Expert (ME) Responses to Interrogatories. This provision includes the requirement to proffer to the claimant and representative as well as instructions if additional evidence is received after receipt of a response to interrogatories.
- Sample interrogatories (physical) and cover letter.

Vocational Experts:

- HALLEX I-2-5-56. Obtaining Vocational Expert (VE) Testimony After the Hearing. Additional testimony post hearing can be obtained by supplemental hearing or interrogatories.
- HALLEX I-2-5-57. Obtaining VE Testimony Through Interrogatories.
- HALLEX I-2-5-58. Action When ALJ Receives VE Responses to Interrogatories.
- HALLEX I-2-5-60. Action When ALJ Receives New Evidence After a VE Has Provided Testimony.
- Social Security Ruling (SSR) 00-4p Titles II and XVI: Use of VE and Vocational Specialist (VS) Evidence, and Other Reliable Occupational Information in Disability Decisions – Direction to identify or address possible conflicts in the record
- Sample interrogatories and cover letter.

Proffer

- HALLEX I-2-7-1. Posthearing Evidence – When Proffer is Required.
- HALLEX I-2-5-29. Prehearing Proffer of Evidence. An ALJ must always proffer interrogatory responses from either a ME or VE. Therefore, proffer is required even if interrogatory responses are obtained prehearing.
- Sample proffer letter. A supplemental hearing is not required unless the evidence is opinion evidence or has significant impact on the outcome. (Note: Some offices may send an old and incorrect letter.)

Continuing Disability Reviews (CDRs)

Overview – General (20 CFR 404.1594 and 416.994)

- There are two types of CDRs: Adult CDRs and Disabled Child CDRs.
- Most disability insurance or supplemental security income claims are reviewed periodically, anywhere from after 6 months to 7 years, to ensure that a person's disability continues.
- CDR procedure -- After an initial cessation determination, the person has a right to file a Request for Reconsideration and meet in person with a **Disability Hearing Officer** (DHO), who will either reverse or affirm the initial determination.
    - If the DHO affirms the cessation, the person can request a hearing on the affirmation.
    - The DHO's report of the meeting, including the findings and conclusions, will be in the eFolder for review.

Adult CDRs

There are eight steps in the sequential CDR process, all of which may or may not be followed, depending on the case. The first two steps may be dispositive.

- **Step One (Title II only) – Is the individual engaged in substantial gainful activity (SGA)?** (20 CFR 404.1594(f)(1))
    - Step 1 applies only to Title II cases.
    - The first dispositive step in a Title II cessation.
    - If the individual is engaged in SGA, then disability ends.

- **Step Two – At the time of the cessation determination, do the CURRENT impairments meet or medically equal a CURRENT Listing of Impairments?** (20 CFR 404.1594(f)(2), 20 CFR 416.994(b)(5)(i))
    - This step is the second potentially dispositive step in a Title II cessation.
    - This step is the first potentially dispositive step in a Title XVI cessation.
    - If the answer is yes, disability continues.

- **Step Three – Has there been medical improvement since the "Comparison Point Decision (CPD)" or most recent favorable determination/decision?** (20 CFR 404.1594(f)(3), 20 CFR 416.994(b)(5)(ii))
    - If the person's current impairments do not meet or medically equal a current listing, apply the "medical improvement review standard" (MIRS) to determine if the person's condition has "medically improved" since the CPD or the date of the most recent favorable medical determination that the person is disabled.
    - Medical improvement is any decrease in medical severity of an individual's impairment(s) that was present at the time of the most recent favorable medical decision.

- **Step Four** – **Does the medical improvement relate to the person's ability to work? Has there been an increase in the person's ability to do basic work-related function?** (20 CFR 404.1594(f)(4), 20 CFR 416.994(b)(5)(iii))

- **Step Five** – **Does a Group I or Group II exception to medical improvement apply?** (20 CFR 404.1594(f)(5), 20 CFR 416.994(b)(5)(iv)
    - If the person has **NOT** medically improved since the CPD, or the person has medically improved but this improvement is not related to the ability to work, determine whether a Group I or Group II exception applies.
      Group I Exceptions:
        - The person is the beneficiary of advances in medical or vocational therapy or technology, which are related to the ability to work;
        - The person has undergone vocational therapy related to the ability to work;
        - New or improved diagnostic or evaluation techniques show the person's impairments are not disabling as thought at the CPD; and
        - The prior determination or decision was in error.
    - If a Group I exception applies, the sequential disability cessation process will continue at Step 6.
      Group II Exceptions:
        - Fraud;
        - Failure to cooperate;
        - Person cannot be located (whereabouts unknown); and
        - Failure to follow prescribed treatment that would be expected to restore the ability to engage in SGA.
    - If a Group II exception applies, the person's disability will end.
    - If NEITHER exception applies, the person's disability will continue.

- **Step Six** – **Does the claimant have a severe impairment?** Consider **ALL** the claimant's impairments, not just those as of the CPD, to determine whether the person has a severe impairment(s) (20 CFR 404.1594(f)(6), 20 CFR 416.994(b)(5)(v)).

- **Step Seven** – **Can the person perform past relevant work (PRW)?** Determine the person's current residual functional capacity (RFC), and whether the person can perform PRW (20 CFR 404.1594(f)(7), 20 CFR 416.994(b)(5)(vi)).

- **Step Eight** – **Can the person perform other work?** Determine whether the person can perform other work in the national economy (20 CFR 404.1594(f)(8), 20 CFR 416.994(b)(5)(vii)).

Disabled Child CDRs

General – A disabled child CDR is a three-step sequential evaluation process.

- **Step One** – **Has there been medical improvement in any CPD impairment?** (20 CFR 416.994a(b)(1))
    - If there has been no medical improvement in any CPD impairment, consider whether a Group I or Group II exception applies.
    - **Group I Exceptions** (20 CFR 416.994a(e)):
        - New or improved diagnostic or evaluative techniques show the child's impairments are not as disabling as thought at the CPD; and
        - The prior determination or decision was in error.
    - If one of the Group I exceptions applies, use the same evaluation steps in an initial claim for disability to determine whether the child is currently disabled.
    - **Group II Exceptions** (20 CFR 416.994a(f)):
        - Fraud;
        - Failure to cooperate;
        - Person cannot be located (whereabouts unknown); and
        - Failure to follow prescribed treatment that would be expected to restore the ability to engage in SGA.
    - If one of the Group II exceptions applies, disability must end. (20 CFR 416.994a(b)(1)(i), (ii))

- **Step Two** – **Do the CPD impairment(s) CURRENTLY meet, equal, or functionally equal the severity of a CPD listing?** (20 CFR 416.994a(b)(2)(i), (ii))
    - Determine whether the child's CPD impairments **CURRENTLY** meet, medically equal, or functionally equal the severity of the listing that they met, medically equaled, or functionally equaled before.
    - Consider the listing in effect at the time of the CPD, even if that listing has been revised or removed.
    - Use the child's age at the time of your decision.
    - If the child's CPD impairments still meet, medically equal, or functionally equal the CPD listing, consider whether Group I or Group II exceptions apply.
        - If a Group I exception applies, use the same evaluation in an initial claim for disability to determine whether the child is currently disabled.
        - If a Group II exception to medical improvement applies, disability must end.

- **Step Three** – **Is the child currently disabled, considering all the impairments?**
    - Determine whether the child is currently disabled considering all of the impairments and using the same evaluation steps in an initial claim for disability (20 CFR 416.994a(b)(3)(i)-(iii))

- Are the child's current impairments severe?
- Do the child's current impairments meet or medically equal the current Listings?
- Do the child's current impairments functionally equal the Listing?

CDR Challenges

- **Prior file missing** (20 CFR 404.1594(c)(3)(v); 416.994b(2)(iv)(E); HALLEX I-2-1-12)
  - If the person CAN engage in SGA currently, reconstruct those portions of the missing file relevant to the most recent favorable disability decision.
  - There is no need to reconstruct file if the person cannot engage in SGA and no Group II exception applies. Benefits continue in such a situation.

- **Prior file available but RFC finding missing, not completed, or vague/unclear** (20 CFR 404.1594(c)(3)(iii), 416.944b(2)(iv)(C)).
  - If the RFC finding is missing, reconstruct the prior RFC by determining the person's maximum RFC consistent with an allowance.
  - If the RFC is not completed, or it is vague or unclear, use whatever you have in the file, MSS, e.g., or the body of the previous, favorable ALJ decision, to derive the prior RFC.
  - If the prior RFC is still unclear, decide if there is medical improvement in any element of the prior RFC.

- **Disability ended, but claimant is disabled again as of adjudication date** (Social Security Ruling (SSR) 13-3p)
  - SSR 13-3p requires us to address the cessation date and the later disability onset date in the decision.
  - For the later finding of disability, consider the person's request for hearing as the protective filing date of an application, which permits a determination through the date of the decision on appeal.
  - Articulate in your decision information about the disability cessation date, application date, and new disability current date.

Special Considerations

- Streamlining File Review – Review CDR process documents, including the DHO report, to streamline file review.
- Flowchart -- Use a flowchart to stay on track with the analysis.
- Earnings -- Look at earnings reports/other records to see if the person is engaged in SGA (only relevant for termination in Title II cases).
- Listings – Consider whether claimant meets a Listing.
- SSR 13-3p -- Make sure the decision contains SSR 13-3p appropriate language.

Writing Instructions

In your decision writing instructions, remember to identify the following:

- The CPD;
- The basis for the prior finding of disability, whether the person met/equaled a Listing or had a work-preclusive RFC;
- The evidence supporting your finding on medical improvement, whether it is related to the person's ability to work;
- Whether any of the Group I or Group II exceptions apply; and
- Whether disability continues, or, if not, the date that disability ended.

Resources

Office of Hearings (OHO) Continuing Education Program (OCEP) 10/2014 –The Three Keys to CDRs

Continuing Disability Reviews - PowerPoint Presentation

Overpayments

The [Commissioner's] practice is to make an ex parte determination... that an overpayment has been made, to notify the recipient of that determination, and then to shift to the recipient the burden of either (i) seeking reconsideration to contest the accuracy of the determination, or (ii) asking the [Commissioner] to forgive the debt and waive recovery. Califano v. Yamasaki, 442 U.S. 682 (1979).

- An overpayment occurs when a recipient receives more than the correct payment due.

- There are countless ways an overpayment occurs, but the most common overpayments occur in the following situations:
    - Estimated wage cases such as SSI deeming
    - Computation of a workers compensation, or
    - Other benefit offset or if retired, works under full retirement age or concurrent retroactive benefits.

What is the Overpayment Issue?

- **Determine what the claimant is contesting**. Assess if the claimant is:
    - Contesting the underlying overpayment,
    - Requesting waiver of overpayment,
    - or both.

- **Contesting the fact or amount of the overpayment?** Claimant may request a hearing before an administrative law judge (ALJ) for a reconsideration determination. The amount of overpayment must be determined first before waiver can be considered.

- **Requesting waiver of overpayment?** Waiver may be requested at any time, even if the overpayment has been partially or completely recovered.

Waiver of Overpayment -- Basics

An individual seeking waiver of overpayment recovery must be without fault and recovery must defeat the purpose of the Act or be against equity and good conscience.

Was the Claimant At Fault in Receiving the Overpayment?

- Waiver of recovery cannot be granted if the claimant was at fault in causing or accepting the overpayment.

- Consider all pertinent circumstances, including the age, intelligence, and any physical, mental, educational or linguistic limitation of the individual.

Fault is defined at 20 CFR 404.507 and 416.552. Did the overpaid individual:

- Make an incorrect statement which he knew or should have known was incorrect;
- Fail to provide information that he knew or should have known was material; or,
- Accept a payment that he knew or could have been expected to know was incorrect?

For Fault, you must determine whether the claimant caused the Overpayment. Did the claimant:

- Understand what caused the overpayment;
- Understand the reporting requirements;
- Attempt to comply with the reporting requirements;
- Previously receive an overpayment;
- Claim to have received misinformation from the Agency.

If NOT at Fault, you must consider whether recovery would (either):

1) "**Defeat the Purpose**" -- To deprive the individual of ordinary and necessary living expenses. In essence, requires an examination of finances.

   If the individual needs substantially all current income (i.e. government benefits, wages board and pension and investment income), including monthly social security benefits, to meet current ordinary and necessary living expenses, recovery defeats the purpose. Consider living expenses, such as food and clothing, rent, mortgage payments, insurance, taxes, medial, hospital expense. Consider all current household income, resources and expenses in making this determination.

2) **"Be Against Equity and Good Conscience"** – Issue does not involve financial considerations; it invokes principles of equitable estoppel.

This concept generally applies when an individual detrimentally relied upon the payments and spent the money believing that the payments were correct (i.e., A widow uses monthly widow's benefits to enroll her child in a private school. She learns a year later that the payments were incorrect and resulted in an overpayment). The regulations at 20 CFR 404.509 and 416.554 provide additional examples of recovery that are against equity and good conscience.

What Should Overpayment File Contain? The file should contain the following information:

- eNon-Disability Summary Sheet (eNDSS)
- Non-Disability Appeal Report (NDAR), and

- The following exhibits:
    - A completed SSA -632 “Request for Waiver of Overpayment Recovery or Change in Repayment rate” (in waiver cases)
    - A notice of determination following the personal conference (reconsideration determination)
    - Overpayment Tracking Sheet
    - The Request for Hearing

Overpayment Resources

- OCEP - Overpayments (July 2013)
- Development in Hearing Cases by the Field Office
- Overpayments Desk Guide – Supplemental ALJ Training Notebook, pp. 322-323
- Hearing Level Electronic Business Process (eBP) provides instructions for processing non-disability case (eBP section 1.4 (C)(5))
- Forwarding the Form HA-501-U5 (Request for Hearing by Administrative Law Judge) and Folder to the Servicing Hearing Office. POMS GN 03103.080

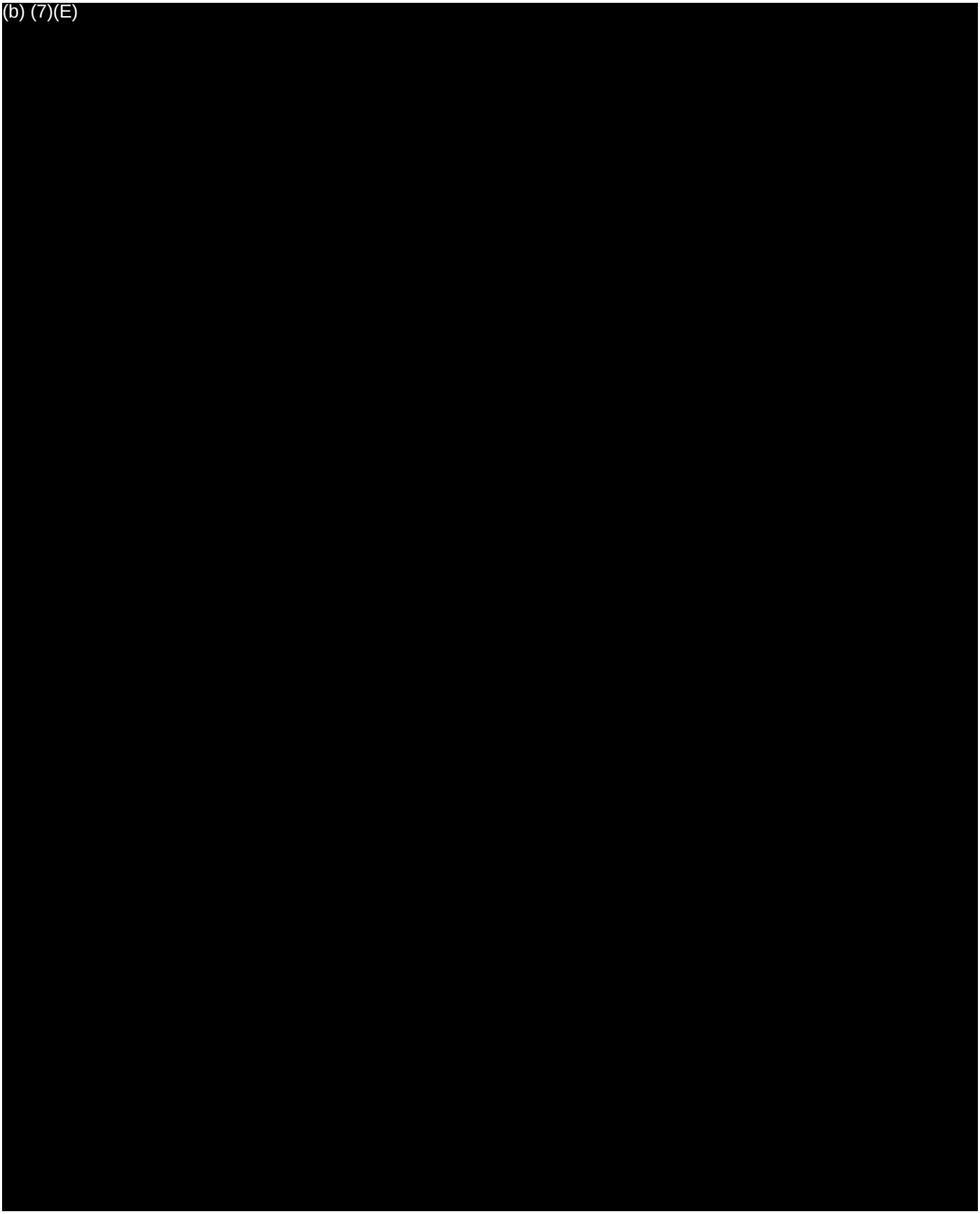
Overpayment/General Direct Examination Script

CLAIMANT NAME _____ SSN: _____

(b) (7)(E)

[redacted]

(b) (7)(E)



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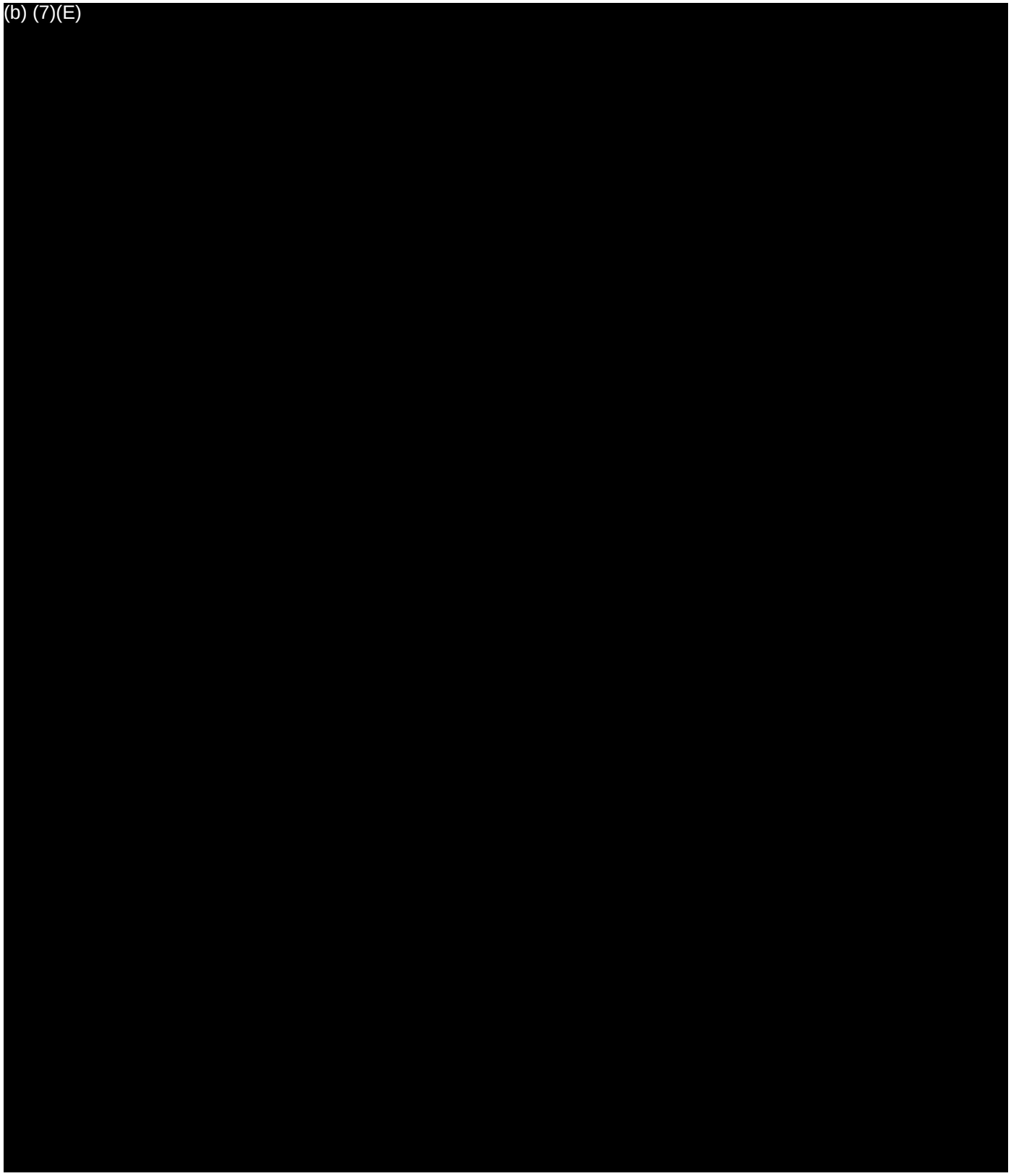

(b) (7)(E)

From: (b) (2) [redacted]
Sent: Wednesday, August 03, 2011 2:36 PM
To: Undisclosed recipients
Subject: ACTION- OQP Report on Administrative Law Judge Decisions

SOCIAL SECURITY

MEMORANDUM

Refer To: 11-1560

Date: August 3, 2011

To: All Regional Chief Administrative Law Judges

From: Debra Bice /s/

Chief Administrative Law Judge

Subject: Office of Quality Performance (OQP) Review Findings Concerning Administrative Law Judge (ALJ) Decisions—**ACTION**

In its most recent study of ALJ hearing decisions issued between October 2009 and March 2010, OQP agreed with 92% of the denial decisions and 85% of the allowance decisions reviewed. The majority of ALJ decisions are substantially correct, and we note an improvement in the agreement rate for denial decisions, from 89% in the prior studied period (April 2009 to September 2009), even with significantly increased productivity. However, there is also a downward trend for allowance decisions compared to the same period, when the agreement rate was 90%. Neither of these constitutes a statistically significant difference; however, we always strive to improve the quality of our decisions. Thus, please ensure that all regional staff, hearing office staff, and administrative law judges remember the following:

1. OQP found a large number of cases it disagreed with required additional evidence to make the correct disability decision. Special attention should be given to the areas noted below:

- Updated medical evidence is often necessary to support a severity finding or to assess residual functional capacity (RFC).

- Additional development of the record might be needed at times to evaluate credibility of the

claimant's allegations.

- New allegations made by the claimant must be addressed through record development. For instance, if the claimant reports new treatment that may change the decision, the adjudicator should attempt to obtain additional information.

- Conflicts in medical evidence should always be addressed and resolved.

2. Treating physician opinions are especially important in disability determinations to help establish the impact of the claimant's impairments on his or her ability to function. Note, however, that these opinions must be supported by the evidence of record (20 CFR 404.1527and 416.927, Social Security Ruling (SSR) 96-2p).

3. RFC findings must be fully supported by rationale and evidence, identify the individual's functional limitations, and demonstrate a function-by-function analysis (SSR 96-8p). The ALJ should resolve material inconsistencies in the case record.

4. Work activity or earnings after the alleged onset date must be fully developed and addressed in the decision. Up-to-date earnings queries should be considered before a decision is issued. Work activity development is also important in terms of establishing the correct dates for disability insured status.

5. Past relevant work should be adequately developed to allow the adjudicator to perform a function-by-function RFC analysis, as required by SSRs 96-8p and 96-9p.

6. Onset dates must be supported by the evidence. The adjudicator must consider not only the alleged onset date, but also the date last worked and the medical evidence to establish the first date the claimant became disabled (SSR 83-20).

7. A well-reasoned decision is of critical importance, and the decision must dispose of all issues raised in connection with the request for hearing. Activities of daily living, third party evidence, consultative exams, and potential drug addiction or alcoholism material evidence should be addressed (20 CFR 404.953 and 416.1453).

If you have any questions, please let me know. My staff contact is Attorney Advisor (b) (6) who can be reached at (b) (6) Hearing office staff may direct ppropriate regional office staff contact.

cc: Regional Office Management Teams

RELEASED BY:

(b) (6)

Office of the Chief Administrative Law Judge

(b) (6)

(b) (6)

From: (b) (2)
Subject: Making "Every Reasonable Effort" to Obtain All Evidence and Documenting Those Efforts -- REMINDER
Date: Friday, August 8, 2014 10:09:15 AM

SOCIAL SECURITY

MEMORANDUM

Refer To: 14-723

Date: August 8, 2014

To: All Hearing Office Personnel

From: Debra Bice */s/ John R. Allen* for

Chief Administrative Law Judge

Subject: Making "Every Reasonable Effort" to Obtain All Evidence and Documenting Those Efforts -- **REMINDER**

The Office of the Inspector General (OIG) recently studied whether staff at the Disability Determination Services and hearing levels fully developed all available medical evidence before making disability determinations. OIG found that staff did not always obtain all available evidence, or follow the regulations and policies on making "every reasonable effort" to obtain evidence and documenting those efforts. The full report is available here: http://oig.ssa.gov/sites/default/files/audit/full/pdf/A-01-13-23082.pdf.

Please remember to follow our regulations and policies on making every reasonable effort to obtain all evidence and documenting the attempts in the disability folder. More specifically:

- 20 C.F.R. §§ 404.1512(d) and 416.912(d) provide, before making a disability determination, we will develop the claimant's complete medical history for at least the 12 months preceding the month in which the claimant filed the application, unless there is a reason to believe that development of an earlier period is necessary or the claimant says that his or her disability began less than 12 months before filing the application.

- Moreover, we "will make every reasonable effort" to help the claimant get medical reports from his or her own medical sources when the claimant gives us permission to request the reports. 20 C.F.R. §§ 404.1512(d) and 416.912(d).

- "Every reasonable effort" means that "we will make an initial request for evidence from [the claimant's] medical source and, at any time between 10 and 20 calendar days after the initial request, if the evidence has not been received, we will make one followup request to obtain the medical evidence necessary to make a determination. The medical source will have a minimum of 10 calendar days from the date of our followup request to reply, unless our experience with that source indicates that a longer period is advisable in a particular case." 20 C.F.R. §§ 404.1512(d)(1) and 416.912(d)(1).

- Generally, we will not request a consultative examination (CE) until we have made every reasonable effort to obtain evidence from the claimant's own medical sources. 20 C.F.R. §§ 404.1512(e) and 416.912(e).

- However, in some instances, such as when a source is known to be "unable to provide certain tests or procedures" or "nonproductive or uncooperative," we may order a CE while awaiting receipt of medical source evidence. We will not evaluate this evidence until we have made every reasonable effort to obtain evidence from the claimant's medical sources. 20 C.F.R. §§ 404.1512(e) and 416.912(e).

- HALLEX I-2-5-14 sets forth specific procedures for obtaining medical evidence from a treating or other medical source. Among other things, this section discusses preparing Reports of Contact to document evidence requests and placing them in the claim(s) folder.

- Finally, "the established onset date must be fixed based on the facts and can never be inconsistent with the medical evidence of record." Social Security Ruling 83-20. For additional guidance on this topic, please see Adjudication Tip #13, "Proper Onset Date."

Hearing office staff should contact their regional office with questions. The staff contact for regional inquiries is (b) (6) who may be reached at (b) (6) (b) (6).

cc: Regional Office Management Teams

RELEASED BY:

(b) (6)

Office of the Chief Administrative Law Judge

(b) (6)

(b) (6)

From: (b) (2)
Subject: Expectations for Legally Sufficient Decisions - INFORMATION
Date: Monday, February 27, 2012 11:26:06 AM
Attachments: Decision Example for 11-1517 and 11-1700.docx

(b) (2)

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Cristaudo,

SOCIAL SECURITY

MEMORANDUM

Refer To: 11-1517, 11-1700

Date: February 27, 2012

To: All Administrative Law Judges, Attorney Adjudicators, and Decision Writers

From: Debra Bice */s/*

Chief Administrative Law Judge

Subject: Expectations for Legally Sufficient Decisions – **INFORMATION**

Our mission is to provide timely and legally sufficient hearings and decisions. It is important not only that we issue decisions in a timely manner, but also that we make sure these decisions are consistent with laws, regulations, rulings, and agency policy.

Claimants who think the decision in their case is incorrect may file a request for review with the Office of Appellate Operations (OAO). If the ALJ decision is supported by "substantial evidence," OAO will deny the request for review. When the OAO issues its own decision, it bases its decision on a preponderance of the evidence. OAO's most frequent remands are due to deficiencies in the decisions when addressing medical opinions, credibility, and the residual functional capacity (RFC).

The Office of Quality Performance (OQP) recently issued two reports: the Disability Case Review of Administrative Law Judge Hearing Decisions report and the Quality Review Assessment Report of Senior Attorney Advisor Disability Decisions. The agreement rate with

299 ALJ allowance decisions issued for the period October 2009 through March 2010 was 85 percent, a decrease from earlier agreement rates. The agreement rate with 301 ALJ denial decisions for the same period was 92 percent. OQP's agreement rate for 987 senior attorney decisions issued in Fiscal Year (FY) 2010 was 94 percent, which is a statistically significant drop from a 98 percent agreement rate in FY 2008. In FY 2011, OAO's Division of Quality reviewed a larger sample of fully favorable decisions by judges and attorney adjudicators pre-effectuation, and identified a higher percentage of adjudicative deficiencies. For more details on OAO's findings, see the recently released report: OAO Executive Director's Broadcast, Volume 3, Special Edition – Quality Review.

In light of these findings, it is important to review our expectations for all decisions, but particularly fully favorable decisions.

MEDICAL OPINIONS

While all evidence need not be recited and discussed in the decision, adjudicators do need to identify and discuss medical opinions, especially those that conflict with the established RFC. The adjudicator must provide rationale in the decision explaining the weight given to these opinions and why a specific opinion(s) is found more persuasive than others. Paragraph (d)(2) of 20 CFR 404.1527 and 416.927, and SSR 96-2p set forth the criteria used in evaluating medical opinions.

CREDIBILITY

In assessing an individual's credibility, it is insufficient for a decision to be limited to only a single, conclusory statement such as "the individual's allegations have been considered" or that "the allegations are (or are not) fully credible." Further, it is inappropriate to establish an RFC or determine an individual's credibility based solely on the individual's subjective statements. Rather, the decision must contain specific reasons for the finding on credibility, including a discussion of how "other evidence" was considered, as required in 20 CFR 404.1529(c)(3) and 416.929(c)(3). The finding must be supported by the evidence in the case record, and must be sufficiently specific so that a claimant or any subsequent reviewers can determine whether the claimant's statements were found to be credible or not credible, as well as the *reasons* for the finding.

A credibility analysis is required under the regulations whether the decision is fully favorable, partially favorable, or unfavorable. While an unfavorable decision may include a much longer discussion of these factors, every decision should include a discussion of: the longitudinal medical record; the consistency of the claimant's statements with medical signs and laboratory findings; the medical history and treatment; and prior statements to treating and other medical sources, SSA at previous steps of the administrative review process, or in connection with claims for other types of disability benefits (*see* SSR 96-7p).

RESIDUAL FUNCTIONAL CAPACITY

The RFC assessment should be well-articulated and fully supported, both by rationale and evidence. While the narrative discussion of the RFC assessment is critical in unfavorable decisions, it is just as important in fully favorable decisions that proceed past step 3. But even in fully favorable decisions, the RFC must be established based on the medical evidence of record, and the RFC assessment should include a function-by-function assessment of an individual's ability to perform work-related activities and it should describe the maximum

amount of each work-related activity the individual can perform based on the evidence of record. See 20 CFR 404.1545 and 404.1569a, 416.945 and 416.969a, as well as Social Security Rulings (SSRs) 96-8p and 96-9p. This is crucial to establish a comparison point RFC in a future Continuing Disability Review. Unsupported, generalized statements that the claimant is unable to work on a full-time basis or is limited to less than sedentary work are not legally sufficient RFCs.

Additional training on developing and articulating an RFC is available via the Office of Learning's website at (b) (2) [redacted]. Suggested Videos on Demand (VOD's) include:

- Sequential Evaluation – Residual Functional Capacity;
- RFC for Less Than a Full Range of Sedentary;
- Mental Residual Functional Capacity;
- Physical RFC;
- Remands and How to Avoid Them;
- Supplemental Decision Writer Training – Residual Functional Capacity;
- Supplemental Decision Writer Training – Tying the Analysis Back to the RFC.

The Interactive Video Training (IVT) introduced on January 18, 2012, is the first installment of the new ODAR Continuing Education Program, a series on substantive disability topics for hearing office personnel. This IVT was mandatory for Administrative Law Judges, attorney adjudicators, and decision writers, and is now available as a VOD.

OPINIONS FROM NON-MEDICAL SOURCES

The case record should reflect the consideration of opinions from medical sources who are not acceptable medical sources and from non-medical sources who have seen the claimant in their professional capacity. The adjudicator generally should explain the weight given to opinions from these other sources, or otherwise ensure that the discussion of the evidence in the decision allows a claimant or subsequent reviewer to follow the adjudicator's reasoning, when such opinions may have an effect on the outcome of the case. Please refer to SSR 06-03p for information about considering opinions from other sources.

EARNINGS

When a claimant's records indicate earnings after the alleged onset date (AOD), the earnings should be addressed, even if they do not amount to substantial gainful activity (SGA). It is not sufficient to state the claimant has not performed SGA in such a situation. Rather, the adjudicator should acknowledge the post-AOD earnings and include a brief discussion as to why these earnings do not constitute SGA. Also, when writing the decision, the decision-writer should be sure to select the appropriate options presented by the FIT template for the Step 1 analysis. Please refer to 20 CFR 404.1574 and 416.974, as well as SSR 83-33, SSR 83-34, and SSR 05-02 for more guidance on SGA issues.

DECISION

For all decisions, adjudicators are to follow the guidelines for writing decisions set forth in HALLEX I-2-8-25. The decision must be written so the claimant can understand it, and it must be carefully proofread. The decision must also follow the sequential evaluation process and clearly state the rationale for the decisionmaker's findings on the relevant issues and the ultimate conclusion. The FIT template guides the writer through all of these requirements. Attached is an excerpt from a well written fully favorable decision.

While we strive to accomplish the agency's number one strategic goal of eliminating the hearings backlog, we must not sacrifice the quality of our decisions. By stating a function-by-function RFC clearly, addressing conflicts in the evidence, identifying supporting evidence, and providing adequate rationale, we can meet our mission of providing both timely and legally sufficient decisions.

Hearing office staff should contact their regional office with questions. The staff contact for regional inquiries is (b) (6), who can be reached at (b) (6).

cc: Associate Chief Administrative Law Judges

Regional Chief Administrative Law Judges

Regional Office Management Teams

Hearing Office Management Teams

Attachment: Decision Excerpt

RELEASED BY:

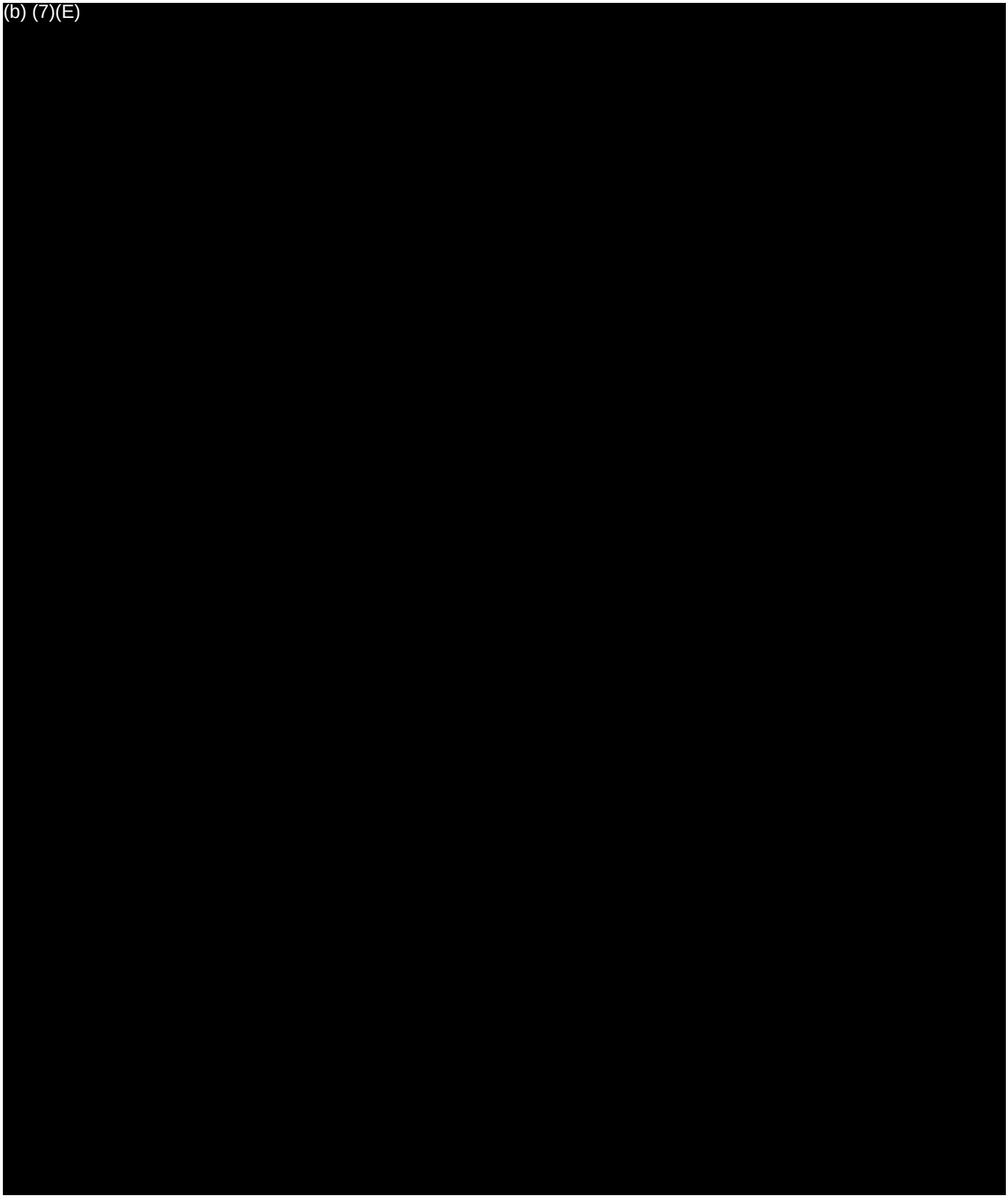
(b) (6)

Office of the Chief Administrative Law Judge

(b) (6)

(b) (6)

(b) (7)(E)



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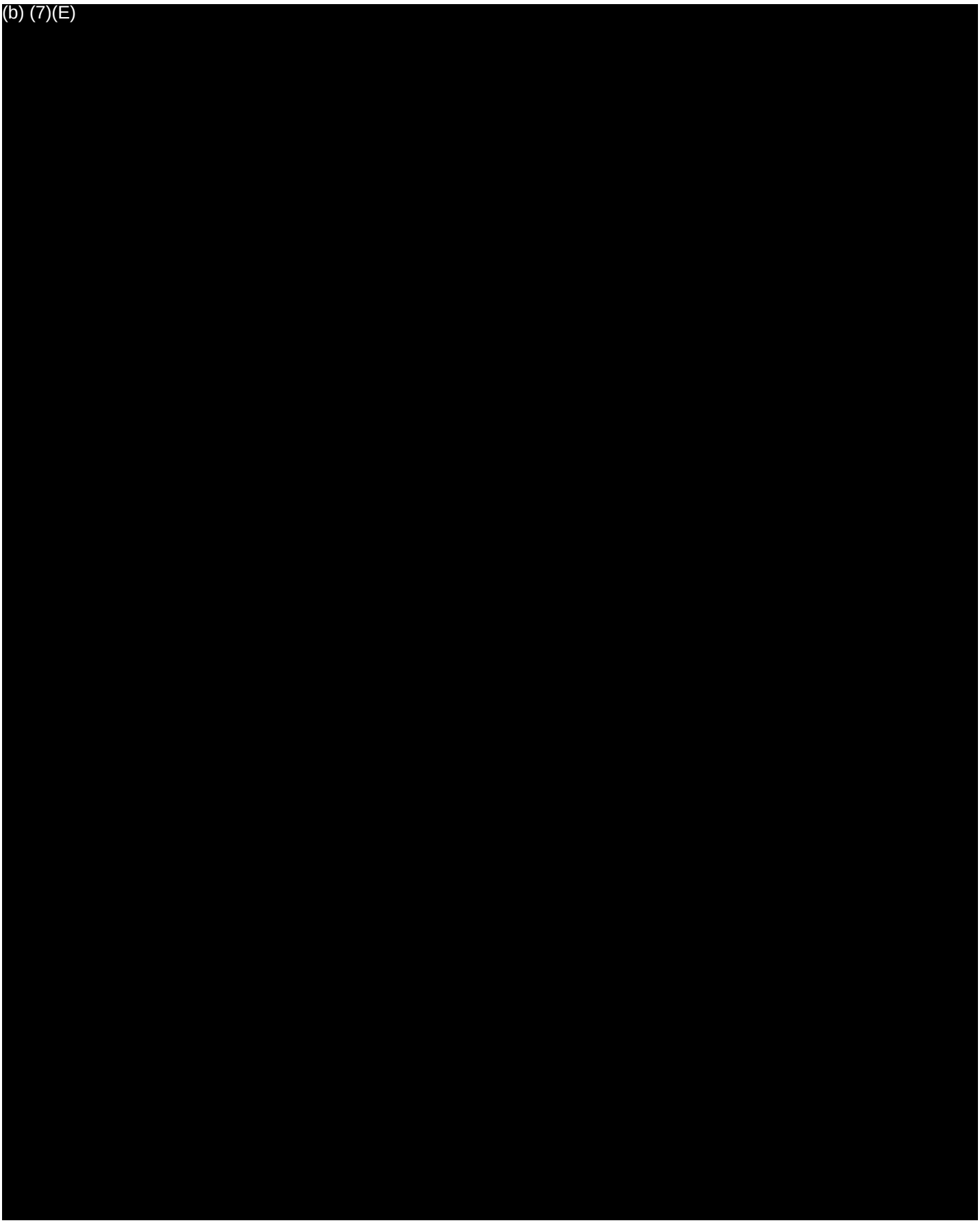

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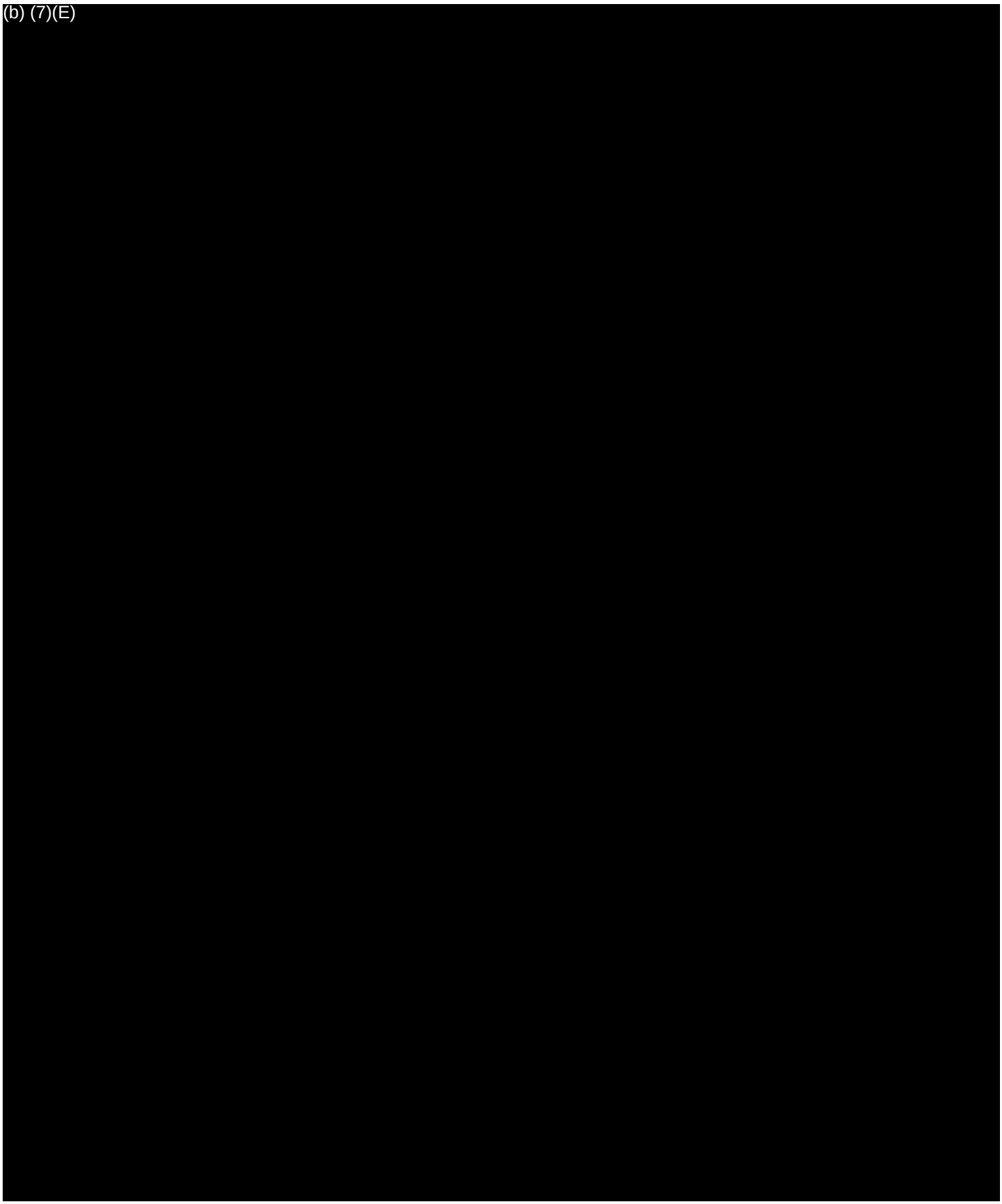

From: (b) (2)
Subject: Expectations for Instructions to Decision Writers -- INFORMATION
Date: Thursday, July 11, 2013 6:49:02 AM

SOCIAL SECURITY

MEMORANDUM

Refer To: ACL 13-203

Date: July 10, 2013

To: All Administrative Law Judges

From: Debra Bice */s/*

Chief Administrative Law Judge

Subject: Expectations for Instructions to Decision Writers -- **INFORMATION**

Last year, I shared some expectations for legally sufficient decisions. Legally sufficient decisions are decisions that are supported by substantial evidence and are reached through the application of the correct legal standard. As expressed in that memorandum, our goal is to provide timely decisions that are consistent with laws, regulations, rulings, and agency policy. To achieve that goal, it is important that the Administrative Law Judge (ALJ) and the decision writer work as a team to produce high quality decisions in a timely manner. The process for legally sufficient decisions begins with the issuance of clear and complete decision-writing instructions.

As expressed in HALLEX I-2-8-20, "the ALJ is responsible for providing clear directions on the rationale supporting the resolution of each issue necessary to reach the ultimate conclusion." Therefore, each ALJ should ensure that his or her instructions to the decision writer are complete, clear, and policy-compliant before releasing a case for decision writing.

In writing your instructions, you should attempt to communicate sufficient accurate information so that the decision writer fully understands the particulars of what you want in the decision and why you made that decision. Tell the decision writer the key evidence that led to your decision, and if applicable, why you did not find the claimant's statements regarding his or her limitations to be credible or supported by the evidence. Where there are

conflicts in the evidence, explain how you want the conflict resolved so that the decision writer does not have to guess. If your instructions are free of ambiguities, the decision writer will be better able to follow your instructions quickly.

The following are some things to keep in mind when preparing decision-writing instructions:

GENERAL

- Provide directions for each step of the sequential evaluation process, and clearly identify the step at which the claim is being allowed or denied. When appropriate, use the "B" and "C" criteria to rate the severity of mental impairments at steps two and three of the sequential evaluation process.

- Identify the major exhibits or testimony that provides support for your specific findings and the ultimate conclusion.

- If appropriate, indicate to the decision writer whether drug addiction and alcoholism is a contributing factor material to the determination that the claimant is disabled, and provide the rationale for the materiality finding. *See* 20 CFR 404.1535, 416.935 and SSR 13-2p.

- To ensure consistency in the form and format of the instructions and to ensure policy compliance, consider using available tools such as Electronic Bench Book and Findings Integrated Templates (FIT) or enhanced FIT instructions.

- Although we recommend that you do not use handwritten instructions, if you elect to do so, you must ensure that your handwriting is legible. Consider typing your instructions or using DRAGON software rather than handwriting the instructions.

- Avoid abbreviations that are not widely known.

- Make the instructions brief but clear. You can cover the necessary points in most cases in a few pages.

HEARING TESTIMONY

- Include the key points from relevant testimony in your instructions.

- Do not routinely instruct the decision writer to listen to the hearing recording unless there are circumstances that require the writer to listen to a particular segment. In such instances, clearly direct the writer to where the relevant testimony can be found on the recording, such as "claimant's testimony at 35:00 to 38:00."

RESIDUAL FUNCTIONAL CAPACITY (RFC)

- Specify the function by function limitations. Avoid general phrases, such as "less than sedentary" or "unable to sustain full time work," that do not phrase the RFC in functional terms.

- Use precise terms that mean the same to all. Avoid use of ambiguous terms like

"moderate" in the RFC.

- Ensure that the limitation(s) for each severe impairment is included in the RFC.

- Ensure that the RFC finding in the decision is identical to the vocational expert (VE) hypothetical used during the hearing.

Medical EVIDENCE AND Opinions

- Assign appropriate weight to all relevant opinions.

- Articulate the reasons for the weight given in clear, concise, and accurate language.

- Cite the supporting evidence.

Credibility

- Discuss the credibility of the individual's complaints of pain and other symptoms.

- Identify specific exhibits, page numbers, and testimony that support the credibility determination.

work history and other work

- When relevant, specify in the instructions your conclusion as to the claimant's past relevant work. Do not include just a recitation of the claimant's work history. See 20 CFR 404.1560 and 416.960.

- If making a step five decision, specify the other work identified by the VE. Do not instruct the decision writer to listen to the hearing recording for the work identified.

The issuance of clear and complete decision-writing instructions is a significant part of our effort to continue providing timely, legally sufficient, and accurate decisions. Although the process of preparing quality decisions may take longer, investing the time to produce a quality decision means there will be fewer remands, resulting in a reduction of the cases we must rework and the delivery of better public service.

Please contact your regional office with questions. The staff contact for regional inquiries is [redacted], who can be reached at [redacted].

cc: Associate Chief Administrative Law Judges

Regional Chief Administrative Law Judges

Regional Office Management Teams

Hearing Office Management Teams

RELEASED BY:

(b) (6)

Office of the Chief Administrative Law Judge

(b) (6)

(b) (6)

SOCIAL SECURITY

MEMORANDUM

Date: June 7, 2016 Refer To: ACL 16-125

To: All Administrative Law Judges
From: Debra Bice */s/*
Chief Administrative Law Judge
Subject: Expectations for Instructions to Decision Writers – **CLARIFICATION**

In light of our current service crisis, with over 1 million cases pending, it is important that we all work efficiently, while still ensuring that our dispositions are policy compliant. One area where Administrative Law Judges (ALJs) may be able to be more efficient is in providing concise decision writing instructions so that they can spend more of their time on hearing and deciding cases.

My memo of July 10, 2013 and the recent HALLEX I-2-8-20 revision include many elements that contribute to good decision writing instructions. In addition, ALJ Marilyn Zahm, President of the Association of Administrative Law Judges, and I recently discussed decision writing instructions in a new video on demand (VOD) (found here and on the OCALJ Website). However, in light of our unprecedented level of cases pending, I want to clarify the elements of decision writing instructions that are ESSENTIAL in all instructions so that you can draft your instructions in the most efficient manner.

ALL decision writing instructions MUST:

- Identify the step of the sequential evaluation process at which the claim is being allowed or denied.
- Identify the medically determinable impairment(s) and indicate the impairment(s) that are considered to be severe. (As appropriate, use the "B" and "C" criteria to rate the severity of mental impairments.)
- Include a function-by-function residual functional capacity (RFC) assessment. A well-crafted RFC is the cornerstone of an effective decision.

- Include rationale regarding symptoms and limitations associated with those symptoms. *See* 20 CFR 404.1529, 404.1569a, 416.929, 416.969a, and Social Security Ruling (SSR) 16-4p
- Articulate the reasons for the weight given to all relevant opinion evidence.
- Explain how any conflicts in the record were resolved.
- If appropriate, provide policy compliant rationale for a later onset date or closed period of disability and indicate whether drug addiction and alcoholism is a contributing factor material to the determination that the claimant is disabled. *See* 20 CFR 404.1535 and 416.935, and SSR 13-2p.

For those of you who would like further guidance, we posted examples of decision-writing instructions, compliant with my expectations, on "In Chambers." We are also planning to have a session on writing concise instructions at Judicial Training this summer.

I welcome your input on other ways to improve our processes so that we can provide better public service.

Please contact your HOCALJs if you have any questions. HOCALJs can relay inquiries to the Regional Offices, as necessary. My staff contact for regional inquiries is (b) (6), who can be reached at (b) (6).

cc: Associate Chief Administrative Law Judges
Regional Chief Administrative Law Judges
Regional Office Management Teams
Hearing Office Management Teams
NTEU
AFGE
IFPTE

From: (b) (2)
Subject: Decision Writing Policy Guidance Part I: Fully Favorable Decisions -- INFORMATION AND REMINDER
Date: Monday, June 18, 2018 2:06:11 PM
Attachments: Updated FF Training Presentation (6.18.18 with link).ppt
Differences Between Regular FF and Updated FF.DOCX
SAMPLE Updated Fully Favorable Decision.pdf
image001.png

SOCIAL SECURITY

MEMORANDUM

Refer To: ACL 17-764

Date: June 18, 2018
To: All Administrative Law Judges
All Decision Writers
From: Patrick Nagle ***/s/ Christopher Dillon for***
Chief Administrative Law Judge
Subject: Decision Writing Policy Guidance Part I: Fully Favorable Decisions -- **INFORMATION AND REMINDER**

There have been multiple Chief Administrative Law Judge messages about drafting legally sufficient decisions. For fully favorable decisions, this memorandum consolidates and supersedes all prior Chief Judge Memoranda on this issue, and sets forth guidance on writing succinct, policy compliant, legally sufficient fully favorable decisions.

To improve the efficiency of drafting a fully favorable decision, we have updated the adult fully favorable Findings Integrated Template. Information on the updated template is attached.

To maintain our accuracy and policy compliance, please consider the guidelines below for drafting succinct fully favorable decisions.

General Considerations

- Focus on articulating necessary policy compliant findings and include a strong rationale with citations to evidence that supports those findings.
- Focus on the most relevant evidence that best supports or challenges the findings. Only briefly analyze evidence that does not strongly support or detract from the findings. Wholesale, untargeted summary of the medical evidence requires time and effort, yet does not increase the overall supportability of the decision.
- Articulate a clear, legally sufficient, and succinct rationale as to why the longitudinal record supports the findings.

Step 1: Substantial Gainful Activity (SGA)

- If there is no evidence of SGA in the record, including post-onset earnings, simply state the record shows no SGA and move on to Step 2.
- If post-onset earnings in the record do not rise to the level of SGA, include a concise rationale supporting your findings on the claimant's earnings. Briefly cite to the material evidence or testimony to support that the claimant's earnings after the established onset date do not constitute SGA.

Step 2: Severe Impairments

- At Step 2, identify the severe medically determinable impairments (MDIs). Nonsevere impairments do not need to be included unless they affect the residual functional capacity (RFC).
- Do not provide a rationale for the identified MDIs at this step.

Step 3: Listings

- There is no need to discuss listings *not* met or equaled.
- If finding the claimant disabled at Step 3, only address and provide rationale for one listing.
- If finding the claimant disabled at Step 3, explain how the claimant's impairment(s) "meets" each of the required elements of the listing or, alternatively, refer to specific evidence that "medically equals" the requirement(s) of the listing as required by Social Security Ruling 17-2p. Address the relevant "B" or "C" criteria for mental impairments.
- If finding that the claimant's impairments "medically equal" the requirements of a listing, concisely discuss the supporting evidence and testimony, including the medical expert's (ME) name and opinion. While you cannot simply rely on an ME's conclusory statement, you can target your discussion on the most supportive medical evidence. Be mindful that most "medically equals" cases require discussion of all severe impairments, especially if the ME based his or her opinion on all of the severe impairments.

RFC:

- The RFC assessment should be well articulated and fully supported by both rationale and evidence. It must contain a comprehensive function-by-function assessment. However, focus the RFC rationale on impairments and limitations that are material to the finding of disability. For example, if the ALJ finds the claimant disabled under a grid rule, the writer should focus on justifying the relevant exertional limitation(s), *e.g.*, standing and/or walking limitations. Spend the bulk of your time and energy supporting those findings material to the outcome. An ALJ may rely on non-medical evidence, such as testimony, in the formulation of the RFC, and this evidence should be addressed as well.
- In a Step 5 decision with mental impairments, include the B criteria rationale within the RFC discussion. Additional explanation is not

necessary unless the mental limitation is significant to the finding of disability.

- Identify the medical opinions in the record, grouping similar medical opinions and/or opinions from the same source. For claims filed before March 27, 2017, assign appropriate weight to each opinion. For claims filed on or after March 27, 2017, provide a written analysis of the persuasiveness of the opinions and prior administrative medical findings. Articulate how you considered the factors of supportability and consistency for all medical opinions and prior administrative medical findings; only address the other factors if two or more medical opinions or prior administrative medical findings are equal in supportability and consistency. Click here for further information on the revised medical evidence rules. If a particular medical opinion drives the outcome, focus on that medical opinion in the discussion.
- Briefly assess the extent to which the claimant's allegations are consistent with, and supported by, the evidence of record. A detailed subjective allegation analysis is only required when one or more of the factors set forth in the regulations (20 C.F.R. §§ 404.1529, 416.929) and Social Security Ruling (SSR) 16-3p is particularly important to the RFC conclusions.

Step 4: Past Relevant Work (PRW)

- Specify the claimant's PRW and state that the demands of the claimant's PRW exceed the residual functional capacity. Typically, a brief statement is sufficient.
- Additional discussion may be necessary in rare cases when it is not apparent how or why the PRW exceeds the RFC.

Step 5: Other Work

- If the ALJ relies on a special medical-vocational profile, provide a brief explanation. See POMS DI 25010.001.
- If the ALJ bases the favorable decision on **direct application** of the grid rules, the Step 5 analysis ends without the need for further discussion. Ensure that the decision specifies the appropriate grid rule(s). If a borderline age situation is at issue, provide an explanation per HALLEX I-2-2-42 C.5.
- If the ALJ relies on the **framework** of a grid rule, ensure that the decision states whether a vocational expert (VE) testified at the hearing. If a VE testified, discuss briefly the VE's testimony that supports the finding that jobs do not exist in significant numbers and that the claimant cannot make an adjustment to other work given his or her vocational factors of age, education and work experience. If no VE testified, or if section 204.00 applies, verify that the decision cites any appropriate SSR(s) and how the SSR(s) preclude adjustment to other work. Specify the relevant grid rule(s).

Unique circumstances may arise, requiring the writer to include information not

discussed above. Further, for all decisions, adjudicators and writers should be mindful of procedural issues such as the date last insured and requests for reopening, both expressed and implied. *See* HALLEX I-2-9-10. Decisions should apply any relevant circuit-specific Acquiescence Rulings. Finally, when applicable, decisions must address drug addiction and alcoholism. *See* SSR 13-2p.

Guidance on partially favorable and unfavorable decision writing is forthcoming.

Hearings Operations staff should forward questions through their management chain. The staff contact for regional inquiries is Attorney-Advisor (b) (6). You may reach her at (b) (6).

cc: Regional Office Management Teams

Hearing Office Management Team

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SOCIAL SECURITY

MEMORANDUM

Date: March 23, 2017

Refer To: 17-383

To: All Hearing Office Personnel

From: Patrick Nagle ***/s/ John R. Allen for***
Chief Administrative Law Judge

Subject: Revised Rules for Evaluating Medical Evidence — **INFORMATION**

On January 18, 2017, the Social Security Administration (SSA) published revisions to the rules regarding the evaluation of medical evidence (82 FR 5844). The preamble to the Federal Register notice and the September 9, 2016 Notice of Proposed Rulemaking (81 FR 62559) provide more background on why the agency made these revisions.

The revisions reorganize our evidence regulations and include major changes to how we evaluate medical evidence, including:

- Redefining and reorganizing several key terms related to evidence;
- Revising the rules about acceptable medical sources (AMS), including adding Physician Assisants, Advanced Practice Registered Nurses, and audiologists (for impairments of hearing loss, auditory processing disorders, and balance disorders);
- Revising how SSA considers and articulates consideration of medical opinions and prior administrative medical findings;
- Revising the rules about medical consultants (MC) and psychological consultants (PC); and
- Revising the rules about treating sources, including eliminating the "treating source rule."

This memorandum includes important information about case processing, training, subregulatory guidance, and systems updates.

CASE PROCESSING

While the revised regulations become effective on March 27, 2017, many of the most important changes will apply only in claims filed on or after March 27, 2017 and will not impact how we process cases filed before that date, including all cases currently pending at the hearing and

Appeals Council levels. However, the agency made a few changes to the rules that apply to cases filed prior to March 27, 2017.

The revised regulations indicate which rules apply to which cases:

- Rules applicable in cases filed before March 27, 2017, but not applicable in cases filed on or after that date, include the following or similar regulatory language: "For claims filed before March 27, 2017, the rules in this section apply." For simplicity, these rules will be referred to in our subregulatory guidance, such as HALLEX, and training materials as the "prior rules."

- Rules applicable in cases filed on or after March 27, 2017, but not applicable in cases filed before that date, include the following or similar regulatory language: "For claims filed on or after March 27, 2017, the rules in this section apply." For simplicity, these rules are referred to as the "current rules."

- Rules with revisions that do not include the regulatory language indicated in either of the bullets above apply in all cases, as appropriate.

Accordingly, it is important to determine the filing date of a claim(s) to decide which set of rules, the prior or the current, will govern the evaluation of medical and nonmedical evidence in a case.

As noted above, while the prior rules are similar to the regulations as they existed before March 27, 2017, there are some important changes to those rules. Most importantly, SSA is rescinding the following four Social Security Rulings (SSRs) and incorporating their policies into the rules applicable in claim(s) filed before March 27, 2017:

- SSR 96-2p: Titles II and XVI: Giving Controlling Weight to Treating Source Medical Opinions.
- SSR 96-5p: Titles II and XVI: Medical Source Opinions on Issues Reserved to the Commissioner.
- SSR 96-6p: Titles II and XVI: Consideration of Administrative Findings of Fact by State Agency Medical and Psychological Consultants and Other Program Physicians and Psychologists at the Administrative Law Judge and Appeals Council Levels of Administrative Review; Medical Equivalence.
- SSR 06-3p: Titles II and XVI: Considering Opinions and Other Evidence from Sources Who Are Not "Acceptable Medical Sources" in Disability Claims; Considering Decisions on Disability by Other Governmental and Nongovernmental Agencies.

SSA is also issuing a new ruling, SSR 17-2p, on medical equivalence, replacing the guidance previously included in SSR 96-6p.

For claim(s) filed before March 27, 2017, you should cite to the following policies instead of the four rescinded SSRs:

- 404.1527(d) and 416.927(d) will now provide guidance on considering medical source opinions on issues reserved to the Commissioner, previously provided in SSR 96-5p.
- 404.1527(e) and 416.927(e) will now provide guidance on considering administrative findings of fact by state agency medical and psychological consultants and other program physicians and psychologists, which was previously provided in SSR 96-6p.
- SSR 17-2p will now provide guidance on issues relating to medical equivalence, which was previously provided in SSR 96-6p.
- 404.1527(f) and 416.927(f) will now provide guidance on considering opinions and other evidence from sources who are not AMSs, and on considering decisions on disability by other governmental and nongovernmental agencies, previously provided in SSR 06-03p.

Other citations in the regulations have changed as well. When you include citations in action documents to regulations in 20 CFR Part 404, Subpart J (404.15XX) or in 20 CFR Part 416, Subpart I (416.9XX), please ensure that you reference the correct authority. To ensure you are consulting the updated regulations, please refer to the Electronic Code of Federal Regulations (eCFR) for 20 CFR Part 404 and 20 CFR Part 416.

TRAINING

In late April, we will provide access to four videos on demand (VOD): three from the Office of Disability Policy (ODP) covering the most significant revisions and a fourth that focuses specifically on case processing in ODAR. The ODAR VOD will also be accompanied by helpful documents, including keys and a facilitator guide to aid in-office discussions. We will also provide access to ODP's desk guide.

We will issue a second memorandum in late April when these materials become available, and the OCALJ intranet site will provide links to the training material.

SUBREGULATORY GUIDANCE

In April, we will publish a temporary instruction (TI) in HALLEX to explain how to determine the filing date for the purposes of these rules. In the meantime, you may consult Program Operations Manual System (POMS) DI 24503.050, which will publish on March 27, 2017. We will also publish revisions to other HALLEX sections to update guidance on evaluating medical and nonmedical evidence.

SYSTEMS UPDATES

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QUESTIONS

All information in this memorandum, and all future guidance related to these revisions, including links to the Federal Register notices, training VODs, written materials, TI and POMS, and an explanation of system changes when they become available, will be posted at the "Chief Judge Resources" webpage in the OCALJ intranet site.

Hearing office staff should contact their Regional Office with questions. The staff contact for Regional inquiries is Attorney Advisor (b) (6) [redacted], who may be reached at (b) (6) [redacted].

cc: Regional Chief Administrative Law Judges
Regional Office Management Teams

SOCIAL SECURITY

MEMORANDUM

Date: May 24, 2017

Refer To: ACL 17-560

To: All Administrative Law Judges
All Decision Writers

From: Patrick Nagle ***/s/ John Allen for***
Chief Administrative Law Judge

Subject: Drafting Succinct Fully Favorable Decisions — **REVISED INFORMATION AND REMINDER**

This memorandum clarifies and supersedes the memorandum of the same title issued on March 27, 2017. Specifically, it updates the guidance provided in the memorandum's fourth bullet under "Step 3: Listings."

Ensuring that a fully favorable decision is accurate and policy-compliant is crucial both for program integrity, and because it may be the comparison point decision for a future continuing disability review. In February 2012, Judge Bice provided guidance regarding expectations for legally sufficient decisions. With those considerations in mind, however, I am sending the following suggestions for drafting fully favorable decisions that are both legally sufficient and succinct.

General Considerations

- Focus on articulating necessary policy compliant findings and include a strong rationale with citations to evidence that supports those findings.
- Wholesale, untargeted summary of the medical evidence requires time and effort, yet does not increase the overall supportability of the decision. Instead, focus on the most relevant medical evidence that best supports or challenges the findings.
- Only briefly summarize evidence that does not strongly support or detract from the findings.
- Articulate a clear, legally sufficient, and succinct rationale as to why the longitudinal record supports the findings.

Step 1: Substantial Gainful Activity (SGA)

- If there is no evidence of SGA in the record, simply state the record shows no SGA and move on to Step 2.
- If post-onset earnings in the record do not rise to the level of SGA, a simple statement to this effect is sufficient.

Step 2: Severe Impairments

- At Step 2, identify the severe medically determinable impairments and include a general statement indicating why these impairments are severe.
- Briefly list non-severe impairments and include a general statement that these impairments either do not satisfy the durational requirement or do not more than minimally impact the claimant's vocational functioning.

Step 3: Listings

- If finding the claimant disabled at Step 3, explain how the record "meets" each of the required elements of the listing or, alternatively, refer to specific evidence that "medically equals" the requirement(s) of the listing.
- If finding that the claimant "medically equals" the requirements of a listing, be sure to concisely discuss the supporting evidence and testimony. While you cannot simply rely on the medical expert's (ME) conclusory statement, you can target your discussion on the most supportive medical evidence.
- In considering non-mental impairments in a Step 5 decision, simply identify the listings considered at Step 3, and then state that the claimant fails to meet or equal the listing(s) at issue.
- If finding a mental impairment meets or equals a listing, the decision must address the relevant "B" (or "C") criteria. However, any ALJ disability decision analyzing mental disorders must demonstrate use of the "special technique," which includes the "B" criteria analysis. 20 C.F.R. §§ 404.1520a and 416.920a. See this desk guide for examples of the four areas of mental functioning and types of evidence that support each area of functioning.

Residual Functional Capacity (RFC):

- The RFC assessment should be well articulated and fully supported by both rationale and evidence. However, focus on impairments and limitations that are material to the finding of disability. For example, it is unnecessary to articulate extensively on a limitation (such as a frequent limitation in a postural activity) that does not significantly impact the claimant's ability to perform past work or significantly erode the remaining occupational base. Spend the bulk of your time and energy supporting those findings material to the outcome.

- Identify the medical opinions in the record, grouping similar medical opinions and/or opinions from the same source. Assign appropriate weight in accordance with our regulations and SSRs, but focus on the medical opinion upon which you are relying.
- Briefly assess the extent to which the claimant's allegations are consistent with, and supported by, the evidence of record. A detailed subjective allegation analysis is only required when an SSR 16-3p factor(s) is particularly important to the RFC conclusions.

Step 4: Past Relevant Work (PRW)

- The most important parts of the Step 4 discussion in a fully favorable decision are explaining whether the claimant has PRW and, if so, why the claimant cannot perform that PRW given the RFC.
- To establish whether the claimant can perform PRW, compare the claimant's function-by-function RFC with the demands of the PRW, both as actually performed by the claimant, and as the work is generally performed in the national economy. Typically, a brief statement is sufficient.

Step 5: Other Work

- If the ALJ bases the favorable decision on **direct application** of the grid rules, the Step 5 analysis ends without the need for further discussion.
- If the ALJ relies on the **framework** of a grid rule, explain whether a vocational expert (VE) testified at the hearing and discuss briefly the VE's testimony that no jobs remain. If no VE testified, or if section 204.00 applies, cite any appropriate SSRs and discuss how they preclude other work.

Hearing office staff should contact the Regional Office with questions. The staff contact for Regional inquiries is Attorney-Advisor (b) (6), who may be reached at (b) (6).

cc: Regional Chief Administrative Law Judges
Regional Office Management Teams
Hearing Office Management Team

From: (b) (2)
To: (b) (2)
Subject: REMINDER - Assessing Medical Evidence
Date: Thursday, October 24, 2013 11:54:00 AM

*****This memorandum will be released to all ALJ's, senior attorneys, decision writers and HOMT's the following day.*****

SOCIAL SECURITY

MEMORANDUM

Refer To:

Date: October 24, 2013

To: All Administrative Law Judges

All Senior Attorney Advisors

All Regional Office Management Teams

All Hearing Office Management Teams

From: Debra Bice **/s/**

Chief Administrative Law Judge

Subject: REMINDER - Assessing Medical Evidence

As Deputy Commissioner Sklar noted in his recent message, the Senate Committee on Homeland Security and Governmental Affairs recently held a hearing and issued a report focusing on a former situation in our Huntington hearing office. The report and the testimony provided during the hearing raised questions regarding claims presented by a particular representative, as well as medical and other documents completed by certain sources. The agency continues to explore all available avenues to address matters identified by the Senate Committee, and moving forward, the agency will issue appropriate guidance, as necessary. In the interim, I want to take a moment and reiterate a few sentiments you have heard me say often.

I am very proud to be the Chief Administrative Law Judge at this agency. The task of hearing and deciding claims is very important. For our process to operate fairly, efficiently and effectively, we must treat members of the public and staff with dignity and respect, adhere to ethical standards and agency policies, and be able to handle the pressures associated with timely moving a high-volume workload while maintaining quality and legally sufficiency. Not only am I outraged by those who attempt to defraud this program, but also I am offended by the assertions that individuals at this agency are abdicating their adjudicatory role by just "paying down the backlog."

As I have often stated, you are the decision maker. It is your responsibility to make benefit determinations in accordance with agency policy. Once the record has been sufficiently developed, you must review all of the evidence in the file and make the appropriate findings in accordance with 5 U.S.C. § 223(d)(5) and 1614(a)(3)(H). Further, you must articulate the reasons for your findings in your decision. You may not simply "rubberstamp" a third party's assessment.

> When assessing the evidence provided by the claimant, you must identify the source and nature of the information. 20 C.F.R. §§ 404.1527(a)(1) and 416.927(a)(1). Evidence from acceptable medical sources, as defined by 20 C.F.R. §§ 404.1513 and 416.913, may establish the existence of a medically determinable impairment (20 C.F.R. §§ 404.1513(a) and 416.913(a)), and may form the basis of a medical opinion (20 C.F.R. §§ 404.1527(a)(2) and 416.927(a)(2)). As you are well-aware, the medical opinion of a treating source may be entitled to controlling weight on the issue(s) of the nature and severity of the claimant's impairment(s), but only if it is well-supported by medically acceptable clinical and laboratory diagnostic techniques and is not inconsistent with the other substantial evidence in the claimant's record. See 20 C.F.R. §§ 404.1527(c)(2) and 416.927(c)(2). In addition to the regulations, you should refer to SSR 96-2p for guidance on assessing treating source medical opinions, including deciding that a treating medical source statement is not entitled to controlling weight.
>
> Evidence from sources other than "acceptable medical sources" also must be handled in accordance with agency policy. Information from these "other sources" cannot establish the existence of a medically determinable impairment. There must be evidence from an "acceptable medical source" for this purpose. However, information from such "other sources" may be based on special knowledge of the individual and may provide insight into the severity of the impairment(s) and how it affects the individual's ability to function. In addition to the regulations, you should refer to SSRs 96-5p, 96-6p and 06-3p for guidance on assessing opinions and evidence from sources other than "acceptable medical sources."
>
> Properly assessing evidence from the various sources is particularly important when determining residual functional capacity (RFC). As noted in the April 2012 ODAR Continuing Education Program (OCEP) on Evaluating Medical Source Statements, making a proper RFC assessment does not include a blind acceptance of a third party's assessment. It also does not include weighing the various medical source statements in the file and determining which one most "closely" matches the claimant's abilities. You determine the RFC by considering all the evidence of record, and if you question the evidence, you must take the appropriate steps to resolve any issues.

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

We covered all of these concepts in the OCEP training identified above. The script, video, and other materials are accessible through that hyperlink. We also will explore these concepts more deeply with specific cases studies in upcoming training sessions. The dates of these sessions will be announced in the course of normal business.

As always, if you have any specific questions or concerns, you should bring them to the attention of your management. It remains the agency and my expectation that you will provide the American public with quality service through timely and legally sufficient decisions.

Thank you for your dedicated service.

cc: Decision Writers

RELEASED BY:

(b) (6)

Office of the Chief Administrative Law Judge

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The Hearings & Decisions Reference Library*

Revised August 2017

**Please note that while certain training materials may still contain references to "credibility," Social Security Ruling 16-3p eliminated the use of the term "credibility" in subregulatory policy. Adjudicators should consider all of the evidence in an individual's record when they evaluate subjective symptoms.*

TABLE OF CONTENTS

(Hold "Ctrl" and click on section title to follow link)

A-Z TRAINING INDEX

- The A-Z training index

ALJ COMPLIANCE WITH AGENCY LAW & POLICY

- 2013 CALJ memo "Compliance with Agency Policy – INFORMATION"
- 2012 ALJ Training Video "Overview of Sequential Evaluation Process module 2"
- 2013 CALJ memo "Expectations for Instructions to Decision Writers – INFORMATION"
- 2016 CALJ memo "Expectations for Instructions to Decision Writers – CLARIFICATION"

Fully Favorable Decisions Requiring Participation in Vocational Rehabilitation

- 20 CFR 404.315, 404.320, 404.953, 416.202, and 416.1453 (For a finding of disability, there is no requirement of participation in vocational rehabilitation); 20 C.F.R. §§ 404.929 *et seq*., 416.1429 *et seq*., 404.944 and 416.1444 (An ALJ's "principal responsibilities are to hold a full and fair hearing and issue a legally sufficient and defensible decision.")
- HALLEX
    - I-2-6-1 (requires an ALJ to "inquire fully into all matters at issue and conduct the administrative hearing in a fair and impartial manner");
    - I-2-0-5 B (An ALJ's "principal responsibilities are to hold a full and fair hearing and issue a legally sufficient and defensible decision.");
    - I-2-8-1 (ALJ findings); and
    - I-2-8-25, *Writing the Decision*
- May 2017 Memo "Drafting Succinct Fully Favorable Decisions – REVISED INFORMATION AND REMINDER"
- 2012 CALJ Memo "Expectations for Legally Sufficient Decisions – INFORMATION" discussed what information must be in ALJ decisions
- March 2010 "Message from the Chief Judge on Quality Decisions"
- 2016 Judicial Training PowerPoint "Legally Sufficient Decisions: Office of the General Counsel's Perspective"
- OCEP entitled "Hearings and Decision Drafting: Tips on Effective Questioning and Persuasive Writing" (October 17, 2012)

Pre-Hearing Orders to Counsel or Representative

- 20 CFR 404.1512 and 416.912 (We assist the claimant in developing the record.); 404.935 and 416.1435 (Evidence should be submitted no later than 5 business days before the scheduled hearing but, under certain circumstances, the ALJ will accept the evidence after the deadline if he or she has not yet issued a decision.); 20 CFR 404.1740(b)(1) and 416.1540(b)(1) (The representative helps the claimant to obtain the evidence.)

- HALLEX
  - I-2-5-1 (Explains when evidence should be submitted and appropriate action when evidence is not submitted timely);
  - I-2-5-2 (*Prehearing Case Review by the Administrative Law Judge*);
  - I-2-6-1 ("The ALJ must inquire fully into all matters at issue and conduct the administrative hearing in a fair and impartial manner."); and
  - I-2-6-40 (ALJ may allow off-the-record discussions but must summarize on record the content and conclusion of that discussion.)
- New ALJ/DW training modules 18 (Evidence needed for hearing)
- Ensuring Program Uniformity at the Hearing and Appeals Council Levels of the Administrative Review Process
- OCEP entitled Submission of Evidence (April 22, 2015)
  - Submission of Evidence Script
  - Four Keys – Submission of Evidence
  - QuickNotes – Submission of Evidence
- Adjudication Tip #50 ("Submission of Evidence")

ALJ PROFESSIONALISM

- 2013 Judicial Training Video "Three Hats…What Does It Mean?"
- Professionalism and Administrative Law Judges as Leaders: Commitment to Quality

BENCH DECISIONS

- 20 C.F.R. §§ 404.953 and 416.1453
- HALLEX I-2-8-19, *Oral Decisions on the Record (Bench Decisions)*

CITATIONS TO COURT RULINGS AND NON-SSA SOURCES

- 20 C.F.R §§ 404.985 and 416.1485, *Application of circuit court law*
- Social Security Ruling (SSR) 96-1p ("Unless and until an AR for a circuit court holding has been issued, SSA adjudicates other claims within that circuit by applying its nationwide policy")
- 2013 CALJ memo "Compliance with Agency Policy – INFORMATION"

COMPLIANCE WITH APPEALS COUNCIL REMAND ORDERS

- 20 C.F.R. §§ 404.977(b) and 416.1477(b) ("The administrative law judge shall take any action that is ordered by the Appeals Council and may take any additional action that is not inconsistent with the Appeals Council's remand order")

- HALLEX I-2-8-1 ("The primary purpose of an ALJ decision is to dispose of relevant issues, including ….in remanded cases, any issues the Appeals Council or a court has directed the ALJ to address.")

CONSULTATIVE EXAMINATIONS

- 20 C.F.R. §§, 404.1512(b)(2), 404.1517 *et seq*., 416.912(b)(2), and 416.917 *et seq.*
- HALLEX I-2-5-20, *Consultative Examinations and Tests*
- HALLEX I-2-5-24, *Claimant Fails or Refuses to Submit Evidence or Undergo a Consultative Examination or Test* (stating that, among other things, "There is no authority for an ALJ to dismiss a request for hearing based on the claimant's failure to attend or refusal to undergo a CE or test."
- New ALJ/DW training module 27 ("Consultative Examination Updated")
- Adjudication Tips #19 ("Post-hearing Consultative Examinations – PART ONE") and #26 ("Post-hearing Consultative Examinations – PART TWO")

CONTINUING DISABILITY REVIEWS

- Chief Judge Bulletin 16-01 REV, "Modifications to DA&A Material, CDR Decisions and other decisions Due to SSR 16-3p and the rescission of SSR 96-7p"
- POMS DI 28005.015, "CDR Evaluation Process – Step-By-Step Discussion"
- SSR 13-3p "Title II: Appeal of an Initial Medical Disability Cessation Determination Decision"
- HALLEX I-3-8-15 "Continuing Disability Reviews and Social Security Ruling 13-3P
- Chief Judge Bulletin 13-01 (Effective 03/22/2013) "Modifications to Unfavorable Title II Medical Cessation Decisions"
- New ALJ/DW training modules 15 ("CDRs") and 17 ("Child SSI")
- Adult CDR Flowchart
- Continuing Disability Review PowerPoint
- Appeals Council Feedback Training "Onset/Closed Period/Continuing Disability Review (CDR)"
- OCEP entitled "Continuing Disability Reviews" (Oct. 22, 2014), and the materials:
    - Script
    - CDR Power Point Slides
    - "Three Keys to CDR"
    - "Quick Notes – CDR"
    - CDR Process Flow Chart

Lack of Development for Unrepresented Claimants

- An ALJ has a duty to ensure that the administrative record is fully and fairly developed to include the claimant's complete medical history and will make every reasonable effort to help the claimant obtain medical reports from his or her own medical sources

when the claimant grants permission. 20 C.F.R. §§ 404.1512(d)-(e) and 416.912(d)-(e); HALLEX I-2-6-56, *Adducing the Evidence*.

- When the record does not contain adequate evidence about the claimant's impairments to allow the ALJ to determine whether the claimant is disabled, and the ALJ or the hearing office staff is unable to obtain adequate evidence from the claimant's treating source(s) or other medical source(s), the ALJ may request a consultative examination (CE) and/or test(s) through the State agency. HALLEX I-2-5-20, *Consultative Examinations and Tests*.
- The hearing office staff is required to document any attempts to develop the record and associate the documentation with the claim(s) file, as such documentation is essential to show, among other things, that the ALJ made every reasonable effort to obtain the evidence. HALLEX I-2-5-13, *Claimant Informs Hearing Office of Additional Evidence*.
- To demonstrate that the ALJ fulfilled his or her duty to develop the record, the hearing office staff must mark as proposed exhibits all documentation showing attempts to obtain the evidence. HALLEX I-2-6-56, *Adducing the Evidence*.
- OCEP titled "Submission of Evidence" (April 22, 2015), and the accompanying materials:
    - Script
    - PowerPoint Slides
    - Four Keys
    - Quick Notes
    - FAQs Part I and Part II
- 2014 Chief Administrative Law Judge (CALJ) Memorandum, "Making 'Every Reasonable Effort' to Obtain All Evidence and Documenting Those Efforts – REMINDER"
- Adjudication Tip #50, "Submission of Evidence" (under "Evidence Issues")
- ALJ/DW Training Course, module 18, "Evidence Needed for Hearing"

DATE LAST INSURED

- 20 C.F.R. §§ 404.101 *et seq*., 404.315, and 404.321
- SSRs 74-8c and 83-20

DISMISSALS

- 20 C.F.R. §§ 404.957 through 404.960, and 416.1457 through 416.1460
- Chapter I-2-4, *Dismissals*, including section I-2-4-25, *Dismissal Due to Claimant's Failure to Appear*
- HALLEX I-2-5-24, *Claimant Fails or Refuses to Submit Evidence or Undergo a Consultative Examination or Test* (stating that, among other things, "It is never proper to dismiss a claimant's RH for failure to provide requested evidence or to undergo a requested CE")
- New ALJ/DW training module 13 ("Procedural Issues")
- OCEP on "Dismissals" (Jan. 16, 2013) and the materials
    - Email Announcements
    - Queries for Claimant Address

- AC Dismissal Guides
  - Dismissal - Failure to Appear
  - Dismissal - Untimely Request for Hearing
  - Dismissal - Withdrawal
- January 2013 Dismissal Script
- ODAR Dismissals Power Point
- Keys to Dismissal
- Notice to Show Cause
  - Notice to Show Cause (Memo)
  - HA-L90
  - HA-L90 Spanish

- 2014 CALJ memo "Procedures for Dismissal of a Request for Hearing – REMINDER"
- HALLEX I-2-1-80, *Withdrawal of a Request for Hearing*; I-2-8-18, *Administrative Law Judge Decisions in Court Remand Cases*; and I-3-3-15, *Review of ALJ Dismissals*

DRUG ADDICTION AND ALCOHOLISM (DAA)

- 20 C.F.R. §§ 404.1535 and 416.935
- SSR 13-2p, *Titles II and XVI: Evaluating Cases Involving Drug Addiction and Alcoholism (DAA)*
- "DAA Social Security Ruling 13-2p" VOD
- HALLEX I-2-8-25 B.4. ("When a case involves drug addiction and alcoholism (DAA) and the claimant is found disabled, a complete supporting rationale regarding whether DAA is a contributing factor material to a finding of disability (see 20 CFR 404.1535 and 416.935")
- New ALJ/DW training module 14 ("DA and A")
- OCEP entitled "Drug Addiction and Alcoholism (DAA)" (April 22, 2015), and the materials:
  - Script
  - DAA Power Point Slides
  - "Four Keys to DAA"
  - "Quick Notes – DAA"
  - DAA Evaluation Process Flow Chart
  - DAA Q&A

Smoking: SSR 13-2p (nicotine not considered when evaluating DAA)

DUTY TO DEVELOP THE RECORD

- Social Security Act, §§ 223(d)(5)(B) and 1614(a)(3)(H)(i): "In making any determination with respect to whether an individual is under a disability or continues to be under a disability, the Commissioner of Social Security shall consider all evidence available in such individual's case record, and shall develop a complete medical history of at least the

preceding twelve months for any case in which a determination is made that the individual is not under a disability."

- 20 C.F.R. §§ 404.1512(b)(1) and 416.912(b)(1): "Before we make a determination that you are not disabled, we will develop your complete medical history for at least the 12 months preceding the month in which you file your application unless there is a reason to believe that development of an earlier period is necessary or unless you say that your disability began less than 12 months before you filed your application. We will make every reasonable effort to help you get medical reports from your own medical sources when you give us permission to request the reports."
- HALLEX I-2-6-56: "An ALJ has a duty to ensure that the administrative record is fully and fairly developed."
- New ALJ/DW training module 18, "Evidence Needed for Hearing"
- OCEP entitled "Hearings and Decision Drafting: Tips on Effective Questioning and Persuasive Writing" (Oct. 17, 2012), and the materials:
    - Email Announcements
    - Script
    - Power Point Slides
    - Four Keys to Effective Questioning and Persuasive Writing
    - Good Writing document
- 20 CFR 404, , and 416 ("Submission of Evidence in Disability Claims")
- OCEP entitled "Submission of Evidence" (April 22, 2015), and the materials:
    - Script
    - Submission of Evidence Power Point Slides
    - "Four Keys to Submission of Evidence"
    - "Quick Notes – Submission of Evidence"
    - Submission of Evidence FAQs
- 2013 Judicial Training Power Point "Legal Sufficiency and Quality Decisions" listed "[f]ailure to adequately develop the record" as a common issue in ALJ focused reviews
- 2014 CALJ memo "Making 'Every Reasonable Effort' to Obtain All Evidence and Documenting Those Efforts – REMINDER"

GLOBAL ASSESSMENT OF FUNCTIONING (GAF) SCORES

- 20 C.F.R §§ 404.1527 and 416.927
- New ALJ/DW training module 7 ("Mental Impairments"), at p. 22
- AM-13066 REV 2, Global Assessment of Functioning (GAF) Evidence in Disability Adjudication – REV (effective June 28, 2017)

HEARING CONDUCT

- 20 C.F.R §§ 404.929 *et seq*. and 416.1429 *et seq*.

- 20 C.F.R. §§ 404.944 and 416.1444 ("At the hearing, the administrative law judge looks fully into the issues, questions you and the other witnesses, and accepts as evidence any documents that are material to the issues.")
- HALLEX Chapter I-2-6, *Conduct of Hearings*, including section I-2-6-1 ("ALJs will conduct administrative hearings in a fair and impartial manner. As explained in 20 CFR 404.944 and 416.1444, the ALJ will look fully into the issues, question the claimant and any witnesses, and accept as evidence any documents that are material to the issues.")
- An ALJ's "principal responsibilities are to hold a full and fair hearing and issue a legally sufficient and defensible decision." HALLEX I-2-0-5 B.
- New ALJ/DW training modules 21 ("Examining the Claimant") and 26 ("Mock Hearing")
- OCEP entitled "Hearings and Decision Drafting: Tips on Effective Questioning and Persuasive Writing," and the materials:
    - Email Announcements
    - Script
    - Power Point Slides
    - Four Keys to Effective Questioning and Persuasive Writing
    - Good Writing document

MEDICAL EXPERTS

- 20 C.F.R §§ 404.1526, 404.1527, 416.926, and 416.927
- HALLEX I-2-5-30, *Medical or Vocational Expert Opinion — General*; I-2-5-32 through I-2-5-45; I-2-5-61, *Use of Dually Qualified Vocational and Medical Experts*; I-2-6-70, *Testimony of a Medical Expert*; I-2-5-95, *Sample-Letter to Expert Witness-Written Interrogatories*; I-2-5-93, *Sample-Interrogatories to Medical Expert*; and I-3-7-12, *Remand for Evidence from a Medical Expert*
- New ALJ/DW training modules 23 ("Medical Expert"), 24 ("Questioning the ME and VE"), and 26 ("Mock Hearing")
- " (April 18, 2012), the, and the materials:
- 2012 CALJ memo "Evidence to Experts – INFORMATION"
- 2011 CALJ memo "Case Assignment and Other Important Reminders" (includes section on "Rotation of Expert Witnesses")

MENTAL IMPAIRMENTS, EVALUATION OF

- Social Security Act, §§ 223(d) and 1614(a)
- 20 C.F.R. §§ 404.1520a and 416.920a, *Evaluation of mental impairments*
- SSR 96-8p
- SSR 85-16, *Titles II and XVI: Residual Functional Capacity for Mental Impairments*
- SSR 96-4p, Titles II and XVI: Symptoms, Medically Determinable Physical and Mental Impairments, and Exertional and Nonexertional Limitations
- New ALJ/DW training modules 5 ("Listing of Impairments"), 6 ("RFC"), and 7 ("Mental Impairments")

- Mental Disorders Listings Training and Resources (Note the medical criteria for evaluating mental disorders, with revisions effective January 17, 2017, including how we evaluate the severity of mental impairments.)
    - Mental Disorder Listings Training: An Overview
        - VOD Part 1
        - 5 Keys
        - QuickNotes
    - Mental Disorder Listings Training: An Overview
        - VOD Part 2
        - 5 Keys
        - QuickNotes
    - Mental Disorder Listings Training: Psychiatric Review Technique
        - VOD Part 3
        - 5 Keys
        - QuickNotes
    - Evaluating Mental Disorders
        - VOD Part 4
        - 5 Key
        - QuickNotes
    - New Mental Listings FAQs
- December 2016 CALJ Memo "New Mental Listings – Information" (provides an overview of the revised medical criteria for evaluating mental disorders)

ONSET DATE ISSUES

Amended or Unsupported Alleged Onset Dates

- 20 C.F.R. §§ 404.953 and 416.1453 (An ALJ must always make findings based on the preponderance of the evidence in the record and must consider all evidence in the case record when making a decision regarding disability)
- SSR 83-20 (". . .the established onset date must be fixed based on the facts and can never be inconsistent with the medical evidence of record")
- 2011 CALJ memo "Office of Quality Performance (OQP) Review Findings Concerning Administrative Law Judge (ALJ) Decisions—ACTION" (observing that "[o]nset dates must be supported by the evidence")
- Adjudication Tips #13, "Proper Onset Date," #46, "Proper Onset Date, Part II," and #56, "Supported Onset Dates"
- OCEP entitled "Onset Date, Borderline Age, Reopening, and Closed Periods" (January 13, 2016), and the accompanying materials

Dismissals

- 20 C.F.R. §§ 404.957 through 404.960, and 416.1457 through 416.1460; HALLEX I-2-1-80, *Withdrawal of a Request for Hearing*; Chapter I-2-4, *Dismissals;* I-3-1-5, *Review of ALJ Dismissals*; II-5-1-4, *Appeals Council Action on a Request for Review of a Dismissal Order Based Upon a Claimant's Withdrawal of the Request for Hearing*
- 2014 CALJ memo "Procedures for Dismissal of a Request for Hearing – REMINDER"
- OCEP on "Dismissals" (Jan. 16, 2013), the Q&A, and the materials:
    - Email Announcements
    - Queries for Claimant Address
    - AC Dismissal Guides
- Dismissal - Failure to Appear
- Dismissal - Untimely Request for Hearing
- Dismissal - Withdrawal
- Notice to Show Cause
    - Notice to show Cause (Memo)
    - HA-L90
    - HA-L90 Spanish

Later Onset Dates

- 20 C.F.R. § 404.321, *When a period of disability begins and ends*
- SSRs 83-20 and 74-8c
- New ALJ/DW training module 16 ("TWP EPE Partially Fav")
- OAO 2012 Judicial Training document "Earnings After the Onset Date"
- Adjudication Tip # 30, "Work After Onset"

ON-THE-RECORD DECISIONS

- 20 C.F.R. §§ 404.948(a) and 416.1448(a)
- Attorney Adjudicator Regulations, Instructions, and Guide

OPINION EVIDENCE

NOTE: The updated rules for evaluating medical evidence, effective March 27, 2017, apply to cases filed on or after March 27, 2017. Also note, however, certain rule changes for cases filed before March 27, 2017: the revised rules rescind SSRs 96-2p, 96-5p, 96-6p, and 06-03p and incorporate their policies into the rules applicable to claims filed before March 27, 2017. See the Chief Judge Memo for details on new citations to use in decisions.

- 20 C.F.R. §§ 404.1512, 404.1513, 404.1520, 404.1520b, 416.912, 416.913, 416.920, and 416.920b; 404.1520c and 416.920c (*How we consider and articulate medical opinions and prior administrative medical findings for claims filed on or after March 27, 2017*)
- 404.1527 and 416.927 (*Evaluating opinion evidence for claims filed before March 27, 2017*)
- Federal Register Notice
- The Office of Disability Policy's Adjudicator Desk Guides
- Final Rule, *Revisions to Rules Regarding the Evaluation of Medical Evidence* (Jan. 18, 2017)
- SSR 96-8p, *Assessing Residual Functional Capacity in Initial Claims* ("The RFC assessment must always consider and address medical source opinions. If the RFC assessment conflicts with an opinion from a medical source, the adjudicator must explain why the opinion was not adopted"); 16-3p (Consider all evidence in the record when evaluating the intensity and persistence of symptoms) and 17-2p (provides guidance on findings about medical equivalence)
- Adjudication Tip #47, "Remember to Evaluate Opinions in the DDE" (under "Sequential Evaluation Issues")
- Chief Judge Resources regarding the evaluation of medical evidence (Training Materials)
    - Medical Evidence Regulation – VOD Part 1
    - Medical Evidence Regulation – VOD Part 2
    - Medical Evidence Regulation – VOD Part 3
    - Evaluating Medical Evidence VOD
    - Evaluating Medical Evidence – Quick Notes
    - Evaluating Medical Evidence - Keys
    - ODP Medical Evidence Regulation Adjudicator Desk Guide
    - ODP Medical Evidence Regulation PP – Part 1
    - ODP Medical Evidence Regulation PP – Part 2
    - ODP Medical Evidence Regulation PP – Part 3
- HALLEX
    - I-2-5-32, *Medical Experts – General*;
    - I-2-6-70 (The ALJ will ask the ME questions designed to elicit clear and complete information)
    - I-2-8-25 (decision will cite and discuss supporting evidence)
- March 2017 CALJ Memo "Revised Rules for Evaluating Medical Evidence (provides guidance on revised policy on evaluating medical evidence – policy changes effective March 27, 2017)
- New ALJ/DW training modules 8 ("Evaluation of Medical Opinion Evidence") and 23 ("Medical Expert")

PAST RELEVANT WORK (STEP 4)

- 20 C.F.R. §§ 404.1545(a)(5)(i) and 416.945(a)(5)(i) ("We will first use our residual functional capacity assessment at step four of the sequential evaluation process to decide if you can do your past relevant work.")
- 20 C.F.R. §§ 404.1520(a)(4)(iv) and 416.920(a)(4)(iv) ("At the fourth step, we consider our assessment of your residual functional capacity and your past relevant work. If you can still do your past relevant work, we will find that you are not disabled."); *see also* §§ 404.1520(f) and 416.920(f)
- 20 C.F.R. §§ 404.1560(b), 404.1565, 416.960(b), and 416.965
- 20 C.F.R. §§ 404.1520(a)(4)(iv) and 416.920(a)(4)(iv), *Evaluation of disability in general*, 404.1545(a)(5)(i), 404.1560, 404.1562(a), 404.1565, 416.945(a)(5)(i), 416.960, 416.962(a), and 416.965
- SSRs 82-61, 82-62, 83-35, and 00-4p
- New ALJ/DW training modules 10 ("Step 4 of the Seq Eval Proc – PRW"), 11 ("Other Work"), 12 ("Framework") at pp. 9-11, 22 ("Vocational Expert"), and 26 ("Mock Hearings") at p. 9
- 2012 Judicial Training PowerPoint entitled "Step 4/5 Expedient"
- Adjudication Tips #9 ("Step 4 – 15 year period"), #10 ("Step 4 – Duration"), #11 ("Step 4 – SGA") and 12 ("Past Relevant Work (PRW)")
- HALLEX I-2-6-74, *Testimony of a Vocational Expert*
- HALLEX I-2-5-50, *When to Obtain Vocational Expert Opinion;*
- HALLEX I-2-5-52 through I-2-5-61, I-2-6-74, *Testimony of a Vocational Expert;* and
- HALLEX I-2-5-94, *Sample-Interrogatories to Vocational Expert*
- ALJ Training Video "Step 4 of the Sequential Evaluation Process: Past Relevant Work (PRW) module 10"
- The Work History Assistant Tool (WHAT):
    - HALLEX I-2-5-72, *Earnings Record Information — General*
    - Office of Quality Review and Improvement Website on the WHAT
    - WHAT Desk Guide
    - WHAT User Guide (June 2014)
    - Automation In Motion Video "WHAT – Work History Assistant Tool"
    - 2009 VOD "The OQP Work History Assistant Tool (WHAT)"
- OQP's "WHAT Online Presentation"
- OCEP entitled "Advanced Topics in Vocational Expert Evidence" (Jan. 21, 2015), and the materials:
    - Four Keys Advanced VE Evidence
    - Quick Notes Advanced Topic VE Evidence
    - Advanced Topics in VE Evidence Script
    - Advanced Topics in VE Evidence
- Appeals Council Feedback Training module on step 4

- ALJ Training Video "Step 4 of the Sequential Evaluation Process: Past Relevant Work (PRW) module 10"
- Adjudication Tips #9 ("Step 4 – 15 year period"), #10 ("Step 4 – Duration"), #11 ("Step 4 – SGA"), 12 ("Past Relevant Work (PRW)"), and 49 ("The Limits of Vocational expert Testimony")

PHRASING HYPOS

- HALLEX I-2-6-74, *Testimony of a Vocational Expert*
- New ALJ/DW training module 22 ("Vocational Expert"), at pp. 500-501 ("Hypothetical Questions for Step Five")
- OCEP entitled "Phrasing the RFC" (Jan. 18, 2012), the Q&A, and the materials:
    - Power point slides
- One Pager – "Five Keys to RFC"
- Chief Judge Memos
- Email Announcements
- OCEP entitled "Hearings and Decision Drafting — Tips on Effective Questioning and Persuasive Writing" (Oct. 17, 2012)) ("The first step to ensure accuracy [of the RFC] is for the judge to articulate the RFC hypothetical clearly, concisely and precisely to the vocational expert. Then the ALJ should ensure that it is accurately stated verbatim in the instructions.")
- 2013 Judicial Training Video "Evaluating the Functional Limiting Effects of Pain & Mental Impairments"
- 2013 Judicial Training Power Point "Vocational Expert Testimony" (discussed "[p]roper phrasing of hypothetical questions" beginning on slide 3)
- 2013 Judicial Training Video "Vocational Expert Testimony"
- 2013 Judicial Training Video "Legally Sufficient Decisions: Office of the General Counsel's Perspective"
- 2013 Judicial Training Power Point "Legally Sufficient Decisions: Office of the General Counsel's Perspective" (discussed hypothetical questions)
- *Phrasing Hypothetical Questions to Vocational Experts Training Guide*:

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al_Question_IVT_Wo

Hypotheticals to VEs regarding Transferable Skills at Step 5

- 20 C.F.R. §§ 404.1568(d) and 416.968(d)
- SSR 82-41 ("When the issue of skills and their transferability must be decided, the adjudicator or ALJ is required to make certain findings of fact and include them in the written decision. Findings should be supported with appropriate documentation.")

- "Nine Stages of Transferability of Work Skills Analysis" document from the "Vocational Expert Evidence"
- OCEP - Vocational Expert Evidence Script
    - Vocational Expert Evidence Power Point
    - Four Keys to Vocational Evidence
    - De Minimis Limitations

Limited Use of Hypothetical Questions

- New ALJ/DW training module 22 ("Vocational Expert"), at pp. 500-501 ("Hypothetical Questions for Step Five"), and 26 ("Mock Hearings")
- Appeals Council Training document "Legally-Sufficient Language for the Hypothetical to the VE and the RFC"
- 2016 Judicial Training PowerPoint on Vocational Expert Testimony and "VE Hypo Chart"
- 2014 Judicial Training "VE HYPO Checklist"
- 2013 Judicial Training Power Point "Legally Sufficient Decisions: Office of the General Counsel's Perspective" (discussed hypothetical questions)
- OCEP entitled "Hearings and Decision Drafting — Tips on Effective Questioning and Persuasive Writing" (Oct. 17, 2012) ("The first step to ensure accuracy [of the RFC] is for the judge to articulate the RFC hypothetical clearly, concisely and precisely to the vocational expert. Then the ALJ should ensure that it is accurately stated verbatim in the instructions.")
- 2013 Judicial Training Power Point "Vocational Expert Testimony" (discussed "[p]roper phrasing of hypothetical questions" beginning on slide 3)2013 Judicial Training Video "Vocational Expert Testimony"

QUALIFIED JUDICIAL INDEPENDENCE

- Administrative Procedure Act, 5 U.S.C. §§ 500 *et seq.*
- *Final Rules Setting the Time and Place for Hearing Before an Administrative Law Judge*, 75 Fed. Reg. 39154, 39156-57 (July 8, 2010) (section entitled "ALJ's Qualified Decisional Independence")
- 2013 Judicial Training Video "Three Hats…What Does It Mean?"
- *Abrams v. Social Sec. Admin.*, No. 2011–3177, slip op. at 12 (Dec. 28, 2012) ("Decisional independence ensures that the hearing examiner exercises his independent judgment on the evidence before him, free from pressures by the parties or other officials within the agency. Furthermore, the APA prohibits substantive review and supervision of the quasi-judicial functions of ALJs. However, decisional independence does not prohibit appropriate administrative supervision that is required in the course of general office management") (citations and quotations omitted).

RATIONALE FOR DECISION, REQUIREMENTS OF

- 20 C.F.R. §§ 404.953(a) and 416.1453(a) ("The administrative law judge shall issue a written decision that gives the findings of fact and the reasons for the decision.")
- SSR 82-62 ("The rationale for a disability decision must be written so that a clear picture of the case can be obtained. The rationale must follow an orderly pattern and show clearly how specific evidence leads to a conclusion.")
- HALLEX I-2-0-5 B ("The ALJ's principal responsibilities are to hold a full and fair hearing and issue a legally sufficient and defensible decision.")
- HALLEX I-2-8-1 ("The ALJ will ensure that the decision is: accurate and legally sufficient; logically organized; written so that the claimant can understand it; and issued as soon as possible after the record is complete.")
- HALLEX I-2-8-25 ("The ALJ will not use…non-prescribed standardized language in the rationale")
- OCEP entitled "Hearings and Decision Drafting: Tips on Effective Questioning and Persuasive Writing" (Oct. 17, 2012), and the materials:
    - Email Announcements
    - Script
    - Power Point Slides
    - Four Keys to Effective Questioning and Persuasive Writing
    - Good Writing document
- 2011 CALJ memo "Office of Quality Performance (OQP) Review Findings Concerning Administrative Law Judge (ALJ) Decisions—ACTION" (noting that a well-reasoned decision is of critical importance")
- 2010 "Message from the Chief Judge on Quality Decisions" discussed "includ[ing] adequate rationale for each finding"
- 2013 Judicial Training Video "Legally Sufficient Decisions: Office of the General Counsel's Perspective"
- 2013 Judicial Training PowerPoint "Legally Sufficient Decisions: Office of the General Counsel's Perspective"
- 2013 Judicial Training Power Point "Legal Sufficiency and Quality Decisions"
- 2012 ALJ Training Video "Request for Voluntary Remand" discussed common decisional issues resulting in Requests for Voluntary Remand

REOPENING

- 20 C.F.R. §§ 404.987 *et seq.* and 416.1487 *et seq.*
- HALLEX Chapter I-2-9, *Reopening and Revision*
- New ALJ/DW training module 13 ("Procedural Issues – Dismissals, Administrative Finality, Reopenings, Res Judicata")
- SSRs 67-22, 68-12a, and 91-5p

- Adjudication Tips #15 ("Implied Request for Reopening") and #16 ("Reopening – Time Limitations")

RESIDUAL FUNCTIONAL CAPACITY

- 20 C.F.R §§ 404.1520a, 404.1545, 404.1546(c), 404.1567, 404.1569a, 416.920a, 416.945, 416.946(c), 416.967, and 416.969a
- 20 C.F.R. §§ 404.1546(c) and 416.946(c) (ALJ is responsible for assessing the claimant's RFC)
- SSRs 85-15, 85-16, 96-8p, and 96-9p
- New ALJ/DW training module 6 ("RFC")
- Chief Judge Memos
- February 2012 CALJ Memo "Expectations for Legally Sufficient Decisions – INFORMATION" ("Unsupported, generalized statements that the claimant is unable to work on a full-time basis or is limited to less than sedentary work are not legally sufficient RFCs.")
- OCEP titled "RFC – Common Problems, Practical Solutions" (Apr. 23, 2014) and the materials:
    - Script
    - Power Point slides
    - Four Keys
    - Quick Notes
- OCEP entitled "Hearings and Decision Drafting: Tips on Effective Questioning and Persuasive Writing" (Oct. 17, 2012) (discussed tape auditing and "[e]nsuring the accuracy of the RFC")
    - RFC Power Point Slides
    - "Four Keys to RFC"
- Adjudication Tip #36, "Less Than Sedentary"
- 2013 Judicial Training Video "Legally Sufficient Decisions: Office of the General Counsel's Perspective"
- 2013 Judicial Training PowerPoint "Legally Sufficient Decisions: Office of the General Counsel's Perspective"
- 2013 Judicial Training Power Point "Legal Sufficiency and Quality Decisions" (discusses "Tips To Avoid Remands – RFC," among other things)
- ORDP Power Point "Mental RFC"
- ALJ Training Video "Developing and Articulating the Residual Functional Capacity (RFC)"
- OCEP titled "Phrasing the RFC" (Jan. 18, 2012) and the "Phrasing the RFC Q&A"
- Adjudication Tip #36 ("Less Than Sedentary")

Boilerplate Mental RFC

- ORDP Power Point "Mental RFC"

Function-by-Function Assessment

- 96-8p ("The RFC assessment is a function-by-function assessment based upon all of the relevant evidence of an individual's ability to do work-related activities")

RFC in the Decision Differs from the Questions Presented to the VE

- "Phrasing the RFC" OCEP document "Five Keys to RFC" Key #3: "Ensure the RFC is the same, in the vocational expert hypothetical, in the decision rationale, and in the decision."

RFC for an Inability to Sustain

- 20 CFR §§ 404.1545, 404.1546(c), 404.1569a, 416.945, 416.946(c), and 416.969a (ALJ is responsible for assessing the claimant's RFC)
- Social Security Rulings (SSRs) 96-8p ("The RFC assessment is a function-by-function assessment based upon all of the relevant evidence of an individual's ability to do work-related activities"), and 96-9p (implications of an RFC for less than a full range of sedentary work)
- February 2012 CALJ Memo "Expectations for Legally Sufficient Decisions – INFORMATION" ("Unsupported, generalized statements that the claimant is unable to work on a full-time basis or is limited to less than sedentary work are not legally sufficient RFCs.")
- New ALJ/DW training module 6 ("RFC")
- OCEP titled "RFC – Common Problems, Practical Solutions" (Apr. 23, 2014) and the materials:
    - Script
    - Power Point slides
    - Four Keys
    - Quick Notes
- OCEP titled "Phrasing the RFC" (Jan. 18, 2012) and the "Phrasing the RFC Q&A"
- Adjudication Tip #36 ("Less Than Sedentary")

Supportability of Inability to Sustain RFC Assessments

- SSR 16-3p, Evaluation of Symptoms in Disability Claims (superseding SSR 96-7p); Chief Judge Resource Page
    - SSR 16-3p VOD
    - Five Keys to Symptom Evaluation
    - Chief Judge Bulletin 16-01 REV, "Modifications to DA&A Material, CDR Decisions and other decisions Due to SSR 16-3p and the rescission of SSR 96-7p"
- Adjudication Tip #57, "Credibility No More" (under "Evidence Issues")

Inadequate Mental Limitations

- Social Security Act, §§ 223(d) and 1614(a)
- 20 C.F.R §§ 404.1520a and 416.920a, Evaluation of mental impairments
- SSRs 85-16 (RFC for mental impairments) and 96-4p, *Titles II and XVI: Symptoms, Medically Determinable Physical and Mental Impairments, and Exertional and Nonexertional Limitations*
- Mental Disorders Listings Training and Resources (Note the medical criteria for evaluating mental disorders, with revisions effective January 17, 2017, including how we evaluate the severity of mental impairments.)
    - Mental Disorder Listings Training: An Overview
        - VOD Part 1
        - 5 Keys
        - QuickNotes
    - Mental Disorder Listings Training: An Overview
        - VOD Part 2
        - 5 Keys
        - QuickNotes
    - Mental Disorder Listings Training: Psychiatric Review Technique
        - VOD Part 3
        - 5 Keys
        - QuickNotes
    - Evaluating Mental Disorders
        - VOD Part 4
        - 5 Key
        - QuickNotes
    - New Mental Listings FAQs
    - December 2016 CALJ Memo "New Mental Listings – Information" (provides an overview of the revised medical criteria for evaluating mental disorders)

Inadequate Non-Exertional, Physical Limitations

- OCEP entitled "RFC - Common Problems, Practical Solutions" (April 23, 2014)
- One Pager – "Five Keys to RFC"
- ALJ Training Video, "Developing and Articulating the Residual Functional Capacity (RFC)"
- 2014 Judicial Training VOD, "Legally Sufficient Decisions"
- OGC Perspective, OAO Perspective, and ALJ Perspective PowerPoint Presentations
    - Smith, John 123-45-6789 (ALJ Unfavorable Instructions)
    - Smith, John 123-45-6789 (FIT Fully Favorable Decision)
    - Smith, John – Judicial Training 2013
    - OAO Newsletter Special Edition
    - Draft Memo to ALJs – Expectations for Instructions to Decision Writers

RIGHT TO REPRESENTATION

- 20 C.F.R. §§ 404.1705 and 416.1505, *Who may be your representative*
- HALLEX I-2-6-50, *Administrative Law Judge Introduction at the Hearing*
- HALLEX I-2-6-52, *Opening Statement*; I-1-1-3, *Notifying Claimants Who Are Not Represented of the Options for Obtaining Representation*; I-2-1-45, *Parties to the Hearing*; I-2-6-97 and -98
- POMS GN 03910.010 B. ("The decision to have or not to have a representative is for the claimant to make. SSA neither encourages nor discourages representation.")
- New ALJ/DW training module 19 ("Opening Statement-Swearing of Witness"), at pp. 419-420
- Adjudication Tip #5, *The Claimant Requests a Postponement in Order to Obtain Representation*
- 2011 CALJ memo "Office of Quality Performance's (OQP) Report on the Assessment of Claimant Representation at the Hearing Level – INFORMATION"

SEVERITY (STEP 2)

- 20 C.F.R §§, 404.1509, 404.1520, 404.1520a, 404.1521, , 416.909, 416.920, 416.920a, and 416.921
- SSRs 85-28, 96-3p, 96-4p, 16-3p
- New ALJ/DW training modules 2 ("Intro to Sequential Evaluation") at p. 38; 4 ("Severity"); and 9 ("Subjective Complaints") at pp. 212, 216-217

STEP 3

- Social Security Act, §§ 223(d) and 1614(a)
- 20 C.F.R. §§ 404.1520(d), 404.1525, 404.1526, 416.920(d), 416.924(d), 416.925, and 416.926
- SSRs 86-8 (section entitled "Does the Individual Have an Impairment(s) Which Meets or Equals the Listing?")
- New ALJ/DW training modules 5 ("Listing of Impairments") and 23 ("Medical Expert")
- ALJ Training Video "Step 3 Meet/Equals a Listed Impairment"
- 2013 Judicial Training PowerPoint "Legal Sufficiency and Quality Decisions" discussed listings among most commonly cited remand reasons
- 2013 Judicial Training Video "Legally Sufficient Decisions: Office of the General Counsel's Perspective"
- 2013 Judicial Training PowerPoint "Legally Sufficient Decisions OGC Perspective – 2013" discussed listings in context of standard of review
- 2013 Judicial Training PowerPoint "Assessing the Functional Limitations of Mental Impairments"

Listing 1.00

- ODP Q&A 02-093, "What degree of muscle weakness is needed to meet Listing 1.04A?"
- 20 C.F.R., Part 404, Subpt. P, App. 1, § 1.00 B.2.b. ("What We Mean by Inability To Ambulate Effectively")
- Adjudication Tip #38 ("Use of Canes, Walkers, or Other Hand-Held Assistive Devices")
- ODP Q&A 02-076 Rev 1, "Since the new listings require the use of 2 canes, how do we evaluate a person who uses only one cane?"
- ODP Q&A 02-075, "Can there be situations where there is ineffective ambulation th[at] meet[s] Listing 1.02A[?]"
- ODP Q&A "Clarify the term gross anatomical deformity in listing 1.02A."

Listing 12.00

- 20 C.F.R. §§ 404.1520a and 416.920a
- 20 C.F.R., Part 404, Subpt. P, App. 1, § 12.00, "Mental Disorders – Adult"
- SSR 85-16, *Titles II and XVI: Residual Functional Capacity (RFC) for Mental Impairments*
- New ALJ/DW training module 7 ("Mental Impairments")

Listing 13.00: ODP Q&A 05-132, "Can you clarify the issues of onset and equivalence in claims where bone marrow or stem cell transplantation has taken place?"

STEP 5

- Social Security Act, §§ 223(d)(2)(A) and 1614(a)(3)(B)
- 20 C.F.R. §§ 404.102 and 416.120(c)(4) (An individual attains a given age on the day before his or her birthday); 404.1520(a)(4)(v), 404.1560, 404.1563, 404.1566, 404.1567, 404.1568(d), 404.1569, 404.1569a, 416.920(a)(4)(v), 416.960, 416.963, 416.966, 416.967, 416.968(d), 416.969, and 416.969a
- SSRs:
  - 82-63, 83-10, 83-11, 83-12, 83-14, 85-15 (Clarifying application of the medical-vocational rules in Appendix 2 of Subpart P);
  - 82-41 and 83-14 (ALJ will consult the DOT for job information and to determine skill levels of past work);
- 00-4p (Resolving conflicts between the VE's testimony and the DOT)
- New ALJ/DW training modules 11 ("Other Work") and 12 ("Framework of the Rules")
- Take Five at Step Five OCEP (January 18, 2017)
  - Take Five at Step Five QuickNotes
  - Take Five at Step Five Keys

    - Take Five at Step Five Script
    - Take Five at Step Five PowerPoint
- "Nine Stages of Transferability of Work Skills Analysis" document from the "Vocational Expert Evidence" OCEP
- OCEP on Onset Date, Borderline Age, Reopening, and Closed Periods (January 13, 2016)
- Appeals Council Feedback Training module on step 5
- Adjudication Tips #44 ("Other Jobs in the National Economy"), #51 ("RFC Between Two Exertional Levels"), and #60 ("Borderline Age")

Grid Rules, Application of

- 20 C.F.R. §§ 404.1560, 404.1566, 404.1569, 404.1569a, 416.960, 416.966, 416.969, and 416.969a
- SSRs 82-63, 83-10, 83-11, 83-14, and 96-9p
- New ALJ/DW training module 12 ("Framework")
- OCEP entitled "Vocational Expert Evidence" (April 17, 2013), and the Q&A

SUBSTANTIAL GAINFUL ACTIVITY (STEP 1)

- Social Security Act, § 223(d)(2)(A)
- 20 C.F.R. §§ 404.1510, 404.1520, 404.1571 *et seq*., 416.910, 416.920, and 416.971 *et seq.*
- SSRs 82-53, 83-33, 83-34, and 85-5c
- SSR 94-1c, *Illegal Activity as Substantial Gainful Activity*
- SSR 05-02: "Titles II and XVI: Determination of Substantial Gainful Activity if Substantial Work Activity is Discontinued or Reduced – Unsuccessful Work Attempt"
- SSR 83-35: "Titles II and XVI: Averaging of Earnings in Determining Whether Work is Substantial Gainful Activity"
- New ALJ/DW training modules 2 ("Intro to Sequential Evaluation") and 3 ("SGA")
- 2011 CALJ memo "Office of Quality Performance (OQP) Review Findings Concerning Administrative Law Judge (ALJ) Decisions—ACTION" (observing that "Work activity or earnings after the alleged onset date must be fully developed and addressed in the decision. Up-to-date earnings queries should be considered before a decision is issued. Work activity development is also important in terms of establishing the correct dates for disability insured status.")
- OAO's 2012 Judicial Training materials "Table of Contents Step 1 Earnings After Onset," "Step 1 Earnings After Onset Tier 1," and "Step 1 Earnings After Onset Tier 2"
- Adjudication Tip #20 – Consideration of Part-time Work (August 2010)
- AC Feedback Training module – Step 1

SYMPTOM EVALUATION

- 20 C.F.R. §§ 404.1529 and 416.929, *How we evaluate symptoms, including pain*
    - "Factors relevant to your symptoms, such as pain, which we will consider include:
      (i) Your daily activities;
      (ii) The location, duration, frequency, and intensity of your pain or other symptoms;
      (iii) Precipitating and aggravating factors;
      (iv) The type, dosage, effectiveness, and side effects of any medication you take or have taken to alleviate your pain or other symptoms;
      (v) Treatment, other than medication, you receive or have received for relief of your pain or other symptoms;
      (vi) Any measures you use or have used to relieve your pain or other symptoms (e.g., lying flat on your back, standing for 15 to 20 minutes every hour, sleeping on a board, etc.); and
      (vii) Other factors concerning your functional limitations and restrictions due to pain or other symptoms."
- SSR 16-3p, *Titles II and XVI: Evaluation of Symptoms in Disability Claims*
    - This SSR supersedes SSR 96-7p, *Titles II and XVI: Evaluation of Symptoms in Disability Claims: Assessing the Credibility of an Individual's Statements*.
- SSR 16-3p VOD, with "Five Keys to Symptom Evaluation" (March 2016)
- HALLEX I-2-8-25 B.4. (decision should contain "[a] discussion of the claimant's subjective complaints, pain, and other symptom evaluation")

Drug and Alcohol Addiction (DA&A), Continuing Disability Review (CDR), and Other Templates

- Chief Judge Bulletin 16-01 REV, "Modifications to DA&A Material, CDR Decisions and other decisions Due to SSR 16-3p and the rescission of SSR 96-7p"

Failure to Seek Treatment and/or Failure to Follow Prescribed Treatment

- 20 C.F.R. §§ 404.1530 and 416.930, *Need to follow prescribed treatment*
- SSR 16-3p, *Titles II and XVI: Evaluation of Symptoms in Disability Claims* (discussing the need to consider possible reasons an individual may not have pursued treatment)
- SSR 82-59, *Titles II and XVI: Failure to Follow Prescribed Treatment*
- HALLEX II-5-3-1, *Good Reason for Failure to Follow Prescribed Treatment*

Obesity

- SSR 02-1p, *Titles II and XVI: Evaluation of Obesity*

- AM-13001, *Policy Reminders for Evaluating Obesity in Disability Claims*

UNEMPLOYMENT BENEFITS

- 20 C.F.R. §§ 404.1512(b) and 416.912(b)
- SSR 00-1c, *Sections 222(c) and 223(a), (d)(2)(a), and (e)(1) of the Social Security Act (42 U.S.C. 422(c) and 423(a), (d)(2)(A), and (e)(1)) Disability Insurance Benefits—Claims Filed Under Both the Social Security Act and the Americans with Disabilities Act*
- 2010 CALJ memo "Receipt of Unemployment Insurance Benefits by Claimant Applying for Disability Benefits – REMINDER"

VOCATIONAL EXPERTS

- 20 C.F.R. §§ 404.1560 *et seq*., 416.960 *et seq*.
- 20 CFR §§ 404.906, 404.1516, 404.1520, 404.1594, 416.916, 416.920, 416.987, 416.994, and 416.1406 (*see also* POMS DI 25005.005, "Expedited Vocational Assessment Under the Sequential Evaluation Process")
- SSRs 83-12, 85-15, and 00-4p
- HALLEX I-2-5-30, *Medical or Vocational Expert Opinion — General*; I-2-5-50, *When to Obtain Vocational Expert Opinion;* I-2-5-52 through I-2-5-61, I-2-6-74, *Testimony of a Vocational Expert,* and I-2-5-94, *Sample-Interrogatories to Vocational Expert*
- HALLEX I-2-5-57 *Obtaining Vocational Expert Opinion Through Interrogatories*
- New ALJ/DW training modules 11 ("Other Work"), 12 ("Framework") at pp. 271-274, 22 ("Vocational Expert"), 24 at pp. 541-542, and 26 ("Mock Hearing") at pp. 563-564
- OCEP entitled "Vocational Expert Evidence" (April 17, 2013), the Q&A, and the materials:
    - Vocational Expert Evidence Script
    - Vocational Expert Evidence Power Point
    - Four Keys to Vocational Evidence
    - De Minimis Limitations
    - Nine Stages of Transferability
- OCEP entitled "Advanced Topics in Vocational Expert Evidence" (January 21, 2015), and the materials:
    - Script
    - Vocational Expert Power Point Slides
    - "Four Keys to Advanced VE Evidence"
    - "Quick Notes – Advanced VE Evidence"
    - Nine Stages of Transferability.
- 2013 Judicial Training Video "Vocational Expert Testimony"
- 2013 Judicial Training materials on "Vocational Expert Testimony"
- 2013 Judicial Training Video "Legally Sufficient Decisions: Office of the General Counsel's Perspective"

- 2013 Judicial Training PowerPoint "Legally Sufficient Decisions: Office of the General Counsel's Perspective"
- OCEP entitled "Hearings and Decision Drafting — Tips on Effective Questioning and Persuasive Writing" (Oct. 17, 2012)
- Adjudication Tip #12, "Past Relevant Work (PRW)"
- 2016 CALJ memo "Vocational Expert Testimony – INFORMATION AND REMINDER"
- 2012 CALJ memo "Evidence to Experts – INFORMATION"
- Acquiescence Ruling 14-1(8), "*Brock v. Astrue*, 674 F.3d 1062 (8th Cir. 2012): Requiring Vocational Specialist (VS) or Vocational Expert (VE) Evidence When an Individual has a Severe Mental Impairment(s) — Titles II and XVI of the Social Security Act"
- Chief Judge Bulletin 09-03, *Prohibition on Use of "Generic" Vocational Expert Interrogatories by Administrative Notice*

ALJ Should Make Past Relevant Work Finding, not the VE

- 20 C.F.R. §§ 404.1545(a)(5)(i) and 416.945(a)(5)(i) ("We will first use our residual functional capacity assessment at step four of the sequential evaluation process to decide if you can do your past relevant work.")
- 20 C.F.R. §§ 404.1560(b)(2) and 416.960(b)(2) ("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 C.F.R. §§ 404.1520(a)(4)(iv) and 416.920(a)(4)(iv) ("At the fourth step, we consider our assessment of your residual functional capacity and your past relevant work. If you can still do your past relevant work, we will find that you are not disabled."); *see also* 20 C.F.R. §§ 404.1520(f) and 416.920(f)
- 20 C.F.R. §§ 404.1565 and 416.965, *Your work experience as a vocational factor*
  SSR 82-62 ("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.")

Hypotheticals to VEs regarding Transferable Skills at Step 5

- 20 C.F.R. §§ 404.1568(d) and 416.968(d)
- SSR 82-41 ("When the issue of skills and their transferability must be decided, the adjudicator or ALJ is required to make certain findings of fact and include them in the written decision. Findings should be supported with appropriate documentation.")
- "Nine Stages of Transferability of Work Skills Analysis" document from the "Vocational Expert Evidence" OCEP

VE Testimony Characterization

- HALLEX I-2-8-1 (ALJ must ensure that the decision is "accurate and legally sufficient," among other things)
- HALLEX I-2-0-5 B ("The ALJ's principal responsibilities are to hold a full and fair hearing and issue a legally sufficient and defensible decision.")

WRITING THE DECISION

- "The administrative law judge shall issue a written decision that gives the findings of fact and the reasons for the decision." 20 C.F.R. §§ 404.953(a) and 416.1453(a)
- SSR 82-62 ("The rationale for a disability decision must be written so that a clear picture of the case can be obtained. The rationale must follow an orderly pattern and show clearly how specific evidence leads to a conclusion.")
- An ALJ's "principal responsibilities are to hold a full and fair hearing and issue a legally sufficient and defensible decision." HALLEX I-2-0-5 B.
- HALLEX I-2-8-1, *General*, and I-2-8-25, *Writing the Decision*
- OCEP entitled "Hearings and Decision Drafting: Tips on Effective Questioning and Persuasive Writing" (Oct. 17, 2012), and the materials:
    - Email Announcements
    - Script
    - Power Point Slides
    - Four Keys to Effective Questioning and Persuasive Writing
    - Good Writing document
- 2012 CALJ memo "Expectations for Legally Sufficient Decisions – INFORMATION"
- 2013 CALJ memo "Expectations for Instructions to Decision Writers – INFORMATION"
- March 2010 "Message from the Chief Judge on Quality Decisions"
- 2013 Judicial Training Video "Legally Sufficient Decisions: Office of the General Counsel's Perspective"
- 2012 Judicial Training had training materials on "Legally Sufficient Decisions: AC Perspective," and the PowerPoint "Legally Sufficient Decisions: OGC Perspective"

Administrative Law Judge/Decision Writer Training Course

Module 8
Evaluation of Medical Opinion Evidence

SOCIAL SECURITY ADMINISTRATION
Office of Human Resources, Office of Training
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TABLE OF CONTENTS

LESSON PLAN

Module Objectives:

At the completion of this module, the students will be able to:

1. Describe the concept of and the sources of information used to assess residual functional capacity (RFC).

2. Distinguish between the "claimant's burden" and the "Commissioner's burden" in developing the medical evidence of record.

3. Identify the factors used to evaluate and weigh medical opinions and other opinion evidence.

Length of Module

3 hours 15 minutes

Reference Material

Code of Federal Regulations

SSR 83-10, SSR 83-12, SSR 83-14, SSR 85-15, SSR 85-16, SSR 96-2p, SSR 96-4p, SSR 96-5p, SSR 96-6p, SSR 96-8p, SSR 96-9p, SSR 06-03p, and SSR 13-2p

OBJECTIVE 1:

Describe the concept of and the sources of information used to assess residual functional capacity (RFC).

Residual Functional Capacity (RFC)

What the Claimant Can Still Do Despite His or Her Limitations and Restrictions (20 CFR § 404.1545 and § 416.945)

- RFC is an assessment based upon all of the relevant evidence.
- In determining RFC, the limiting effects of all impairments, even those that are not severe, must be considered.
- Ordinarily, RFC is the most that an individual can do and is the individual's maximum sustained work capability on a regular and continuing basis (eight hours a day, five days a week or an equivalent thereof). (Section 200.00(c) of part 404, subpart P, Appendix 2 and SSR 96-8p).
- RFC is a function-by-function assessment of an individual's ability to do each of the basic work activities (SSR 96-8p).

Considerations in Assessing RFC

RFC is assessed by considering the following terms which describe how we characterize what an individual can still do despite his/her limitations:

- **Basic work activities** (20 CFR § 404.1521 and § 416.921)

  When we talk about basic work activities, we mean the abilities and aptitudes necessary to do most jobs. Examples of these include:

1. Physical functions such as walking, standing, sitting, lifting, pushing, pulling, reaching, carrying or handling;

2. Capacities for seeing, hearing and speaking;

3. Understanding, carrying out and remembering simple instructions;

4. Use of judgment;

5. Responding appropriately to supervision, co-workers and usual work situations; and

6. Dealing with changes in a routine work setting.

- **Physical and mental abilities** (20 CFR § 404.1545(b) and (c) and § 416.945(b) and (c))

  When we assess an individual's physical abilities, we first assess the nature and extent of his or her physical limitations and then determine his or her physical residual functional capacity for work activity on a regular and continuing basis. A limited ability to perform certain physical demands of work activity, such as sitting, standing, walking, lifting, carrying, pushing, pulling, or other physical functions (including manipulative or postural functions, such as reaching, handling, stooping or crouching), may reduce an individual's ability to do past work and other work.

  When we assess his or her mental abilities, we first assess the nature and extent of the individual's mental limitations and restrictions and then determine his or her mental residual functional capacity for work activity on a regular and continuing basis. A limited ability to carry out certain mental activities, such as limitations in understanding, remembering, carrying out instructions, and in responding appropriately to supervision, co-workers, and work pressures in a work setting may reduce an individual's ability to do past work and other work.

- **Exertional and non-exertional limitations** (20 CFR § 404.1569a, § 416.969a, and SSR 96-4p)

  NOTE: A symptom in itself is neither exertional nor non-exertional. Rather, it is the nature of the functional limitations and restrictions caused by an impairment-related symptom that determines whether the impact of the symptom is exertional, non-exertional, or both. The application of the medical-vocational rules in Appendix 2

depends on the nature of the limitations and restrictions imposed by an individual's medically determinable physical or mental impairment(s) and any related symptoms (SSR 96-4p).

Exertional limitations. When the limitations and restrictions imposed by an impairment(s) and related symptoms, such as pain, affect only an individual's ability to meet the strength demands of jobs (sitting, standing, walking, lifting, carrying, pushing, and pulling), we consider that he or she has only exertional limitations. When his or her impairment(s) and related symptoms only impose exertional limitations and his or her specific vocational profile is listed in a rule contained in Appendix 2 of subpart P of part 404, we will directly apply that rule to decide whether the individual is disabled.

Non-exertional limitations. When the limitations and restrictions imposed by an individual's impairment(s) and related symptoms, such as pain, affect only his or her ability to meet the demands of jobs other than the strength demands, we consider that he or she has only non-exertional limitations or restrictions. Some examples of non-exertional limitations or restrictions include the following:

1. Difficulty functioning because of nervousness, anxiety, or depression;

2. Difficulty maintaining attention or concentrating;

3. Difficulty understanding or remembering detailed instructions;

4. Difficulty in seeing or hearing;

5. Difficulty tolerating some physical feature(s) of certain work settings, e.g., cannot tolerate dust or fumes; or

6. Difficulty performing the manipulative or postural functions of some work, such as reaching, handling, stooping, climbing, crawling, or crouching.

Components of RFC Assessment

Physical Abilities/Exertional Limitations

- The term exertional has the same meaning in the regulations as it has in the U.S. Department of Labor's publication, the Dictionary of Occupational Titles (DOT). In the DOT supplement, Selected Characteristics of Occupations (SCO) Defined in the DOT, occupations are classified as sedentary, light, medium, heavy, and very heavy according to the degree of primary strength requirements of occupations. (See also 20 CFR § 404.1567, § 416.967 and Social Security Ruling SSR 83-10 for SSA definitions of these terms).

- Strength requirements consist of three work positions (stand, walk and sit) and four worker movements of objects (lift, carry, push and pull). Limitations in these strength activities are called "exertional limitations." (See 20 CFR § 404.1569a (b), § 416.969a (b) and SSR 83-10, SSR 83-12, SSR 83-14, SSR 85-15, SSR 96-4p, SSR 96-8p and SSR 96-9p).

- One must know these definitions and the activities encompassed at each exertional level to accurately assess an individual's RFC. Also, SSR 83-10 must be reviewed to better understand the definition of terms (for example, "occasionally" and "frequently") used in the Regulations and SCO.

Non-Exertional Limitations

Any limitations imposed by an impairment that affect the claimant's ability to meet the demands of work other than the strength demands (20 CFR § 404.1569a(c) and § 416.969a(c)).

- **Mental Abilities** include maintaining attention and concentration; understanding, remembering and carrying out instructions; and responding appropriately to supervision, co-workers and work situations. (See 20 CFR § 404.1545 and § 416.945, and SSR 85-16).

- **Other Abilities** include limitations arising from impairments of the skin, vision, hearing or other senses; those associated with

environmental restrictions (temperature extremes, noise, dust, vibrations, humidity/wetness, hazards (machinery/heights, fumes and odors); postural restrictions (climb, balance, kneel, crouch, crawl, and stoop); and manipulative restrictions (reach, handle, finger, and feel). (See the above regulations and Social Security Rulings SSR 83-12, SSR 83-14, SSR 85-15, and SSR 96-9p).

Evidence Used to Assess RFC

We will assess RFC based on all of the relevant medical and other evidence (20 CFR § 404.1545 and § 416.945). Evidence is anything the individual or anyone else submits to us or that we obtain that relates to his or her claim as described in 20 CFR § 404.1512(b) and § 416.912(b). This includes, but is not limited to:

- Objective medical evidence, that is, medical signs and laboratory findings as defined in 20 CFR § 404.1529(a) and § 416.929(a) and defined in 20 CFR § 404.1528(b) and (c) and § 416.928(b) and (c).
- Other evidence from medical sources, such as medical history, opinions, and statements about treatment.
- Medical source statements from acceptable medical sources about what the individual can still do despite his or her impairment(s).
- RFC assessments made by State agency medical and psychological consultants as described in 20 CFR § 404.1527(e) (2) and § 416.927(e) (2), and SSR 96-6p.
- Statements that the individual makes about his or her impairment(s), including symptoms, as described in 20 CFR § 404.1529 and § 416.929 (see SSR 16-3p for how to evaluate symptoms), as well as descriptions of activities of daily living, efforts to work, or any other relevant statements made to medical sources or to us.
- Information from other sources, such as social workers, friends, family members, relatives, neighbors, and clergy as described in 20 CFR § 404.1513(d) and § 416.913(d), and SSR 06-03p.

OBJECTIVE 2:

Distinguish between the "claimant's burden" and the "Commissioner's burden" in developing the medical evidence of record.

Regulatory Requirements for Development of Medical Evidence

The Claimant's Burden

"You have to prove to us that you are blind or disabled" and "you must furnish medical and other evidence that we can use to reach conclusions about your medical impairment(s)." (20 CFR § 404.1512(a) and § 416.912(a), see also 20 CFR § 404.1516 and § 416.916).

The Commissioner's Burden

- Develop the claimant's "complete medical history" for at least the 12 months preceding the month in which the application is filed (or 12 months prior to the date last insured) (20 CFR § 404.1512(d) and § 416.912(d)).

- Make "every reasonable effort" to help the claimant obtain medical reports from his or her medical sources, including an initial request and a follow-up request within 10 to 20 calendar days thereafter if the evidence has not been received. We will give the medical source a minimum of 10 calendar days from the date of our follow-up request to reply. (A longer period can be granted if experience with the source indicates that a longer period is advisable in a particular case (20 CFR § 404 1512(d) (1) and § 416.912(d) (1).)

Consultative examination (CE): Obtained by SSA if necessary information is not readily available from records of claimant's medical sources (20 CFR §404.1512(f) and § 416.912(f)). Claimant's treating source is the "preferred source" to perform such an examination (20 CFR § 404.1519h and § 416.919h).

Treating source: The claimant's own physician, psychologist or other acceptable medical source that has provided treatment or evaluation and has or has had an ongoing treating relationship with the claimant. It is a medical source seen "with a frequency consistent with accepted medical practice for the type of treatment and/or evaluation required for [the claimant's] medical condition(s)." (20 CFR § 404.1502, § 416.902, and SSR 96-2p)

OBJECTIVE 3:

Identify the factors used to evaluate and weigh medical opinions and other opinion evidence.

20 CFR § 404.1527, § 416.927 and SSR 96-2p, SSR 96-5p, SSR 96-6p and SSR 06-03p

Historically, this issue frequently results in remands of ALJ decisions by the courts and the Appeals Council (AC).

SSA policy and circuit case law has generally established a hierarchy of medical opinions with greater weight generally accorded in the following order: treating source, non-treating source, non-examining source who testifies at the hearing and non-examining source who does not testify.

How much weight to accord medical opinions from these sources must be determined by evaluating the opinions in accordance with 20 CFR § 404.1527(c) and § 416.927(c) and SSR 06-03p. It should be noted, however, that the medical opinion from a medical source may outweigh the medical opinion from another medical source, depending on how well the opinions are supported by the evidence and other factors as described below. For example, the medical opinion from a non-treating or non-examining medical source may outweigh a treating source's medical opinion.

Regulations Require that Every Medical Opinion Must Be Considered (20 CFR § 404.1527(b) and (c) and § 416.927(b) and (c)).

Medical opinions are statements from physicians and psychologists or other acceptable medical sources that reflect judgment about the nature and severity impairments (20 CFR § 404.1527(a)(2) and § 416.927(a)(2).

Regulations (20 CFR § 404.1527(c) and § 416.927(c)) identify factors that will be considered in evaluating every medical opinion including:

- **Examining relationship:** Generally, we give more weight to the opinion of a source who has examined the claimant than to the opinion of a source who has not examined the claimant.

- **Treatment relationship:** Generally, we give more weight to opinions from the claimant's treating sources as they are:

  - most able to provide a detailed, longitudinal picture of the impairments, and

  - may bring a unique perspective that cannot be obtained from medical findings alone or reports of individual examinations.

Length of the treatment relationship and frequency of examination: Generally, the longer a treating source has treated the claimant and the more times the claimant has been seen by the source, the greater weight we will give the opinion.

Nature and extent of the treatment relationship: Generally, the more knowledge the source has about the claimant's impairments, the more weight we will give the opinion. We will look at the kinds and extent of examinations and testing the source has performed or ordered.

- **Supportability:** The more a medical source presents relevant evidence to support an opinion, particularly medical signs and findings, and the better an explanation of the opinion a source provides, the more weight we will give the opinion.

- **Consistency:** Generally, the more consistent an opinion is with the record as a whole (other medical opinions, lay statements, etc.), the more weight we will give the opinion.

- **Specialization:** We generally give more weight to the opinion of a specialist about the medical issues related to his or her area of specialty than to the opinion of a source who is not a specialist in that area.

- **Other factors:** There are any factors the claimant or others bring to our attention which tend to support or contradict the opinion. Examples of relevant factors to be considered in deciding the weight to give to an opinion include:

  - the amount of understanding that an acceptable medical source has of our disability programs and their evidentiary requirements regardless of the source of that understanding; and

  - the extent to which an acceptable medical source is familiar with the other information in a claimant's case record.

Acceptable Medical Sources (20 CFR § 404.1513(a) and § 416.913(a))

Acceptable Medical Sources

We need evidence from acceptable medical sources to establish the existence of a medically determinable impairment. These sources are:

- Licensed physicians – medical (M.D.) or osteopathic doctors (D.O.);
- Licensed or certified psychologists. Included are school psychologists, or other licensed or certified individuals with other titles who perform the same function as a school psychologist in a school setting for purposes of establishing intellectual disability, learning disabilities, and borderline intellectual functioning only;
- Licensed optometrists (O.D.) for the purposes of establishing visual disorders only (except in the U.S. Virgin Islands, licensed optometrists for measurement of visual acuity and visual fields only);
- Licensed podiatrists (D.P.M.) for purposes of establishing impairments of the foot or foot and ankle only, depending on whether the State in which the podiatrist practices permits the practice of podiatry on the foot only or the foot and ankle; and
- Qualified speech-language pathologists for purposes of establishing speech or language impairments only. For this source, "qualified" means that the speech-language pathologist must be licensed by the State professional licensing agency, or be fully certified by the State education agency in the State in which he or she practices, or holds a Certificate of Clinical Competence from the American Speech-Language-Hearing Association.

Only Acceptable Medical Sources can:

- Establish the existence of a medically determinable physical or mental impairment (20 CFR § 404.1513(a) and 20 CFR § 416.913(a)
- Give medical opinions (20 CFR § 404.1527(a)(2) and 20 CFR § 416.927(a)(2)

- Be considered a treating source whose medical opinion may be entitled to controlling weight (20 CFR § 404.1527(a)(2), § 416.927(a)(2), and SSR 96-2p)

"Other" Sources

Sources other than acceptable medical sources may provide information to help us understand how the individual's impairments affect his or her ability to work. This information must be evaluated as opinion evidence from other sources. (See SSR 06-03p). "Other" sources include:

- "Medical sources" that are not "acceptable medical sources." They include nurse practitioners, physician assistants, licensed clinical social workers, naturopaths, chiropractors, audiologists, and therapists;

- "non-medical sources" who have seen the claimant in a professional capacity such as teachers, counselors, and social workers; and

- "Non-medical sources" that do not have a professional relationship with the claimant such as a spouse, parents, friends, relatives, employers, or coworkers.

Factors for evaluating other opinion evidence

- The factors used to evaluate opinion evidence from an "acceptable medical source" may be applied to opinion evidence from "other sources" since they encompass general principles applicable to all evidence (see SSR 06-03p).

- Consider the source's qualifications and area of specialty or expertise when evaluating opinions from professionals who are not medical sources.

- If an opinion from a source is afforded greater weight than a medical opinion from a treating source, the ALJ must explain the reasons in the decision.

Treating Source Opinions May Be Entitled to "Controlling Weight"

Treating source opinions on the nature and severity of an individual's impairment(s) may be entitled to "controlling weight" (20 CFR § 404.1527(c) (2), § 416.927(c) (2), and SSR 96-2p). A treating source is the claimant's own physician, psychologist, or other acceptable medical source who provides (or has provided) medical treatment or evaluation and who has (or had) an ongoing treatment relationship with the claimant (20 CFR §404.1502 and §416.902. A treating source opinion is entitled to controlling weight if the opinion:

- Is **well supported** by medically acceptable clinical and laboratory techniques; and
- Is **not inconsistent** with the other substantial evidence of record.

If the treating source opinion is not entitled to controlling weight, it is not rejected but must be evaluated using all the factors identified in 20 CFR § 404.1527(c) (3) through (6) and § 416.927(c) (3) through (6).

Opinions on Issues Reserved to the Commissioner

Under 20 CFR § 404.1527(d) and § 416.927(d), some issues are not medical issues regarding the nature and severity of an individual's impairment(s) but are administrative findings that are dispositive of a case; that is, that would direct the determination or decision of disability. The following are examples of such issues:

- Whether claimant is "**disabled**" or unable to work;
- Whether an impairment(s) **meets or equals** the listings;
- The claimant's **residual functional capacity**;
- Whether claimant can perform **past relevant work (PRW)**; and
- Application of the vocational factors (age, education and work experience).
- The finding on DAA materiality.

The regulations provide that the final responsibility for deciding issues such as these is reserved to the Commissioner.

Nevertheless, our rules provide that adjudicators must always carefully consider opinions about any issue, including opinions about issues that are reserved to the Commissioner. For treating sources, our rules further require that adjudication may include recontact with the treating source when the basis for his or her opinion on an issue reserved to the Commissioner is not clear to us See 20 CFR § 404.1520b(c) and (d) and 20 CFR § 416.920b(c) and (d).

However, treating source opinions on issues reserved to the Commissioner should never be accorded controlling weight or special significance (20 CFR § 404.1527(d)(3)), § 416.927(d)(3)), and SSR 96-5p). While not given controlling weight, such opinions must still be considered and evaluated using the factors identified in 20 CFR § 404.1527(c) and § 416.927(c).

All Medical Opinions and Opinions from Medical Sources and Others Who Have Seen the Claimant in a Professional Capacity Must Be Considered (20 CFR § 404.1527(b) and (c), 20 CFR § 416.927(b) and (c), and SSR 06-03p

The regulations explicitly provide that every "medical opinion" must be considered. This includes the opinions of nonexamining DDS medical and psychological consultants (but not the opinions of DDS “single decision makers” who are neither physicians nor psychologists). (See 20 CFR § 404.1527(e), § 416.927(e), and SSR 96-6p).

- The ALJ must explain in the decision the weight given to the opinions of a state agency medical/psychological consultant or other program medical or psychological source.

- The decision must include an explanation of how the opinions were considered.

In addition, the ALJ decision should reflect consideration of opinions from medical sources that are not "acceptable medical sources" and from "non-medical sources" that have seen the claimant in a professional capacity using those factors in 20 CFR § 404.1527(c), 20 CFR § 416.927(c), in addition to the qualifications of the source (SSR 06-03p).

Decisions on Disability by Other Governmental and Nongovernmental Agencies (20 CFR § 404.1504, § 416.904, and SSR 06-03p

- A determination by another agency (e.g., Workers' Compensation, the Department of Veterans Affairs, an insurance company) that the claimant is disabled is not binding on Social Security. However, evidence of a disability decision by another governmental or nongovernmental agency cannot be ignored and must be considered and evaluated using the factors identified in 20 CFR § 404.1527(c) and § 416.927(c).

Distinguish Between Medical Source Statements (Medical Opinions) and RFC Assessments

SSR 96-5p

A medical source statement is a medical opinion from an acceptable medical source about what an individual can still do despite his or her impairment(s).

RFC is an assessment by an adjudicator that is based on consideration of all the relevant evidence (20 CFR § 404.1545 and § 416.945).

A medical source statement may be based on the acceptable medical source's records and examinations of the claimant but may not reflect consideration of other medical and non-medical evidence of record. Thus, medical source statements may provide an incomplete picture of claimant's abilities.

Format of Medical Opinions

Narrative Reports

Physical Capacities Assessments include:

- SSA-4734-BK (Physical RFC Assessment Form) – Completed by DDS medical consultants, and

- HA-1151 BK (04/2009) (Medical Source Statement of Ability to Do Work-Related Activities (Physical) – Used by ODAR.

Mental Capacities Assessments include:

- SSA-4734-F4 SUP (Mental Residual Functional Capacity Assessment) – Completed by DDS medical and psychological consultants, and

- Form HA-1152-U3 (06/2006) (Medical Source Statement of Ability to Do Work-Related Activities (Mental)) – Used by ODAR.

Medical opinions can be in the form of testimony, as for example, the testimony of a medical expert at the hearing.

EXERCISE

Estimated time to complete – 10 minutes

1. What sources opinions are used in the assessment of RFC?

2. What is the claimant's burden in providing medical evidence?

3. What is the Commissioner's burden?

4. What is a medical opinion?

5. Who are acceptable medical sources?

6. Name the factors considered when evaluating medical opinions.

7. Name the issues reserved to the Commissioner.

EXERCISE ANSWERS

1. Opinions used in the assessment of RFC include :

   - medical opinions from acceptable medical sources,
   - opinions from other health care providers who are not acceptable medical sources, such as physician assistants, chiropractors and audiologists,
   - opinions from non-medical sources, such as school teachers, developmental center workers, daycare center workers, and from public and private social welfare agency personnel who have seen the individual in their professional capacity, and
   - opinions from relatives, friends, neighbors, clergy and employers.

2. The claimant has the burden of proving to the Administration that he or she is blind or disabled and must provide medical and other evidence that shows he or she has an impairment(s) and how severe it is during the time he or she is claiming to be disabled. The individual must also provide evidence showing how the impairment(s) affects functioning during this time period, and any other information that is needed to make a determination or decision.

3. The SSA Commissioner has the burden of making every reasonable effort to help an individual get medical reports from his or her medical sources when the individual gives the agency permission to request the reports. Before SSA can make a determination that an individual is not disabled the agency will develop the individual's complete medical history, for at least the 12 months preceding the 12 months in which the application is filed unless there is reason to believe that development of an earlier period is necessary or unless the individual says that disability began less than 12 months before the application was filed.

4. A medical opinion is a statement from an "acceptable medical source" about the nature and severity of a claimant's impairment(s), including symptoms, diagnosis and prognosis, what the claimant can do despite the impairment(s), and physical or mental restrictions.

5. Acceptable medical sources are licensed physicians or osteopathic doctors, licensed or certified psychologists, including school psychologists, or other licensed or certified individuals with other titles who perform the same function as a school psychologist in a school setting, for establishing intellectual disability, learning disabilities and borderline intellectual functioning only, licensed optometrists (for purposes of establishing visual disorders only (in U.S. VI, for the measurement of visual acuity and visual fields only), licensed podiatrists for purposes of establishing

impairments of the foot or foot and ankle only, and qualified speech-language pathologists for purposes of establishing speech or language impairments only.

6. When evaluating medical opinions we must consider the examining and treatment relationship, length and frequency of examinations, the nature and extent of the treatment relationship, the supportability of the opinion, the consistency of the record, the source's specialty, and any other factors that support or contradict the opinion.

7. Issues reserved for the Commissioner are whether the claimant is disabled or unable to work, whether the impairment meets or equals a listing, the claimant's RFC, whether the claimant can perform PRW and the application of the vocational factors of age, education, and work experience.

From:	(b) (2)
To:	(b) (2)
Cc:	(b) (2) ; Swansiger, Susan J.; (b) (6)
Subject:	Addressing Findings of Fact Made by State Agency Medical and Psychological Consultants Found in the Disability Determination Explanation (DDE) - REMINDER
Date:	Monday, February 27, 2012 9:10:05 AM
Attachments:	(b) (5)

SOCIAL SECURITY

MEMORANDUM

Refer To: 12-711

Date: February 27, 2012

To: Regional Chief Administrative Law Judges

From: Debra Bice */s/*

Acting Chief Administrative Law Judge

Subject: Addressing Findings of Fact Made by State Agency Medical and Psychological Consultants Found in the Disability Determination Explanation (DDE) – **REMINDER**

In the course of the Office of Quality Performance's Disability Case Review, it has run across several cases in which Administrative Law Judge (ALJ) decisions state that the record contains no state agency medical opinions and that therefore SSR 96-6p did not apply when in fact the "A" Section of the e-file contained a Disability Determination Explanation (DDE) and medical opinion evidence. In addition, in some cases, the DDE in the file was not exhibited.

On April 25, 2011, I sent out a memorandum reminding hearing office personnel that state agencies using the Electronic Claims Analysis Tool (eCAT) will produce a DDE that includes medical and vocational findings. *See* Attached April 25, 2011 Memorandum.

(b) (7)(E)

As a reminder, pursuant to 20 CFR §§ 404.1527, 416.927 and SSR 96-6p, findings of fact made by state agency medical and psychological consultants and other program physicians and psychologists regarding the nature and severity of an individual's impairment(s) must be evaluated as expert opinion evidence of non-examining sources at the hearing level. In eCAT

cases, these findings of fact may be contained in the DDE.

Kindly remind your hearing offices that the DDE must be exhibited and any state agency consultants' opinions in the DDE must be addressed in the decision.

If you have any questions or comments, please let me know. The staff contact is (b) (6), Attorney-Advisor, who may be reached at (b) (6).

cc: Regional Office Management Teams

Attachment: April Memo

RELEASED BY:

(b) (6)

Office of the Chief Administrative Law Judge

(b) (6)

(b) (6)

SOCIAL SECURITY

MEMORANDUM

Date: April 25, 2011

Refer To: 10-1599

To: All Regional Chief Administrative Law Judges

From: Debra Bice */s/*
Acting Chief Administrative Law Judge

Subject: Placement of the Disability Determination Explanation (DDE) in the Certified Electronic Folder (CEF) -- **INFORMATION**

This memorandum is to remind hearing office personnel that state agencies are using the Electronic Claims Analysis Tool (eCAT) tool in the Disability Processing Branches (DPBs), Disability Processing Units (DPUs), Office of International Operations (OIO), Office of Disability Operations (ODO), Office of Medical and Vocational Expertise (OMVE), and 42 states, with the rollout scheduled for completion in May 2011. Using eCAT, these adjudicative components will produce a disability determination explanation (DDE) that includes medical and vocational findings. (b) (7)(E)

(b) (7)(E)

More information is available via a Video-on-demand on the Office of Learning's Intranet site or you can simply click this link: eCAT DDE and ODAR. We also created a mailbox for any additional questions (b) (2)).

Please share this information with hearing office staff. If you have any questions or comments, please let me know. The staff contact is (b) (6) , attorney-advisor, who may be reached at (b) (6) .

cc: Regional Management Officers
Regional Office Management Teams

SOCIAL SECURITY ADMINISTRATION

Notes – Please e-mail memo from (b) (2) **to** (b) (2) **) and cc:** (b) (2) (b) (2) (b) (6) **, and** (b) (6) **.**

Please close ACL

Please return assignment folder to (b) (6) **.**

Thank-you.

Saved As: (b) (2)

Attachment:
ICN or Unassigned:
Draft Completion Date: 01/14/2011
Prepared By: (b) (6)
E-File Code:
Reviewed/Revised By: (b) (6)

FILE COPY

OFFICE	SURNAME	DATE	OFFICE	SURNAME	DATE
OCALJ	(b)	4/19/11	OCALJ	Judge Bice	4/22/11
OCALJ	(b)	4/19/11	ODP	(b) (6)	3/30/11
OCALJ	(b)	3/25/11	OAO	(b) (6)	4/19/11
OCALJ	Swansiger				
CERTIFIED: WRITTEN IN PLAIN LANGUAGE					

For Form SSA-294 (1-2000) Destroy Prior Editions

From: (b) (2)
Sent: Tuesday, September 14, 2010 9:32 AM
Subject: Consideration of Single Decisionmaker (SDM) Residual Functional Capacity Assessments and Other Findings -- REVISED

SOCIAL SECURITY

Office of the Chief Administrative Law Judge

MEMORANDUM

Refer To: 10-1691

Date: September 14, 2010

To: Regional Chief Administrative Law Judges

From: John P. Costello*/s/*

Acting Associate Chief Administrative Law Judge

Subject: Consideration of Single Decisionmaker (SDM) Residual Functional Capacity Assessments and Other Findings -- **REVISED**

This memorandum revises and replaces all previously issued memoranda addressing the evaluation of SDM residual functional capacity (RFC) assessments.

> Under procedures set out in 20 CFR 404.1615 and 416.1015, a team comprised of a State agency disability examiner and a State agency medical consultant (MC) or psychological consultant (PC) ordinarily makes the State agency's disability determination. Both members of the team are responsible for the determination. However, under the test modifications to the disability determination process found in 20 CFR 404.906(b)(2) and 416.1406(b)(2), State agency disability examiners designated as SDMs may make disability determinations alone in many cases. In making these determinations, SDMs may consult with State agency MCs or PCs, but they are not required to, and MCs and PCs do not approve these determinations even when SDMs ask for their assistance. Since the SDMs are solely responsible for the determinations, they must make all of the necessary findings of fact, including their own assessments of RFC when necessary.

For this reason, many case files that come from States that use SDMs will include Physical RFC Assessment forms (Form SSA-4734-BK) signed by SDMs, or their electronic equivalents in States that use the Electronic Claims Analysis Tool (eCAT) program. There may also be other forms containing other SDM findings. Agency policy is that findings made by SDMs are not opinion evidence that Administrative Law Judges (ALJs) or Attorney Adjudicators (AAs) should consider and address in their decisions. See, for example, POMS DI 24510.050C, which states that SDM-completed forms are not opinion evidence at the appeal levels. SDM findings are not "medical opinion" evidence since they do not come from medical sources. However, agency policy is that they are also not the opinions of non-medical sources as described in SSR 06-3p.

Therefore, ALJs and AAs must not consider SDM RFC assessment forms and other findings as opinion evidence and must not evaluate them in their decisions. ALJs and, by extension, AAs must continue to consider findings made by State agency MCs and PCs as opinion evidence and weigh that evidence together with the other evidence in the record when they make their decisions. 20 CFR 404.1527(f) and 416.927(f) and Social Security Ruling 96-6p.

The State agency should clearly identify any forms that are signed by SDMs. Nevertheless, the ALJ or AA is ultimately responsible for checking the signature lines of any relevant forms and ensuring that the decision does not erroneously include an evaluation of SDM findings. In addition, since SDMs are permitted to consult with MCs and PCs, some case files will include RFC assessment or other forms that are signed by MCs and PCs in addition to forms signed by SDMs. ALJs and AAs should be aware that the case file may contain some forms that they must evaluate and some forms that they must not, and ensure that they are evaluating only forms that contain opinions from MCs and PCs.

(b) (7)(E)

[redacted]

Please share this information with all hearing office personnel in your region. If you would like to discuss this matter, please let me know. My staff contact is Attorney-Advisor (b) (6), who may be reached at (b) (6).

cc: Regional Office Management Teams

RELEASED BY:

(b) (6)

Management Analyst

Office of the Chief Administrative Law Judge

HQ Support Branch

Social Security Administration

5107 Leesburg Pike, Suite 1608

Falls Church, VA 22041

(b) (6)

(b) (6)

Evaluating Medical Opinions

Module 8

20 CFR 404.1502, 416.902, 404.1513, 416.913, 404.1527, 416.927

SSRs 96-2p, 96-5p, 96-6p, 06-3p

Every Medical Opinion Must Be Considered

- Consider all relevant evidence
- Often conflicting medical opinions
- Decision is a legal determination
- RFC is function by function assessment

Examining Relationship

- Generally, more weight to the opinion of a source who has examined the claimant.

Treating Relationship

- More able to provide a detailed, longitudinal picture of the impairments, and
- May bring a unique perspective that cannot be obtained from medical findings alone or reports of individual examinations

Length of the treatment relationship

- Frequency of examination = Greater weight

Nature and Extent

- Knowledge of impairments
- Kinds and extent of examinations and testing the source has performed or ordered

Supportability

- Relevant evidence to support an opinion
- Medical signs and findings
- Persuasive explanation

Consistency

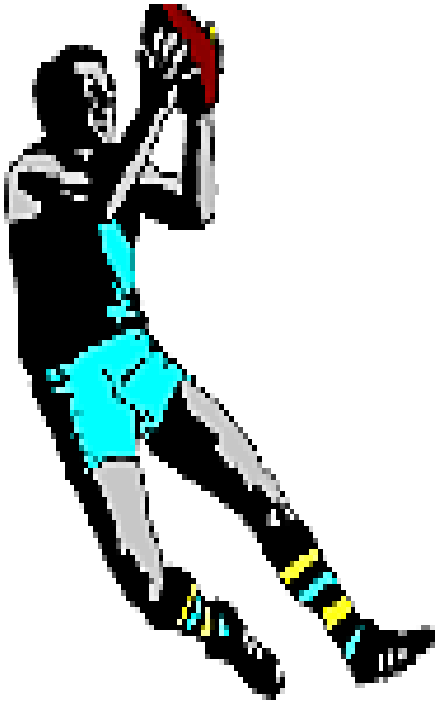
- With the record as a whole (other medical opinions, lay statements)

Specialization

- Medical issues related to her area of specialty
- Professional Qualifications Statement

Other Factors

- Understanding of SSA Disability
- Other information in the claimant's case

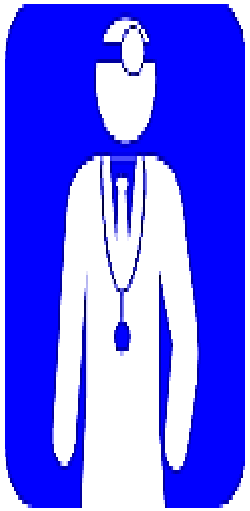


Acceptable Medical Sources - Licensed

- Physicians – M.D. or D.O.
- or certified psychologists
- Optometrists
- Podiatrists
- Speech-Language Pathologists

Acceptable Medical Sources

- Medically Determinable Impairment
- Give medical opinions
- Entitled to controlling weight



Other Sources

- Medical Sources
- Non-Medical Sources (In capacity)
- Non-Medical Sources (Out of capacity)

Opinions on Issues

- Reserved to the Commissioner

IT'S THE LAW!

Decisions on Disability

- By other Governmental and nongovernmental agencies
- Not binding on SSA but must be considered

MSS/RFC

- Medical Source statements may provide an incomplete picture of a claimant's abilities
- RFC is the adjudicator's assessment

Medical Opinions

- Narrative Reports (Physical/Mental)
- Testimony
- Limited circumstances for controlling weight
- Accepted or rejected in part
- Support the weight without stock phrases
- May decide without a MSS

Role of DDS

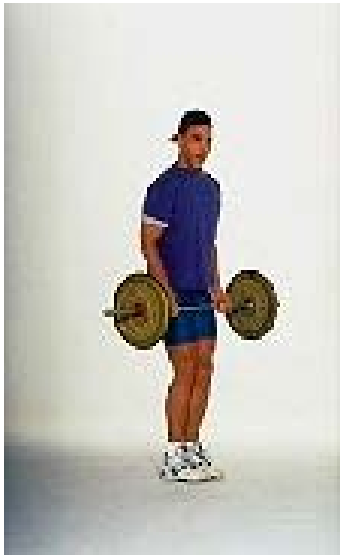
- Address and assign weight to all opinions by the Disability Determination Service
- Single Decision Makers are neither physicians nor psychologists

All Together Now

- Acceptable Medical Source
- Treating, Examining, Consultative
- Frequency of Exams
- Nature, Extent and Length of Treatment
- Specialization
- Supportability
- Consistency
- Other Factors

How Much Weight

- And why?



MANAGEMENT FACILITATOR GUIDE FOR
REVISIONS TO THE RULES REGARDING THE EVALUATION OF MEDICAL EVIDENCE

This Guide is for use by the HOCALJ, HOD, DCAAJ, DD, and/or their designee(s) leading the discussion following the May 2017 IVT on the *Revisions to the Rules Regarding the Evaluation of Medical Evidence*.

To prepare for the discussion, the designated facilitator(s) should review the Keys. Handouts of these documents should be distributed to all attendees. The purpose of this guide is to provide structure for the discussion, offer some practical tips, and identify materials to encourage a timely and interactive group discussion with broad participation. The facilitator should prepare in advance of the training session by reviewing the Keys and Quick Notes. This format should be an interactive discussion rather than a lecture. The session should last 45 minutes to an hour.

Please distribute the "Keys" and "Quick Notes" to all attendees.

Here are some tips to help facilitate the discussion:

- ask topical, open-ended questions;
- listen well;
- ask questions of those who haven't participated;
- model respectful discourse;
- paraphrase a participant's input;
- sequence or "stack" inputs when several people want to speak to the same issue;
- ask for other points of view;
- elaborate on positive contributions.

Here are some things NOT to do as a facilitator:

- start or end the session late;
- force participation of an unwilling attendee;
- read lengthy prepared text;
- allow yourself to get behind then rush through material to make up for lost time;
- belittle or ignore any participant or any participant's input;
- make disparaging comments about Judges, staff, managers, the agency, or agency components;
- use evaluative terms in describing an input, either good or bad, e.g. "wrong" or "excellent."

Use the THREE Keys as a starting point to structure and guide the post-training discussion. Bullet points of relevant topics/ideas are included at each "key" to facilitate discussion. Some of the questions posted are open-ended and do not have corresponding answers or examples. Please feel free to include additional bullets points to encourage more participation.

KEY ONE: The current rules, or those that apply to claims filed on or after March 27, 2017, redefine and classify evidence into five categories; and clarify the definition of a medical opinion.

- What are the five categories of evidence?
    - Answer: *Objective medical evidence, medical opinions, other medical evidence, evidence from nonmedical sources, and prior administrative findings.*

- What are examples of objective medical evidence?
    - Answer: *Signs and/or laboratory findings.*

- How do the current rules define a medical opinion for an adult claim?
    - Answer: *An opinion by a medical source regarding the claimant's ability to perform mental, physical, or other demands (seeing/hearing/using other senses) of work activities and adapt to environmental conditions.*

- What providers are included as acceptable medical sources in the current rules?
    - Answer: *APRN (Advanced Practice Registered Nurse, certified nurse midwives, nurse practitioner, certified registered nurse anesthetists, and clinical nurse specialists), Physician Assistants (PAs), and Audiologists.*

- What must an opinion for child cases include?
    - Answer: *Mention a child's impairment-related limitation in ability related to six domains of functioning.*

- Identify some examples of other medical evidence.
    - Answer: *Medical history, prognosis, prescribed treatment.*

- Identify an example of evidence from nonmedical sources.
    - Answer: *Statements from a teacher, counselor, or social worker.*

- What are prior administrative findings?
    - Answer: *DDS (Medical and/or Psychological Consultant) findings.*

- Hypothetical: For a claim filed on or after March 27, 2017, the claimant's chiropractor, Ms. Jones, finds that the claimant's right knee pain is due to degenerative joint disease, as shown on an MRI. As a result, Ms. Jones noted that the claimant is limited to sitting up to six hours in an eight-hour workday.
    - What portion of the statement is opinion evidence? ***Claimant is limited to sitting up to six hours in an eight-hour workday.***
    - What portion of the statement is objective medical evidence? ***The MRI.***
        - *Important to note that because Ms. Jones qualifies as a medical source we do not need to see if she is an acceptable medical source to determine if the statement is a medical opinion; however, only objective

medical signs, laboratory findings, or both from acceptable medical source can establish the existence of MDI*

KEY TWO: The current rules explain the type of evidence that we do not find inherently valuable or persuasive such as evidence on issues reserved to the Commissioner and decisions of other governmental entities and nongovernmental entities.

- For claims filed on or after March 27, 2017, what are the two types of evidence that are neither valuable nor persuasive?
    - Answer: (1) *Decisions by other governmental agencies and nongovernmental agencies and (2) issues reserved for the Commissioner*

- Is written analysis required?
    - Answer: *For claims filed on or after March 27, 2017, the answer is no, unless it is a prior administrative medical finding by a DDS medical/psychological consultant.*
        - *Note- Though under the current rules written analysis is not required on decisions by other governmental and nongovernmental entities, we must always consider all of the supporting evidence underlying the other agency or entity's decision that we receive in a claim. The underlying evidence may require a written analysis.

- What are some examples of other governmental agencies and nongovernmental agencies that issue decisions we do not find inherently valuable or persuasive?
    - Answer: *The Department of Veteran's Affairs, Department of Defense, Department of Labor, Office of Personnel Management, State agencies and private insurers. These agencies and entities make disability, blindness employability, Medicaid, workers' compensation and other benefit decisions for their own programs using their own rules. See 20 CFR 404.1504 and 416.904.*

- Do the prior or current rules change how we expedite processing for military casualty or wounded warrior cases?
    - Answer: *No, these cases continue to receive expedited processing under HALLEX I-2-1-40 and I-3-1-5. These cases involve current or former military member who sustained an illness, injury, or wound; alleges physical or mental impairment regardless of how the impairment occurred; AND sustained impairment while on active duty status on or after October 1, 2001. For additional information on Wounded Warriors and Veterans, see https://www.ssa.gov/people/veterans.*

- What are examples of statements on issues reserved for the Commissioner?
    - Answer: That a claimant is or is not disabled, blind, able to work, or able to perform regular or continuing work;

- Whether a claimant has a severe impairment;
- Whether an impairment meets the duration requirement;
- Whether an impairment meets or medically equals any listing; Title 16 child claims: whether or not an impairment functionally equals listings;
- What a claimant's RFC is that uses our programmatic terms about the functional exertional levels instead of descriptions about the claimant's functional abilities and limitations;
- Whether a claimant's RFC prevents him/her from doing PRW;
- That a claimant does or does not meet requirements for a medical-vocational rule; AND
- Whether an individual's disability continues or ends when we conduct a CDR

- Hypothetical: In a claim filed on or after March 27, 2017, Dr. Brown, a cardiologist, says that due to coronary artery disease, the claimant has a history of shortness of breath and chest pain and can never climb ladders, ropes, and scaffolds or work around pulmonary irritants. Additionally, the claimant cannot sustain regular and continuous work due to her coronary artery disease.
  - What is the medical opinion? ***The portion of the first sentence that says the claimant "can never climb ladders, ropes, and scaffolds or work around pulmonary irritants."***
  - What is the issue reserved for the Commissioner? ***The second sentence****.*

- Hypothetical: During the hearing, a medical expert testifies that a claimant's mood disorder meets listing 12.04. What questions should an ALJ ask the medical expert?
  - How did you reach this conclusion? OR How does the evidence support these findings?
  - Which mental status exams did you consider?
  - If the evidence does not show all of the requirements to meet the listing, is there other evidence present that tends to support the claimant's impairment is severe enough to equal the listing? What is that evidence?

- Hypothetical: Under the current rules, the claimant has been diagnosed with obesity and lumbar degenerative disc disease. Nurse practitioner, Ms. Smith, indicates, as a result of these impairments that the claimant can perform sedentary work. Specifically, the claimant needs to alternate between sitting and standing every ten minutes, can lift and carry no more than 10 pounds, and cannot stand or walk for more than four hours in an eight-hour workday. Lastly, Ms. Smith states the claimant is disabled and cannot work.
  - What portion of this statement is an issue reserved for the Commissioner?
    - *The claimant can perform sedentary work; AND*
    - *The claimant is disabled and cannot work.*
  - What portion is a medical opinion? *The claimant can alternate between sitting and standing every ten minutes, lift and carry no more than 10 pounds, and cannot stand or walk for more than four hours in an eight-hour workday.*

KEY THREE: The current rules change how we consider and articulate our consideration of medical opinions and prior administrative findings for claims filed on or after March 27, 2017.

- Under the current rules, we no longer need to give specific weight to any medical opinion or prior administrative medical finding. Instead, we MUST consider the persuasiveness of the evidence in file. What are the most important factors in assessing persuasiveness and the ones we have to provide articulation for on all medical opinions?
    - Answer: *Supportability and consistency.*

- For a claim filed on or after March 27, 2017, which medical opinion is more persuasive?
    - Treatment notes from Dr. Black include a nerve conduction study that shows moderate bilateral carpal tunnel syndrome, with weakness in both hands and decreased range of motion in both wrists. Dr. Black explains that, based on the claimant's bilateral carpal tunnel syndrome and the results of the physical examination, the claimant is limited to lifting five pounds, can occasionally push or pull, and can occasionally engage in fine manipulation.
    - In contrast, Dr. Davis says that the claimant is limited to lifting five pounds, cannot push or pull, and cannot engage in fine manipulation due to her bilateral carpal tunnel syndrome. Dr. Davis provides no additional information or evidence.
    - *Based on the facts, Dr. Black's opinion is more persuasive. Dr. Davis merely provided a diagnosis to support his medical opinion.*

- Is the following medical opinion persuasive based on the consistency of the information provided?
    - Dr. Wilson, the claimant's psychologist, says that the claimant could not interact with the public and would be absent from work three days a month due to her generalized anxiety disorder. There are no other documented or alleged impairments. Regular mental health treatment notes show that the claimant was prescribed Xanax. She reports her mood as improved and stable with no panic attacks when using medication. The claimant reported no other symptoms of anxiety. At the hearing, the claimant testified that she works part time as a cashier and was no longer isolating herself from others.
    - *Not persuasive because this is inconsistent with objective medical evidence.*

- In the event two or more medical opinions are equally well supported and consistent with the evidence on the same issue, but are not exactly the same, under the current rules, we are required to discuss the other most persuasive factors, which can include?
    - Answer: *Relationship with the claimant, specialization, and other relevant factors (such as new evidence).*

- When evaluating the relationship with a claimant, what do we consider?
    - Answer: *Length of treatment relationship, frequency of exams, purpose of treatment relationship, extent of treatment relationship, and examining relationship.*

- Where there are multiple medical opinions from a single medical source, how should we discuss them?
    - Answer: *Articulate all opinions together and provide only one written analysis.*

- Do we need to provide written analysis on how we consider medical opinions from ALL medical sources?
    - Answer: *Yes, it does not matter if the opinion is from an acceptable medical source or not. This is due to the changing nature of healthcare.*

- Hypothetical – How to evaluate the following opinions under the current rules:
    - The claimant alleges disability due to bipolar disorder. Throughout the period at issue, Dr. Taylor, a psychiatrist, has treated the claimant repeatedly for his mental impairment. Dr. Taylor's treatment notes show that the claimant complains of going on buying sprees, a decreased need for sleep, and increased energy. Dr. Taylor noted on examination that the claimant was distracted, exhibited increased agitation, and was not always easy to follow. The claimant also regularly performed poorly on mental status exams; he presented with impaired concentration. Based on her experience treating the claimant and her medical specialty, Dr. Taylor said the claimant could concentrate for up to two hours at a time and needs low stress work environment, which means rare changes and no fast-paced production rate.

    - The claimant receives her primary care from a PA, Mr. Moore. While the claimant has discussed his mental condition with him, Mr. Moore does not provide any specific treatment for it. Nevertheless, Mr. Moore said the claimant's bipolar disorder limits the claimant to low stress work.

    - Two DDS psychological consultants also reviewed the record. They both found that, due to bipolar disorder, the claimant can never understand, remember, and carry out complex instructions and can only work in a low stress environment.

    - Answer:

        - *Mr. Moore's opinion is not persuasive because Mr. Moore provides no explanation for his opinion.*

        - *The objective medical evidence, such as exam findings and clinical observations, as well as explanations, supports Dr. Taylor's opinion. It is*

consistent with the evidence of the other medical and nonmedical sources.

- *The prior administrative findings are also supported by the objective medical evidence and consistent with the evidence from the other sources.*

- *Because Dr. Taylor and the DDS' findings are equally well supported and consistent with the record, we need to articulate how we considered the other most persuasive factors. For example, Dr. Taylor's long-term treatment of the claimant's mental condition and specialization because Dr. Taylor is a psychiatrist. We also should consider other most persuasive factors, such as DDS' familiarity with other evidence in the claim and understanding of our program's policies and evidentiary requirements.*

- Do the current rules change the fact that we need to provide articulation on our evaluation of the claimant's alleged symptoms?
  - Answer: *No, we must still apply the policies of SSR 16-3p and provide written articulation on how we evaluated the claimant's alleged symptoms.*

- Under the current rules, do we need to consider statements from nonmedical sources?
  - Answer: *We are not required to provide the same articulation for nonmedical sources that we are for medical opinions and prior administrative medical findings. However, there may be some instances where such articulation is necessary. Teachers, counselors, and social workers are nonmedical sources who have close contact with child claimants.*

Remember the current rules apply only to claims filed on or after March 27, 2017*

OTHER ISSUES: We rescinded SSR 96-2p; SSR 96-5p; SSR 96-6p; and SSR 06-03p, and we incorporated these policies into the prior rules, those that apply to cases filed before March 27, 2017. What are four SSRs that we rescinded?

- *Answer:*
  - *SSR 96-2p: Titles II and XVI Giving Controlling Weight to Treating Source Medical Opinions*

  - *SSR 96-5p: Titles II and XVI: Medical Source Opinions and Issues Reserved to the Commissioner*

  - *SSR 96-6p: Titles II and XVI: Consideration of Administrative Findings of Fact by State Agency Medical and Psychological Consultants and Other Program*

Physicians and Psychologists at the Administrative Law Judge and Appeals Council -Levels of Administrative Review; Medical Equivalence

- *SSR 06-03p: Titles II and XVI: Considering Opinions and Other Evidence from Sources Who Are Not "Acceptable Medical Sources" in Disability Claims; Considering Decisions on Disability by Other Governmental and Nongovernmental Agencies*

- For the prior rules, the following final regulation cites were updated and to include the policies previously in the rescinded SSRs. USE THESE REGULATIONS INSTEAD OF CITING TO RESCINDED SSRs
    - 404.1527(d) and 416.927(d) give guidance on how to consider medical source opinions on issues reserved to the Commissioner, which was previously provided in SSR 96-5p.

    - 404.1527(e) and 416.927(e) provide guidance on considering administrative findings of fact by state agency medical and psychological consultants and other program physicians and psychologists, which was previously provided in SSR 96-6p.

    - 404.1527(f) and 416.927(f) provide guidance on considering opinions and other evidence from sources who are not acceptable medical sources and on considering decisions on disability by other governmental and nongovernmental agencies, which was previously provided in SSR 06-03p.

    - SSR 17-2p provides guidance on issues relating to medical equivalence, which was previously provided in SSR 96-6p.

- Example: In a case filed before March 27, 2017, the medical record includes an opinion from a nurse practitioner, who provided treatment to the claimant. Under SSR 06-03p, an opinion from a nurse practitioner, who is a medical source but not an acceptable medical source under the prior rules may be found to have greater weight than the opinion of an acceptable medical source. Adjudicators should explain the weight given to that opinion. Because we rescinded SSR 06-03p and updated the prior rules. What prior rules should we use in this scenario:
    - *Answer: In evaluating this opinion under the prior rules, we should cite to 404.1527(f) and 416.927(f) NOT SSR 06-03p.*

- How do attendees currently keep up/stay up-to-date with other sub-regulatory changes that will be made in POMS and HALLEX that relate to the rules?
    - *We receive "Daily PolicyNet Instructions Postings" via <u>email</u> to advise if an SSR/Hallex/POMS/or Code section is rescinded, updated, amended, etc. This is the best way to stay up-to-date with changes.*

- Filing Date Scenarios

- For a single claim, either Title II or Title XVI with a filing date before March 27, 2017, we must use the prior rules – the same for concurrent claims

- For a single claim, either Title II or Title XVI with a filing date on or after March 27, 2017, we must use the current rules – the same for concurrent claims.

- If a Title II claim has a filing date before March 27, 2017 and a later Title XVI claim has a filing date on or after March 27, 2017, we must apply the prior rules for both claims. The same is true if the titles were switched around.

- What are two unique situations that we face in ODAR regarding filing dates?

- *Answer: Two unique situations: (1) The Appeals Council sometimes offers a claimant a Protected Filing Date (PFD) for a subsequent application if initiated within 60 days for a Title XVI claim or 6 months for a Title II claim. So, the official filing date may predate when the claimant initiates a subsequent application. (2) A subsequent application could be consolidated with an existing claim. This happens most with court remands and when exceptions are granted under SSR 11-1p. In those scenarios, we sometimes consolidate claims if they have overlapping periods. If the claims are going to be consolidated and the existing or claim filed first was filed before March 27, 2017 then we use the prior rules, regardless of if the subsequent claim was filed on or after March 27, 2017. HALLEX will be updated to reflect this.*

- Review POMS DI 24503.050 to see which rules apply in other less common scenarios, such as reopening, when a claim was chosen for Quality Review at the initial or reconsideration level, claim escalation situations, CDRs, claims involving different Social Security numbers (such as child disability benefits), and collateral estoppel.

- When you anticipate processing claims filed on or after March 27, 2017?
  - We will most likely see critical cases first and those may come in a couple of months. Then, depending if you are in a prototype state at the hearing level or work prototype state cases at the Appeals Council, those will be the cases you see first on a regular basis. Generally, discuss when you anticipate seeing cases in your area. Also, remind people that they can look for the eView indicator to help identify if a case was filed under the prior or current rules or they can always look at the application date.

Adjudication Tip #17 – Medical Source Statements Submitted Without Supporting Treatment Notes

Revised April 05, 2018

For claims filed *before* March 27, 2017, a medical opinion is a statement from an acceptable medical source reflecting judgments about the nature and severity of impairment(s), including symptoms, diagnosis and prognosis, what a claimant can still do despite his or her impairment(s), and physical or mental restrictions. In weighing a medical opinion, the factors set forth in 20 CFR 404.1527(c) and 416.927(c) must be considered. One of those factors is supportability. "The more a medical source presents relevant evidence to support an opinion, particularly medical signs and laboratory findings, the more weight we will give that opinion." See 20 CFR 404.1527(c)(3) and 416.927(c)(3).

For claims filed on or after March 27, 2017, a medical opinion is a statement from a medical source about what an individual can still do despite his or her impairment(s) and whether the individual has one or more impairment-related limitations or restrictions in the following abilities: physical demands of work activities; mental demands of work activities; other demands of work, such as seeing, hearing, or using other senses; and ability to adapt to environmental conditions. Adjudicators will articulate the medical opinion's persuasiveness in the decision as appropriate under 20 CFR 404.1520c and 416.920c.

However, some medical opinions are submitted without supporting medical evidence from the medical source who provided the medical opinion. In that case, an adjudicator should consider obtaining or requesting the medical source's examination and progress notes. See 20 CFR 404.1520b(b) and 416.920b(b).

See 20 CFR 404.1512,404.1513, 404.1520, 404.1520b, 416.912, 416.913, 416.920, and 416.920b. For claims filed on or after March 27, 2017, see 404.1520c and 416.920c , and for claims filed before March 27, 2017, see 404.1527 and 416.927 .

Revised April 05, 2018

We all know that we must address and discuss medical source opinions in the record, but did you know that there are articulation techniques that can improve your medical opinion evaluations? Please note that these tips apply only to claims filed before March 27, 2017. For claims filed on or after March 27, 2017, see 404.1520c and 416.920c.

Below are some quick tips for evaluating medical source opinions, presented by the Office of General Counsel, Philadelphia Region:

1. Have all relevant medical opinions been mentioned in the decision?
   State names rather than exhibit numbers.
2. Is the weight given to each and every medical opinion articulated?
   Be specific – "little," "significant," "partial."
3. Are the reasons for rejecting the medical source opinion clearly explained?
   Follow and use the language of the regulations to support your evaluation.
4. Are the reasons for rejecting the medical source opinion supported by the evidence?
   Be specific and cite to exhibits.
5. Are all portions of the treating source's opinion addressed?
   Be aware of multiple opinions offered by the same medical source. Articulate why some portions of a medical source opinion are accepted and why some are rejected.

Remember, the key to avoiding remands is articulation. See 20 CFR 404.1512, 404.1513, 404.1520, 404.1520b, 416.912, 416.913, 416.920, and 416.920b. For claims filed on or after March 27, 2017, see 404.1520c and 416.920c, and for claims filed before March 27, 2017, see 404.1527 and 416.927 .

From: (b) (2)
Subject: Adjudication Tip #55 – Global Assessment of Functioning
Date: Tuesday, February 23, 2016 8:37:59 AM

Greetings ODAR! Here is the latest Adjudication Tip. We will publish this tip on the Office of the Chief Administrative Law Judge's website shortly.

How do you address Global Assessment of Functioning (GAF) ratings in your decisions? Although the Diagnostic and Statistical Manual of Mental Illness, fifth edition (DSM-5, effective in June 2013), does not include a GAF rating for assessment of mental disorders, you are likely to encounter medical evidence that includes GAF ratings. We consider a GAF rating as opinion evidence. See AM-13066REV.

Common problems with using GAF ratings to evaluate disability include that GAF ratings are not standardized, GAF ratings are not designed to predict outcomes, and GAF ratings need supporting detail. Because of these drawbacks, an adjudicator cannot rely solely upon a GAF rating to support a disability decision, nor equate a particular GAF rating with a listing-level limitation or with a particular mental residual functional capacity assessment. See AM-13066REV.

As GAF ratings are considered opinion evidence, an adjudicator needs to evaluate whether the GAF rating is well supported and consistent with other evidence in the record. For more information about assessing opinion evidence, see 20 CFR 404.1527(c), 416.927(c), and SSR 06-03p. As a GAF rating is a medical opinion, the weight the adjudicator assigns to a GAF score must be addressed in the decision.

For more information, see also Appeals Council Feedback Training-Opinion Evidence, A Special Note: GAF Scores and "Medical Source Statements" OCEP Q&A: "Are Global Assessment of Functioning (GAF) scores opinion evidence that must be weighed in a decision?"

In case you missed them, past adjudication tips are available on OCALJ's intranet site: (b) (2) *Please continue to send all comments and suggestions to* (b) (2) *Thank you.*

Assessing and Determining Credibility

Hon. Gregory Holiday, ALJ
Hon. Aaron Morgan, ALJ
Hon. Robert Johnson, DCAAJ
(b) (6)

Overview

- Credibility Refresher
- CFRs and SSR
- Appeals Council Practice Tips
- Office of General Counsel Practice Tips
- ALJ Instructions
- Summary

20 CFR 404.1527; 416.927

- Inconsistent evidence – weigh the evidence
- Hierarchy of Weighing Medical Evidence
  - Treating, Examining, Non-examining
- Supportability
- State Agency/Program Health Professionals
  - ALJs not bound, but…

20 CFR 404.1529(c)(2); 416.929(c)(2)

Evaluating Symptoms, Including Pain

- Must have MDI(s)
- Signs, Symptoms, Laboratory Findings
- Other Evidence (3rd Party Statements, ADLs)
- Impact of Pain and Symptoms on RFC

SSR 96-7p

When assessing credibility of statements, consider:

- ADLs
- Location, duration, frequency, intensity…
- Precipitating and aggravating factors
- Medications and side-effects
- Treatment (other than medications)
- Other measures and factors

SSR 96-7p

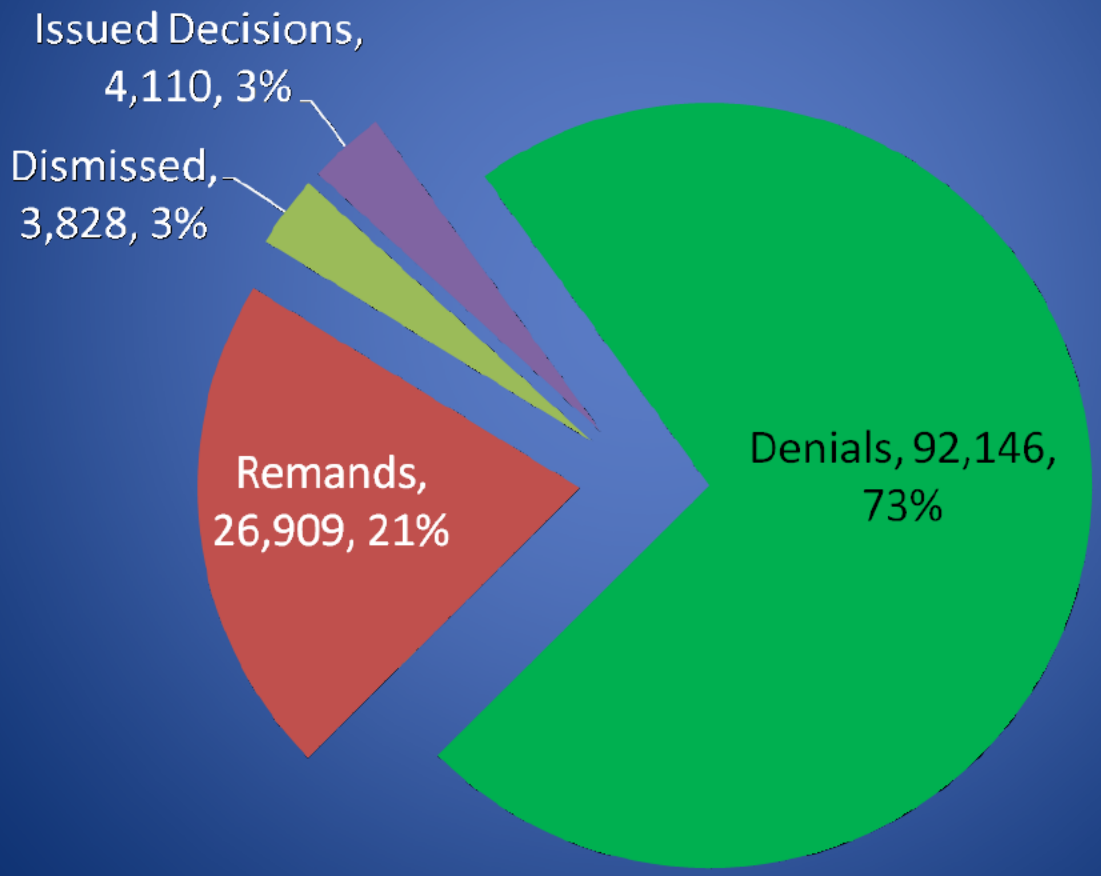
In making credibility findings:

- We can't use intuition or other intangibles
- Look for both consistency and inconsistency (internal and external)
- Need not totally accept or totally reject the person's statements.
- If relying on failure to seek treatment, consider reasons for same.

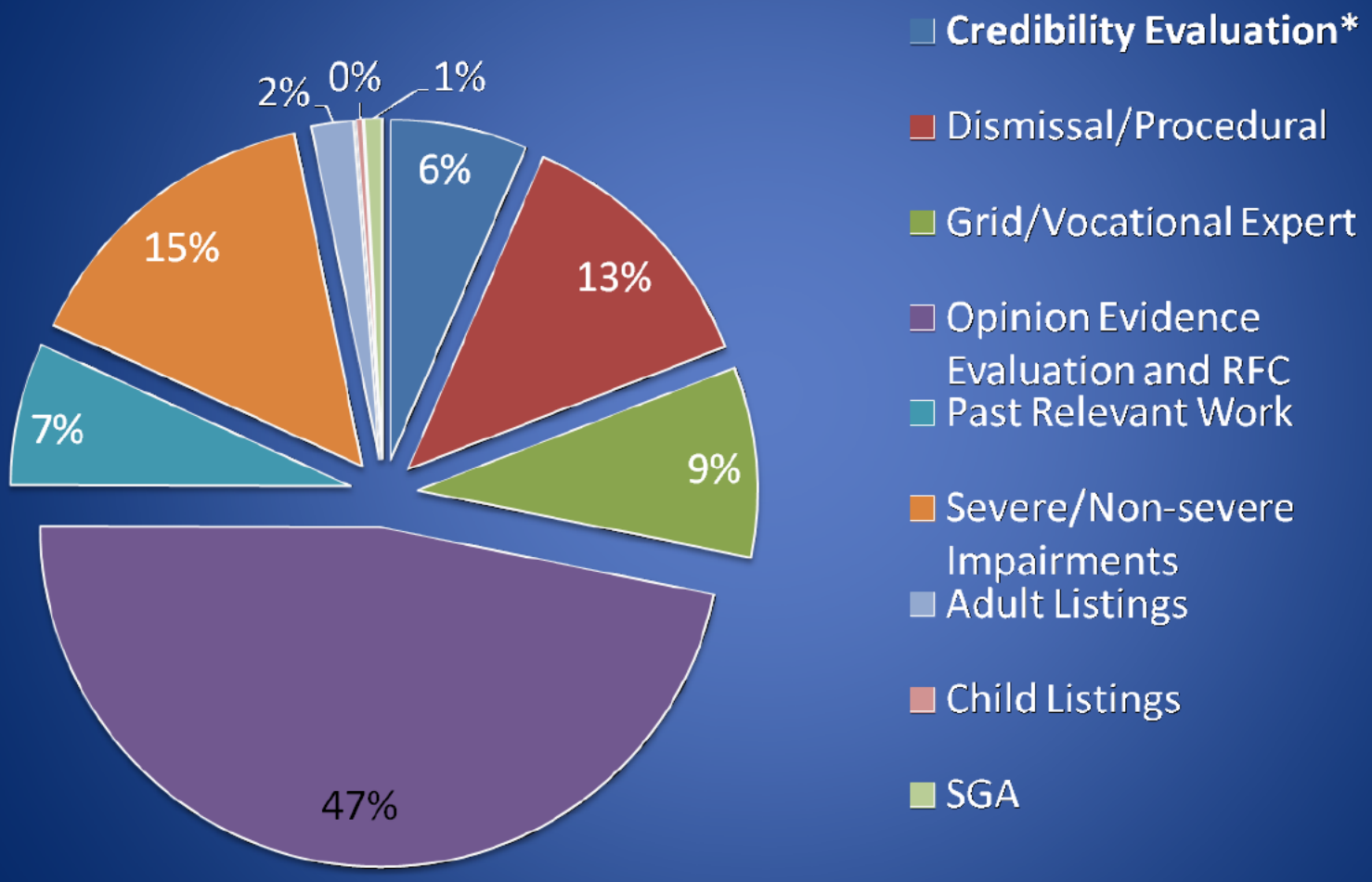
CREDIBILITY EVALUATION

THE APPEALS COUNCIL AND OFFICE OF THE GENERAL COUNSEL PERSPECTIVE

AC DISPOSITIONS – FY2011
Request for Review Cases

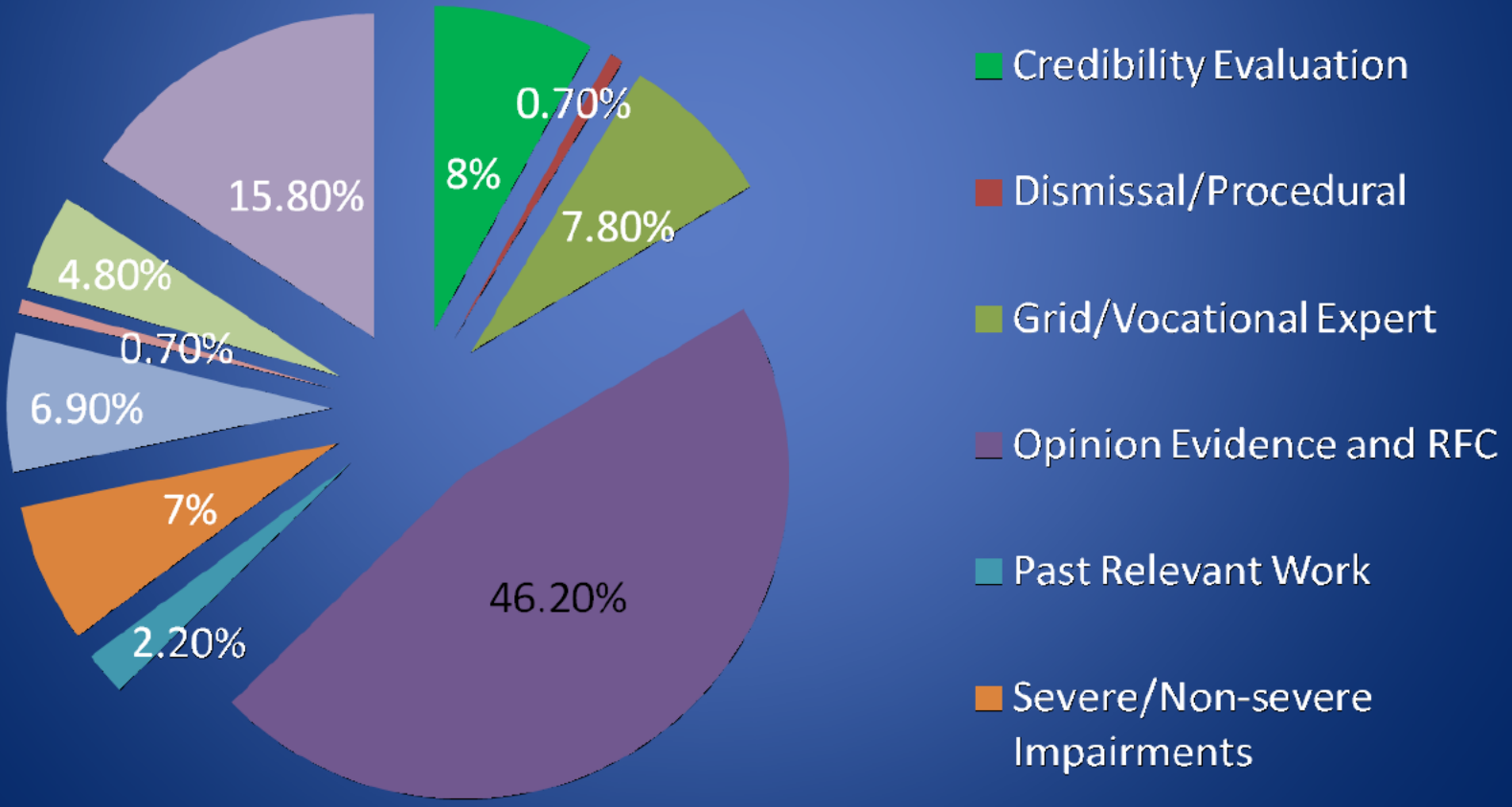


Primary Reasons for Remand – R/R

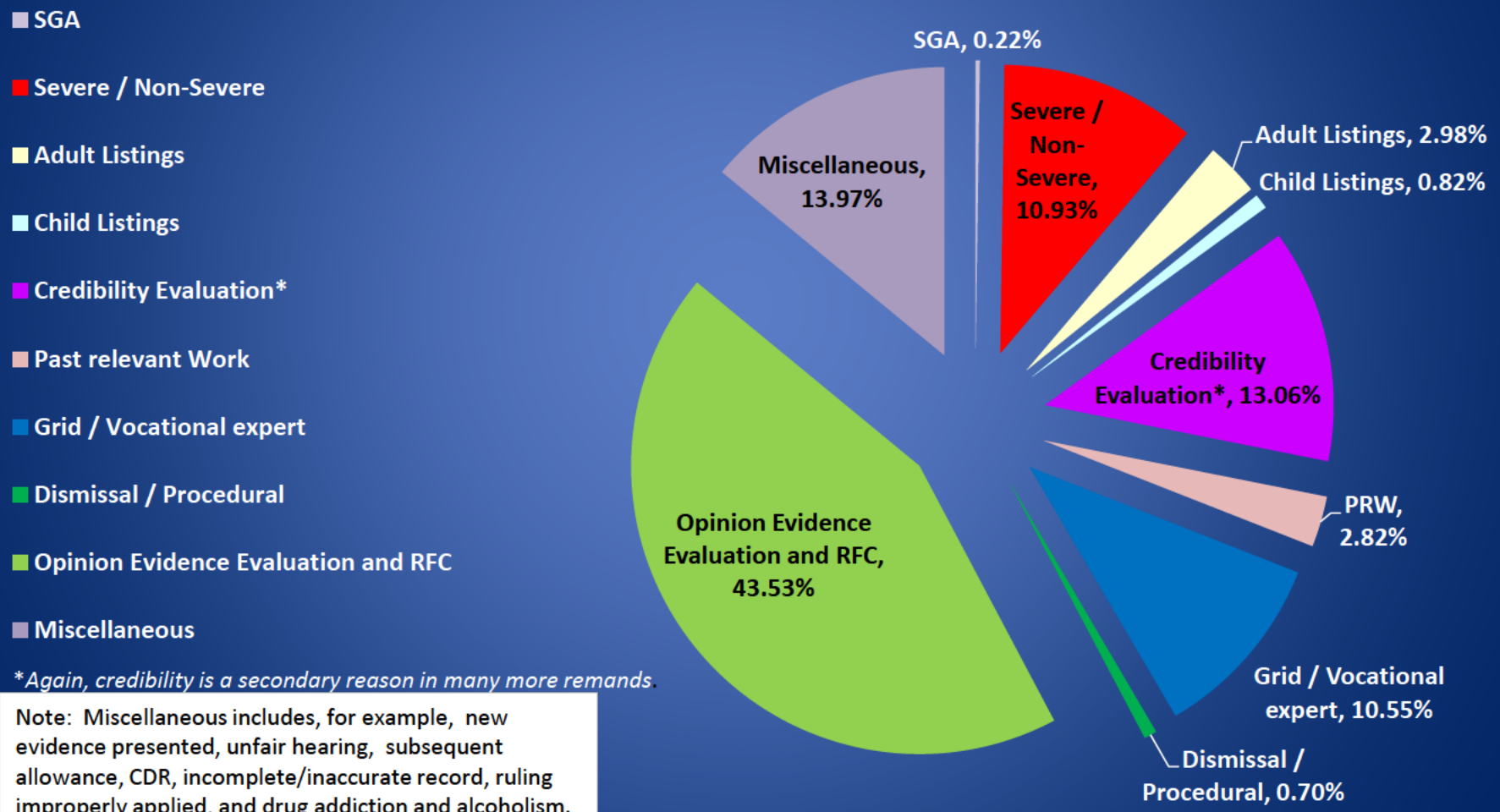


*Though credibility is the primary reason for remand in only 6% of cases, it is a secondary reason in many more remands.

Reasons for Remand – Own Motion



Primary Reasons for Court Remand FY 2011



**Again, credibility is a secondary reason in many more remands*.

Note: Miscellaneous includes, for example, new evidence presented, unfair hearing, subsequent allowance, CDR, incomplete/inaccurate record, ruling improperly applied, and drug addiction and alcoholism.

Refresher
Credibility

- Subjective Complaints
- Medical Opinions
- Non medical Opinions

Appeals Council and Office of the General Counsel Credibility Guidance Practice Tips

- Appeals Council: Need a discussion (rationale) for the credibility finding; do not rely solely on FIT
- OGC: Generally, a credibility finding is more defensible when a decision states multiple, specific reasons to support the credibility finding

Appeals Council and Office of the General Counsel Credibility Guidance Practice Tips

- Addressing
  - Subjective complaints (discussing each allegation)
  - Side effects
  - Evidence conflicting with the credibility finding
- The limits and uses of ADLs
- The limits and uses of treatment

Appeals Council and Office of the General Counsel Credibility Guidance Practice Tips

- How ALJ observations can be used
- Suggestions for other evidence to consider
- Third-party statements and medical opinions
- Things to avoid: selective use of the evidence, ignoring evidence, overreliance on objective evidence and limited ADLs

ALJ Instructions

- Pre hearing notes
- Post hearing draft instructions/ credibility bullets – when and why?
- Examples -- good (better), bad, ugly

Example Instruction
The "Ugly"

John Doe 111-11-1111

Instructions

- CL is not credible. Exaggerator. I think he can work.

Inputs: LBP, HTN, Obesity

See Notes for RFC.

Example Instruction
The "Bad" – "but why?"

- **Credibility - Allegations Not Fully Credible**

- **Objective Evidence & Subjective Factors:** this clmt is not credible. Claimant smokes; looks like he can do light work.

- Lots of VA records.

- **Medical Opinions:** Dr. Kornick -- no weight. Clmt can do more than sed work . DDS light – significant weight.

Example Instruction
"Better" – "but why" answered

- **Objective Evidence & Subjective Factors:**

"BUT WHY" ANSWERED:

- ADLs --
- Objective --
- Meds --
- Treatment --

Example Instruction
"Better" – "but why" answered

- **Medical Opinions:**

VA doctor Dr. Kornick (8F) – given little weight. His <sedentary work limitation is based on a 1x visit. He has seen the claimant a couple of times now, but the work limitations when completed were based on very little. Treatment records do not document clmt is experiencing severe pain and show pain is well controlled (Exhibit 8F). Exam findings unremarkable. Also, clmt testified to being able to do more than the work limitations suggest (daily 1 hour walks, computer use for 30-45 minutes at one time, and driving a car daily to run errands).

Example Instruction
"Better" – "but why" answered

- **Medical Opinions:**

- 5F CE + 7F PRFC– significant weight. Clmt ADLs + testimony about lifting at least 10-15 lbs is consistent with light work. Exam findings show mild DJD. No surgery anticipated. Meds controlled pain. Records since this opinion do not highlight significant worsening (see 5F and 8F).

Example Instruction
"Better" – What makes it better?

- Findings supported by specific references to testimony and record
- Exhibits provided to aid decision writer
- RFC findings referenced/explained

Editing Draft Decisions

- Ask “but why” to determine need for additional analysis – general/boilerplate to specific
- Good notes/instructions will aid edit process

Example Credibility – Good/Poor Articulation

- Poor Articulation: "The claimant has described daily activities that are not limited to the extent one would expect, given the complaints of disabling symptoms and limitations."

Example Credibility – Good/Poor Articulation

- Good Articulation: "The claimant alleges significantly limited daily activities due to chronic pain. However, she is the sole caregiver and receives no help in the care of her three-year-old child (Exhibit 3E). In testimony, she admitted to daily driving, twice daily walking of the dog, preparing meals and weekly grocery shopping. These activities are inconsistent with the disabling symptoms complained of by the claimant.

Summary

- Credibility Refresher
- CFRs and SSR
- Appeals Council Practice Tips
- Office of General Counsel Practice Tips
- ALJ Instructions
- Examples
- Editing Draft Decisions

Questions

SOCIAL SECURITY
Office of the General Counsel

Legally Sufficient Decisions: Office of the General Counsel's Perspective

2012 Judicial Training

OGC’S MISSION

The Office of the General Counsel promotes, advocates, and protects all legal interest of the Social Security Administration.

RECENT OGC WORKLOAD

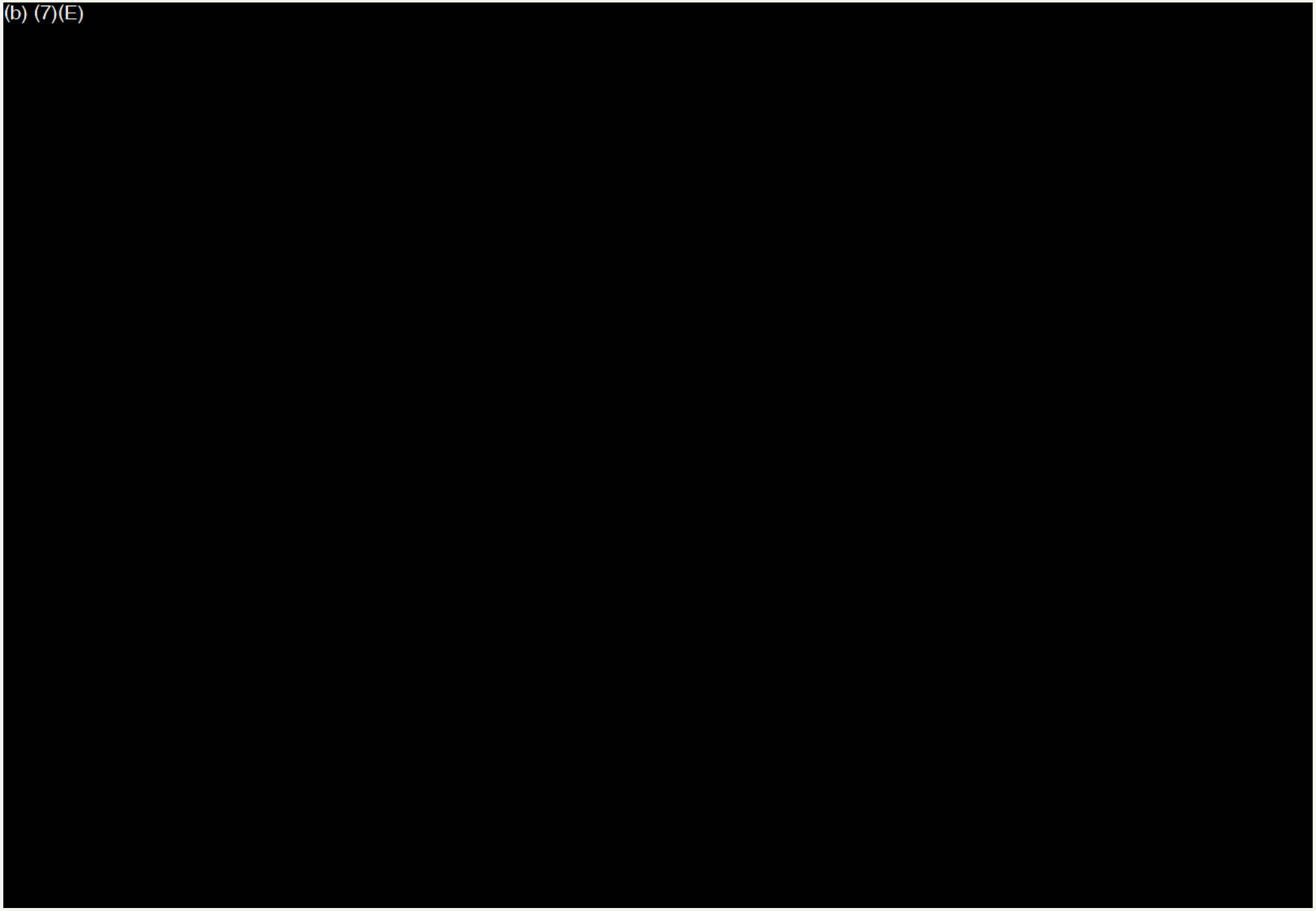
FY 2011

- 15,644 program litigation receipts (almost 1,300 more than FY 2010)
- Processed 14,236 program litigation cases
- Affirmance rate of 51.02% (highest since 1997 which was 50%)

OGC'S RELATIONSHIP WITH THE APPEALS COUNCIL

OGC'S RELATONSHIP WITH THE U.S. ATTORNEY'S OFFICE

- U.S. Attorney is the attorney of record.
- We are "of counsel" because of our technical knowledge of Social Security disability law.
- In some Districts we are appointed as Special Assistant U.S. Attorneys (SAUSA).
- In other Districts we file our motions and briefs via the U.S. Attorney's office.


(b) (7)(E)

STANDARD OF REVIEW

"The findings of the Commissioner of Social Security as to any fact, if supported by substantial evidence, shall be conclusive…"

Section 205(g) of the Social Security Act,

codified at 42 U.S.C. § 405(g).

STANDARD OF REVIEW

The deferential standard of review applied to the agency's findings of fact does not apply to conclusions of law or the application of the correct legal standards.

"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, 517 (4th Cir. 1987).

STANDARD OF REVIEW

- Supported by substantial evidence
- Reached through application of the correct legal standard

STANDARD OF REVIEW

Example citation

"This Court is authorized to review the Commissioner's denial of benefits under 42 U.S.C.A. § 405(g). Under the Social Security Act, a reviewing court must uphold the factual findings of the ALJ if they are supported by substantial evidence and were reached through application of the correct legal standard. Substantial evidence means such relevant evidence as a reasonable mind might accept as adequate to support a conclusion. It consists of more than a mere scintilla of evidence but may be less than a preponderance. In reviewing for substantial evidence, we do not undertake to reweigh conflicting evidence, make credibility determinations, or substitute our judgment for that of the ALJ. Where conflicting evidence allows reasonable minds to differ as to whether a claimant is disabled, the responsibility for that decision falls on the ALJ."

Hancock v. Astrue, 667 F.3d 470, 472 (4th Cir. 2012) (all citations omitted).

EXAMPLE APPLICATIONS OF THE STANDARD OF REVIEW

Background:

- Several medical reports confirmed claimant's circulation problem in legs resulting in fatigue.
- ALJ relied on medical expert testimony to conclude claimant capable of sedentary work.
- Neither the ALJ nor the Appeals Council indicated the weight given to the various medical reports, some of which supported the medical expert's testimony and some of which did not.

Gordon v. Schweiker, 725 F.2d 231 (4th Cir. 1984).

EXAMPLE APPLICATIONS OF THE STANDARD OF REVIEW

"We cannot determine if findings are unsupported by substantial evidence unless the Secretary explicitly indicates the weight given to all of the relevant evidence. The courts face a difficult task in applying the substantial evidence test when the Secretary has not considered all relevant evidence. Unless the Secretary has analyzed all evidence and has sufficiently explained the weight he has given to obviously probative exhibits, to say that his decision is supported by substantial evidence approaches an abdication of the court's duty to scrutinize the record as a whole to determine whether the conclusions reached are rational."

Gordon v. Schweiker, 725 F.2d 231, 235-36 (4th Cir. 1984) (all citations omitted).

EXAMPLE APPLICATIONS OF THE STANDARD OF REVIEW

Background:

- ALJ did not indicate the weight he accorded to consultative physical and psychological examinations performed after the claimant's DLI.
- ALJ mentioned the physical evaluation in passing; the RFC was generally consistent with the physician's report.
- ALJ did not mention the psychological evaluation; overall the psychologist's opinion was consistent with the ALJ's decision.

Stewart v. Apfel, 182 F.3d 909 (Table), 1999 WL 485862 (4th Cir. 1999) (unpublished).

EXAMPLE APPLICATIONS OF THE STANDARD OF REVIEW

"We recognize the continuing requirement that ALJs must be thorough in discussing the weight given to all of the evidence. Although the ALJ in this case was not as thorough as he could have been, we affirm the district court. Both the magistrate judge and the district court evaluated the record as a whole and entered summary judgment against Stewart because there is substantial evidence in the record to support the ALJ's decision to deny benefits."

Stewart v. Apfel, 182 F.3d 909 (Table), 1999 WL 485862, *5 (4th Cir. 1999) (unpublished).

EXAMPLE APPLICATIONS OF THE STANDARD OF REVIEW

Background:

- ALJ found that claimant's severe impairments were major depression and somatization disorder.
- This finding arguably triggered a discussion of Listings 12.04 and 12.07.
- ALJ stated only that "[T]he evidence did not demonstrate that claimant's impairments are of a severity to meet or equal any of the listings contained at Appendix 1 to Subpart P of the Regulations No. 4."

Schoofield v. Barnhart, 220 F. Supp. 2d 512 (D. Md. 2002).

EXAMPLE APPLICATIONS OF THE STANDARD OF REVIEW

"In this case, the ALJ uttered only a sweeping, naked conclusion that Mr. Schoofield's condition did not meet or equal a listing. He offered no indication as to the evidence upon which he relied at Step Three or even which listing he supposedly considered. In this case, that treatment does not suffice and would not suffice in any case in which the evidence of record generates a substantive issue regarding a particular listing, whether that evidence was introduced by claimant's counsel or otherwise.[FN7]"

Schoofield v. Barnhart, 220 F. Supp. 2d 512, 520 (D. Md. 2002).

EXAMPLE APPLICATIONS OF THE STANDARD OF REVIEW

"FN7. . . This standard of review is deferential to the Commissioner, but the benefits that it confers are earned only if the ALJ fulfills his responsibility to provide a meaningful explanation of the conclusions reached and the factual support for them. If this is not done, the Court cannot conduct its limited review, but instead, as the government in essence argues, must conduct a *de novo* evaluation of the evidence to see if there is any evidence that *could* have supported the ALJ's findings. Manifestly, that is not the responsibility of the Court…"

Schoofield v. Barnhart, 220 F. Supp. 2d 512, 520 (D. Md. 2002).

EXAMPLE APPLICATIONS OF THE STANDARD OF REVIEW

"When the evidence in the administrative record clearly generates an issue as to a particular listing in the LOI and the ALJ fails properly to identify the LOI considered at Step Three, and to explain clearly the medical evidence of record supporting the conclusion reached at that critical stage of the analysis, a remand can be expected to result, except…"

Schoofield v. Barnhart, 220 F. Supp. 2d 512, 520 (D. Md. 2002).

EXAMPLE APPLICATIONS OF THE STANDARD OF REVIEW

"…in those circumstances where it is clear from the record which listing or listings in the LOI were considered, and there is elsewhere in the ALJ's opinion an equivalent discussion of the medical evidence relevant to the Step Three analysis which allows this Court readily to determine whether there was substantial evidence to support the ALJ's Step Three conclusion."

Schoofield v. Barnhart, 220 F. Supp. 2d 512, 520 (D. Md. 2002).

BURDEN OF PROOF

- The claimant has the initial burden to show that he or she is unable to perform previous work because of medically determinable impairment(s). (Steps 1 through 4.)
- The burden shifts to the Commissioner at Step 5 to establish that work is available in the national economy which the claimant could perform.

BURDEN OF PROOF

Because the Commissioner has the burden of proof at Step 5, errors at this step are very difficult to defend.

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STEP 5 ERRORS WITH GRID RULES

- Reliance on the Grid Rules despite non-exertional limitations in the RFC that significantly erode the occupational base.
- Relying on SSR 85-15, but RFC includes limitations not addressed in the basic mental demands of unskilled work such as “low-stress” or “not at a production pace.”
- Relying on Grid Rules where the aggregate effect of multiple non-exertional limitations is unclear.

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VE TESTIMONY

- In order for a vocational expert's testimony to constitute substantial evidence, the ALJ must pose a hypothetical question which fairly sets forth all of the claimant's limitations.
- The ALJ is not required to include findings in the hypothetical question that the ALJ has found to be unsupported.

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- RFC does not match the hypothetical question.
- VE testimony internally inconsistent or materially inconsistent with the DOT.
- RFC limitation to "simple, routine tasks" or "unskilled" work and corresponding VE hypothetical may not account for limitations in concentration, persistence, or pace or social interaction.
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NO POST HOC RATIONALIZATIONS

"A Simple But Fundamental Rule of Administrative Law"

"A reviewing court, in dealing with a determination or judgment which an administrative agency alone is authorized to make, must judge the propriety of such action solely by the grounds invoked by the agency. If those grounds are inadequate or improper, the court is powerless to affirm the administrative action by substituting what it considers to be a more adequate or proper basis."

Securities and Exchange Comm'n v. Chenery Corp., 332 U.S. 194, 196 (1947).

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"If the administrative action is to be tested by the basis upon which it purports to rest, that basis must be set forth with such clarity as to be understandable. It will not do for a court to be compelled to guess at the theory underlying the agency's action; nor can a court be expected to chisel that which must be precise from what the agency has left vague and indecisive."

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Example from the Third Circuit

Background:

- Claimant had a back injury. Treating physician reports and opinions tended to support his claim, but workers compensation independent exams and State agency opinions contradicted his claim.
- ALJ found an RFC of light work.
- The ALJ did not evaluate relevant evidence or explain weight given to treating source medical opinions and contradictory findings in the medical evidence.
- The ALJ also did not mention supporting evidence. The Commissioner argued this evidence supported the ALJ's decision and won in the District Court.

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"The District Court, apparently recognizing the ALJ's failure to consider all of the relevant and probative evidence, attempted to rectify this error by relying on medical records found in its own independent analysis, and which were not mentioned by the ALJ. This runs counter to the teaching of *Chenery* that the grounds upon which an administrative order must be judged are those upon which the record discloses that its action was based."

Fargnoli v. Massanari, 247 F.3d 34, 44 n.7 (3rd Cir. 2001).

HARMLESS ERROR

"…[T]he court shall review the whole record or those parts of it cited by a party, and due account shall be taken of the rule of prejudicial error."

Administrative Procedures Act, 7 U.S.C. § 706.

HARMLESS ERROR

- Applied in court review of administrative bodies.
- Case-specific application of judgment, based upon examination of the record.
- The burden of showing that an error is harmful normally falls upon the party attacking the agency's determination.

See Shinseki v. Sanders, 556 U.S. 396 (2009).

HARMLESS ERROR

Example from the Seventh Circuit

"We agree with Justin that the ALJ conducted a marginal hearing. . . . [But], in the end, the ALJ had before him a fairly complete picture of Justin's developmental and behavioral problems, in spite of the manner in which the hearing was conducted. Furthermore, Justin has not . . . demonstrated prejudice by showing a significant omission from the record. Therefore, although the ALJ conducted the hearing in a marginal manner, the relevant evidence about Justin's condition still managed to find its way into the record, and there is no reason to remand for a new hearing."

Nelson v. Apfel, 131 F.3d 1228, 1235–36 (7th Cir. 1997) (all citations omitted).

LIMITS OF HARMLESS ERROR

Example from the Seventh Circuit

"The ALJ's opinion is unsatisfactory, and likewise the government's brief and oral argument, which misstate the record in several places and, worse, seem determined to dissolve the *Chenery* doctrine in an acid of harmless error… [T]he fact that the ALJ, had she considered the entire record, might have reached the same result does not prove that her failure to consider the evidence was harmless. Had she considered it carefully, she might well have reached a different conclusion."

Spiva v. Astrue, 628 F.3d 346, 353 (7th Cir. 2010).

LIMITS OF HARMLESS ERROR

Example from the Sixth Circuit

(ALJ mistakenly referred to 12.05D rather than 12.05C.)

"Appellant contends the district court's attempt to legitimize the ALJ's error is an illegitimate post hoc rationalization, contrary to the rule of *Chenery*… Consistent with *Chenery,* the district court evaluated the actual grounds invoked by the ALJ and found them to be supported by substantial evidence, despite the technically erroneous reference included in the ALJ's decision. The district court's reasoning is also fully consistent with this Circuit's precedents. Thus, the district court's judgment does not run afoul of the rule against *post hoc* rationalizations."

Williams v. Comm'r of Soc. Sec., 227 Fed. App'x 463, 464 (6th Cir. 2007) (unpublished) (all citations omitted).

LIMITS OF HARMLESS ERROR

Example from the Ninth Circuit

Background:

- Claimant's sister and brother-in-law submitted uncontradicted evidence concerning the effect of claimant's mental impairments on his ability to work.
- The ALJ did not mention this evidence.
- A line of Ninth Circuit cases establishes that ALJs must consider and comment upon uncontradicted lay testimony.
- The District Court found the error harmless because the sister's testimony suggested claimant always had mental limitations yet was able to work and the brother-in-law's letter was based on a 15-year history of working with the claimant.

Stout v. Comm'r, 454 F.3d 1050 (9th Cir. 2005).

LIMITS OF HARMLESS ERROR

Example from the Ninth Circuit

"We note that two considerations caution, if not preclude, us from adopting these justifications for embracing harmless error here. First, the ALJ, not the district court, is required to provide specific reasons for rejecting lay testimony. Indeed, we cannot rely on independent findings of the district court. Rather, we are constrained to review the reasons the ALJ asserts. Second, we cannot affirm the decision of an agency on a ground that the agency did not invoke in making its decision. [*Chenery*]. Consequently, if the Commissioner's request that we dismiss the ALJ's error as harmless invites this Court to affirm the denial of benefits on a ground not invoked by the Commissioner in denying the benefits originally, then we must decline."

Stout v. Comm'r, 454 F.3d 1050, 1054, 1056 (9th Cir. 2005).

LIMITS OF HARMLESS ERROR

Example from the Ninth Circuit

Stout's review of Ninth Circuit harmless error precedents:

- Error was non-prejudicial to claimant.
- Error was inconsequential to the ultimate nondisability determination.
- Error occurred during a procedure or step the ALJ was not required to perform (e.g., alternative Step 5 determination).

Stout v. Comm'r, 454 F.3d 1050, 1054, 1056 (9th Cir. 2005).

LIMITS OF HARMLESS ERROR

Example from the Ninth Circuit

"[W]e hold that where the ALJ's error lies in a failure to properly discuss competent lay testimony favorable to the claimant, a reviewing court cannot consider the error harmless unless it can confidently conclude that no reasonable ALJ, when fully crediting the testimony, could have reached a different disability determination."

Stout v. Comm'r, 454 F.3d 1050, 1056 (9th Cir. 2005).

LIMITS OF HARMLESS ERROR

Example from the Ninth Circuit

"In the present case, we cannot so conclude. If fully credited, the lay testimony supports a conclusion that Stout's mental impairments render him in need of a special working environment which, particularly when considering the VE's testimony, a reasonable ALJ could find precludes Stout from returning to gainful employment. Consequently, the ALJ's error in failing to provide reasons for rejecting it was not harmless."

Stout v. Comm'r, 454 F.3d 1050, 1056 (9th Cir. 2005).

LIMITS OF HARMLESS ERROR

Example from the Ninth Circuit

"I respectfully dissent from the majority's conclusion that the ALJ's failure to comment properly on the lay witness testimony. . . was not harmless error. I am persuaded, as was the District Court, that even if the lay witness testimony is credited, all the evidence taken as a whole overwhelmingly supports denial of Stout's application for DIB and SSI."

Stout v. Comm'r, 454 F.3d 1050, 1056 (9th Cir. 2005) (O'Scannlain, J. dissenting).

From our perspective, the key to avoiding remands is…

Articulation

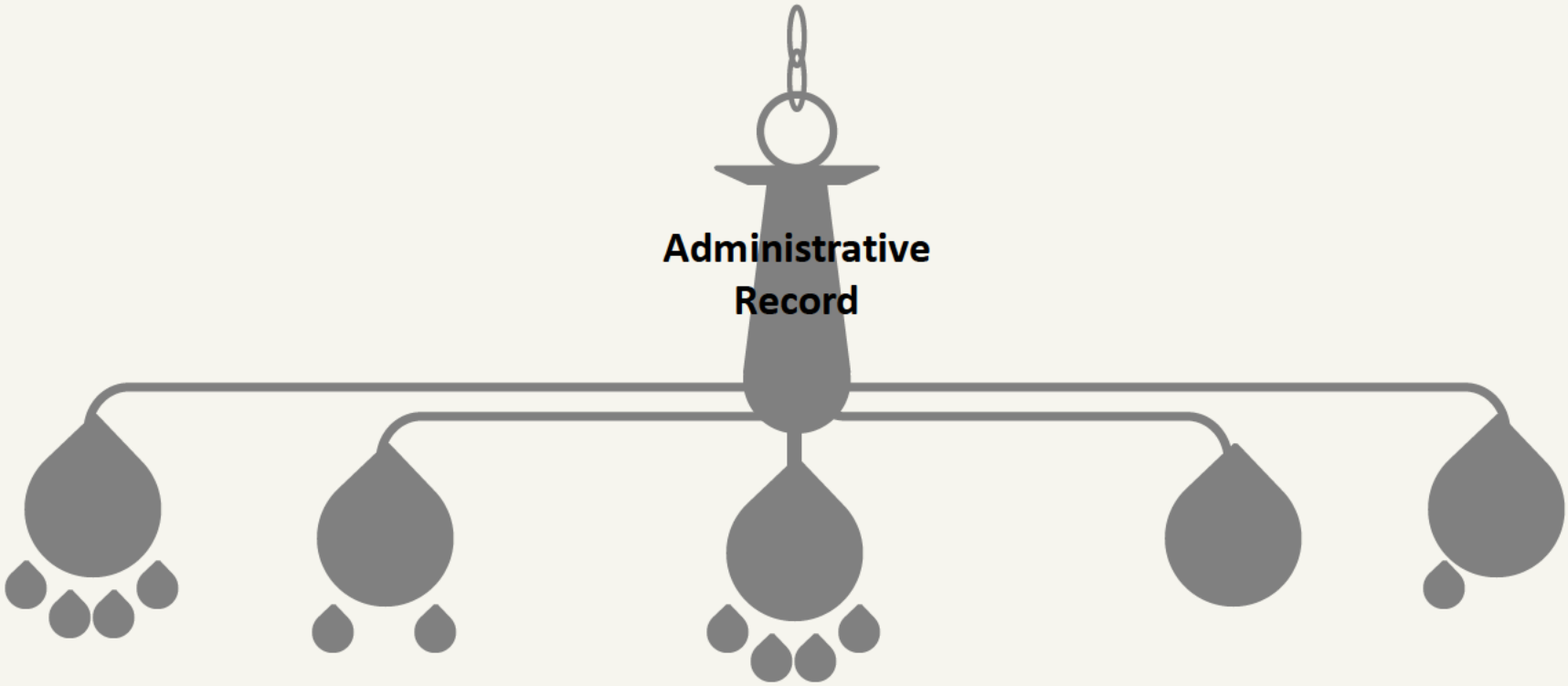
Articulation

- Articulation applies at every step of the sequential evaluation process.
- The more detailed the decision, the more defensible it becomes.
- Consider adding the word “because” throughout the decision.

Articulation

- Courts look to see how and why you reached your conclusions.
- Just a few more sentences—or even a few more words—can make the difference between a case that is legally defensible and a case that is remanded.

The Chandelier:
Everything Must Hang Together



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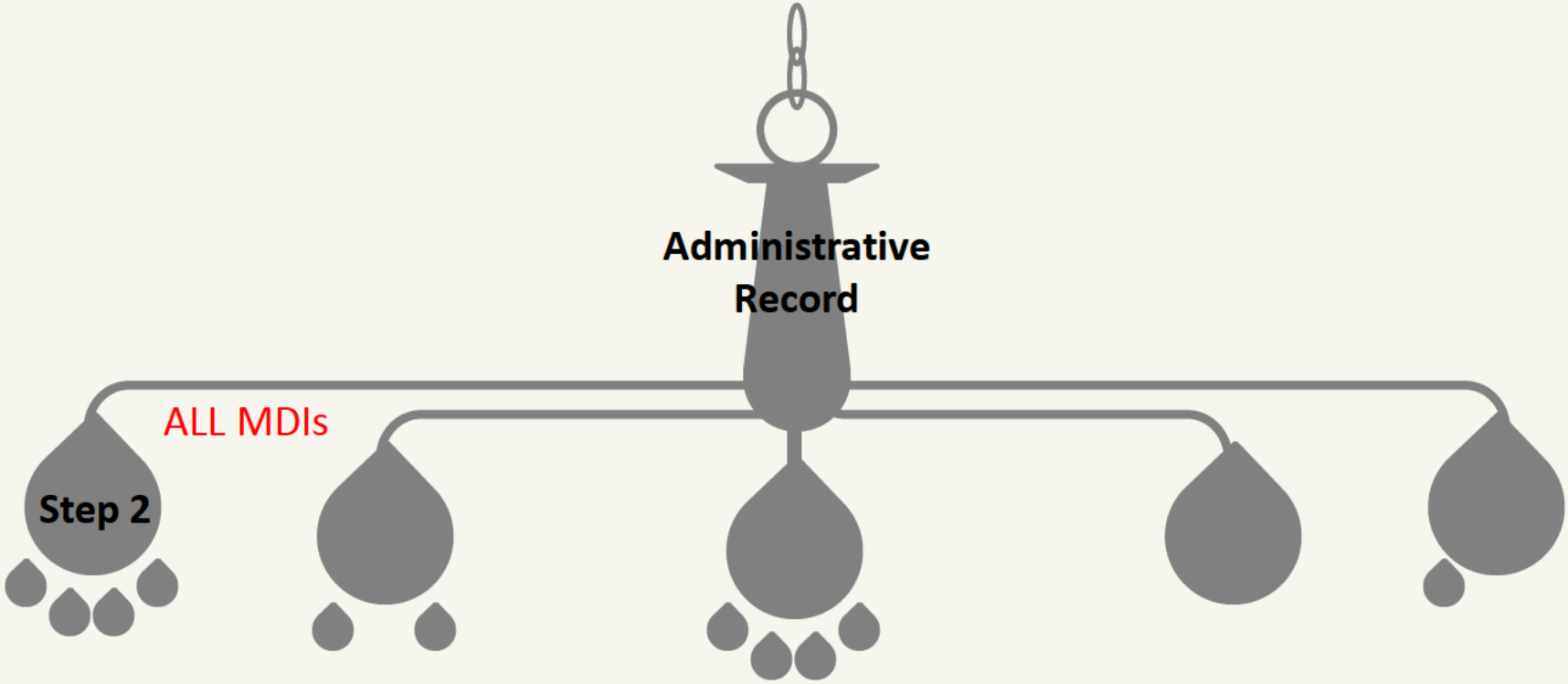

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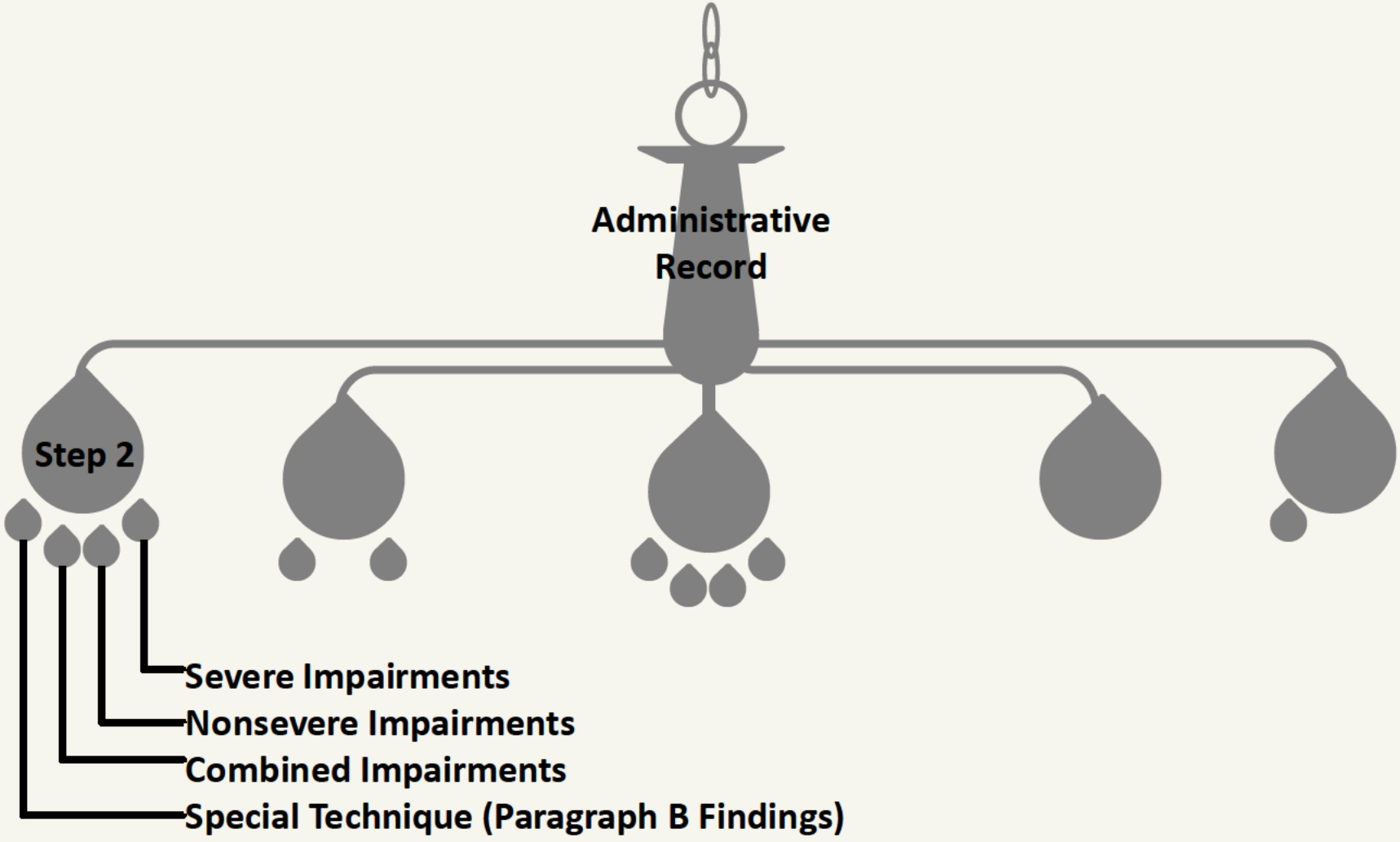

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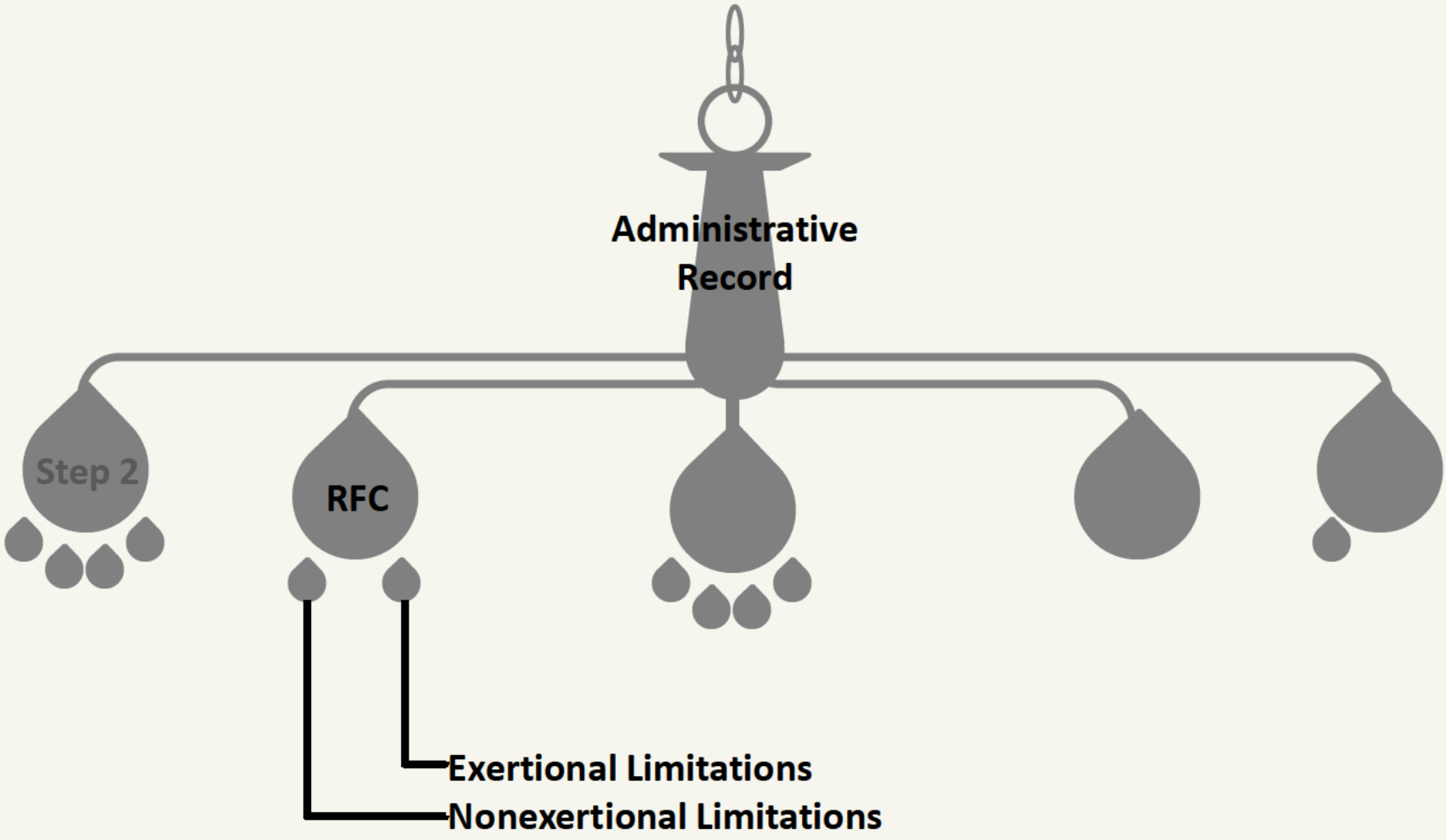

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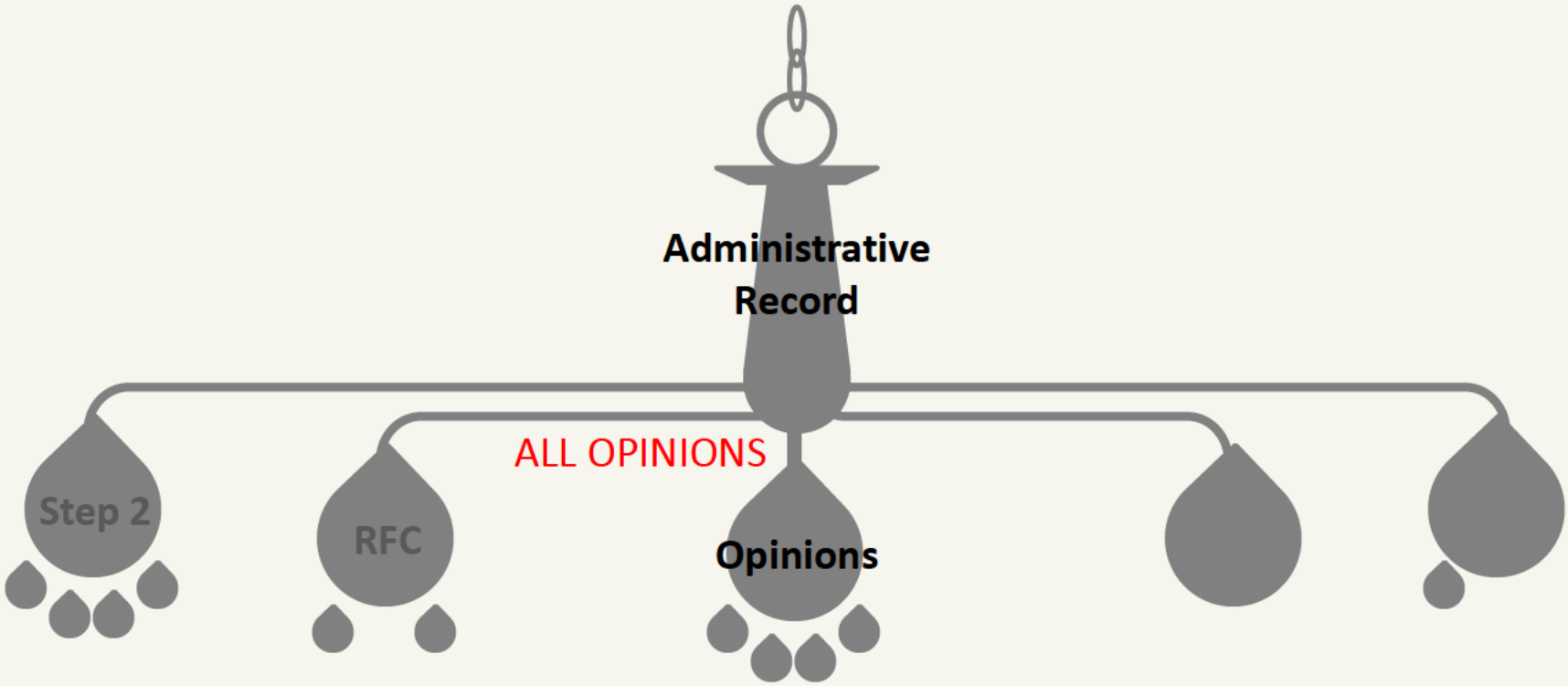

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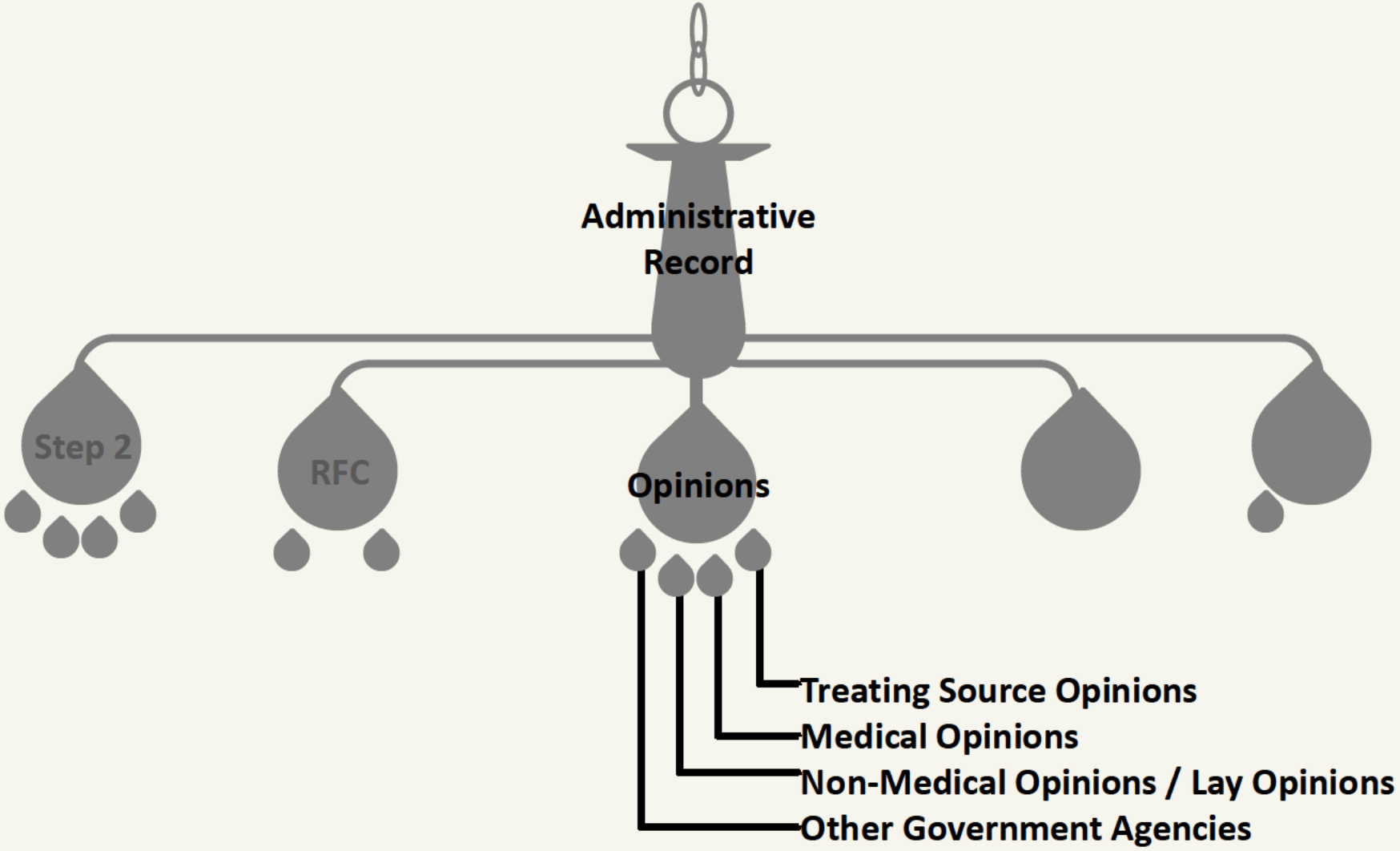

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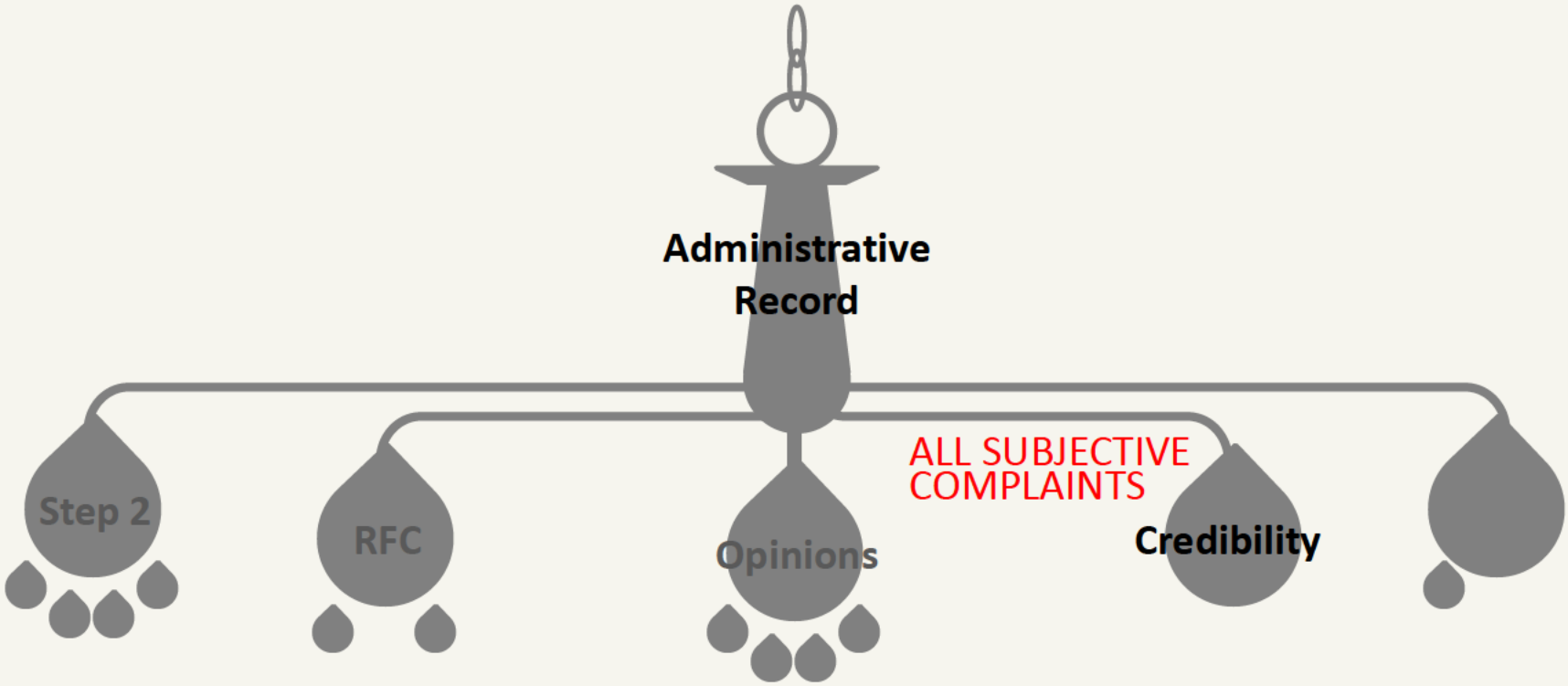

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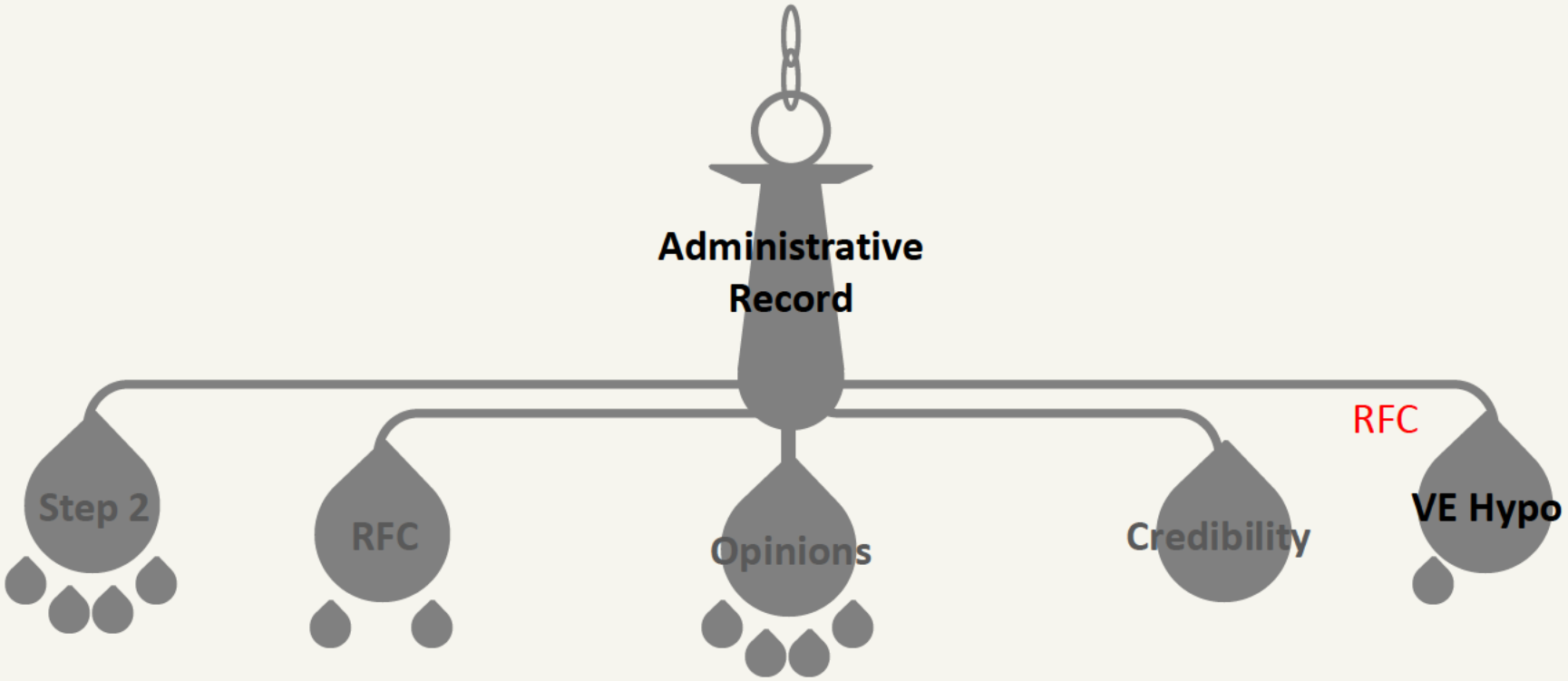

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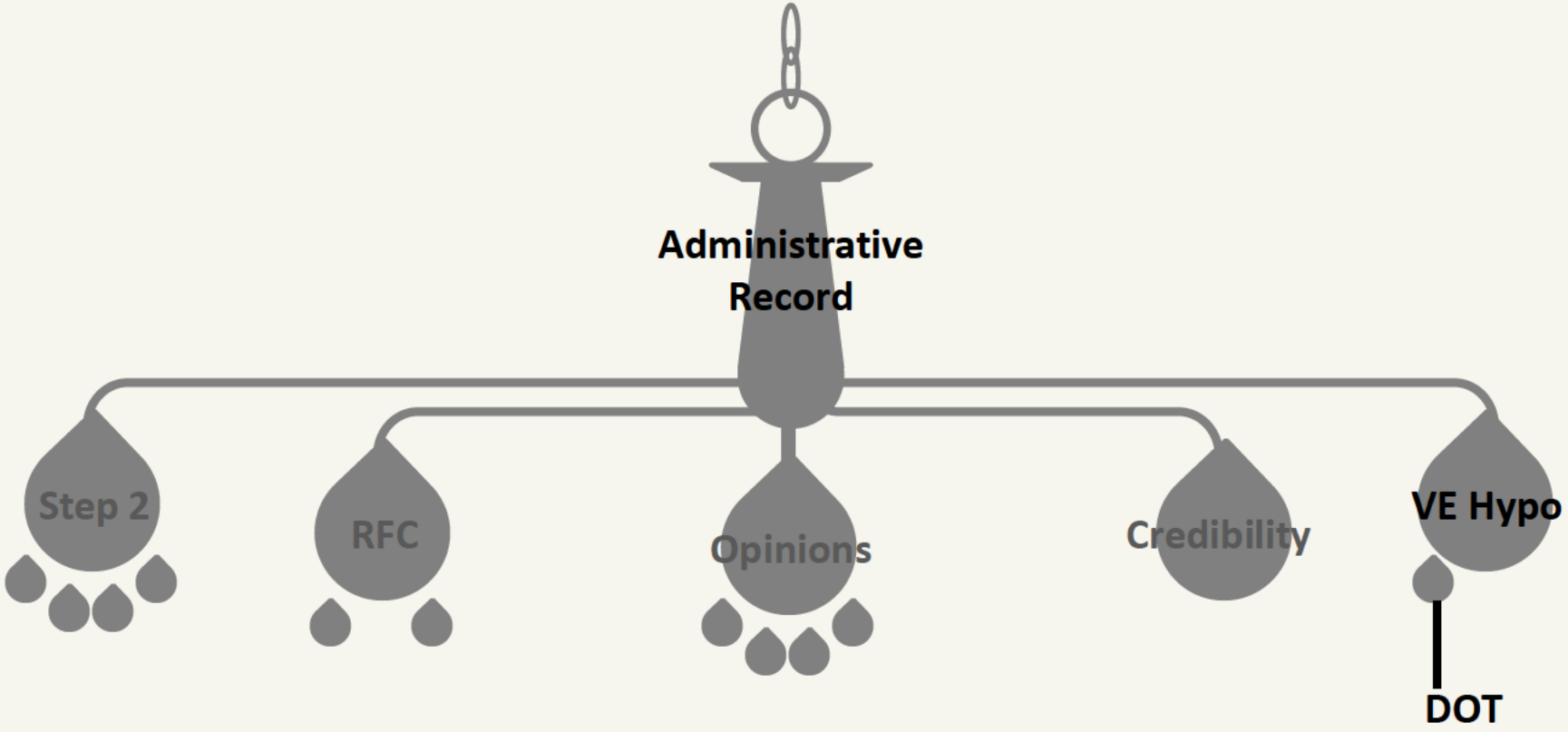

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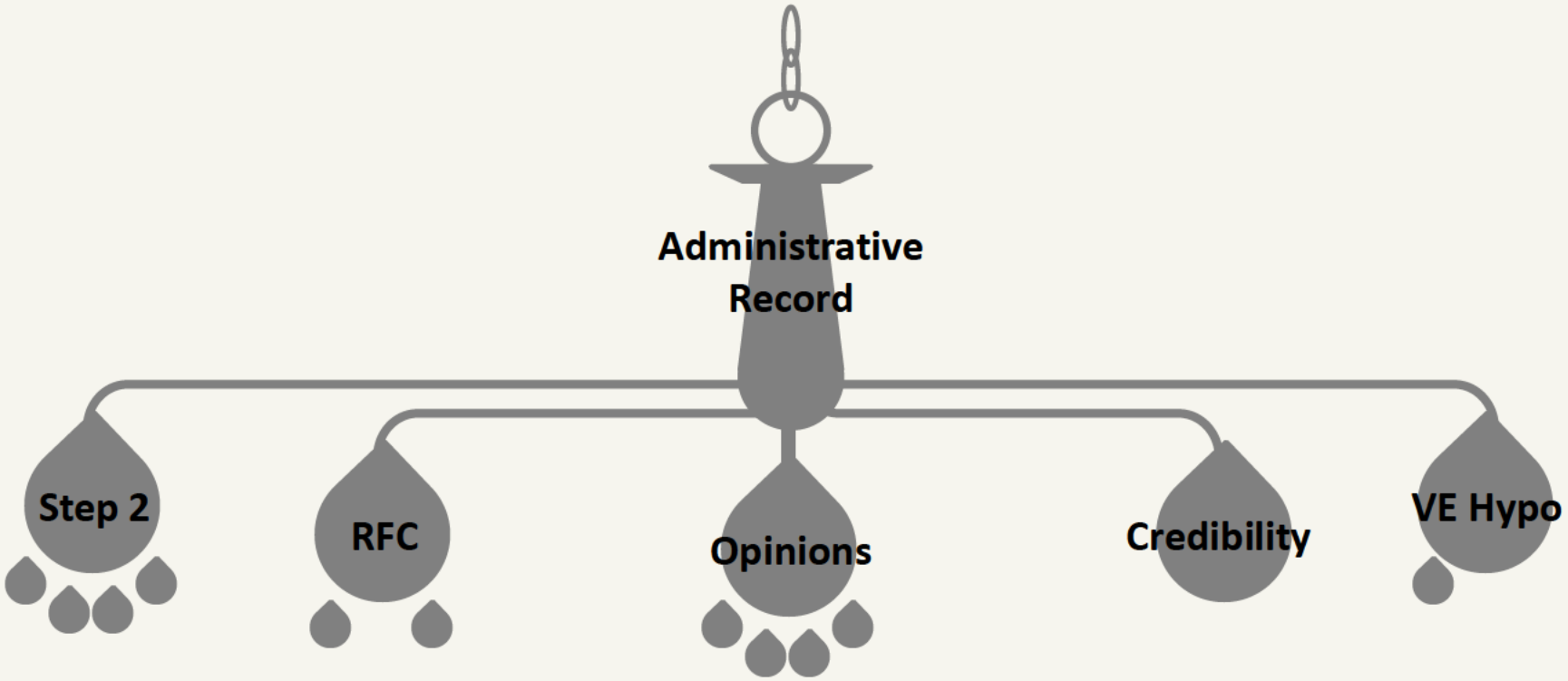

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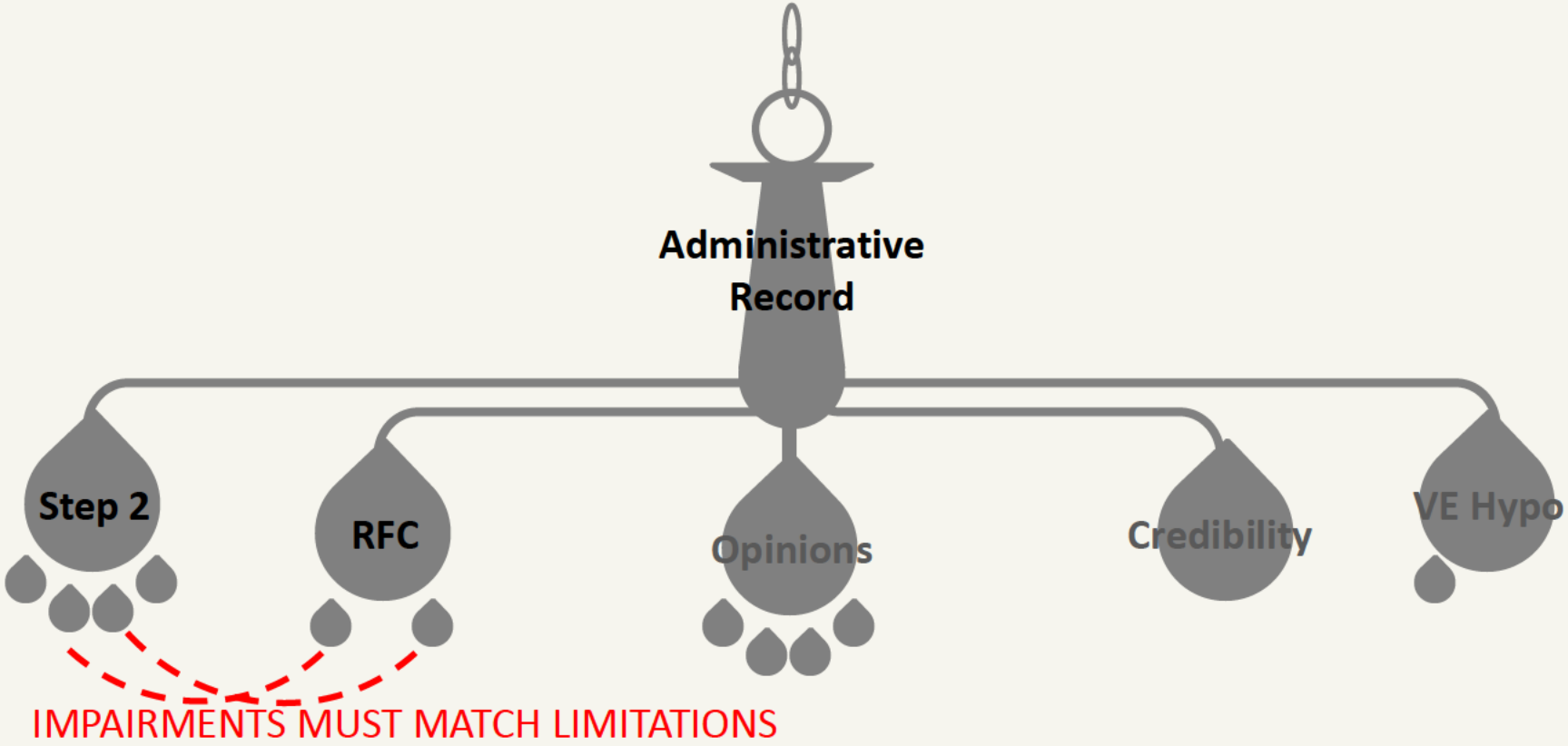

Severe Impairment → **Corresponding Exertional or Nonexertional Limitation**
Nonsevere Impairment → **Corresponding Limitation IF Limiting When Combined**
Combined Impairment → **Corresponding Exertional or Nonexertional Limitation**

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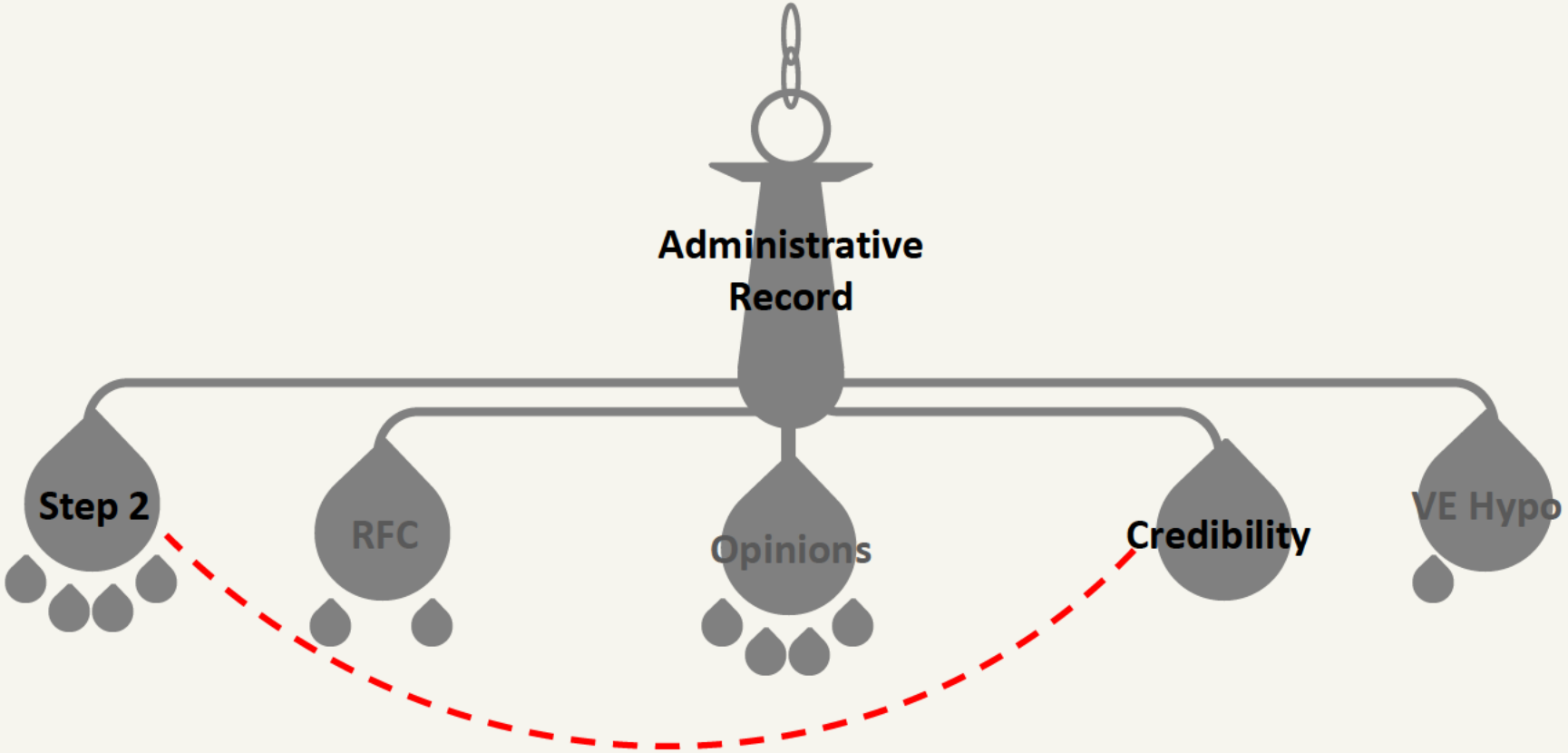
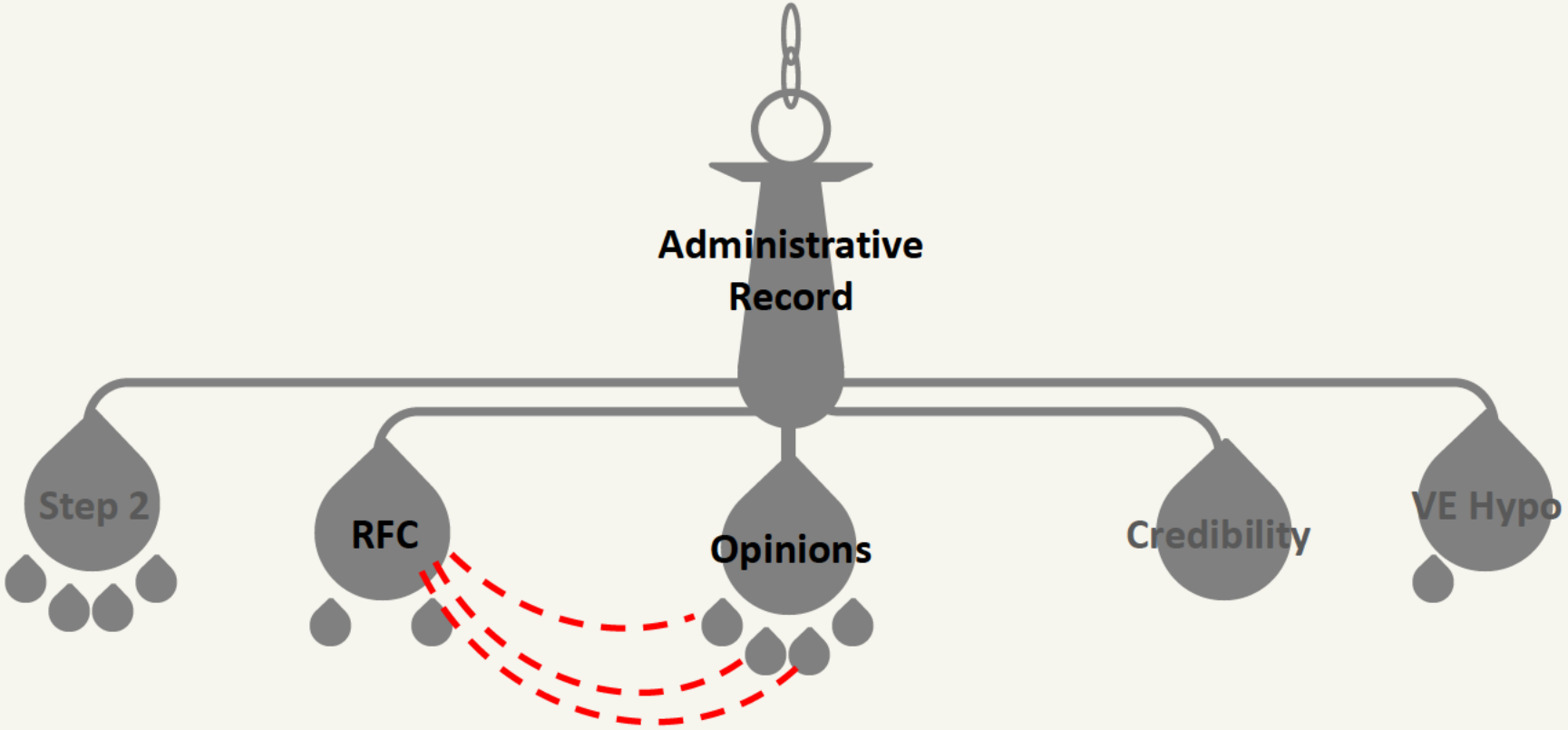


STEP 1: COMPARE SUBJECTIVE COMPLAINTS WITH MDIs

The Chandelier:
Everything Must Hang Together



MUST MATCH OR DIFFERENCE MUST BE EXPLAINED

Opinion Matches RFC → Assign Great Weight and Explain Reasoning

Opinion Differs from RFC → Assign Appropriate Weight and Explain Reasoning

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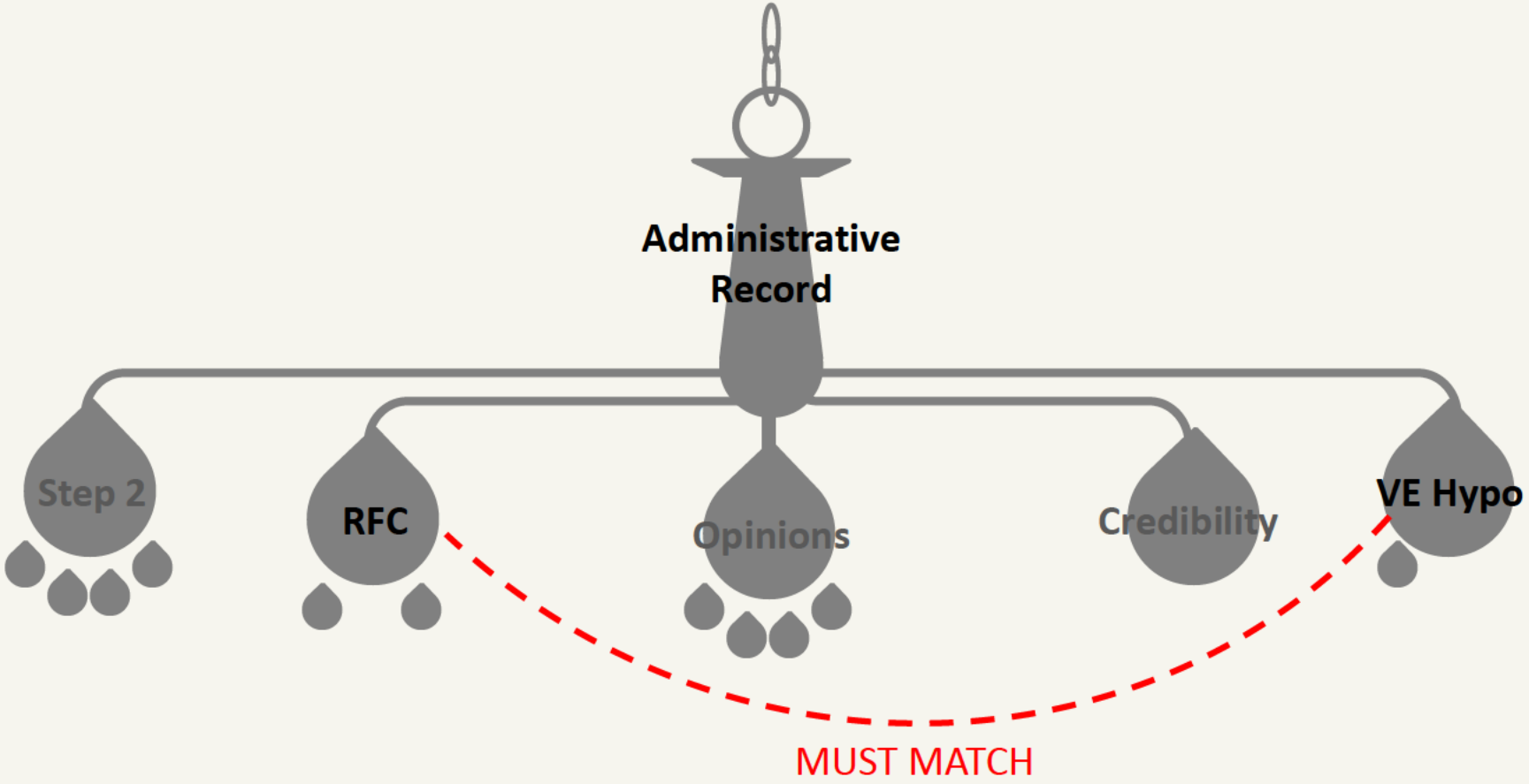

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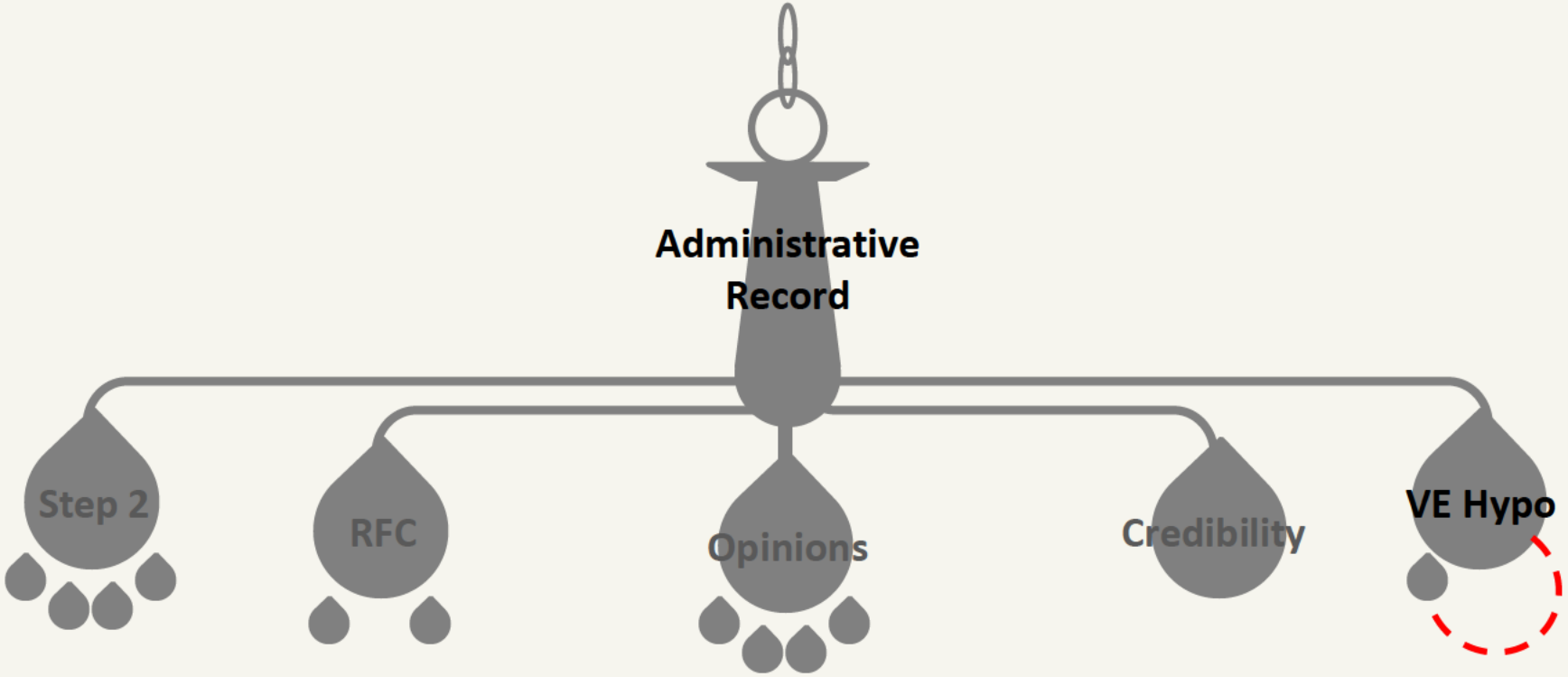

VE TESTIMONY MATCHES THE DOT
OR VE EXPLAINS WHY NOT

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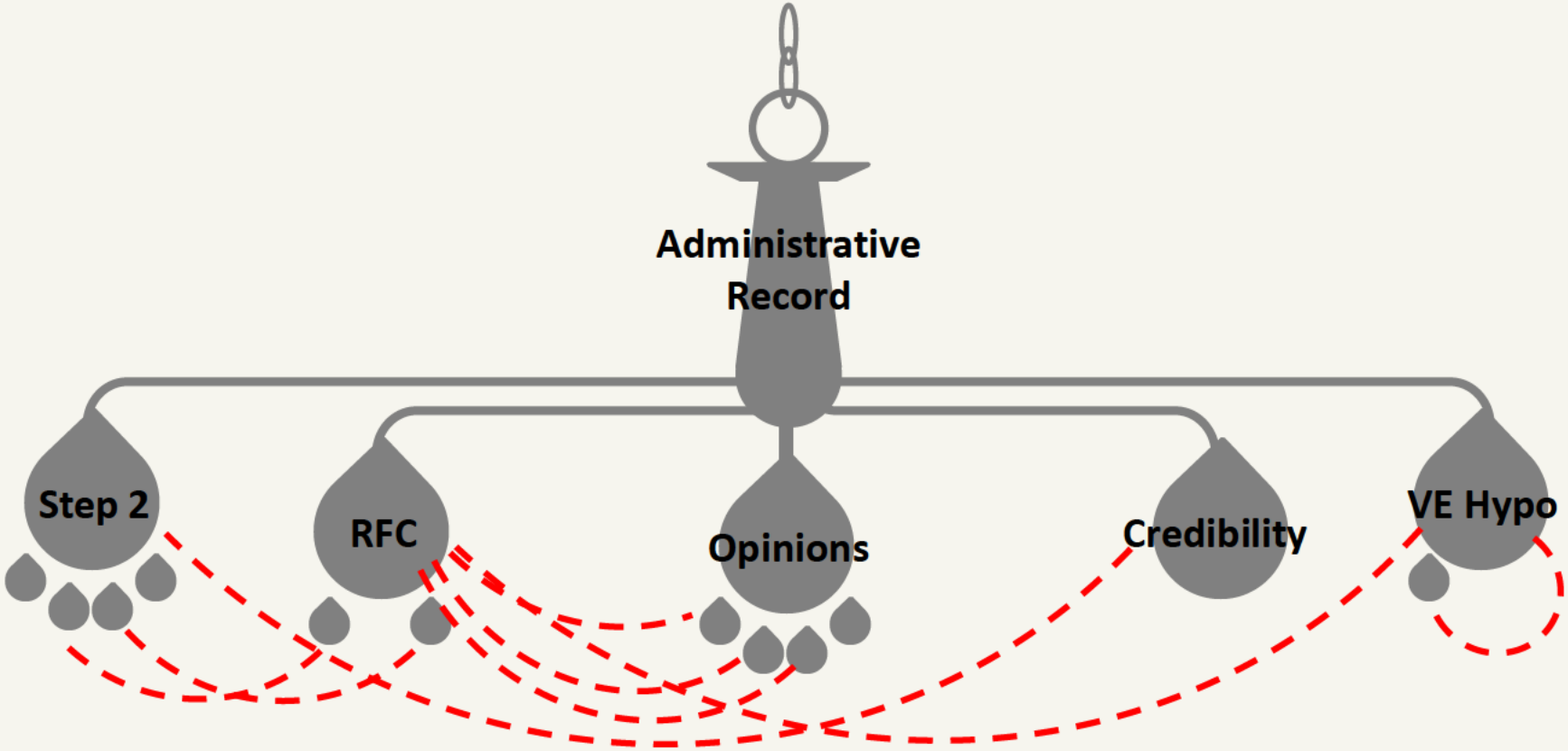
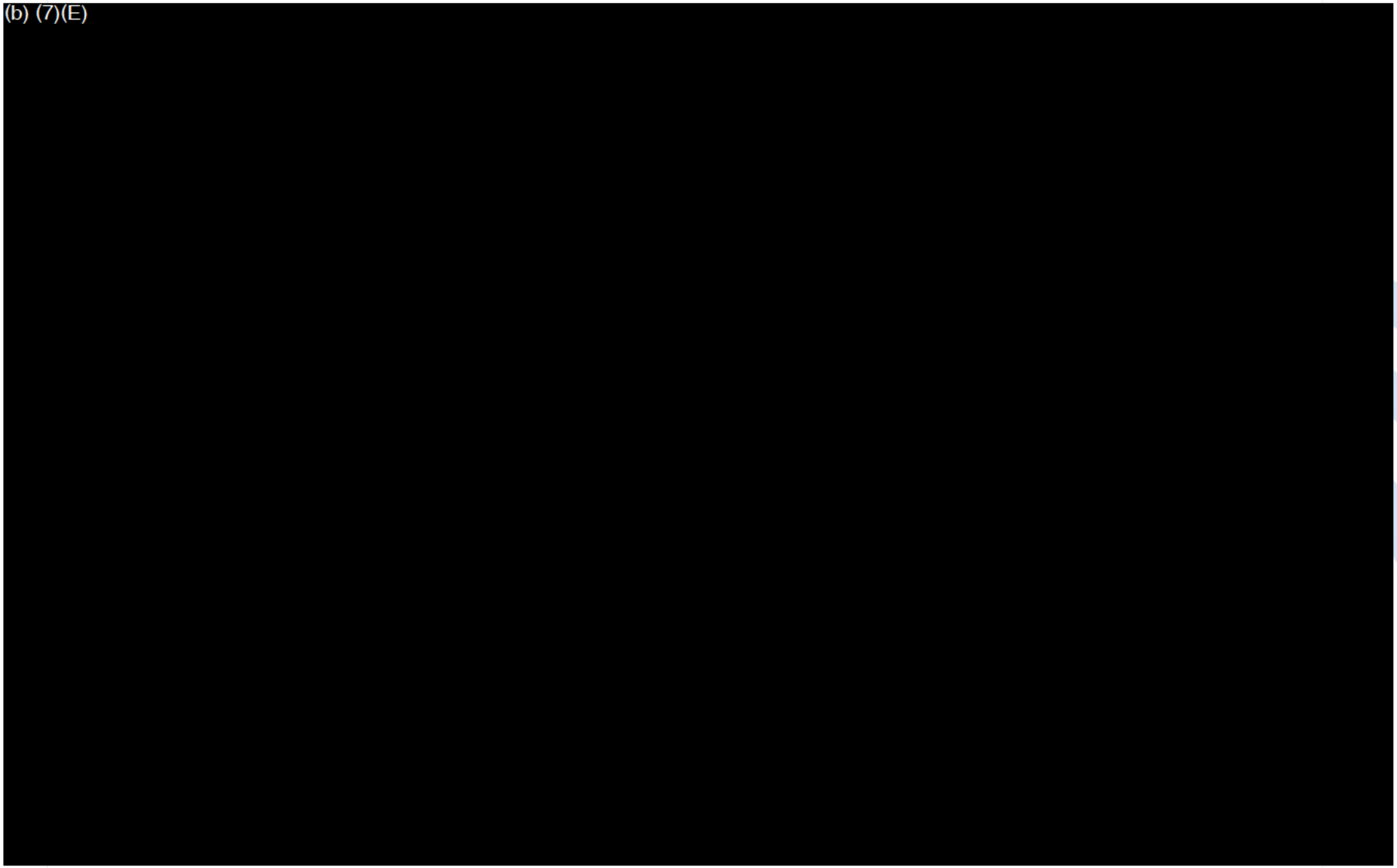


SOCIAL SECURITY
Office of the General Counsel

Legally Sufficient Decisions: Office of the General Counsel's Perspective

2013 Judicial Training

(b) (7)(E)


(b) (7)(E)

STANDARD OF REVIEW

"The findings of the Commissioner of Social Security as to any fact, if supported by substantial evidence, shall be conclusive…"

Section 205(g) of the Social Security Act, *codified at* 42 U.S.C. § 405(g).

STANDARD OF REVIEW

The deferential standard of review applied to the agency's findings of fact does not apply to conclusions of law or the application of the correct legal standards.

"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, 517 (4th Cir. 1987).

STANDARD OF REVIEW

"We hold that the ALJ committed an error of law by failing to give appropriate weight to the VA rating decision on the ground that it became effective after [the claimant's] DLI."

Bird v. Commissioner, 699 F.3d 337, 344 (4th Cir. 2012) (emphasis added).

STANDARD OF REVIEW

Although OGC argued that the evidence underlying the VA rating decision demonstrated post-DLI deterioration, the Court found that "[b]ecause we conclude that the ALJ committed legal error by failing to consider properly all the record evidence, an assessment of the weight of the evidence must be left to the ALJ on remand in the first instance." *Bird*, 699 F.3d at 341 n.1 (emphasis added).

STANDARD OF REVIEW

- Supported by substantial evidence
- Reached through application of the correct legal standard

EXAMPLE APPLICATIONS OF THE STANDARD OF REVIEW

Background:

- Claimant had been diagnosed with fibromyalgia.
- Claimant testified to “virtual immobility” because of her pain.
- All physicians agreed that claimant had a frozen left shoulder.
- But physicians disagreed about the impact of her pain on her general ability.

Sarchet v. Chater, 78 F.3d 305 (7th Cir. 1996).

EXAMPLE APPLICATIONS OF THE STANDARD OF REVIEW

"If the [ALJ] believed the medical reports that found that [the claimant] has enough strength to work and disbelieved [the claimant's] own testimony, this would compel the denial of the application for benefits. We cannot say that this combination of belief and disbelief would be unreasonable but we cannot uphold a decision by an administrative agency . . . if, while there is enough evidence in the record to support the decision, the reasons given by the trier of fact do not build an accurate and logical bridge between the evidence and the result."

Sarchet v. Chater, 78 F.3d 305 (7th Cir. 1996) (emphasis added).

EXAMPLE APPLICATIONS OF THE STANDARD OF REVIEW

Background:

- ALJ found that claimant's severe impairments were major depression and somatization disorder.
- This finding arguably triggered a discussion of Listings 12.04 and 12.07.
- ALJ stated only that "[T]he evidence did not demonstrate that claimant's impairments are of a severity to meet or equal any of the listings contained at Appendix 1 to Subpart P of the Regulations No. 4."

Schoofield v. Barnhart, 220 F. Supp. 2d 512 (D. Md. 2002).

EXAMPLE APPLICATIONS OF THE STANDARD OF REVIEW

"In this case, the ALJ uttered only a sweeping, naked conclusion that Mr. Schoofield's condition did not meet or equal a listing. He offered no indication as to the evidence upon which he relied at Step Three or even which listing he supposedly considered. In this case, that treatment does not suffice and would not suffice in any case in which the evidence of record generates a substantive issue regarding a particular listing, whether that evidence was introduced by claimant's counsel or otherwise.[FN7]"

Schoofield v. Barnhart, 220 F. Supp. 2d 512, 520 (D. Md. 2002).

EXAMPLE APPLICATIONS OF THE STANDARD OF REVIEW

"FN7 . . . This standard of review is deferential to the Commissioner, but the benefits that it confers are earned only if the ALJ fulfills his responsibility to provide a meaningful explanation of the conclusions reached and the factual support for them. If this is not done, the Court cannot conduct its limited review, but instead, as the government in essence argues, must conduct a *de novo* evaluation of the evidence to see if there is any evidence that *could* have supported the ALJ's findings. Manifestly, that is not the responsibility of the Court…."

Schoofield v. Barnhart, 220 F. Supp. 2d 512, 520 (D. Md. 2002).

EXAMPLE APPLICATIONS OF THE STANDARD OF REVIEW

"When the evidence in the administrative record clearly generates an issue as to a particular listing in the LOI and the ALJ fails properly to identify the LOI considered at Step Three, and to explain clearly the medical evidence of record supporting the conclusion reached at that critical stage of the analysis, a remand can be expected to result, except…"

Schoofield v. Barnhart, 220 F. Supp. 2d 512, 520 (D. Md. 2002).

EXAMPLE APPLICATIONS OF THE STANDARD OF REVIEW

"…in those circumstances where it is clear from the record which listing or listings in the LOI were considered, and there is elsewhere in the ALJ's opinion an equivalent discussion of the medical evidence relevant to the Step Three analysis which allows this Court readily to determine whether there was substantial evidence to support the ALJ's Step Three conclusion."

Schoofield v. Barnhart, 220 F. Supp. 2d 512, 520 (D. Md. 2002).

BURDEN OF PROOF

- The claimant has the initial burden to show that he or she is unable to perform previous work because of medically determinable impairment(s). (Steps 1 through 4.)
- The burden shifts to the Commissioner at Step 5 to establish that work is available in the national economy which the claimant could perform.

BURDEN OF PROOF

Because the Commissioner has the burden of proof at Step 5, errors at this step are very difficult to defend.

BURDEN OF PROOF
STEP 5 ERRORS WITH GRID RULES

- Reliance on the Grid Rules despite non-exertional limitations in the RFC that significantly erode the occupational base.
- Relying on SSR 85-15, but RFC includes limitations not addressed in the basic mental demands of unskilled work such as “low-stress” or “not at a production pace.”
- Relying on Grid Rules where the aggregate effect of multiple non-exertional limitations is unclear.

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- In order for a vocational expert's testimony to constitute substantial evidence, the ALJ must pose a hypothetical question which fairly sets forth all of the claimant's limitations.
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- RFC does not match the hypothetical question.
- VE testimony internally inconsistent or materially inconsistent with the DOT.
- RFC limitation to "simple, routine tasks" or "unskilled" work and corresponding VE hypothetical may not account for limitations in concentration, persistence, or pace or social interaction.
  - (*See e.g.*, *Winschel v. Comm'r of Soc.* Sec., 631 F.3d 1176, 1180-81 (11th Cir. 2011); *Stewart v. Astrue*, 561 F.3d 679, 684-85 (7th Cir. 2009); *but see Milliken v. Astrue*, 397 Fed App'x 218, 221 (7th Cir. 2010) (unpublished).

NO POST HOC RATIONALIZATIONS

"A Simple But Fundamental Rule of Administrative Law"

"A reviewing court, in dealing with a determination or judgment which an administrative agency alone is authorized to make, must judge the propriety of such action solely by the grounds invoked by the agency. If those grounds are inadequate or improper, the court is powerless to affirm the administrative action by substituting what it considers to be a more adequate or proper basis."

Securities and Exchange Comm'n v. Chenery Corp., 332 U.S. 194, 196 (1947).

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"If the administrative action is to be tested by the basis upon which it purports to rest, that basis must be set forth with such clarity as to be understandable. It will not do for a court to be compelled to guess at the theory underlying the agency's action; nor can a court be expected to chisel that which must be precise from what the agency has left vague and indecisive."

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NO POST HOC RATIONALIZATIONS

Example from the Third Circuit

Background:

- Claimant had a back injury. Treating physician reports and opinions tended to support his claim, but workers compensation independent exams and State agency opinions contradicted his claim.
- ALJ found an RFC of light work.
- The ALJ did not evaluate relevant evidence or explain weight given to treating source medical opinions and contradictory findings in the medical evidence.
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"The District Court, apparently recognizing the ALJ's failure to consider all of the relevant and probative evidence, attempted to rectify this error by relying on medical records found in its own independent analysis, and which were not mentioned by the ALJ. This runs counter to the teaching of *Chenery* that the grounds upon which an administrative order must be judged are those upon which the record discloses that its action was based."

Fargnoli v. Massanari, 247 F.3d 34, 44 n.7 (3rd Cir. 2001).

NO POST HOC RATIONALIZATIONS

Example from the Seventh Circuit

The ALJ had discounted the opinion of a consultative examiner on the grounds that "it was 'not consistent with the medical evidence of record' and 'seem[ed] to be based solely on the [applicant's] subjective complaints.'" The Court faulted the ALJ for not identifying the inconsistent medical evidence and "ignor[ing]" that [the doctor] conducted a 90-minute consultative examination.

"Characteristically, and sanctionably, the government's brief violates the *Chenery* doctrine . . . , arguing for example that the administrative law judge rejected [the CE]'s report because he is not a pulmonologist."

Hughes v. Astrue, 705 F.3d 276 (7th Cir. 2013).

HARMLESS ERROR

"…[T]he court shall review the whole record or those parts of it cited by a party, and due account shall be taken of the rule of prejudicial error."

Administrative Procedures Act,

5 U.S.C. § 706.

HARMLESS ERROR

- Applied in court review of administrative bodies.
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- The burden of showing that an error is harmful normally falls upon the party attacking the agency's determination.

See Shinseki v. Sanders, 556 U.S. 396 (2009).

HARMLESS ERROR

Example from the Seventh Circuit

"We agree with Justin that the ALJ conducted a marginal hearing. . . . [But], in the end, the ALJ had before him a fairly complete picture of Justin's developmental and behavioral problems, in spite of the manner in which the hearing was conducted. Furthermore, Justin has not . . . demonstrated prejudice by showing a significant omission from the record. Therefore, although the ALJ conducted the hearing in a marginal manner, the relevant evidence about Justin's condition still managed to find its way into the record, and there is no reason to remand for a new hearing."

Nelson v. Apfel, 131 F.3d 1228, 1235–36 (7th Cir. 1997) (citations omitted).

LIMITS OF HARMLESS ERROR

Example from the Seventh Circuit

"The ALJ's opinion is unsatisfactory, and likewise the government's brief and oral argument, which misstate the record in several places and, worse, seem determined to dissolve the *Chenery* doctrine in an acid of harmless error….. [T]he fact that the ALJ, had she considered the entire record, might have reached the same result does not prove that her failure to consider the evidence was harmless. Had she considered it carefully, she might well have reached a different conclusion."

Spiva v. Astrue, 628 F.3d 346, 353 (7th Cir. 2010).

HARMLESS ERROR

Example from the Sixth Circuit

(ALJ mistakenly referred to 12.05D rather than 12.05C.)

"Appellant contends the district court's attempt to legitimize the ALJ's error is an illegitimate post hoc rationalization, contrary to the rule of *Chenery*… Consistent with *Chenery,* the district court evaluated the actual grounds invoked by the ALJ and found them to be supported by substantial evidence, despite the technically erroneous reference included in the ALJ's decision. The district court's reasoning is also fully consistent with this Circuit's precedents. Thus, the district court's judgment does not run afoul of the rule against *post hoc* rationalizations."

Williams v. Comm'r of Soc. Sec., 227 Fed. App'x 463, 464 (6th Cir. 2007) (unpublished) (all citations omitted).

LIMITS OF HARMLESS ERROR

Example from the Ninth Circuit

Background:

- Claimant's sister and brother-in-law submitted uncontradicted evidence concerning the effect of claimant's mental impairments on his ability to work.
- The ALJ did not mention this evidence.
- A line of Ninth Circuit cases establishes that ALJs must consider and comment upon uncontradicted lay testimony.
- The District Court found the error harmless because the sister's testimony suggested claimant always had mental limitations yet was able to work and the brother-in-law's letter was based on a 15-year history of working with the claimant.

Stout v. Comm'r, 454 F.3d 1050 (9th Cir. 2006).

LIMITS OF HARMLESS ERROR

Example from the Ninth Circuit

"We note that two considerations caution, if not preclude, us from adopting these justifications for embracing harmless error here. First, the ALJ, not the district court, is required to provide specific reasons for rejecting lay testimony. Indeed, we cannot rely on independent findings of the district court. Rather, we are constrained to review the reasons the ALJ asserts. Second, we cannot affirm the decision of an agency on a ground that the agency did not invoke in making its decision. [*Chenery*]. Consequently, if the Commissioner's request that we dismiss the ALJ's error as harmless invites this Court to affirm the denial of benefits on a ground not invoked by the Commissioner in denying the benefits originally, then we must decline."

Stout v. Comm'r, 454 F.3d 1050, 1054, 1056 (9th Cir. 2006).

LIMITS OF HARMLESS ERROR

Example from the Ninth Circuit

Stout's review of Ninth Circuit harmless error precedents:

- Error was non-prejudicial to claimant.
- Error was inconsequential to the ultimate nondisability determination.
- Error occurred during a procedure or step the ALJ was not required to perform (e.g., alternative Step 5 determination).

Stout v. Comm'r, 454 F.3d 1050, 1054, 1056 (9th Cir. 2006).

LIMITS OF HARMLESS ERROR

Example from the Ninth Circuit

"[W]e hold that where the ALJ's error lies in a failure to properly discuss competent lay testimony favorable to the claimant, a reviewing court cannot consider the error harmless unless it can confidently conclude that no reasonable ALJ, when fully crediting the testimony, could have reached a different disability determination."

Stout v. Comm'r, 454 F.3d 1050, 1056 (9th Cir. 2006).

LIMITS OF HARMLESS ERROR

Example from the Ninth Circuit

"In the present case, we cannot so conclude. If fully credited, the lay testimony supports a conclusion that Stout's mental impairments render him in need of a special working environment which, particularly when considering the VE's testimony, a reasonable ALJ could find precludes Stout from returning to gainful employment. Consequently, the ALJ's error in failing to provide reasons for rejecting it was not harmless."

Stout v. Comm'r, 454 F.3d 1050, 1056 (9th Cir. 2006).

LIMITS OF HARMLESS ERROR

Example from the Ninth Circuit

"I respectfully dissent from the majority's conclusion that the ALJ's failure to comment properly on the lay witness testimony. . . was not harmless error. I am persuaded, as was the District Court, that even if the lay witness testimony is credited, all the evidence taken as a whole overwhelmingly supports denial of Stout's application for DIB and SSI."

Stout v. Comm'r, 454 F.3d 1050, 1056 (9th Cir. 2006) (O'Scannlain, J. dissenting).


The Key To Avoiding Remands:
Articulation

ARTICULATION

- Articulation applies at every step of the sequential evaluation process.
- The more detailed the decision, the more defensible it becomes.
- Consider adding the word “because” throughout the decision.

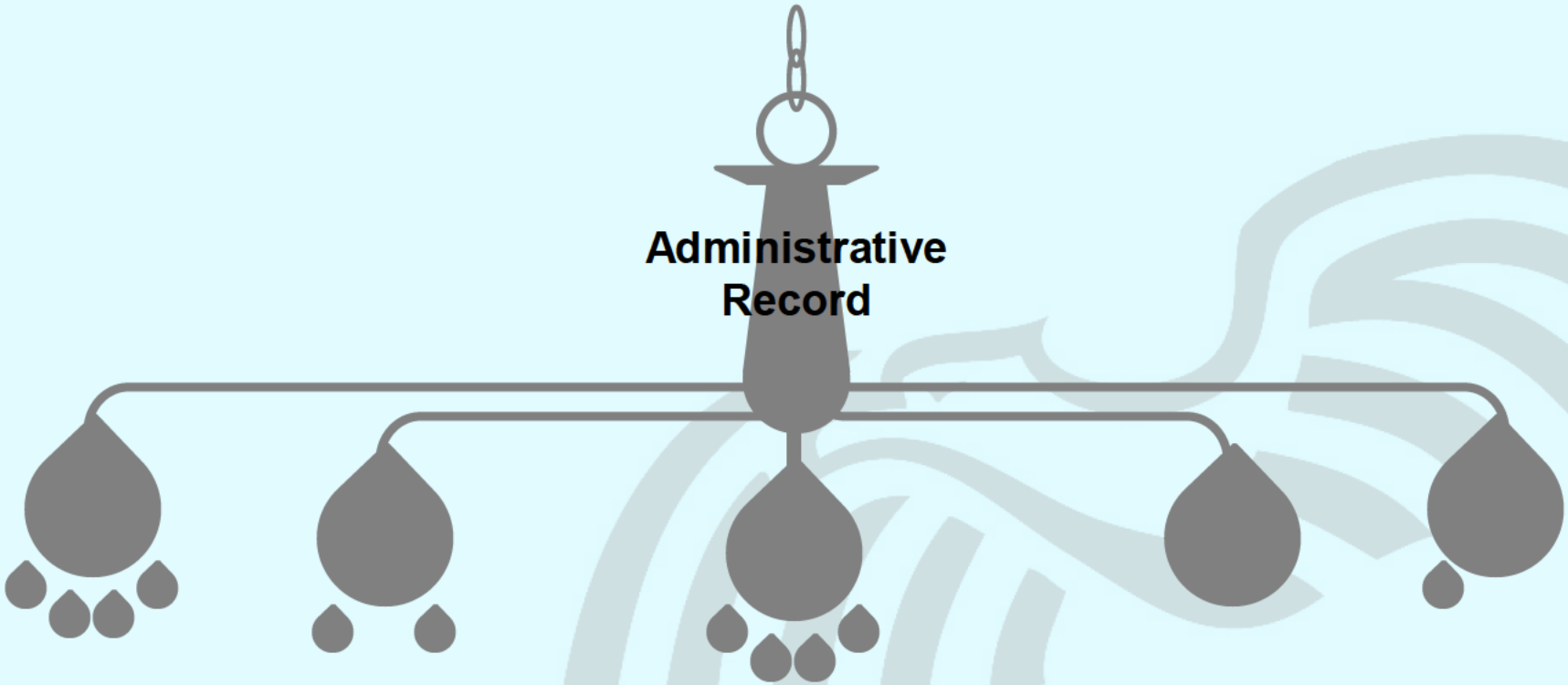
ARTICULATION

- Courts look to see **how** and **why** you reached your conclusions.

- Just a few more sentences—or even a few more words—can make the difference between a case that is legally defensible and a case that is remanded.

THE CHANDERLIER:

Everything Must Hang Together



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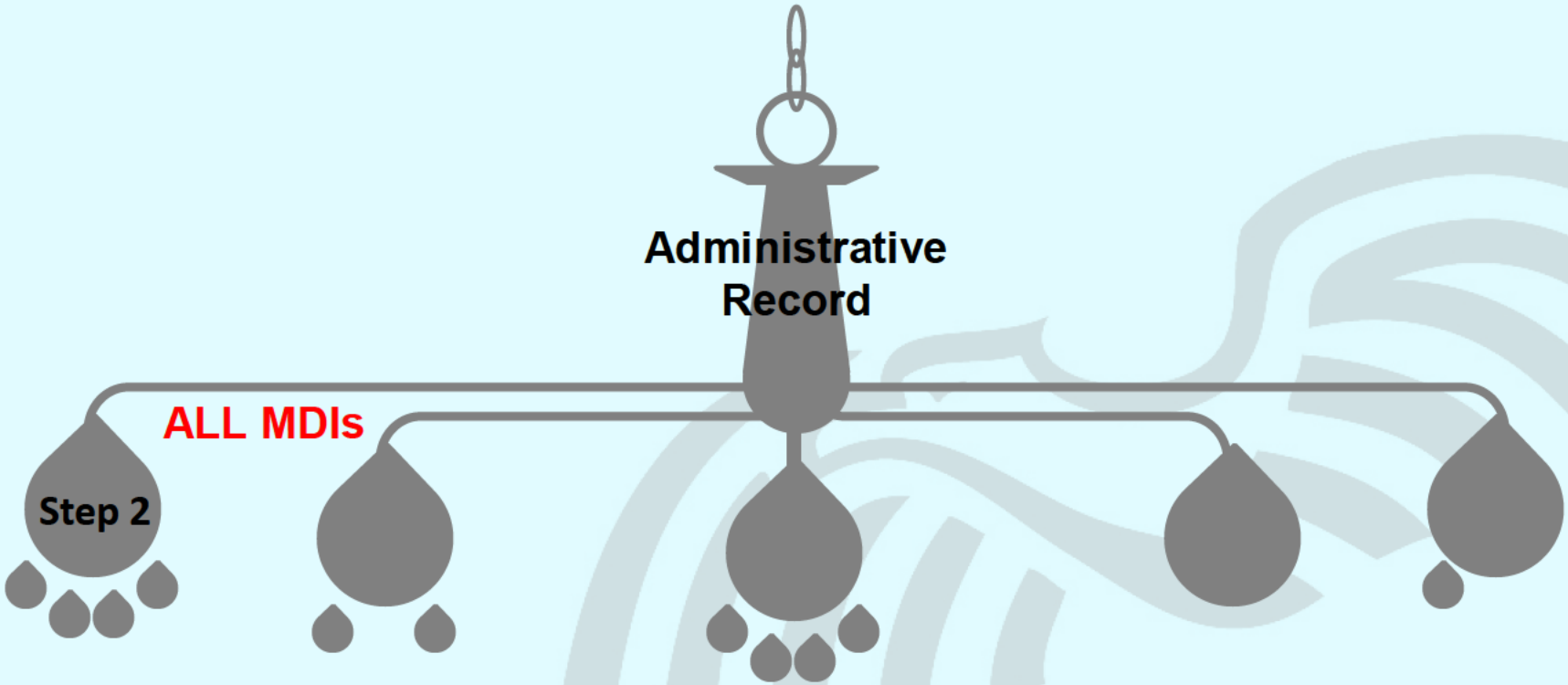

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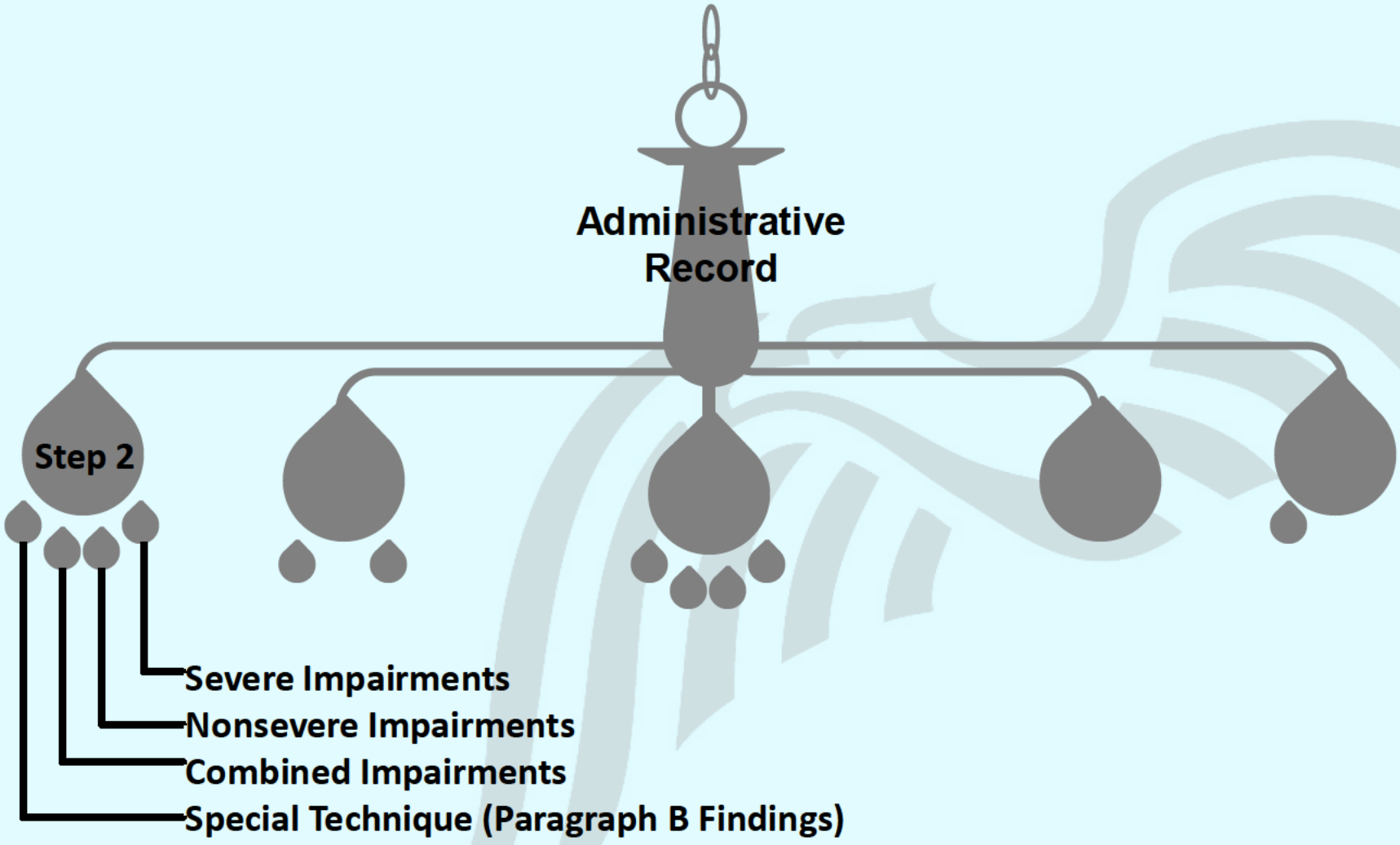

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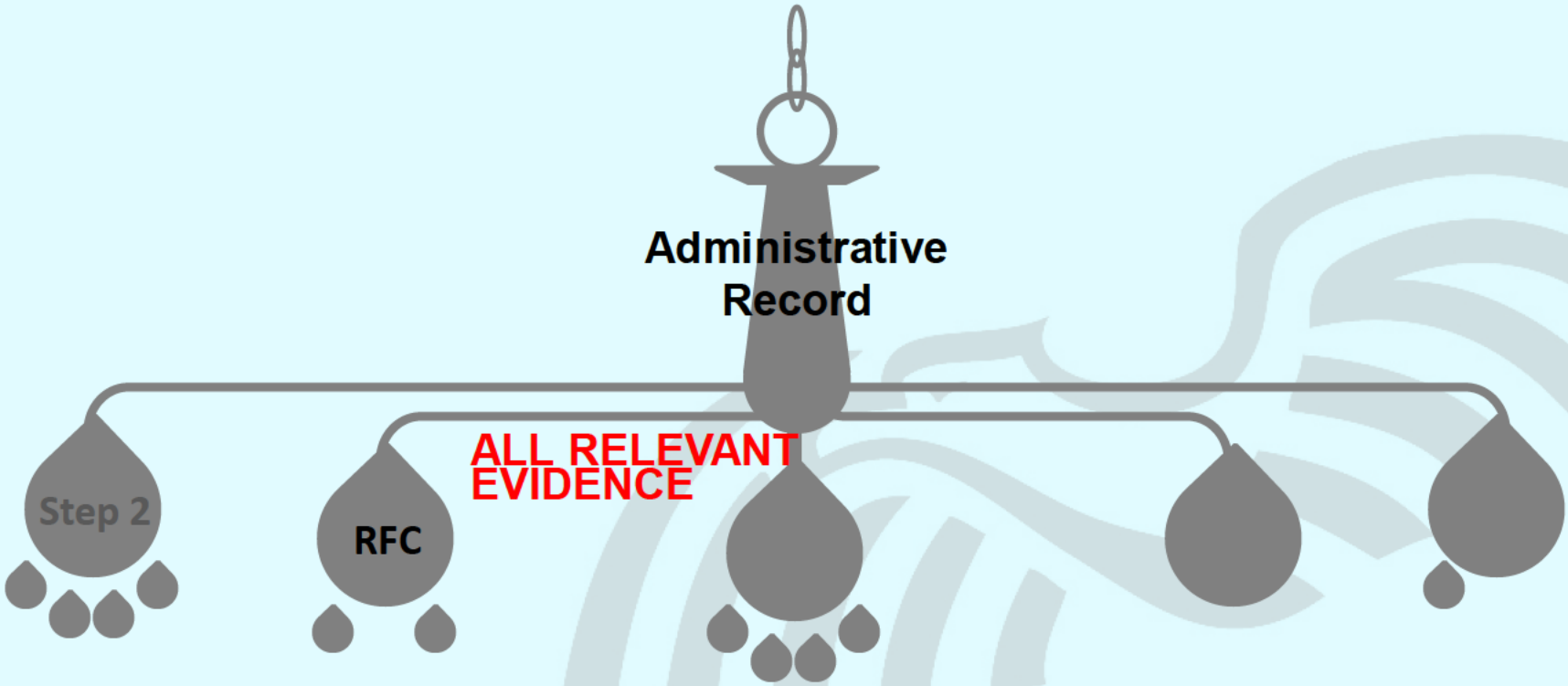

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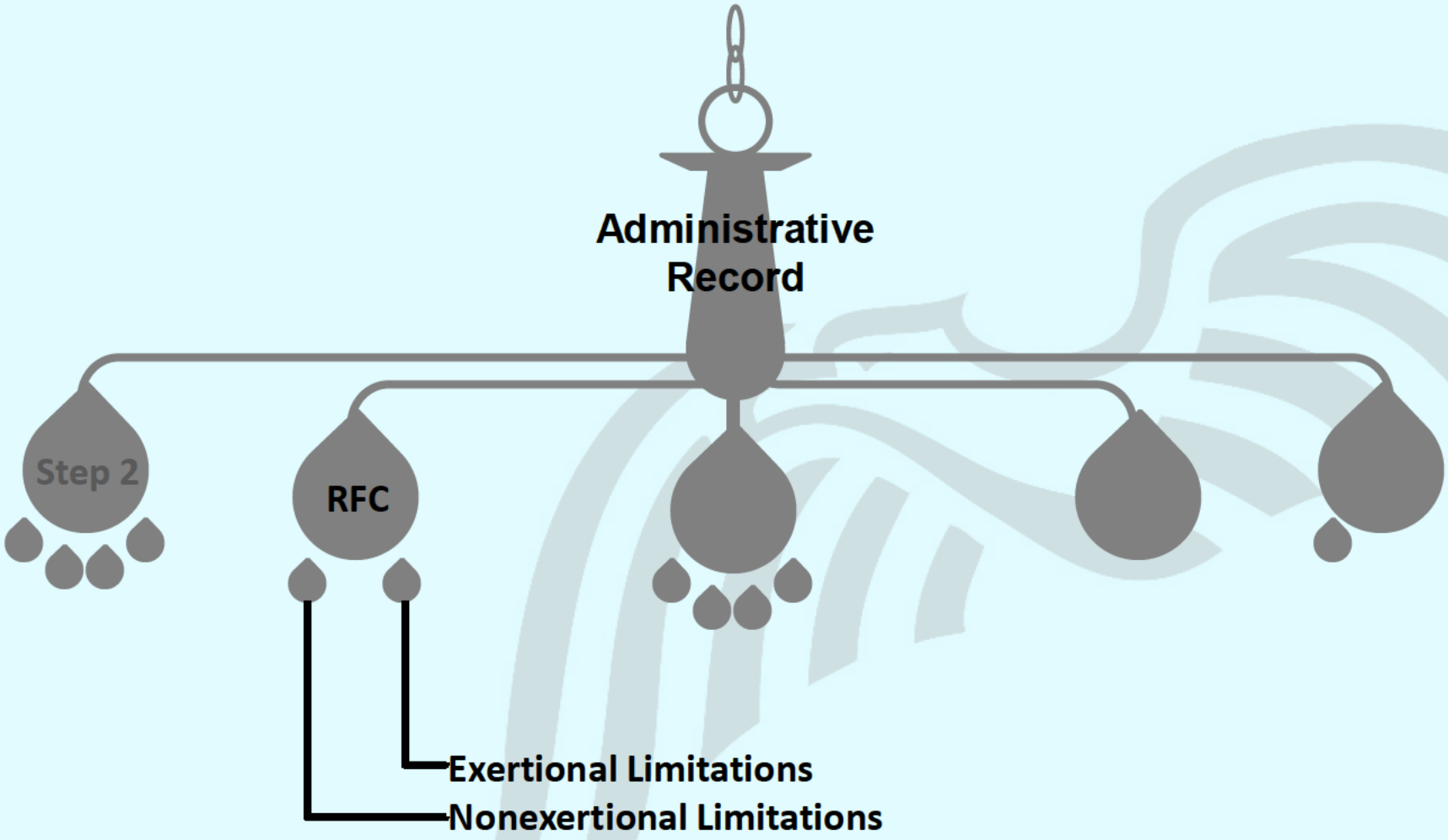

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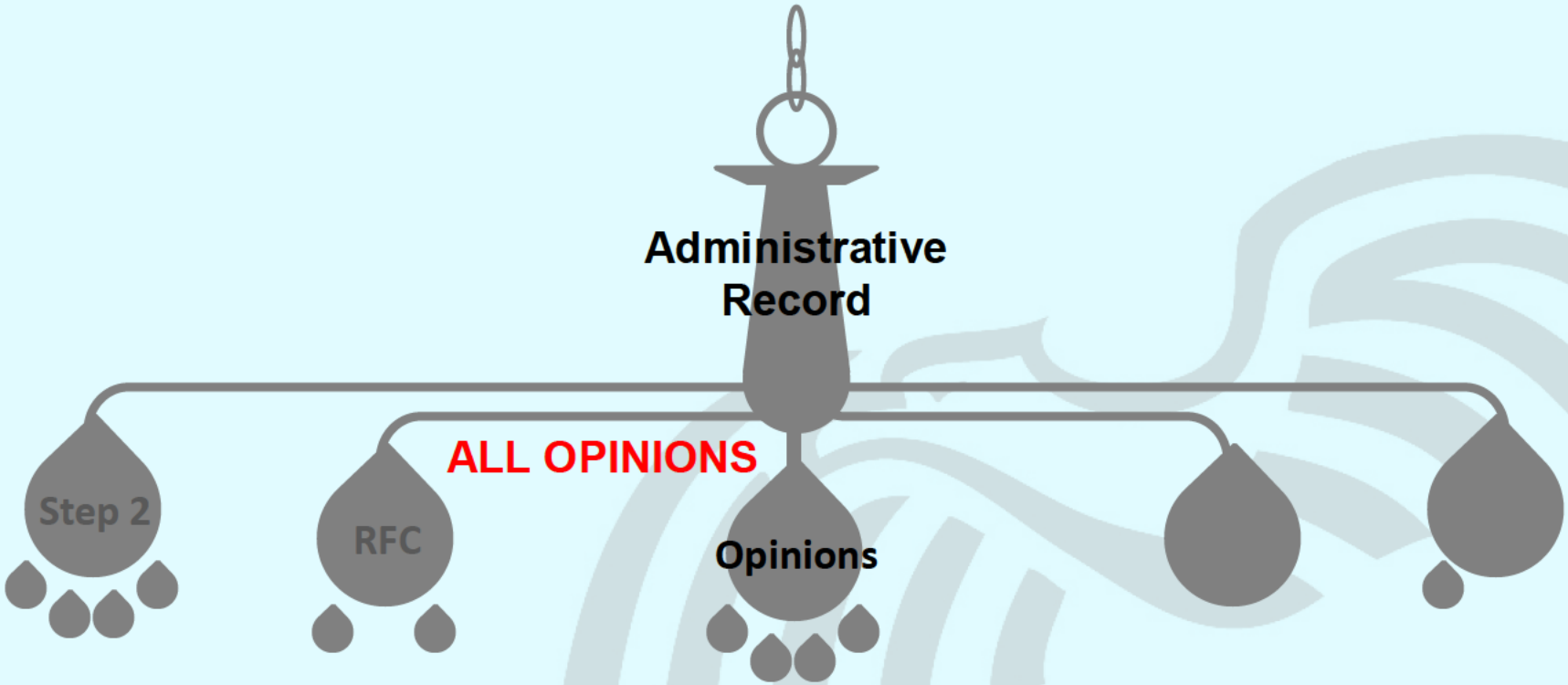

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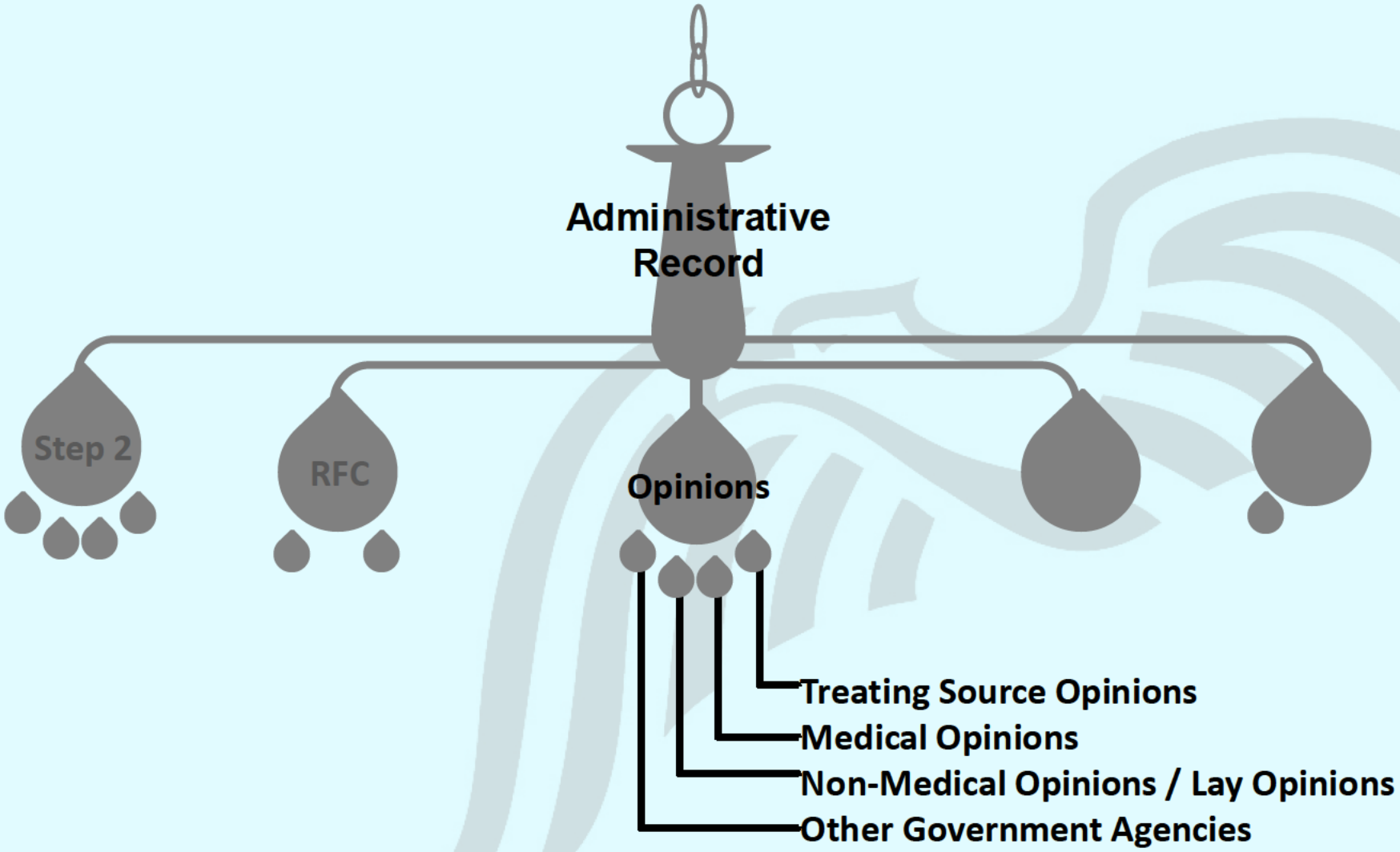

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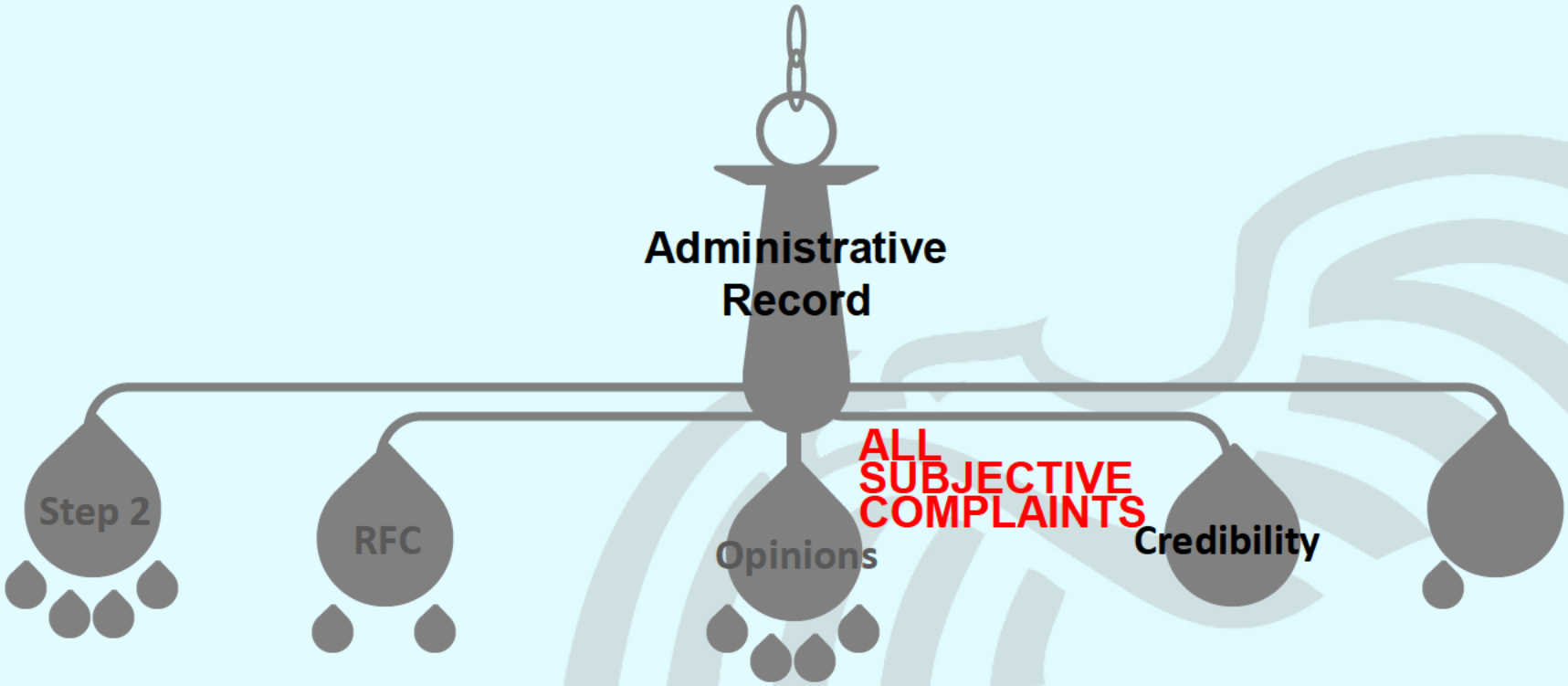

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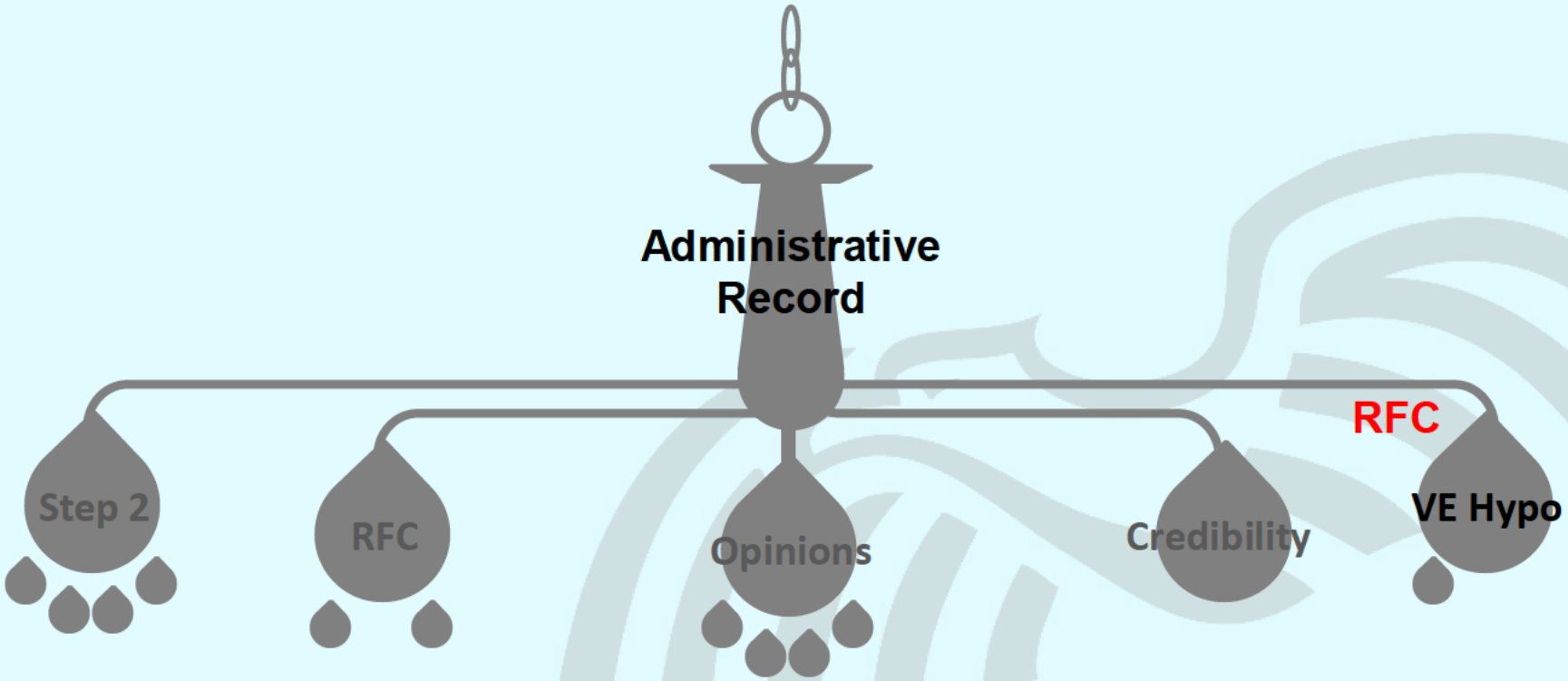

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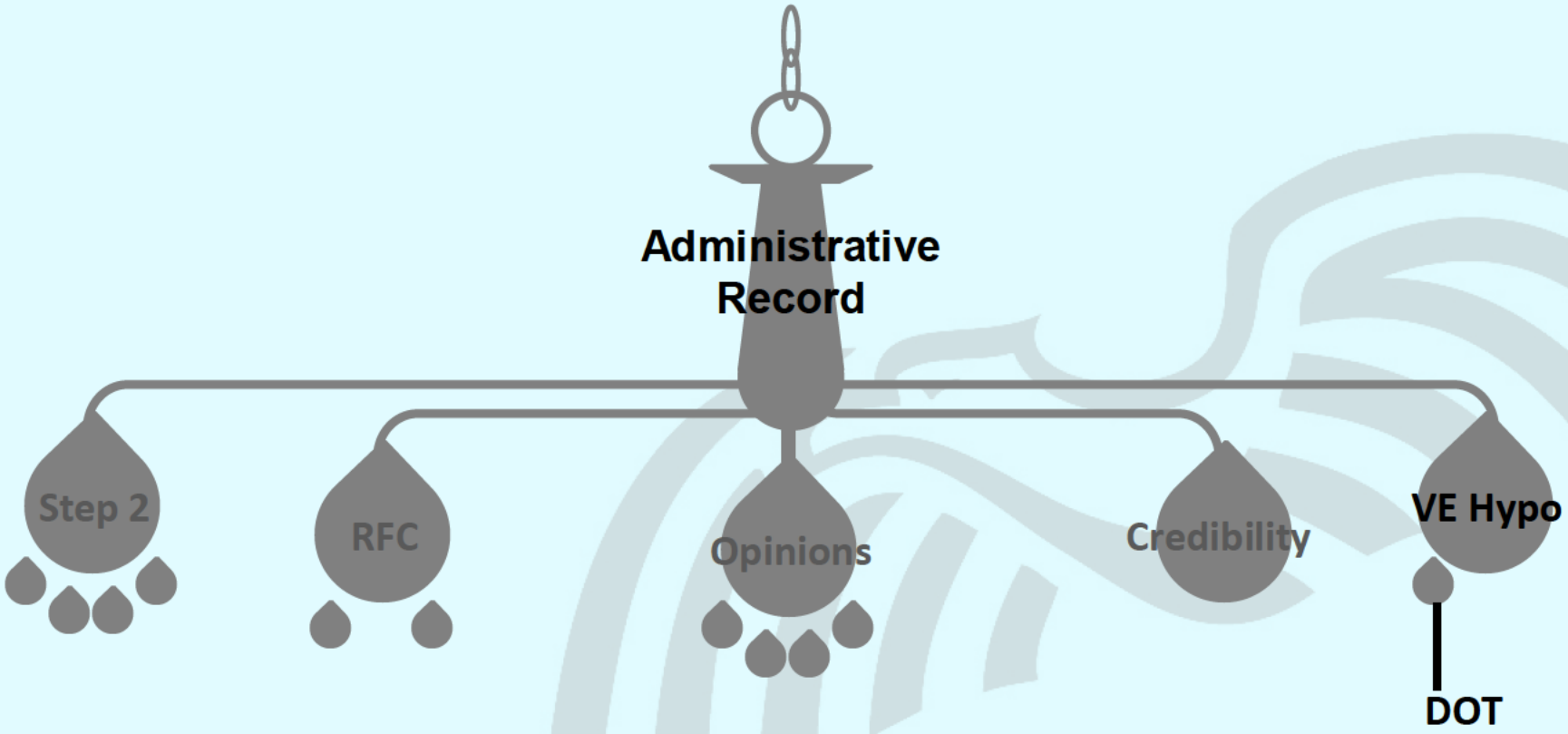

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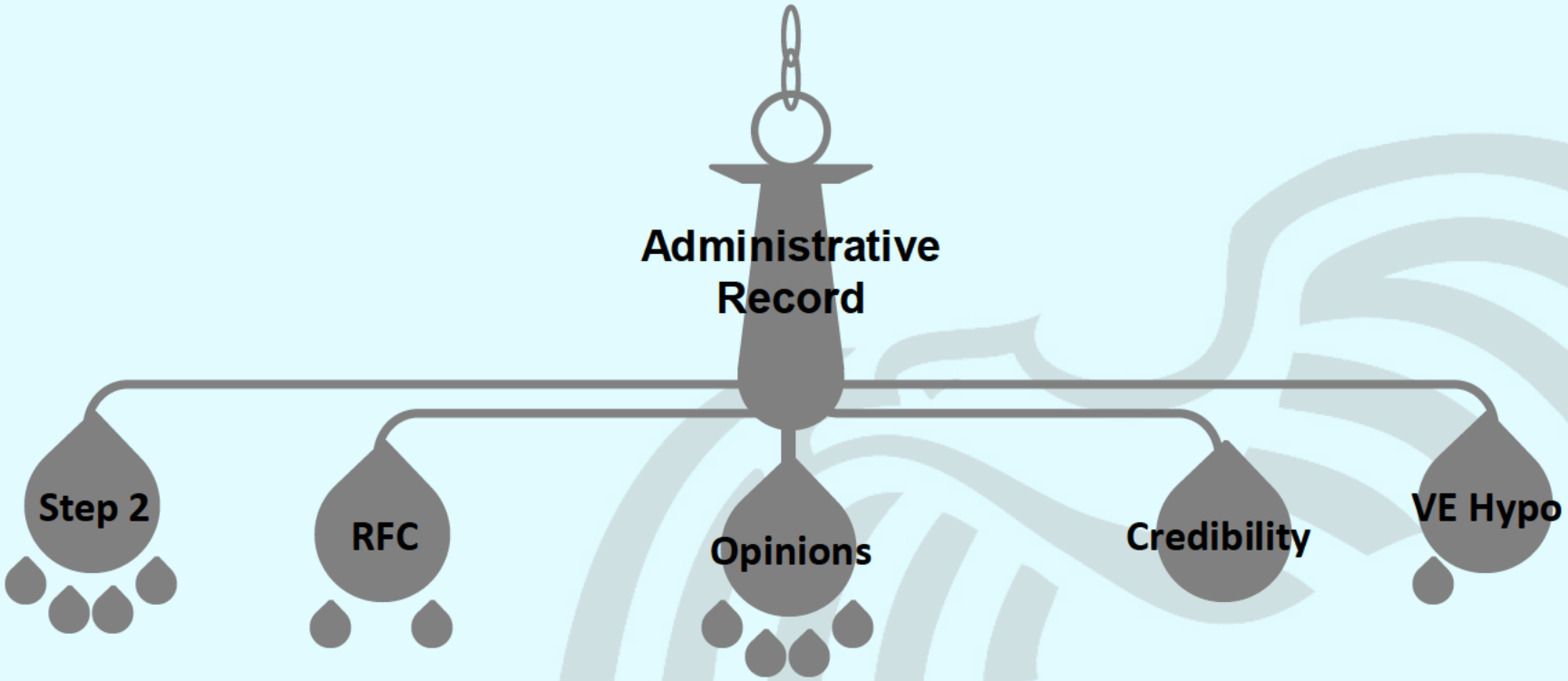

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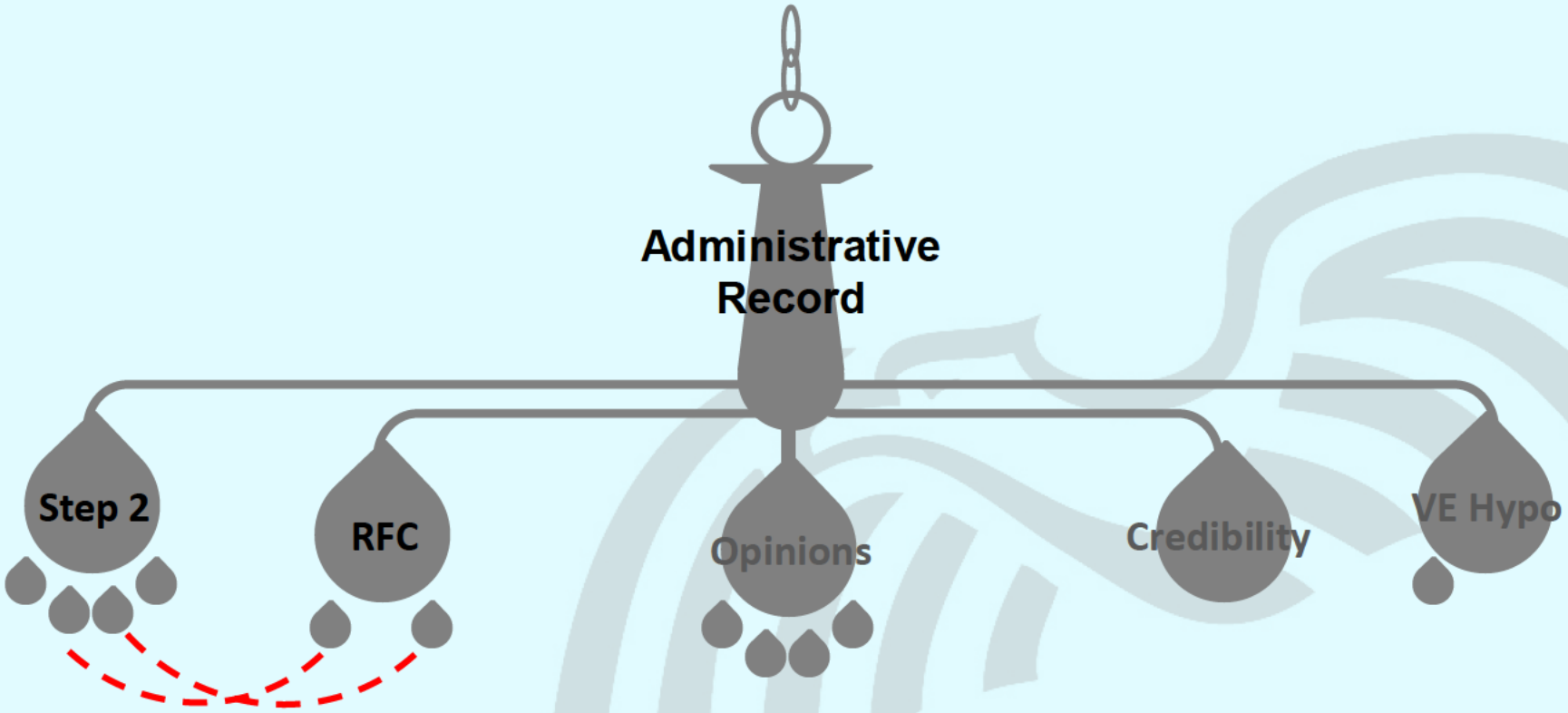
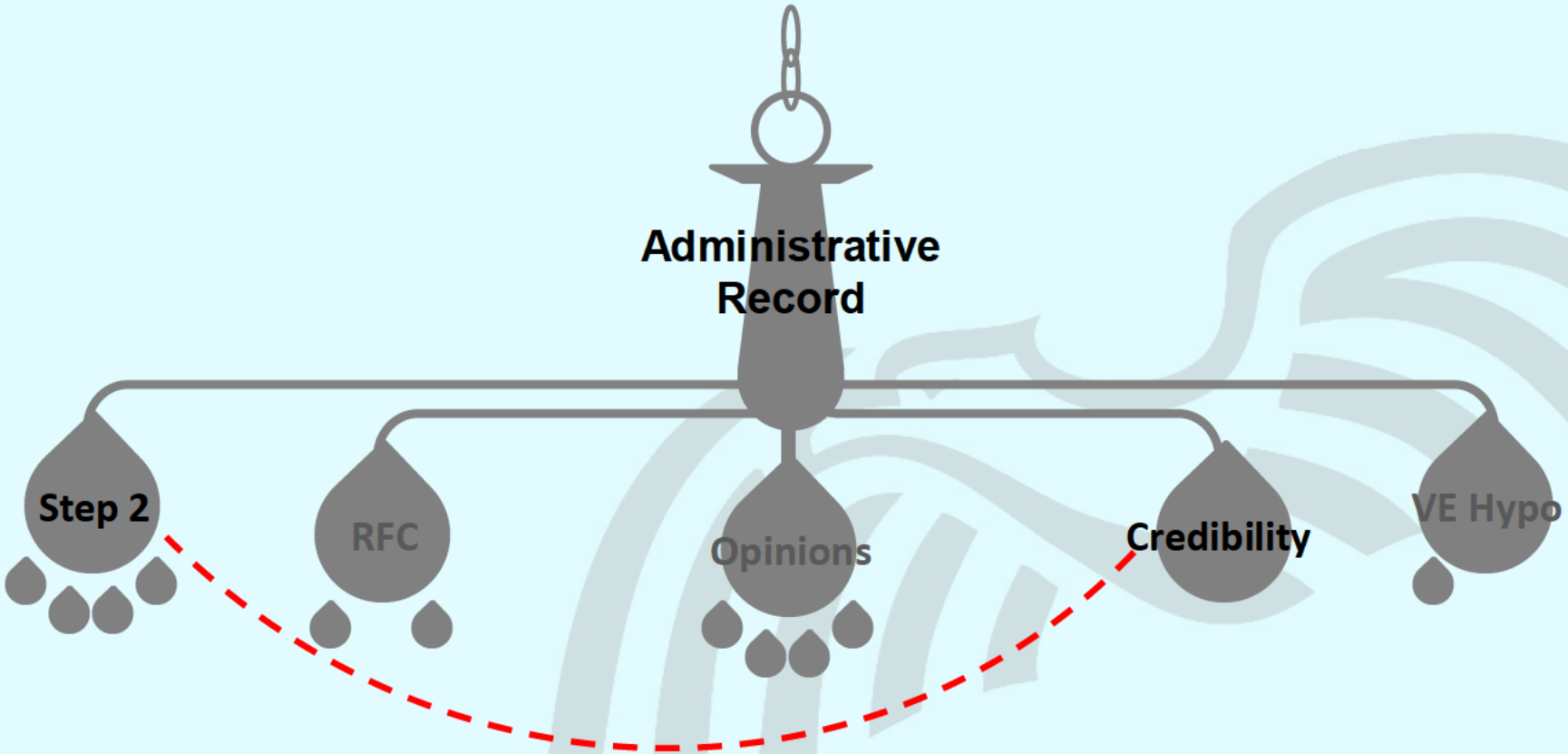


IMPAIRMENTS MUST MATCH LIMITATIONS

Severe Impairment → Corresponding Exertional or Nonexertional Limitation
Nonsevere Impairment → Corresponding Limitation IF Limiting When Combined
Combined Impairment → Corresponding Exertional or Nonexertional Limitation

THE CHANDERLIER:

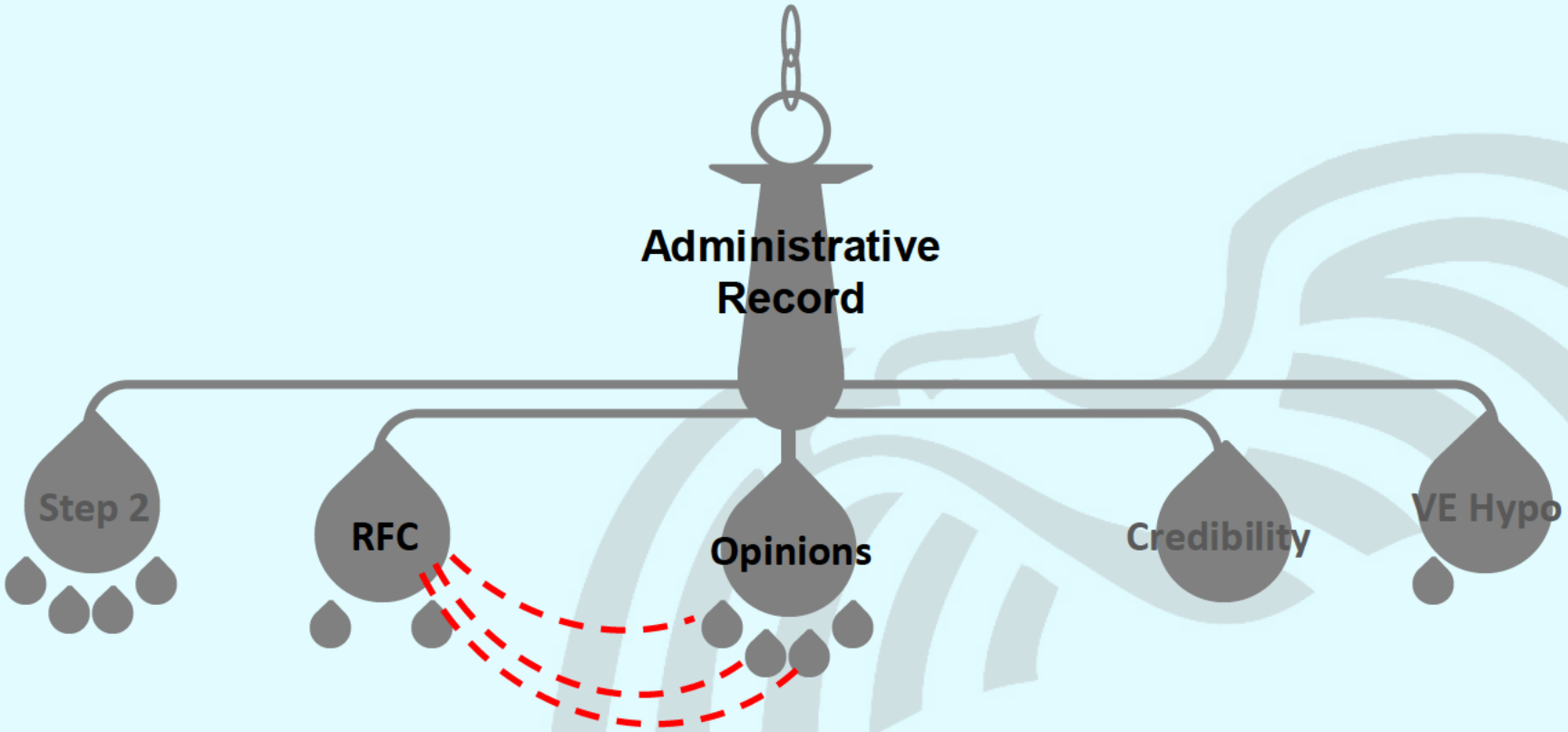
Everything Must Hang Together



STEP 1: COMPARE SUBJECTIVE COMPLAINTS WITH MDIs

THE CHANDERLIER:

Everything Must Hang Together



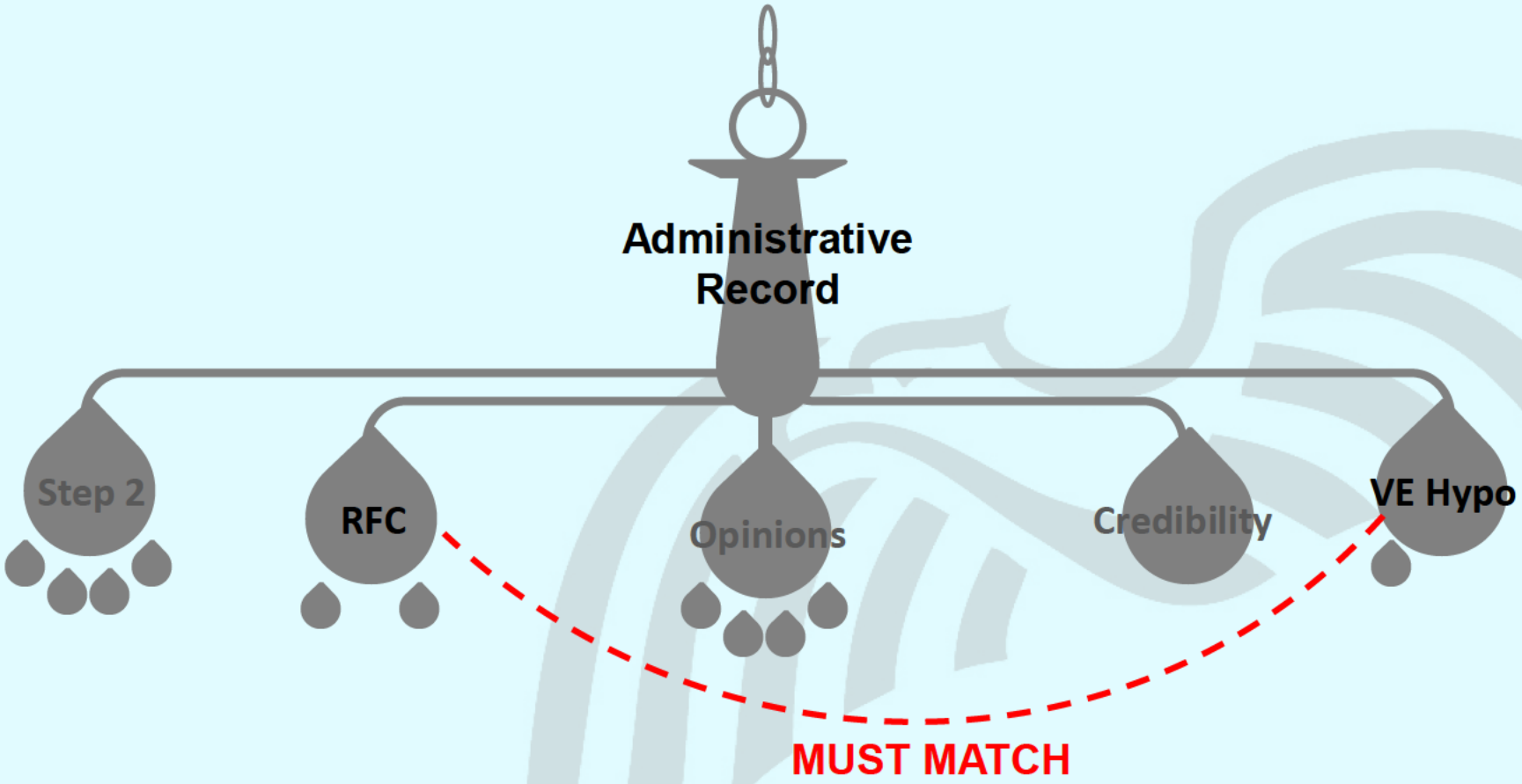
MUST MATCH OR DIFFERENCE MUST BE EXPLAINED

Opinion Matches RFC → Assign Great Weight and Explain Reasoning

Opinion Differs from RFC → Assign Appropriate Weight and Explain Reasoning

THE CHANDERLIER:

Everything Must Hang Together



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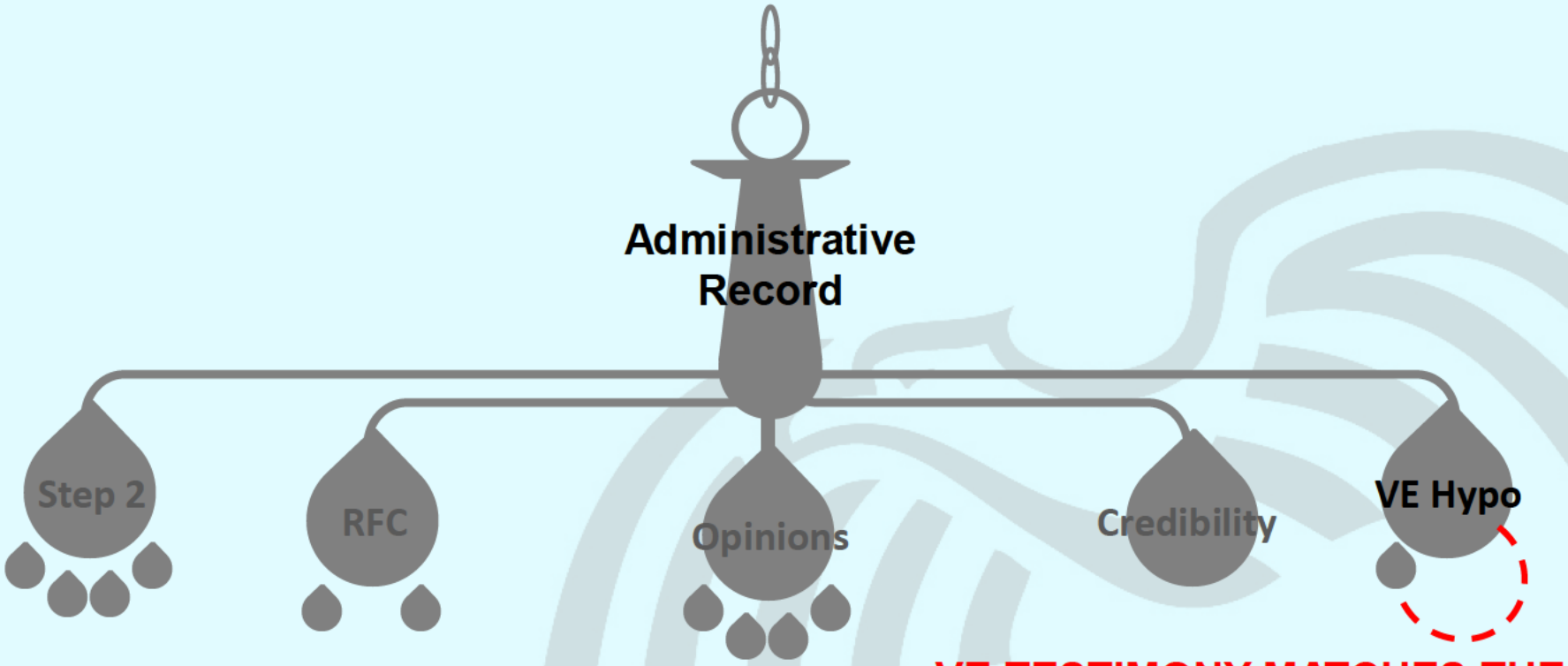
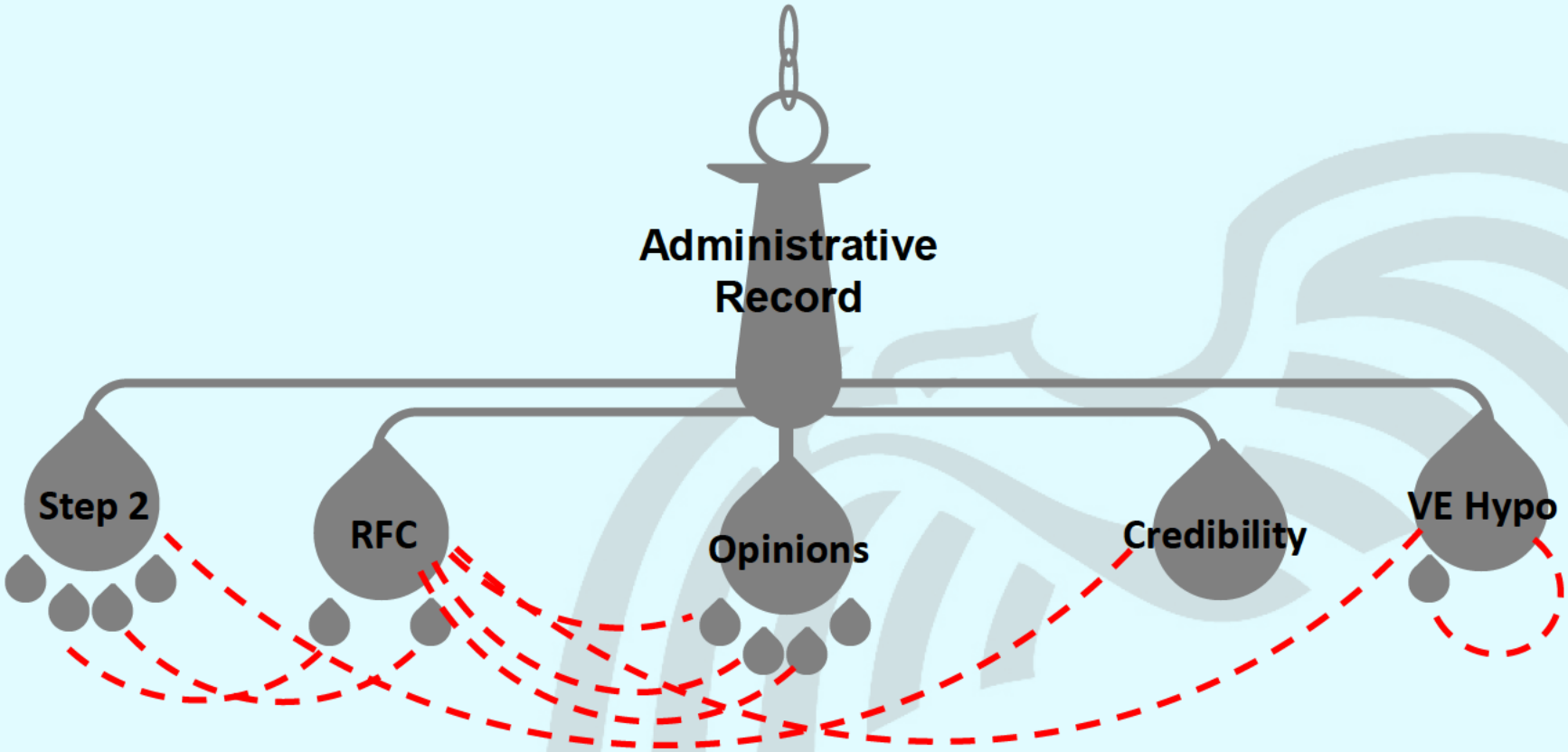


VE TESTIMONY MATCHES THE DOT OR VE EXPLAINS WHY NOT

THE CHANDERLIER:

Everything Must Hang Together



Opinion Evidence

Crafting a Legally Sufficient Articulation of the Opinion Evidence Analysis

OAO Training – Appeals Council

Opinion Evidence

THE PROBLEM	SSA POLICY
The Administrative Law Judge's treatment of opinion evidence cannot be supported because: ➢ The decision does not discuss opinion evidence that suggests greater limitations than found by the decision. ➢ The decision accords "significant" or "great" weight to an opinion, but does not adopt or address all the limitations suggested by the opinion. ➢ The decision discredits or discounts an opinion using stock phrases, but does not provide an adequate articulation of the rationale (i.e., "the opinion is inconsistent with the overall record", "the opinion is about an issue reserved to the commissioner", or "the opinion is from a non-acceptable medical source or non-medical source"). ➢ The decision mischaracterizes the source (i.e., the decision identifies a treating source as nontreating; or the decision identifies the source as an "orthopedic specialist" when the source is not a specialist). ➢ The decision mischaracterizes the nature or content of the opinion, or of the evidence relating to the opinion. ➢ The decision evaluates a form completed by an SDM (single decision maker).	Medical opinions are statements from physicians and psychologists or other acceptable medical sources that reflect judgments about the nature and severity of a claimant's impairments (20 CFR 404.1527(a)(2), (b) and 416.927(a)(2), (b)). The regulations require that we will always consider the medical opinions in the case record together with the rest of the relevant evidence, and we will evaluate every medical opinion we receive, regardless of the source. • **Treating Source (**20 CFR 404.1527(d)(2) and 416.927 (d)(2)). If a treating source's opinion on the nature and severity of the claimant's impairments is well-supported by medically acceptable clinical and laboratory diagnostic techniques and is not inconsistent with the other substantial evidence in the case record, we will give it controlling weight. When we do not give the treating source's opinion controlling weight, we consider all of the factors we use in deciding the weight we give to any medical opinion. We will always give good reasons in the decision for the weight we give a treating source's opinion. • **Examining source (**20 CFR 404.1527(d)(1) and 416.927 (d)(1)). Generally, we give more weight to the opinion of a source who has examined the claimant than to the opinion of a source who has not. • **Nonexamining sources (**20 CFR 404.1527(e) and 416.927 (e)). We consider all evidence from nonexamining sources to be opinion evidence. • We must consider findings made by **State agency medical consultants (MCs) and psychological consultants (PCs)** as opinion evidence and weigh that evidence together with the other evidence in the record when we make our decisions. 20 CFR 404.1527(e) and 416.927(e) and Social Security Ruling 96-6p. Social Security Ruling 06-03p reminds us that we must consider all opinion evidence in the record, including that from lay witnesses and opinions of medical sources who are NOT "acceptable medical sources" such as nurse practitioners, physician assistants, licensed clinical social workers, naturopaths, chiropractors, audiologists, and therapists. Some opinions are opinions on issues reserved to the Commissioner, because they are administrative findings that are dispositive of a case; *i.e.*, that would direct the determination or decision of disability. This includes opinions that the claimant is disabled, that the requirements of a listing are met, that purport to determine the claimant's residual functional capacity, or that apply vocational factors. (20 CFR 404.1527(d) and 416.927(d) and Social Security Ruling 96-5p).

Why It Matters	Watch Out in These Situations	What to Do
★ Unsupported or absent evaluation of opinion evidence can undermine the entirety of any finding that would be materially affected by the opinion. This may include step 2, step 3, step 4 and step 5 findings, any of which may be affected by an opinion that is inconsistent with the Administrative Law Judge's findings and conclusions. ★ Issues with opinion evidence and residual functional capacity account for the greatest percentage of remands from the Appeals Council, for both favorable and unfavorable decisions, and from the federal courts. ★ A legally sufficient decision is an efficient and effective use of agency resources.	The record contains several medical source opinions.	Evaluate all medical opinions in the record, and articulate the weight given to each medical opinion. Be specific – "none", "little," "great," "controlling" Address all portions of the medical opinion. Be sure that the discussion of the evidence in the decision will allow a claimant or subsequent reviewer to follow your reasoning.
	Numerous forms completed by the same source that are inconsistent, or parts of one statement are inconsistent with other parts.	Provide clear reasons for rejecting a medical opinion. Follow and use the language of the regulations to support your evaluation. Use evidence to support the reasons for rejecting the medical opinion. Be specific and cite to exhibits. You can accept some or all of an opinion; just be sure to articulate a weight for each part of an opinion if you are not treating it as a whole, and a reason for that weight.
	Evidence that states "the claimant is disabled."	Evaluate all medical source opinions, including those that express an opinion on an issue reserved to the Commissioner. These opinions must be considered, but they are not entitled to controlling weight or special significance. It is not sufficient to make a conclusory statement that the opinion is "on an issue reserved to the Commissioner" or similar statement; further evaluation is required under SSR 96-5p. Remember also that we may have a duty to recontact the source of the opinion, depending on the facts of the case.
	Medical Source Statements that state conclusions but do not provide rationale or support.	Use evidence to support the reasons for rejecting the medical opinion. Be specific and cite to exhibits.
	Forms completed by non-acceptable medical sources or non-medical sources.	Explain the weight given to opinions from non-acceptable medical sources and non-medical sources who have seen the claimant in their professional capacity.
	A State Agency form completed by a single decision maker (SDM).	An SDM statement or decision is an administrative conclusion, not a medical opinion.

OAO Training – Appeals Council

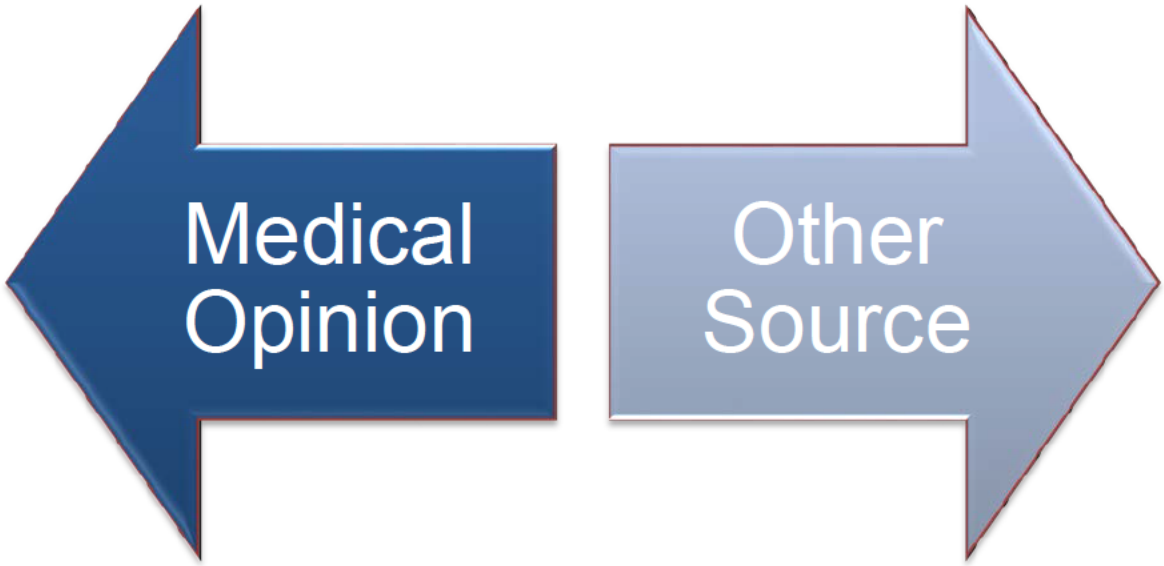
Opinion Evidence

Crafting a Legally Sufficient Articulation of the Opinion Evidence Analysis

Table of Contents

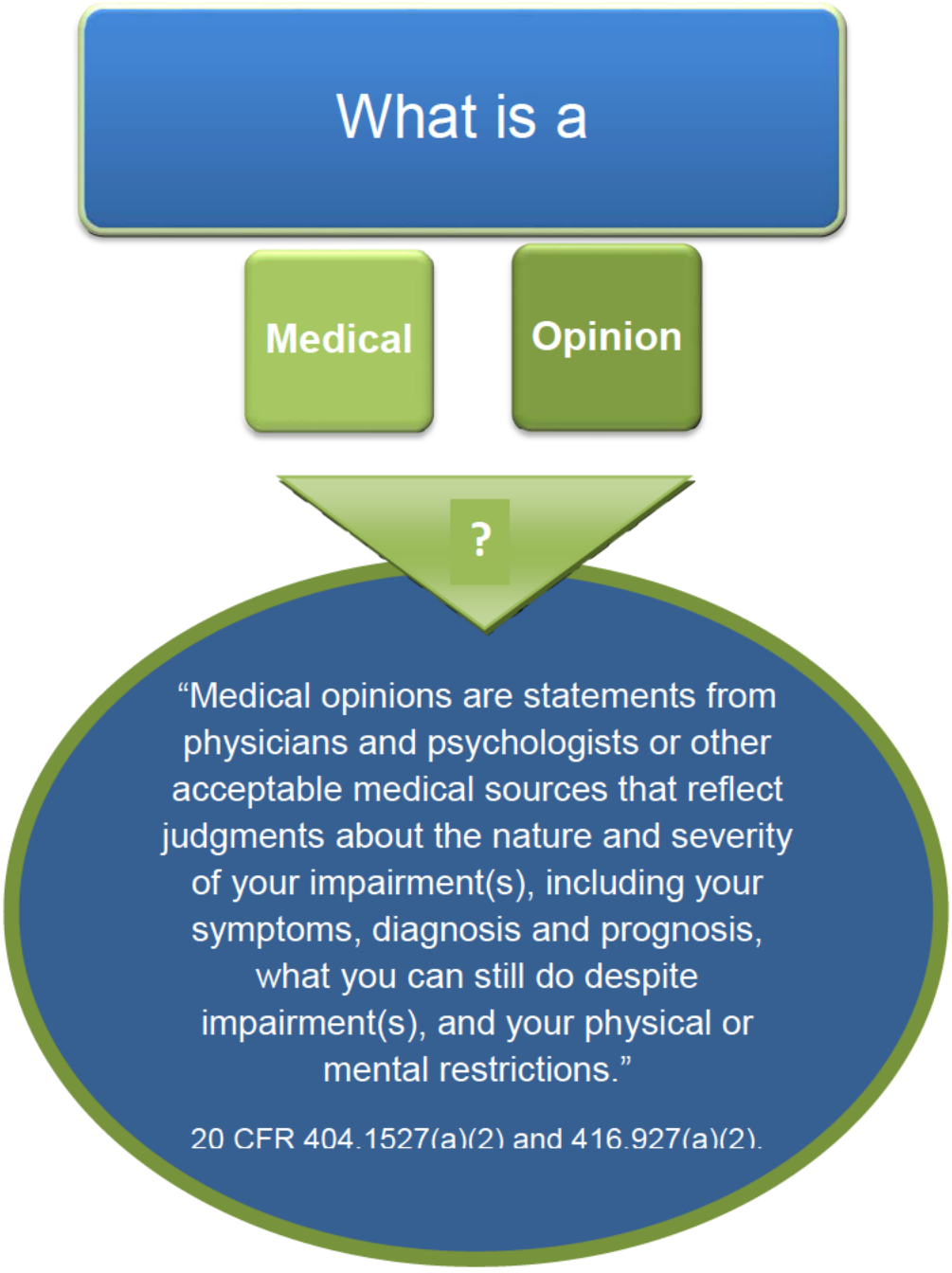
Categorizing Opinion Evidence

The evidence of record likely contains opinion evidence. This type of evidence falls into two categories:



Each of these categories is treated differently. Therefore, an adjudicator must begin by recognizing and categorizing the opinion evidence in the record.

First, we need to determine…



That is, a medical opinion is a statement from a specific type of source – an "acceptable medical source".

Who is an "acceptable medical source"?

- **Licensed Physician.** This includes both medical and osteopathic doctors.
- **Licensed or certified psychologists.** For purposes of establishing mental retardation, learning disabilities, and borderline intellectual functioning only, this also includes school psychologists, or other licensed or certified individuals with other titles who perform the same function as a school psychologist in a school setting.
- **Licensed Optometrists.** This is an acceptable medical source for the purpose of establishing visual disorders only (except in the U.S. Virgin Islands, this is an acceptable medical source for the measurement of visual acuity and visual fields only).
- **Licensed Podiatrists.** This is an acceptable medical source for the purpose of establishing impairments of the foot, or foot and ankle only.
- **Qualified Speech-Language Pathologists.** This is an acceptable medical source for the purpose of establishing speech or language impairments only.
- 20 CFR 404.1513(a) and 416.913(a)

Only specific categories of medical practitioners are acceptable medical sources.

Further, we divide acceptable medical sources into three groups (20 CFR 404.1502 and 416.902):

(1) treating

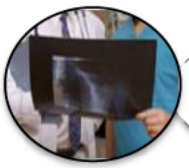
(2) nontreating

(3) nonexamining

(1) Treating Source

- **The claimant's own acceptable medical source:**
- **Who provides, or has provided, the claimant with medical treatment or evaluation, and**
- **Has, or had, an ongoing treatment relationship with the individual.**

An acceptable medical source is considered to have an ongoing treatment relationship when the medical evidence establishes that the claimant sees, or has seen, the source with a frequency consistent with accepted medical practice for the type of treatment and/or evaluation required for the claimant's medical conditions.



An acceptable medical source who has treated or evaluated the claimant only a few times or only after long intervals still may be considered a treating source, if the nature and frequency of the treatment or evaluation is typical for the claimant's conditions.

An acceptable medical source will **not** be considered a treating source if the claimant's relationship with the source is not based on the medical need for treatment or evaluation, but solely on the need to obtain a report in support of a claim for disability. In such a case, the acceptable medical source will be considered a **nontreating** source.

(2) Nontreating Source

- **An acceptable medical source who has examined the claimant but does not have, or did not have, an ongoing treatment relationship with the claimant.**
- **The term includes an acceptable medical source who is an agency-contracted consultative examiner, when the consultative examiner is not a treating source.**

(3) Nonexamining Source

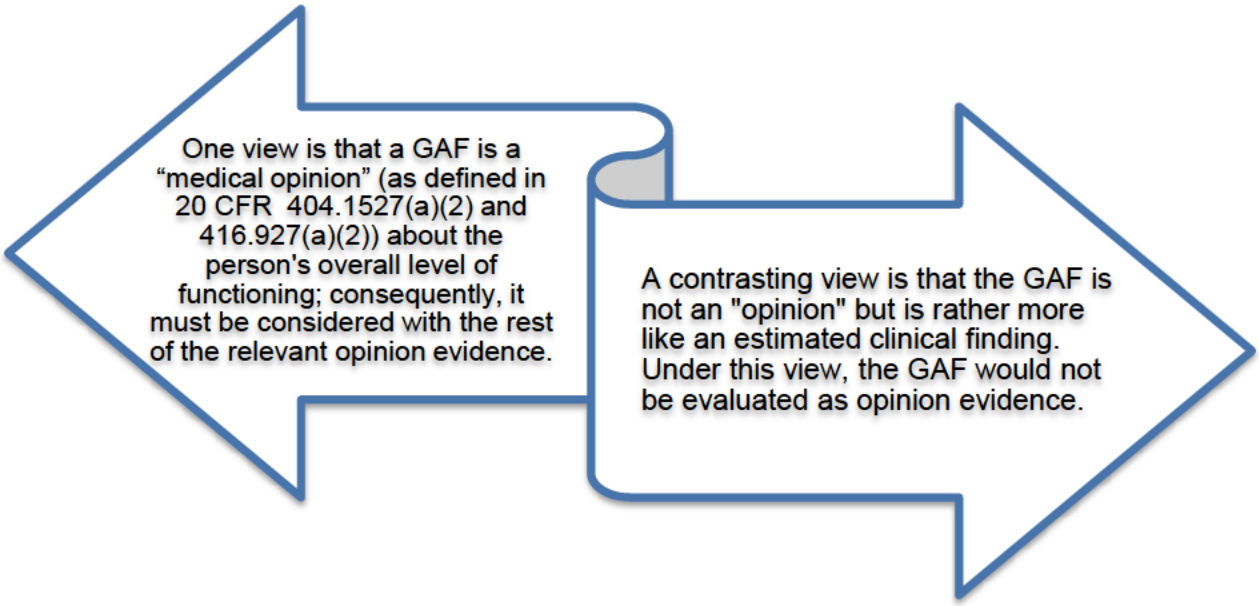
- **An acceptable medical source who has not examined the claimant but provides a medical or other opinion in the case.**
- **At the Administrative Law Judge hearing and Appeals Council levels of the administrative review process, it includes State agency medical and psychological consultants, other program physicians and psychologists, and medical experts or psychological experts whom we consult.**

A fundamental concept: We make a distinction between "acceptable medical sources" and "other sources." The distinction between "acceptable medical sources" and other medical sources is necessary for three reasons:

- Evidence from an acceptable medical source is necessary to establish the existence of a medically determinable impairment (see 20 CFR 404.1513(a), 416.913(a)),
- Only acceptable medical sources can give us "medical opinions" (although others can give opinions as to severity and functionality) (see 20 CFR 404.1527(a)(2), 416.927(a)(2)), and
- Only acceptable medical sources can be considered treating sources, whose medical opinions may be given controlling weight (see 20 CFR 404.1527(d), 416.927(d)).

A special note: GAF Scores

There is a difference of opinion as to whether a Global Assessment of Functioning (GAF) score is a medical opinion.



The GAF is of limited use in assessing the severity of a mental impairment for several reasons:

- A GAF score represents a clinician's judgment about the severity of an individual's symptoms or level of mental functioning at a particular moment in time. It does not provide a reliable longitudinal picture of the claimant's mental functioning.
- The GAF is only a snapshot opinion about the general, overall level of functioning.
- GAF does not predict prognosis or treatment outcomes, and the GAF scale does not directly correlate to the severity requirements in our mental disorders listings.

In the federal courts, failure to address a low GAF score is likely to result in a remand:

- The courts acknowledge that, standing alone, a low GAF score does not necessarily indicate an impairment seriously interfering with a claimant's ability to work.
- However, a GAF score of fifty or less has been construed by the federal courts as suggesting an inability to keep a job.

A low score should not be ignored, particularly if it is substantiated to large extent by other GAF scores of 50 or below that were assigned to the claimant by other treating physicians; these scores would also reflect significant functional impact.

It is equally important to note that there are inherent problems in giving great weight to the GAF under our rules:

Each range of scores on the GAF considers two elements, symptoms and functioning. The functioning element considers two aspects of functioning: social and occupational. The DSM-IV-TR gives some guidance on putting these elements together. However, there are no fixed rules about doing so. This means that an identical GAF from two clinicians will not mean the same thing; one may have based the GAF on symptom severity, the other on functioning. The GAF has little meaning without knowing what the clinician considered in deriving the score.

The research on the GAF indicates that the reliability between raters is relatively low. What this means is that two clinicians rating the GAF for the same person are likely to derive different scores.

The research on the GAF shows very little predictive validity. In other words, it does not tell us much about how the person will function in the future. For SSA, this means that it has little value in projecting duration or assessing functional limitations over the entire relevant period.

Bottom Line: Whether or not you consider the GAF an "opinion," it needs to be addressed.

Unless the GAF is well supported and consistent with other evidence in the file, it is entitled to little weight under our rules. When it is inconsistent with other evidence, it is important to remember that the GAF is usually an estimate of the best level of functioning over the last week or so, or over the entirety of the past year. As such, it would rarely override a more specific longitudinal picture. Because of its drawbacks, you should not rely on GAF evidence as the primary support for findings of impairment severity or of mental limitations. However, you should consider whether GAF scores are supported by other clinical findings and whether they are consistent with other evidence in the case record.

Sample language:

With respect to the question of the GAF scores, which may be considered a form of opinion, the undersigned generally gives less weight to a specific GAF score than to the bulk of other, more convincing evidence. The GAF score represents a particular clinician's subjective evaluation at a single point in time. The GAF score may vary from day to day, from time to time, and between practitioners. Finally, the GAF score is not designed for adjudicative determinations. Other evidence may outweigh GAF scores, and in this case, the other evidence is more informative and is given more weight, as described above. The GAF scores given by the claimant's practitioners were somewhat inconsistent, but were generally indicative of mild to moderate overall impairment. However, it is impossible to determine what type or types of limitations or abilities are contemplated by these practitioners' GAFs. Further, a GAF rating may indicate problems that do not necessarily relate to the ability to hold a job; thus, standing alone without further explanation, the rating does not evidence an impairment seriously interfering with a claimant's ability to work. The undersigned, therefore, gives little weight to the GAF scores in this case.

Who is an other source?

- Medical sources who are not "acceptable medical sources". (for example, nurse-practitioners, physicians' assistants, naturopaths, chiropractors, audiologists, and therapists);
- Educational personnel (for example, school teachers, counselors, early intervention team members, developmental center workers, and daycare center workers);
- Public and private social welfare agency personnel; and
- Other non-medical sources (for example, spouses, parents and other caregivers, siblings, other relatives, friends, neighbors, and clergy).

Every source who is not an acceptable medical source is an "other source". Examples of other sources include:

(1) Medical Sources Who are Not Acceptable Medical Sources

- Nurse practitioners
- Physician assistants
- Licensed clinical social workers
- Naturopaths
- Chiropractors
- Audiologists
- Therapists

(2) Non-Medical Sources

- Educational personnel (teachers, counselors, early intervention team members, developmental center workers, and daycare center workers)
- Public and private social welfare agency personnel, rehabilitation counselors
- Spouses, parents and other caregivers, siblings, other relatives
- Friends, neighbors clergy, and employers

Statements from lay persons, such as a relative or friend of the claimant, are considered to be "other sources", but their statements are not considered "opinions." They are instead considered "other evidence" and may be used to help show the severity of the claimant's impairments and how they affect the claimant's work activity.

Failure to address a third party statement is an error of law (20 CFR §§404.1512 (b)(3), 404.1513(d)(4), 404.1529, 416.912(b)(3), 416.913(d)(4), 416.929, SSR 96-7p).

Social Security Ruling 06-03p reminds us that we must consider **all** opinion evidence in the record, including statements from lay witnesses. This Ruling also applies to opinions of medical sources who are NOT "acceptable medical sources". These are not considered to be "medical opinions," but are opinions from "other sources." The regulations provide specific criteria for evaluating medical opinions from "acceptable medical sources" but they do not explicitly address how to consider relevant opinions and other evidence from "other sources."

Opinions from these medical sources, who are not deemed "acceptable medical sources" under our rules, are important and should be evaluated on issues such as impairment severity and functional effects. Per 06-03p, an opinion from someone considered an "other source" may be entitled to greater weight than an opinion from an acceptable medical source or even a treating medical source. The most important point in 06-03p is that we give the opinions that are best supported by and consistent with the bulk of the evidence in the file the most weight. It's important to remember this because often these "other sources" such as therapists or physician's assistants see the claimant more frequently than the treating source and may be more familiar with the claimant's functioning.

A Special Note

Other Governmental and Non-Governmental Agencies

> *For example, this includes Veterans Affairs disability ratings, vocational rehabilitation services determinations, or state social service agency ratings.*

- A decision by a governmental agency other than SSA, or by a nongovernmental agency, about whether an individual is disabled is based on that agency's rules (20 CFR 404.1504, 416.904). It is not an SSA decision, based on SSA policy, about whether the individual is disabled; the use of other rules and standards may limit the relevance of that agency's determination to SSA. Thus, a determination made by another agency [e.g., Workers' Compensation, the Department of Veterans Affairs, an insurer] is not binding on us.

- However, since we are required to evaluate all the evidence in the case record that may have a bearing on our determination or decision of disability, this includes decisions by other governmental and nongovernmental agencies, and the supporting documentation (20 CFR 404.1512(b)(5), 416.912(b)(5)).

- When we have in our records the information used by the other agency, we will evaluate the opinion evidence from medical sources and from "non-medical sources" who have had contact with the individual in their professional capacity, in accordance with 20 CFR 404.1527, 416.927, SSRs 96-2p and 96-5p, and 06-03p. In other words, we will evaluate those opinions just as we do all others.

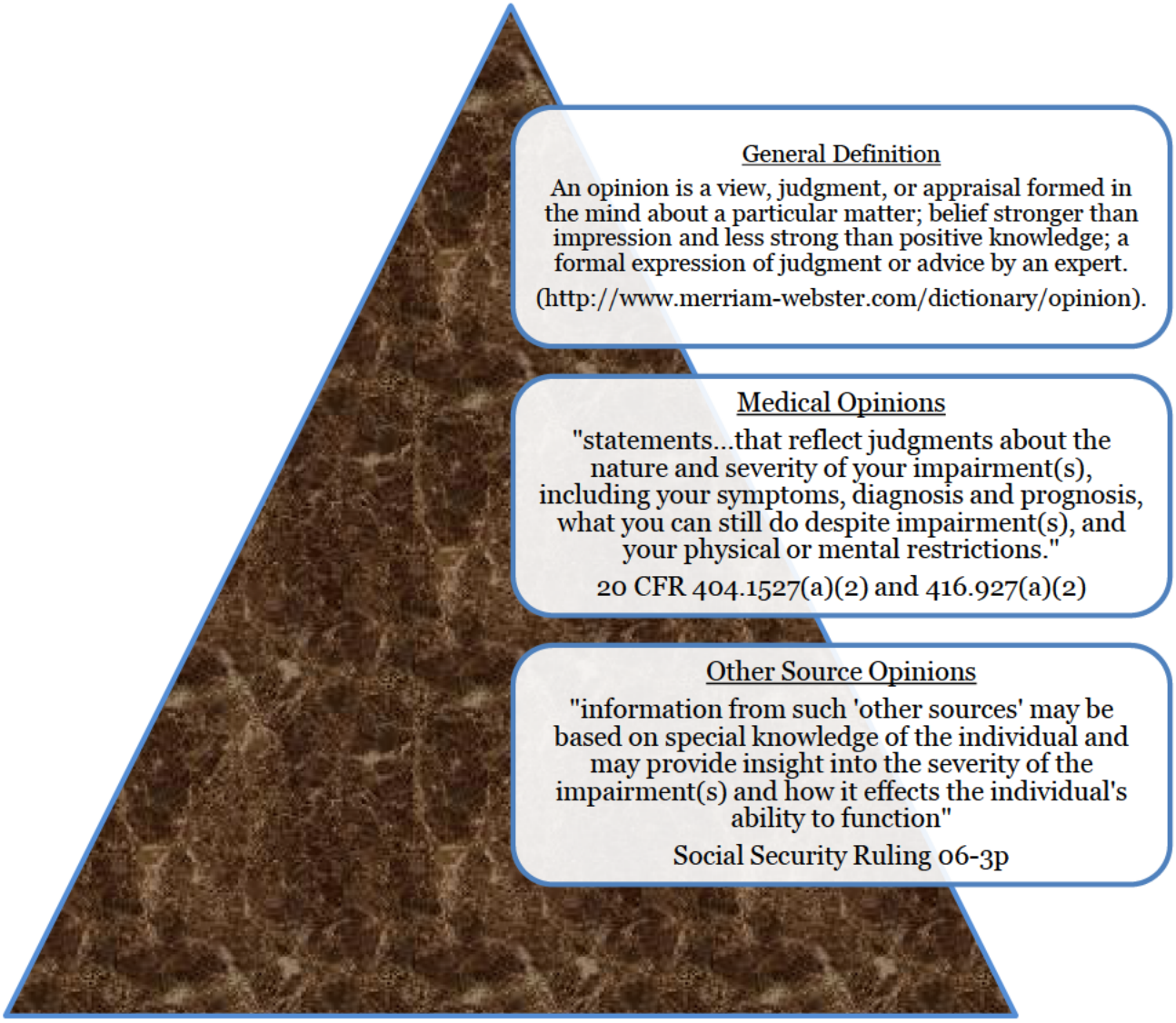
Single Decision Maker (SDM)

In some jurisdictions, a qualified disability examiner (DE) designated as an "SDM" can make both fully favorable and unfavorable determinations in many cases without the medical/psychological consultant's signoff, with the exception that the SDM may not make an unfavorable determination for a claimant with a mental impairment without input from a psychological consultant.

SDM assessments should not be treated as evidence or given any weight. See EM-08068.

Under the test modifications to the disability determination process found in 20 CFR 404.906(b)(2) and 416.1406(b)(2), State agency disability examiners designated as SDMs may make disability determinations alone in many cases. Agency policy is that findings made by SDMs are not opinion evidence that Administrative Law Judges should consider and address in their decisions. The SDM functional assessment is not a medical source statement and the qualifications of the individual rendering the assessment do not appear in the record. These documents are considered adjudicatory

What do you look for in the evidence?



General Definition

An opinion is a view, judgment, or appraisal formed in the mind about a particular matter; belief stronger than impression and less strong than positive knowledge; a formal expression of judgment or advice by an expert.

(http://www.merriam-webster.com/dictionary/opinion).

Medical Opinions

"statements…that reflect judgments about the nature and severity of your impairment(s), including your symptoms, diagnosis and prognosis, what you can still do despite impairment(s), and your physical or mental restrictions."

20 CFR 404.1527(a)(2) and 416.927(a)(2)

Other Source Opinions

"information from such 'other sources' may be based on special knowledge of the individual and may provide insight into the severity of the impairment(s) and how it effects the individual's ability to function"

Social Security Ruling 06-3p

What issues does opinion evidence address?

Diagnosis	**Prognosis**	**Severity** of the medically determinable impairment	Effectiveness of the **course of treatment**	**Limitations, restrictions** and **capacities**
• The nature of a disease; the identification of an illness.	• The prediction of the probable outcome or course of a disease.			

Conversely, what issues are beyond the scope of opinion evidence?

Issues reserved to the Commissioner: Some issues regarding the nature and severity of the claimant's impairment(s) are not medical issues, but are administrative findings

(20 CFR 404.1527(e) and 416.927(e)).

- The determination or decision about whether you meet the statutory definition of disability
- The claimant's RFC
- Whether the impairment meets or equals a listing
- Whether a claimant can perform PRW

Other issues that are not medical in nature

- Application of the vocational factors of age, education and work experience

ADJUDICATION TIP:

It is important to differentiate between an opinion and a clinical observation or other statement made by an acceptable medical source.

For example, a statement from a treating physician that the claimant walks with an "unsteady gait" is a clinical observation. It does not reflect a judgment or conclusion about the claimant's impairment, or about the claimant's abilities or limitations.

However, the same report would contain a medical opinion if the doctor indicated that the claimant's knee impairment caused an unsteady gait and, as a result, he should avoid standing or walking for more than four hours a day. The recommendation to limit standing and walking reflects the doctor's judgment about the nature and severity of the claimant's knee impairment; therefore, it is an opinion.

More Examples:

- SUBJECTIVE REPORTS OF PAIN AND REPORTED ACTIVITIES – NEITHER MEDICAL OBSERVATIONS NOR MEDICAL OPINION:

Mike returns for recheck. He is having ongoing pain in his knee localized diffusely around the anterior knee. He has popping and pain. He has not had any patellar instability complaints. It bothers him when he sits for long periods of time with his knees bent or when he drives, and when he does stairs.

Michael is now twelve days out from left knee debridement of the medial patellar plica with a lateral retinacular release. He is still having pain with ambulation. It is difficult for him to get full flexion and full extension. He did help his mom move over the weekend, although he did mostly driving.

- OBJECTIVE OBSERVATIONS, BUT NOT MEDICAL OPINIONS:

Examination shows him to be a pleasant gentleman in no apparent distress. He walks with an antalgic gait. He has slight genu valgum alignment. His Q angle in the standing position measures approximately 13 degrees in full extension and normalizes to about 3 or 4 degrees in 90 degrees of flexion. He has retropatellar irritability with grind testing. He has significant tenderness over the lateral facet and to a lesser degree over the medial facet. Knee motion shows 0 to 140. he has pain with McMurray's. He has pain with grind testing. No apprehension. The medial and lateral joint lines are nontender. Ligament examination is rock solid in all directions. The hip and ankle move well.

- MEDICAL OPINION:

The claimant does not require the use of an assistive device.

The claimant's ability to lift and/or carry is not restricted.

The claimant's ability to engage in postural and manipulative activities is not restricted. The claimant is not limited in his ability to use his hands for grasping and manipulating or for fine and dexterous movements.

There are no environmental restrictions.

Where do you find opinion evidence?

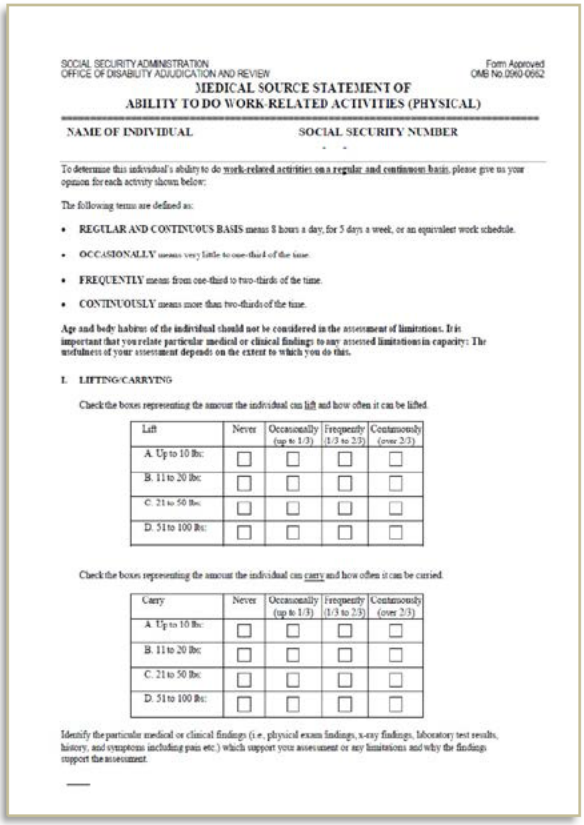
VISUAL CLUES TO QUICKLY IDENTIFY WHERE OPINION EVIDENCE MAY BE LOCATED

- ☒ READ "DOCUMENT NAME" OF EVIDENCE (Box 1)
- ☒ READ "NOTE" SECTION RELATED TO EVIDENCE (Box 2)
- ☒ CONSIDER "SOURCE" OF EVIDENCE (Box 3) – treating sources are often listed multiple times, and when the evidence includes a CE report, it is highly likely that the report will include opinion evidence
- ☒ CONSIDER NUMBER OF PAGES OF REPORT (Box 4) – fewer pages are more likely to be an opinion; larger numbers of pages are more likely to be progress/office notes
- ☒ CONSIDER DATES OF EVIDENCE (Box 5) – be sure the evidence falls within or addresses the relevant time period WATCH OUT for retrospective opinions

(b) (7)(E)

What An Opinion May Look Like

1. Medical Source Statement of Ability to Do Work-Related Activities (Physical or Mental) signed by a treating or examining physician or psychologist



SOCIAL SECURITY ADMINISTRATION
OFFICE OF DISABILITY ADJUDICATION AND REVIEW

Form Approved
OMB No.0960-0662

MEDICAL SOURCE STATEMENT OF
ABILITY TO DO WORK-RELATED ACTIVITIES (PHYSICAL)

NAME OF INDIVIDUAL — SOCIAL SECURITY NUMBER

To determine this individual's ability to do work-related activities on a regular and continuous basis, please give us your opinion for each activity shown below:

The following terms are defined as:

- **REGULAR AND CONTINUOUS BASIS** means 8 hours a day, for 5 days a week, or an equivalent work schedule.
- **OCCASIONALLY** means very little to one-third of the time.
- **FREQUENTLY** means from one-third to two-thirds of the time.
- **CONTINUOUSLY** means more than two-thirds of the time.

Age and body habitus of the individual should not be considered in the assessment of limitations. It is important that you relate particular medical or clinical findings to any assessed limitations in capacity: The usefulness of your assessment depends on the extent to which you do this.

I. **LIFTING/CARRYING**

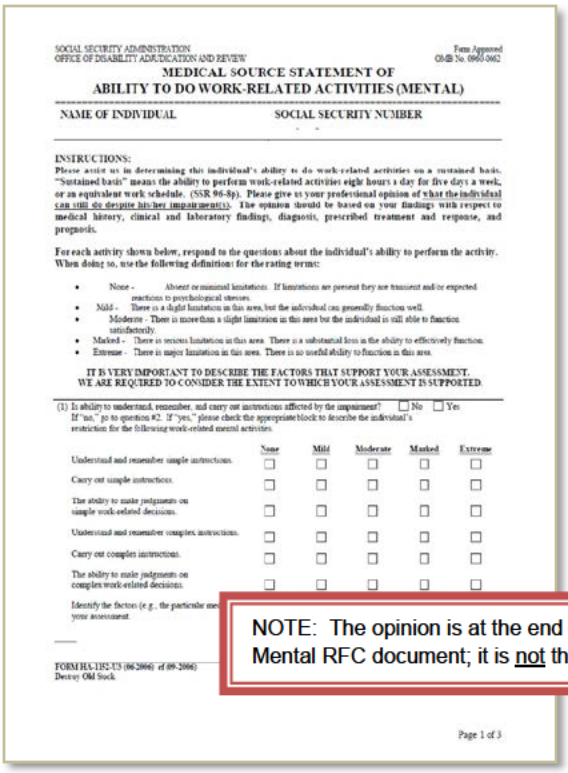
Check the boxes representing the amount the individual can lift and how often it can be lifted.

Lift	Never	Occasionally (up to 1/3)	Frequently (1/3 to 2/3)	Continuously (over 2/3)
A. Up to 10 lbs:	☐	☐	☐	☐
B. 11 to 20 lbs:	☐	☐	☐	☐
C. 21 to 50 lbs:	☐	☐	☐	☐
D. 51 to 100 lbs:	☐	☐	☐	☐

Check the boxes representing the amount the individual can carry and how often it can be carried.

Carry	Never	Occasionally (up to 1/3)	Frequently (1/3 to 2/3)	Continuously (over 2/3)
A. Up to 10 lbs:	☐	☐	☐	☐
B. 11 to 20 lbs:	☐	☐	☐	☐
C. 21 to 50 lbs:	☐	☐	☐	☐
D. 51 to 100 lbs:	☐	☐	☐	☐

Identify the particular medical or clinical findings (i.e., physical exam findings, x-ray findings, laboratory test results, history, and symptoms including pain etc.) which support your assessment or any limitations and why the findings support the assessment.



SOCIAL SECURITY ADMINISTRATION
OFFICE OF DISABILITY ADJUDICATION AND REVIEW

Form Approved
OMB No. 0960-0662

MEDICAL SOURCE STATEMENT OF
ABILITY TO DO WORK-RELATED ACTIVITIES (MENTAL)

NAME OF INDIVIDUAL — SOCIAL SECURITY NUMBER

INSTRUCTIONS:
Please assist us in determining this individual's ability to do work-related activities on a sustained basis. "Sustained basis" means the ability to perform work-related activities eight hours a day for five days a week, or an equivalent work schedule. (SSR 96-8p). Please give us your professional opinion of what the individual can still do despite his/her impairment(s). The opinion should be based on your findings with respect to medical history, clinical and laboratory findings, diagnosis, prescribed treatment and response, and prognosis.

For each activity shown below, respond to the questions about the individual's ability to perform the activity. When doing so, use the following definitions for the rating terms:

- None - Absent or minimal limitations. If limitations are present they are transient and/or expected reactions to psychological stressors.
- Mild - There is a slight limitation in this area, but the individual can generally function well.
- Moderate - There is more than a slight limitation in this area but the individual is still able to function satisfactorily.
- Marked - There is serious limitation in this area. There is a substantial loss in the ability to effectively function.
- Extreme - There is major limitation in this area. There is no useful ability to function in this area.

IT IS VERY IMPORTANT TO DESCRIBE THE FACTORS THAT SUPPORT YOUR ASSESSMENT. WE ARE REQUIRED TO CONSIDER THE EXTENT TO WHICH YOUR ASSESSMENT IS SUPPORTED.

(1) Is ability to understand, remember, and carry out instructions affected by the impairment? ☐ No ☐ Yes
If "no," go to question #2. If "yes," please check the appropriate block to describe the individual's restriction for the following work-related mental activities:

	None	Mild	Moderate	Marked	Extreme
Understand and remember simple instructions.	☐	☐	☐	☐	☐
Carry out simple instructions.	☐	☐	☐	☐	☐
The ability to make judgments on simple work-related decisions.	☐	☐	☐	☐	☐
Understand and remember complex instructions.	☐	☐	☐	☐	☐
Carry out complex instructions.	☐	☐	☐	☐	☐
The ability to make judgments on complex work-related decisions.	☐	☐	☐	☐	☐

Identify the factors (e.g., the particular me… your assessment.

FORM HA-1152-U3 (06-2006) ef (09-2006)
Destroy Old Stock

Page 1 of 3

NOTE: The opinion is at the end of this Mental RFC document; it is not the check

2. Narrative statements from an acceptable medical source

Opinion as to physical functioning/ability to work:

to see him in 4 weeks. I do not think he is able to work at this point because of his limp and his atrophy and weakness. We will see him back in 4 weeks for reassessment.

Opinion as to mental functioning:

Summary of Psychological Assessment: In an educational or academic setting could benefit from accommodations that would include but not be limited to having a scribe take notes for him in class and a scribe available to write out his responses to test questions. I think with someone taking notes for him he could improve somewhat his attention span in class to better recall information verbally brought up in class. In addition, I think because of his hyperactivity and restlessness that he might be accommodated by allowing him to get up and pace back and forth in the back of the class room if his hyperactivity continues to be at the same level after trials of medication.

I have suggested to him that his continuing to focus on visual types of work tasks would be wise. I think he would experience less frustration and is much more capable in carrying out visually mediated work tasks than he is about remembering and carrying out and dealing with frustrating auditory work tasks.

3. Statements of the medical source regarding claimant's limitations contained in medical records or reports prepared for workers compensation

Can return to work full time? If not, how many hours?
is best suited to the sedentary category of the Physical Demands Characteristics of work chart which requires lifting occasionally of up to 10 lbs. and no frequent lifting. She would, however, require a job that did not require prolonged neck positioning or repetitive cervical rotation.

Are s subjective reports reliable?
Overall test findings in combination with clinical observation suggest fully reliable subjective reports. Furthermore, effort testing in combination with clinical observation suggest the presence of full physical effort on s behalf.

Is capable of competitive employment?
While qualifies for sedentary work, it is unlikely she is a candidate for competitive employment due to her inability to tolerate repetitive cervical rotation or prolonged neck positioning.

4. Consultative examinations

INTERNAL MEDICINE EXAMINATION

The claimant is a 45-year-old male referred by the Division of Disability Determination for an internal medicine examination.

...

MEDICAL SOURCE STATEMENT: Sitting, standing, walking, reaching, pushing, pulling, lifting, climbing, and bending are unrestricted.

The above-mentioned claimant was examined for a consultative examination. No doctor-patient relationship exists or is implied by this examination. I affirm, under the penalty of

5. Physical Residual Functional Capacity Assessment (PRFC), Mental Residual Functional Capacity Assessment (MRFC), and Psychiatric Review Technique Form (PRTF) completed by State agency medical consultants

From the Physical RFC Assessment Form:

FORM APPROVED
OMB NO. 0960-0431

PHYSICAL RESIDUAL FUNCTIONAL CAPACITY ASSESSMENT

A. EXERTIONAL LIMITATIONS

☐ None established. (Proceed to section B.)

1. **Occasionally** lift and/or carry (including upward pulling) (maximum) - when less than one-third of the time or less than 10 pounds, explain the amount (time/pounds) in item 6.

   ☐ less than 10 pounds
   ☐ 10 pounds
   ☒ 20 pounds
   ☐ 50 pounds
   ☐ 100 pounds or more

2. **Frequently** lift and/or carry (including upward pulling) (maximum) - when less than two-thirds of the time or less than 10 pounds, explain the amount (time/pounds) in item 6.

   ☐ less than 10 pounds
   ☒ 10 pounds
   ☐ 25 pounds
   ☐ 50 pounds or more

6. Explain how and why the evidence supports your conclusions in item 1 through 5. Cite the specific facts upon which your conclusions are based.

27 yr old public school teacher (reading specialist) applies for T2 claim with AOD 12/15/08-DLI 9/30/10. Alleges limitations related to rheumatoid arthritis. ADLs active with youth -her own children & those at church on weekly basis. Hands painful with grasping objects most limiting. Chronic fatigue/exhaustion part of constitutional effects with her polyarthitis.Variability in joint symptoms -good days, bad days -difficulty at times walking, hands hurting, elbows painful with. limited extension.Variable capacity to help church youth depending on activity of RA. Sleeps 12 hrs + with nap in daytime for an hour (not usual behavior prior RA).

B. If yes, are there medical source conclusions about the claimant's limitations or restrictions which are significantly different from your findings?

☒ Yes ☐ No

C. If yes, explain why those conclusions are not supported by the evidence in file. Cite the source's name and the statement date.

Claimant has chronic juvenile onset polyarthritis with persistent joint inflammation in hands, wrists, ankles, elbow, knees -variable -but weak grasp, limited fist formation. No radiographs or lab in file. Morning stiffness from 1 hr to 4 hrs. Apart for the 3 pregnancies no reprieve from pain of RA. Enbrel, MTX & steroid help but are not controlling her persistent joint disease, attendent fatigue/exhaustion. Believe L/C 20/10, W/S 4-5 hrs day, sitting unrestricted, limit pushing, pulling to occasional. Limit postural activities. Limit manipulative activities to handling, fingering to occasional bilaterally.Global measures noted support persistent active disease with disruption in her usual life (stopped working due to pain), home life limited, despite ongoing rheumatologist management. Believe less than sed appropriate. Chronic fatigue further limits claimant's ability to work 40 hr week.

From the PRTF:

III. RATING OF FUNCTIONAL LIMITATIONS

A. "B" Criteria of the Listings

Indicate to what degree the following functional limitations (which are found in paragraph B of listings 12.02-12.04, 12.06-12.08 and 12.10 and paragraph D of 12.05) exist as a result of the individual's mental disorder(s).

NOTE: Item 4 below is more than a measure of frequency and duration. See 12.00C4 and also read carefully the instructions for this section.

Specify the listing(s) (i.e., 12.02 through 12.10) under which the items below are being rated **12.02, 12.05**

FUNCTIONAL LIMITATION	DEGREE OF LIMITATION				
1. Restriction of Activities of Daily Living	None ☐	Mild ☐	Moderate ☒	Marked* ☐	Extreme* ☐
2. Difficulties in Maintaining Social Functioning	None ☐	Mild ☐	Moderate ☒	Marked* ☐	Extreme* ☐

NOTE: The check boxes in the "B Criteria" are a screening tool; this is NOT a medical opinion. Look at the end of the document for the "Consultant's Notes" narrative; this is where the opinion will be

IV. CONSULTANT'S NOTES

Age 18. Alleges: LD, mildly retarded, ADD

The claimant is enrolled in Special Education courses in high school. She has a designation of OHI (ADHD) and SLD. **WAIS-III testing in March 2009** yielded the following scores: **FSIQ 67**. Verbal 75; Performance 64. VCI was 84 and POI was 65. The Verbal Comprehension Index of 84 was determined to be the best reflection of her overall ability at this time. On the WJ-III her performance was low average in written expression and was ***low or very low in all other areas***. The Teacher Questionnaire reports claimant has daily obvious problems with attending and completing tasks. She has serious problems with acquiring information and is noted to have her work modified and to receive assistance in all classes. She reportedly has difficulty with interactions with others and with handling frustration appropriately, being patient, and taking care of her personal hygiene. The claimant's foster mother reports the claimant is very immature and generally has much younger friends.

Statements are credible. Evidence from the claimant's school records suggests she is not capable of managing her funds.

ADJUDICATION TIP:

SSR 96-8p reminds us that the "B" and "C" criteria are used to rate the severity of mental impairments at steps 2 and 3 of the sequential evaluation process. The mental RFC assessment used at steps 4 and 5 of the process requires a more detailed functional assessment in work-related terms. Using terms such as "moderate" or "extreme" in a hypothetical to the vocational expert or in the residual functional capacity findings would not be policy-compliant because the terms are unclear from the standpoint of describing the nature and scope of the impact on work-related functioning.

From the Mental RFC form:

MENTAL RESIDUAL FUNCTIONAL CAPACITY ASSESSMENT

NAME [redacted] | SOCIAL SECURITY NUMBER [redacted]

CATEGORIES *(From 1C of the PRTF)*: 12.04

ASSESSMENT IS FOR:
- ☐ Current Evaluation
- ☐ 12 Months After Onset: _____ (Date)
- ☐ Date Last Insured: _____ (Date)
- ☒ Other: 01/05/2009 (Date) to 03/27/2009 (Date)

I. SUMMARY CONCLUSIONS

This section is for recording summary conclusions derived from the evidence in file. Each mental activity is to be evaluated within the context of the individual's capacity to sustain that activity over a normal workday and workweek, on an ongoing basis. Detailed explanation of the degree of limitation for each category (A through D), as well as any other assessment information you deem appropriate, is to be recorded in Section III (Functional Capacity Assessment).

If rating category 5 is checked for any of the following items, you MUST specify in Section II the evidence that is needed to make the assessment. If you conclude that the record is so inadequately documented that no accurate functional capacity assessment can be made, indicate in Section II what development is necessary, but DO NOT COMPLETE SECTION III.

	Not Significantly Limited	Moderately Limited	Markedly Limited	No Evidence of Limitation in this Category	Not Ratable on Available Evidence
A. UNDERSTANDING AND MEMORY					

C. SOCIAL INTERACTION					
12. The ability to interact appropriately with the general public.	1. ☒	2. ☐	3. ☐		
13. The ability to ask simple questions or request assistance.	1. ☒	2. ☐	3. ☐		
14. The ability to accept instructions and respond appropriately to criticism from supervisors.	1. ☒	2. ☐	3. ☐		
15. The ability to get along with coworkers or peers without distracting them or exhibiting behavioral extremes.	1. ☒	2. ☐	3. ☐		
16. The ability to maintain socially appropriate behavior and to adhere to basic standards of neatness and cleanliness.	1. ☒	2. ☐	3. ☐		

NOTE: The check boxes in the "Summary Conclusions" are essentially a screening tool; this is NOT a medical opinion. Look at the end of the document for the "Conclusions" narrative; this is where the opinion is found.

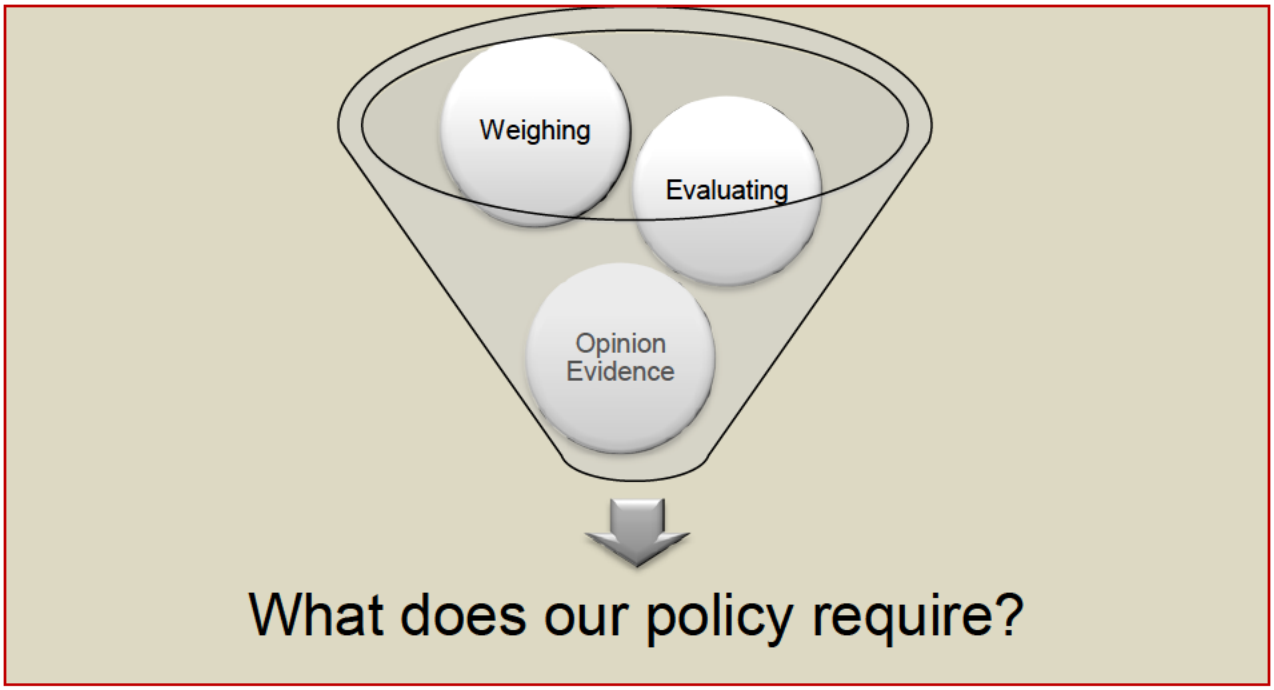
CONCLUSIONS section has been completed. Explain your summary conclusions in narrative form. Include any information which clarifies limitation or function. Be especially careful to explain conclusions that differ from those of treating medical sources or from the individual's allegations.

56 YR OLD FEMALE ALLEGING NECK/ARM INJURY SECONDARY TO AN MVA RESULTING IN PAIN AND PHYSICAL LIMITATIONS. SHE REPORT 15 GRADES OF EDUCATION FOR NURSING AND A GOOD WORK HISTORY AS AN RN IN VARIOUS CAPACITIES. SHE REPORTS LAST WORKING FULL-TIME FOR THE LOCAL VISITING NURSE ASSN. FROM 2003 TO 1/09. SHE REPORTS THAT SHE WAS TERMINATED FROM THAT POSITION BUT DOES NOT STATE WHY. SINCE 2/09, SHE HAS WORKED PART-TIME GIVING INJECTIONS AT LOCAL PHARMACIES. SHE REPORTS NOT BEING ON ANY PSYCH MEDS BUT DOES SEE A PSYCHIATRIST ON A WEEKLY BASIS. THE TREATING PSYCHIATRIST NOTES A 30 YR HISTORY OF DEPRESSION AND SEEING THE CLMT SINCE 2002. SHE NOTES THAT THE CLMT HAS A NUMBER OF PHYSICAL PROBLEMS RESULTING IN LIMITATIONS; THE ONLY MENTAL LIMITATION NOTED BY THE PSYCHIATRIST IS FLUCTUATING CONCENTRATION. OTHERWISE, SHE REPORTS THAT THE CLMT IS COGNITIVELY INTACT, HAS APPROPRITATE AFFECT, NO PSYCHOSIS, IS VERBAL AND COOPERATIVE. THE PSYCHIATRIST, DR. OPINES THAT SHE DOES NOT BELIEVE THAT THE CLMT IS CAPABLE OF CONTINUING TO WORK FULL-TIME EVEN THOUGH SHE HAS BEEN QUITE A SUCCESSFUL NURSE FOR OVER 30 YEARS. DR. OPINION APPEARS TO BE BASED PRIMARILY ON CLMT'S PHYSICAL DIFFICULTIES. SHE REPORTS MINIMAL PROBLEMS DUE TO THE DEPRESSION JUST AS THE CLMT ALLEGES MINIMAL PROBLEMS DUE TO DEPRESSION. WEIGHT WILL BE AFFORDED DR. OPINION BY PROVIDING LIMITATIONS IN CONCENTRATION. CLMT DOES NOT APPEAR TO BE ON AN ANTIDEPRESSANT AT THE PRESENT TIME. SHE IS IN A STABLE RELATIONSHIP, HAS FULL AND INDEPENDENT ADLs AND SOCIAL ACTIVITIES ALTHOUGH SHE REPORTS A DECREASE DUE TO HER PHYSICAL DIFFICULTIES. SHE REPORTS INVOLVEMENT WITH THE CARE OF HER ELDERLY PARENTS.

A. RETAINS THE MEMORY/COMPREHENSION FOR 3-4 STEP INSTRUCTIONS.

B. WOULD HAVE DIFFICULTY WITH CONSISTENT 4+ STEP TASKS DUE TO DEPRESSIVE SXs. AT TIMES SHE WOULD HAVE SOME DIFFICULTY WITH CONCENTRATION DUE TO DEPRESSION BUT CPP IS RETAINED FOR 1-3 STEP TASKS FOR 2 HRS OVER AN 8 HR PERIOD THROUGHOUT A WEEK.

C. RETAINS THE SOCIAL CAPACITY FOR ROUTINE INTERACTIONS.



20 CFR 404.1527(b) and 416.927(b) state:

"we will always consider the medical opinions in your case record

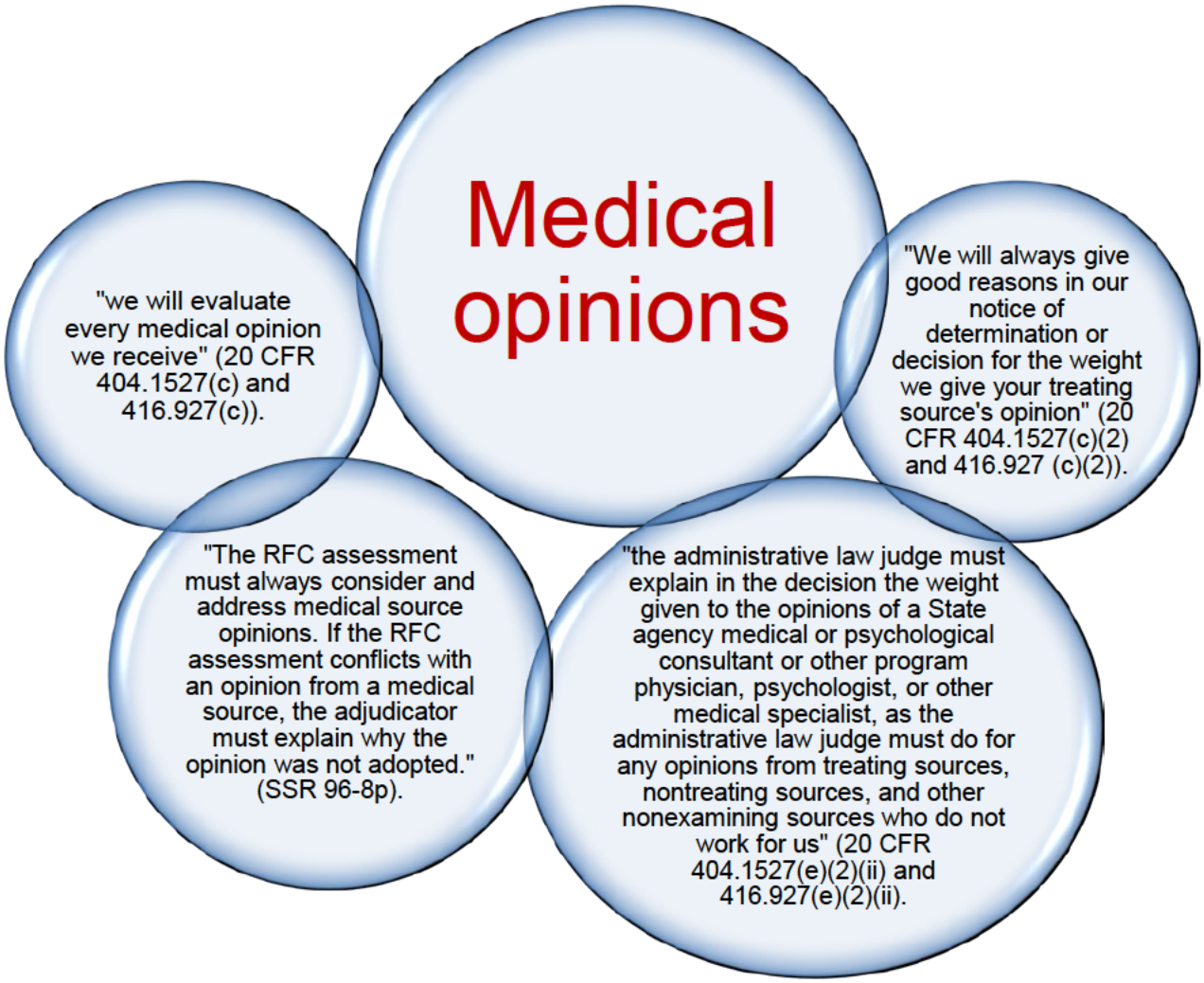
- Medical Opinions

together with the rest of the relevant evidence we receive."

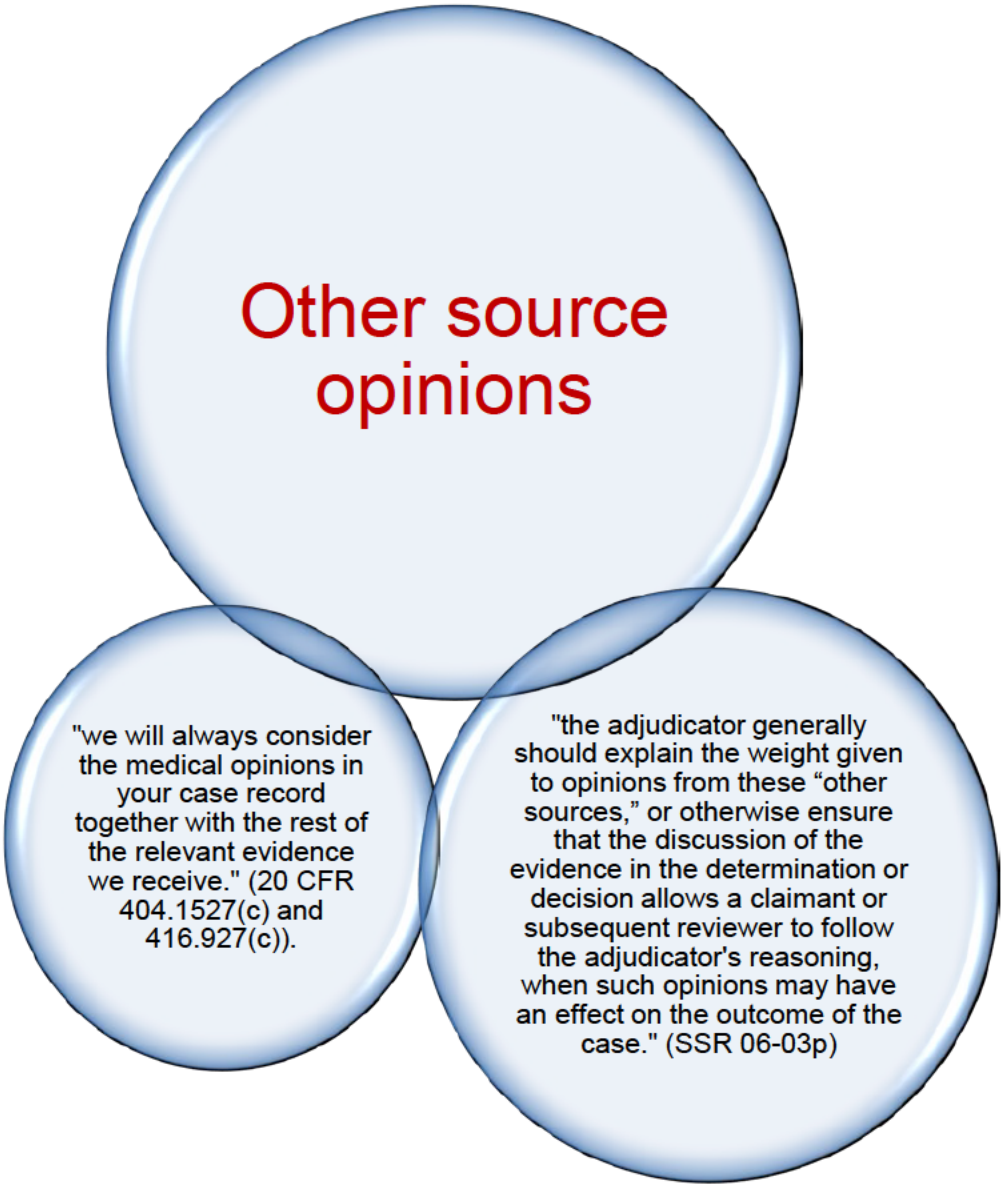
- This includes other source opinions

Thus, the regulations require us to consider every medical opinion and other source opinion. The other source opinion is part of the "relevant evidence" in the record (See SSR 06-03p).

Our policy treats each category of opinion differently:

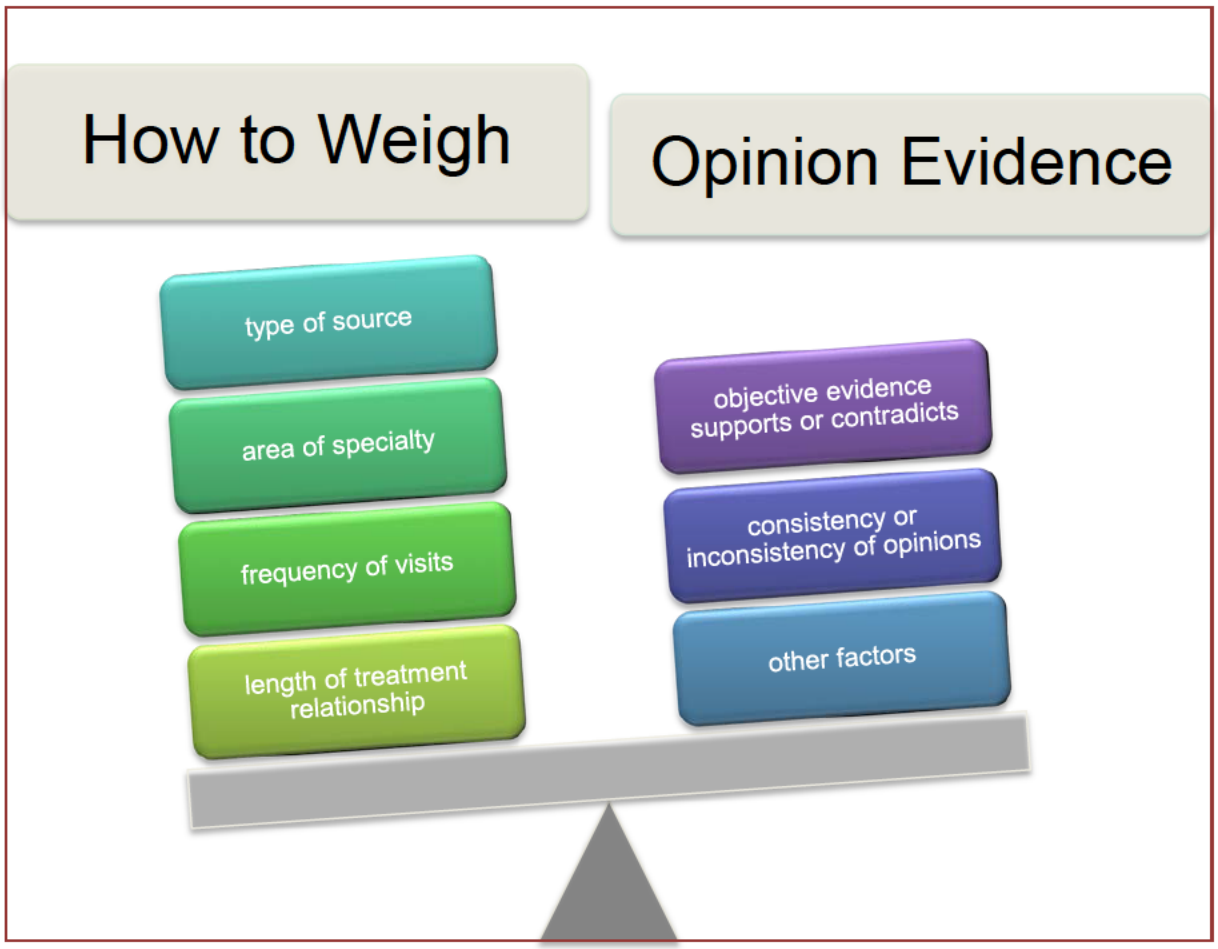


- The ALJ must evaluate every medical opinion;
- The ALJ must give good reasons for the weight given to a treating source opinion;
- The ALJ must explain the weight given to all medical opinions;
- The ALJ must explain why a medical opinion was not adopted if the opinion is inconsistent with the hearing decision's RFC finding.



- The ALJ must consider all other source opinions;

- When other source opinions may have an effect on the outcome of the case, the ALJ should specifically explain the weight given to the other source opinion or provide adequate discussion of the evidence that allows a subsequent reviewer to follow the ALJ's reasoning regarding this opinion.



The weight an Administrative Law Judge must give each opinion varies according to the relationship between the medical professional and the claimant (SSR 96-6p). The weight to be given such opinion evidence also varies according to the facts of the case, the source of the opinion (including that source's qualifications), the issues addressed by the opinion and a number of other factors.

...it is important to take good notes!

WEIGHING OPINION EVIDENCE NOTETAKING CHART

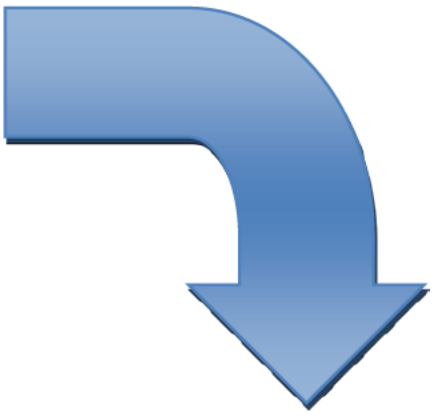
Name And Type Of Provider	Area Of Expertise	Dates	Exhibit Number And Page	Opinions And Findings	My Notes

...etc...

To be most efficient and effective, develop a strategic approach to reviewing the evidence and to identifying and evaluating opinions:

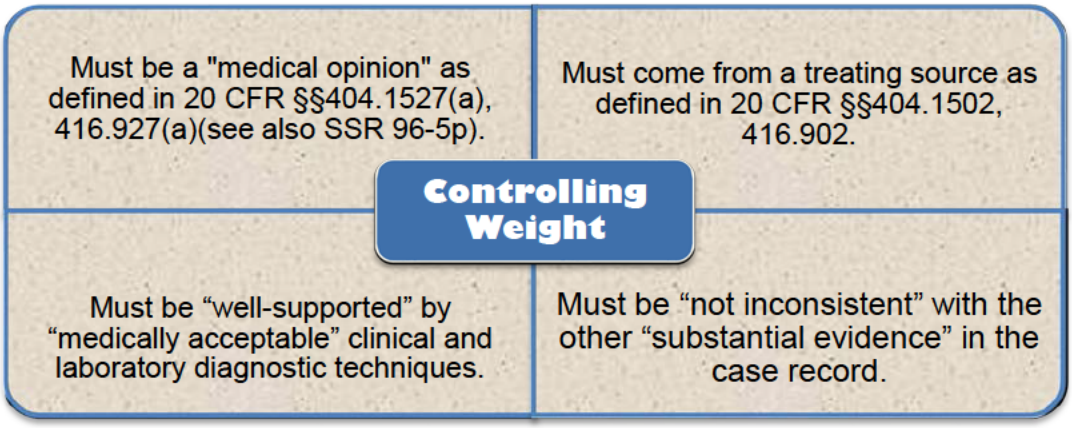
Identify the opinion	Categorize the opinion according to its source	Be able to identify the claimant's relationship with the source
Identify the opinion evidence language	Distinguish medical opinions from a recitation of the claimant's subjective complaints	Identify and review the various records that may contain medical opinions
Identify supported functional abilities and limitations	Review the record for limitations that are consistent with the diagnoses, treatment records, and other objective evidence	Compare and contrast all of the consistent and divergent points between the medical source opinions

…and then articulate the weight given the opinion and the reasons for assigning that weight



Controlling Weight

An ALJ should generally give more weight to opinions from a claimant's treating sources, in particular because of the treating physician's unique perspective that cannot be obtained from the objective medical findings alone or from reports of individual examinations, such as consultative examinations or brief hospitalizations (20 CFR 404.1527(d)(2), 416.927(d)(2)). The rule on controlling weight applies when *all* of the following are present:

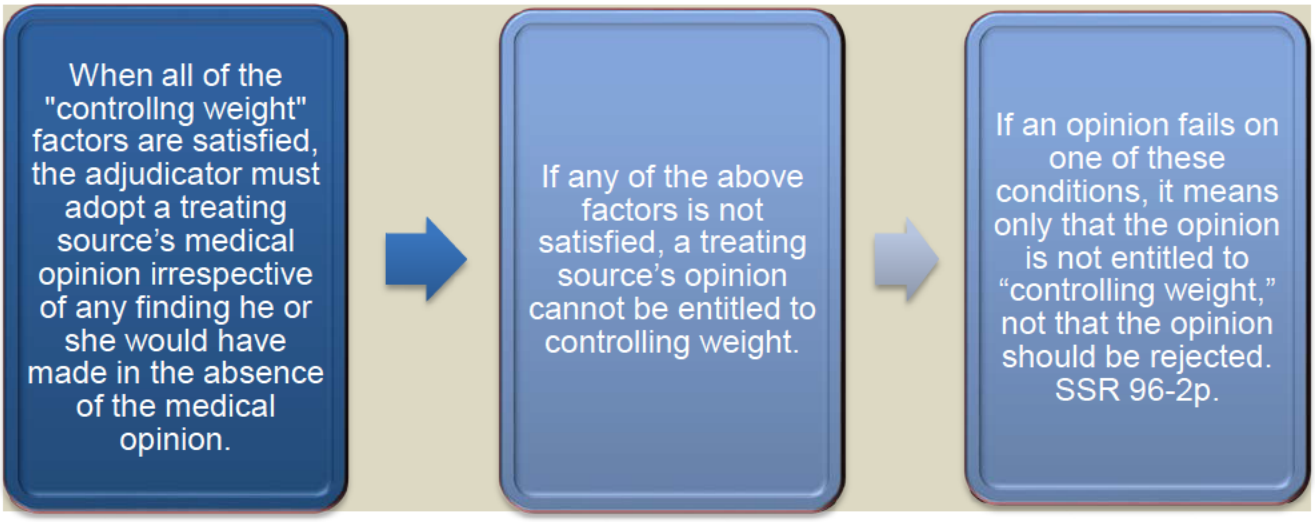


"Well-supported" means that the opinion must be supported by medically acceptable clinical and laboratory techniques (i.e., objective medical evidence).

"Not inconsistent" means that the opinion does not have to be consistent with all the other evidence as long as there is no substantial evidence that contradicts or conflicts with the opinion.

"Substantial evidence" means such relevant evidence as a reasonable mind might accept as adequate to support a conclusion.

NOTE: Finding that a treating source's opinion is entitled to controlling weight means that it is dispositive on the issues of the nature and severity of the impairments addressed by the opinion. It does not mean that the treating source's opinion on residual functional capacity has controlling weight; the residual functional capacity assessment is an administrative determination that is reserved to the Commissioner (SSR 96-5p).

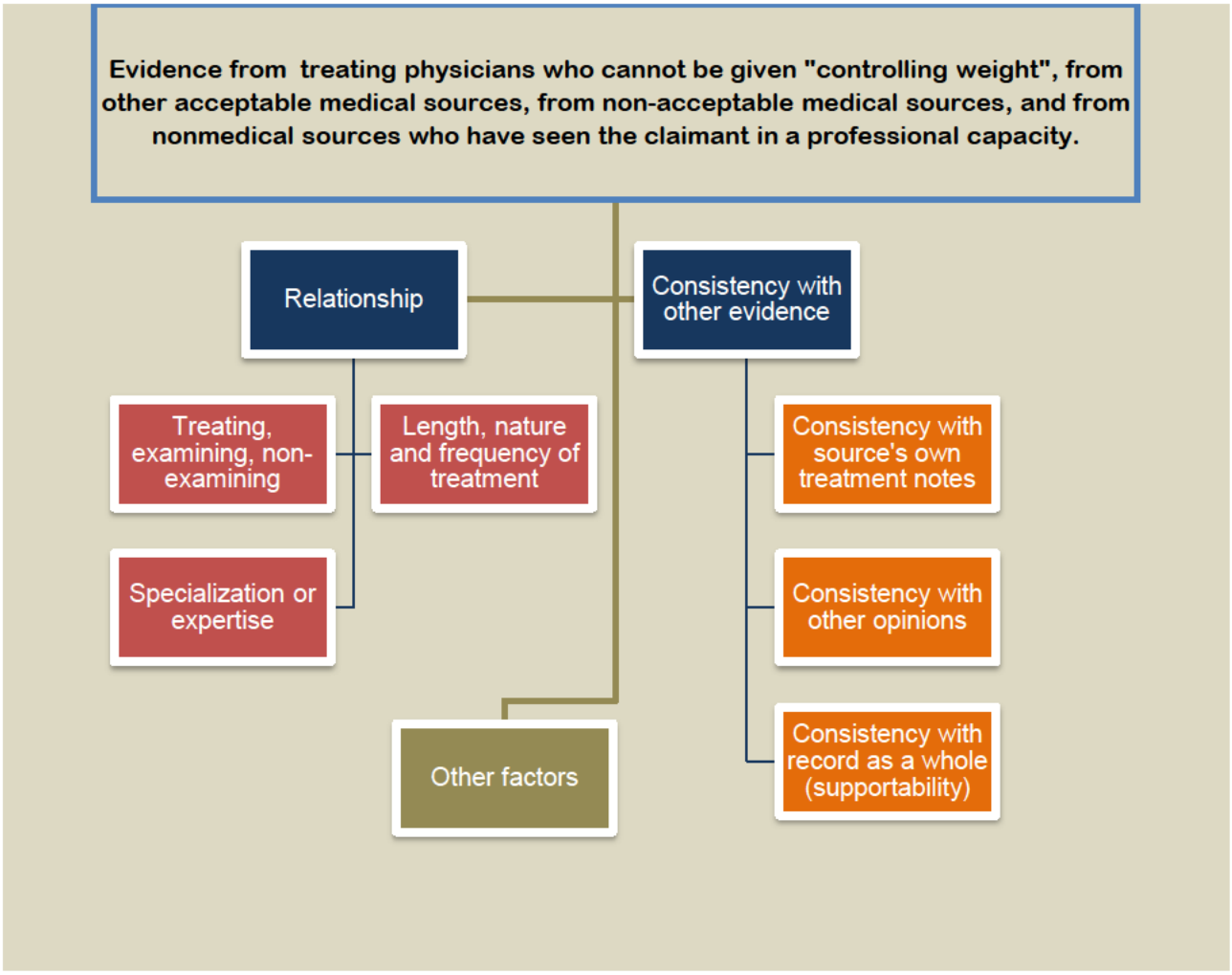


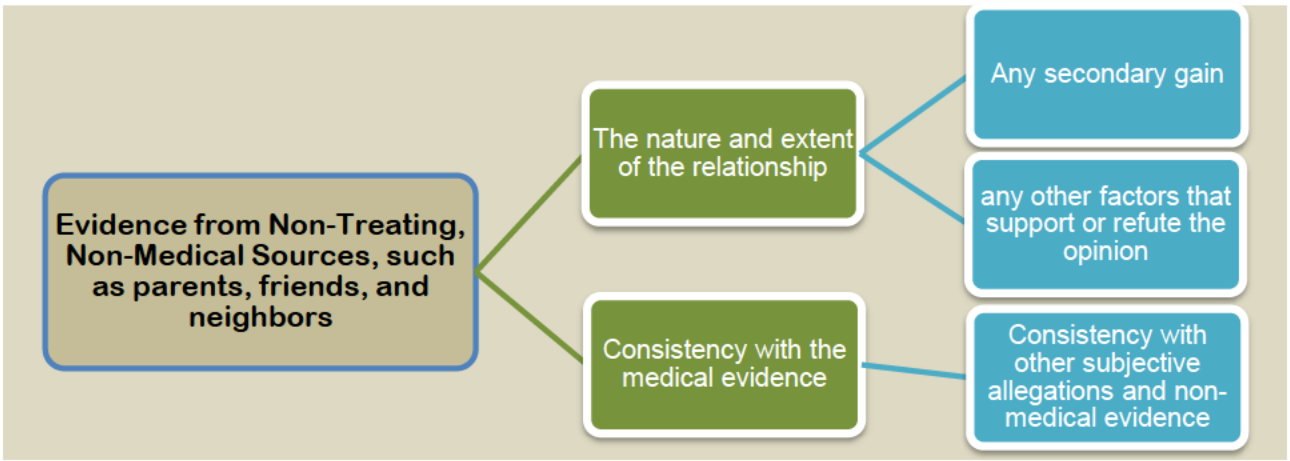
If the treating physician's opinion cannot be given "controlling weight," then it is weighed in the same way that we consider other opinions.

Weighing Other Medical Opinions

The opinion of an examining physician is generally entitled to less weight than that of a treating physician, and the opinion of an agency physician who has never seen the claimant is entitled to the least weight of all. 20 C.F.R. 404.1527(d)(1), (2) and 416.927(1), (2); Social Security Ruling 96-6p.	Opinions from other acceptable medical sources may be entitled to great weight, and may even be entitled to more weight than a treating source's opinion in appropriate circumstances, but opinions from sources other than treating sources can never be entitled to "controlling weight."

Factors for Evaluating Opinion Evidence





(b) (7)(E)

ADJUDICATION TIPS:

No evidence in the record automatically "trumps" another merely on the strength or weakness of one type of credential or another. The factors outlined in 20 CFR 404.1527 and 416.927 act as a helpful general rubric that we can use to evaluate and weigh all opinion evidence whether or not the opinions are given by an "acceptable medical source" (20 CFR 404.1513 and 416.913 and SSR 06-03p). There is one time that an opinion does "trump" and that is if a treating source opinion is entitled to controlling weight.

In a hypothetical scenario where the opinion of the severity of certain side effects of a drug interaction is material to the outcome of a case, it is reasonable that an adjudicator might indeed assign the opinion of a Pharm. D. significant or great weight on the basis of the pharmacist's specialized knowledge base. Similarly, the opinion of a R.N. or even a L.P.N might be afforded greater weight than a M.D. in certain situations if the record establishes persuasive factors under the regulations, such as a longer treatment relationship, greater consistency with the record as a whole and better supportability of the opinions with regard to accompanying medical signs and laboratory findings. On the other hand, if all the evidence were generally equal, we would generally give greater deference to the M.D.

As you may have heard before: whatever weight we end up deciding to assign to an opinion, *explanation and articulation* of our analytical thought process often is the key to a decision that is legally sufficient and which will pass scrutiny by the Appeals Council and the courts.

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Articulation of the Rationale:

The Final Step in Your Treatment of Opinion Evidence

Explain the weight given to all medical opinions

Generally should explain the weight given to opinions from other sources or otherwise ensure that the discussion of the evidence in the decision allows a subsequent reviewer to follow your reasoning, when such opinions have an effect on the outcome of the case.

You should not use stock phrases alone to support the weight you give an opinion; avoid clichés *and* cite to the evidence.

Apply the regulations, rulings, and your analysis of the consistencies and inconsistencies in the evidence.

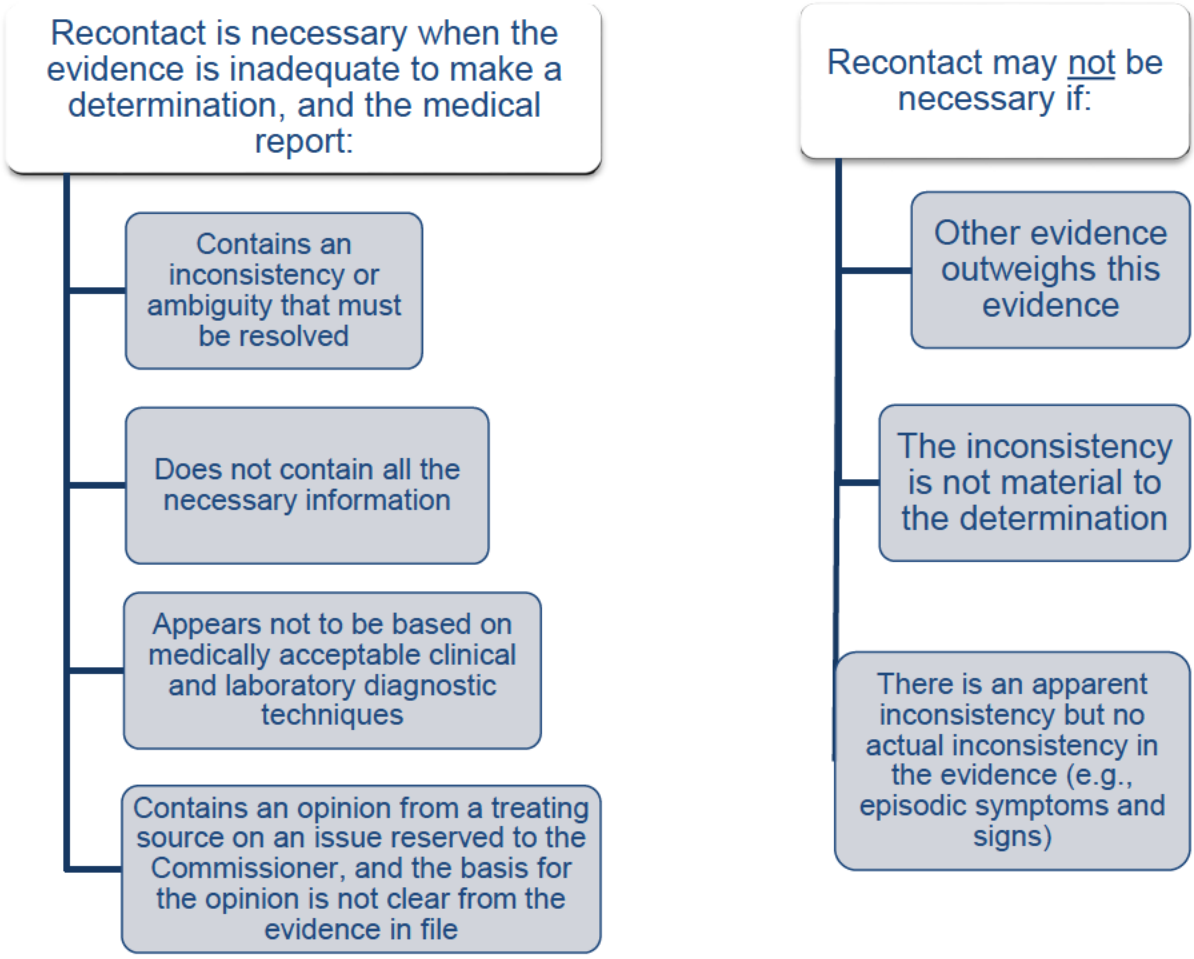
You may accept a medical source statement in part; you are not required to accept every part of the opinion.

You do not need a medical source statement to decide a case.

Determining the Need to Recontact a Provider:

If the evidence is consistent but we do not have sufficient evidence to decide whether you are disabled, or if after weighing the evidence we decide we cannot reach a conclusion about whether you are disabled, we will try to obtain additional evidence under the provisions of §§ 404.1512 and 404.1519 through 404.1519h.

- ✓ We will request additional existing records, recontact your treating sources or any other examining sources, ask you to undergo a consultative examination at our expense, or ask you or others for more information.
- ✓ We will consider any additional evidence we receive together with the evidence we already have.
- ✓ When there are inconsistencies in the evidence that cannot be resolved, or when despite efforts to obtain additional evidence the evidence is not complete, we will make a determination or decision based on the evidence we have (20 CFR 404.1527 (c)(3), (4) 416.927(c)(3), (4)).



IMPORTANT RULINGS REGARDING OPINION EVIDENCE

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

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

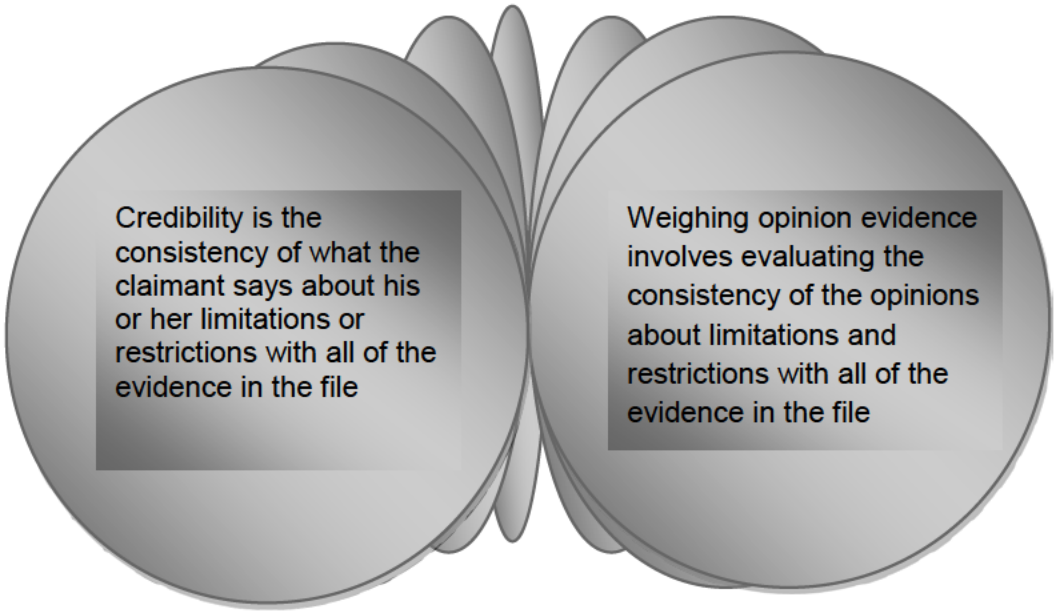
SSR 96-6p – Consideration of administrative findings of fact by DDS medical and psychological consultants at ALJ and AC levels

SSR 06-03p - Considering opinions and other evidence from sources who are not "acceptable medical sources"; Considering disability decisions by other governmental and nongovernmental agencies.

Recurring Reasons for Remand With Regard to Opinion Evidence:

- Opinion not identified or discussed
- Opinion rejected without adequate rationale
- Weight accorded to the opinion evidence is not specified

One way to look at the analysis of opinion evidence and credibility of allegations is to think of them as two sides of the adjudicative coin:



This approach may help you to make sure your decision includes adequate evaluation and supporting rationale with regard to both credibility and opinion evidence.

Management Facilitator Guide for OCEP – Medial Source Statements

April 2012

This Facilitator Guide is for use by the HOCALJ and/or HOD or their designee(s)leading the discussion on "Medical Source Statements" following the April 18, 2012 OCEP IVT. Each of the four key points below should be addressed in the discussion. Additional discussion points are included below each topic to assist the facilitator in leading the discussion. The session should endeavor to generate discussion rather than a lecture or presentation. Distribute the one-touch questions to the participants and conclude the discussion by covering each. An answer sheet is provided for the facilitator. Total time for the session should be approximately 45 minutes to one hour.

1. **Review and Discuss the "Four Keys to Medical Source Statements." Encourage all to use it as a desk aid.**
    a. Tip: bring extra printed copies to ensure all have one for discussion.
    b. Use each of the keys as a starting point for discussion. The notes below may facilitate in-depth discussion as they elaborate upon the "Four Keys." Emphasize the following points in discussion:

I. A MEDICAL SOURCE STATEMENT IS GIVEN "CONTROLLING WEIGHT" ONLY UNDER LIMITED CIRCUMSTANCES.

a. It must come from a "treating source" as defined in 20 CFR 404.1502 and 416.902 (only treating source opinions are given "controlling" weight);
b. The opinion must be a "medical opinion" under 20 CFR 404.1527(a) and 416.927(a); and
c. The Opinion must satisfy a Two-Part Test (20 CFR 404.1527[d][2] and 416.927[d][2]):
    1. Well-Supported by medically accepted clinical and diagnostic techniques; and
    2. Not Inconsistent with other substantial evidence
d. Briefly discuss who is a treating source and what constitutes clinical vs. diagnostic techniques. Note that substantial evidence that is "inconsistent" with a treating source opinion can be non-medical evidence (testimony or 3rd party statements) as well as medical evidence (other medical source opinions or clinical or diagnostic techniques). Refer to SSR 96-2p for further discussion of the regulations on this point.

II. A MEDICAL SOURCE STATEMENT MAY BE ACCEPTED IN PART. YOU ARE NOT REQUIRED TO ACCEPT EVERY PART OF THE OPINION.

a. Point out that each functional limitation, adopted by the ALJ in the decision, must be supported by the record. If you do not give "controlling weight" to a treating source opinion, you may nonetheless give great weight to all of the opinion, or only to certain parts of the opinion, depending on other factors.

b. Similarly, you may give greater weight to all or only parts of a non-treating medical source opinion (such as a CE opinion, ME opinion, or other qualified medical source) depending on other factors. You may adopt parts of several opinions or include limitations not specifically identified in a particular medical opinion.
c. When considering the weight to be given each part of a medical source statement, factors to consider are set forth in 20 CFR 404.1527(d) and 416.927(d):
    i. Examining relationship;
    ii. Treatment relationship (including length of the relationship);
    iii. Specialization of the medical sources (e.g. an orthopedist may give an opinion concerning the claimant's mental condition but this opinion does not qualify as a medical source opinion with respect to the claimant's mental RFC);
    iv. Supportability;
    v. Consistency with the record as a whole including non-medical evidence;
    vi. Any other relevant factor.
d. If only part of an opinion is accepted, rationale must be provided for why the other parts are not accepted.

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

a. As examples, one should not use the phrase "the opinion is consistent with the evidence in the record," or "great weight is given the treating source opinion," or "this is an issue reserved to the Commissioner" without specifically referring to the relevant evidence that supports your point or addressing evidence that is inconsistent. Otherwise, the decision may appear to be vague, unsupported or inconsistent with other evidence. Again, use the regulatory factors set forth in 20 CFR 404.1527(d) and 416.927(d).
b. On the other hand, the record can contain an abundance of evidence, much of which may not be relevant to the functional limitations adopted or may not be relevant to the time frame of the disability period point being discussed. Be specific and focus on the evidence that ties into your conclusion. Reciting every piece of evidence in the record, like a roll call, without purpose may confuse and distract the reader from the point being made. A few sentences should be sufficient to guide the reader.

IV. YOU MAY DECIDE A CASE WITHOUT A MEDICAL SOURCE STATEMENT. A MEDICAL SOURCE STATEMENT IS NOT REQUIRED.

a. Discuss the situations where "new impairments" are raised at the hearing level or new impairments arise since the alleged onset date of disability.
b. When developing the record post hearing, ensure that staff sends a Medical Source Statement of Ability Form with all requests for medical records.

c. Keep in mind that a Single Decision Maker (SDM) opinion is not a medical opinion. It is not entitled to any weight.
d. Although a medical source statement may be helpful, it is not necessary to order a CE examination if the file lacks a medical source statement. A medical source statement is not necessary to determine if a claimant's medical condition meets or equals a listed impairment or in deciding an RFC.
e. Formulating an RFC, or deciding whether a medical condition meets or equals the requirements of a listed impairment, is an administrative determination you make as an adjudicator based on all the evidence – medical reports, diagnostic tests, treatment modalities, statements of the claimant and third parties (MEs, friends, relatives, social workers, etc) through affidavits, in written form or by testimony, etc.
    i. Encourage discussion on how the ALJ would decide capacities and limitations without arriving at medical conclusions.
    ii. E.g., one way would be to start with the DDS RFC and add capacities/limitations based on testimony, etc.

2. Reinforce key regulations and SSRs

a. Distribute (or provide all with electronic link to) 20 CFR 404.1502, 1513 and 1527 (and companion regulations at 20 CFR 416). The facilitator should briefly summarize these key regulations and SSR to reinforce their importance.
b. Distribute or give cites (or links) to key SSRs; emphasize that this is not a complete list. Encourage all to reread these SSRs.
    i. 96-2p
    ii. 96-5p
    iii. 06-3p
c. Solicit input from group on other SSRs that might **be applicable**

3. Discuss how to incorporate the "Four Keys" in DW instructions and draft decisions

a. Encourage ALJ to state clearly the weight given to medical source statements in decision instructions.
b. Encourage those preparing draft decisions to follow the "Four Keys."
c. Discuss how ambiguities in decision instructions/drafting may be clarified.

4. **Distribute and Discuss the examples provided**

a. These examples are taken from the IVT script.
b. Distribute questions without answers to the group (facilitator should have a copy of questions and answers).
c. If group disagrees with proposed answer to an example or wishes to share other concerns, comments or suggestions, please submit to the OCEP mailbox at ^ODAR Continuing Education Program.

5. **Remind all of the OCEP website**
    a. The site is: (b) (2) [redacted]
    b. The website will maintain a copy of the OCEP IVT script, Questions/Answers submitted to the website, the "Four Keys to Medical Source Statements" Links to the IVT presentation, CLE information, and other related documents. Questions related to "Weighing Medical Source Statements" may continue to be submitted until May 16, but encourage to submit as soon as possible.

ODAR Continuing Education Program
Quarterly IVT

FOUR KEYS TO MEDICAL SOURCE STATEMENTS

Social Security Administration
Office of Disability Adjudication and Review

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

Give controlling weight to an MSS only if it is:

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

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

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

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

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

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

YOU MAY DECIDE A CASE WITHOUT AN MSS

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

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VOD Title:

Delivery:
IVT for VOD ☑ VOD Only ☐ VOD for IVT ☐

Articulate: One Window ☐ Three Window ☐

Microsoft Producer: One Window ☑ Three Window ☐

IVT Air Date: 4/18/2012

VOD Date: 4/25/2012

EWD Date (VOD Techs Only): Enter a date here.

Producer(s): (b) (6) [redacted]

Client(s): ODAR

SME(s): Judge John Costello, Judge Marilyn Faulkner, Judge David Pang, Judge Chris Gavras and (b) (6) [redacted]

Talent: Chief Judge Debra Bice, Judge John Costello, Judge Marilyn Faulkner, Judge David Pang, Judge Chris Gavras and (b) (6) [redacted] (b) (6) [redacted]

Location in VOD Library (Section and Subsection, if applicable):

Comments:

Description:

This IVT will identify the factors used to evaluate and weigh "medical source statements" from "acceptable medical sources." The program will further define these terms and discuss the proper approach in weighing medical source statements. The broadcast will also offer ways to articulate the reasons for the weight given to these statements, emphasizing the need to do so in clear, concise, and accurate language. The audience, including ALJs, Senior Attorney and Attorney Advisors, Paralegal Specialists, AAJs and Appeals Officers, will learn various tips in evaluating medical source statements, from the limited role the application of "controlling weight" plays, to the need to avoid stock phrases in applying one's analysis of medical source statements within the record, and other concepts.

Note:
For VOD: Submit the final script, graphics, and this cover sheet to the VOD Techs no later than 24 hours before taping begins.
For IVT: Take the script or flash drive to the studio, along with printed copies for the IVT technician.

Bookmark Title	Small Window Cues*	Large Window Cues**	Script
Judge Bice Introduction		G1 Title Slide CG	**Judge Bice:** I'm Chief Judge Debra Bice. I am very excited about introducing the second installment of our Continuing Education Program for 2012. I hope you found the last presentation on the proper phrasing of residual functional capacity to be helpful. We present these programs on important topics on a quarterly basis to further our efforts to provide quality hearings and decisions to the claimants. Our goal for these broadcasts is to reduce the number of remands on issues over which we have control. Today's topic is the proper handling of Medical Source Statements, one of the reasons for many of our remands. I want to thank Administrative Law Judge John Costello, from our Rochester, NY, Hearing Office, again for serving as the overall lead for planning these programs, and the planning team and presenters for producing and presenting another outstanding broadcast. The remaining programs for this calendar year will be held on July 18th and October 17th. The topic for the July broadcast will be credibility analysis. If you have suggestions for the July program on credibility or for any future program topics, please submit them to Judge Costello or Susan Swansiger, the Director of the Division of Field Procedures in my office. I am going to turn the program over to Judge Costello at this point to introduce our presenters and today's topic in more

Bookmark Title	Small Window Cues*	Large Window Cues**	Script
			detail. Thank you again for your commitment to public service and the issuance of timely and legally sufficient decisions. Judge Costello?
Judge Costello Introduction		CG	**Judge Costello** Thank you Judge Bice. Before introducing today's topic, let me further explain the reason for these quarterly presentations, and our expectations. I'm one of four ALJs in Rochester, New York. I have the same expectations, experience the same pressure, and face the same challenges that you do. You want to give full due process to each claimant. This means a comprehensive file review, a full and fair hearing, a thoughtful evaluation, and a well-reasoned decision. It's not just a matter of professional responsibility; it's a matter of personal pride. You take pride in the quality of your work. You want to do quality work, but you don't have the luxury of unlimited time. You face the daily pressure of rising caseloads and the need to provide timely decisions. So how do you meet these demands and still provide the careful attention each case deserves? Our goal in each of these quarterly broadcasts is to show how you can provide timely, quality adjudication to each claimant.

Bookmark Title	Small Window Cues*	Large Window Cues**	Script
			John Wooden, the Hall of Fame basketball coach of UCLA famously said, "If you don't have time to do it right, when will you have time to do it over?" In other words, quality and timeliness are not two opposing forces pulling at you; they're two sides of the same coin. Each of these broadcasts addresses a critical adjudication topic. Last time it was articulating RFC. Today, it's evaluating medical source statements. To use Coach Wooden's phrase, we talk about how to "do it right" so you don't have to do it over. Our goal is also to show that this is not onerous or burdensome. Doing it right does not necessarily mean spending more time on a case or writing more pages in a decision. It may require less. Our primary objective in the OCEP broadcasts is not to point out problems, but to provide clear, concise, practical solutions. Solutions you can easily recall and apply when evaluating evidence or drafting a decision. Think back to our January program, where we provided examples of poor and proper RFC articulation. The examples of proper articulation were more precise and concise. We gave you Five Keys to RFC – a simple, easy to recall guide to proper phrasing. I encourage you to go to our website again and reread the five keys or print it for reference. You may reach the website easily through the OCALJ site at (b) (2) [redacted] The OCEP logo appears on the ocalj homepage and is a
		CG	

Bookmark Title	Small Window Cues*	Large Window Cues**	Script
			hotlink to the OCEP site. We asked you to send questions and you have. We posted answers to each on the website. You'll find issues addressed here that we could not reach in our one-hour broadcast. The complete broadcast script as well as a link to a VOD of the program is available. You can also find information on CLE credit. We'll post the same information for this broadcast when it becomes available. These are all tools to quality adjudication. Now let me introduce today's program. It's a logical sequel to our first broadcast on phrasing RFC and will form part of a triptych with our third broadcast on "Assessing Credibility" in July. In today's broadcast on medical source statements, we provide excerpts of inadequate analysis from actual decisions. Then we show how to correct it, simply and efficiently. We'll also introduce the second in our series of "Keys" today with "Four Keys to Medical Source Statements." Like the "Five keys to RFC," the Keys provide a simple, one page reminder of the critical points discussed in the broadcast. I'd encourage you to print it or keep a link on your desktop. We've again asked the management team in each office to incorporate a discussion of evaluating medical source statements at a meeting either immediately following today's broadcast or soon thereafter. The meetings on RFC were very successful and helped to

Bookmark Title	Small Window Cues*	Large Window Cues**	Script
			reinforce and clarify the points made in the broadcast. We encourage you to meet as one group. Judges, Senior Attorneys, Attorneys and Paralegals each play critical roles in evaluating and addressing medical evidence and the interchange can only improve the quality of our work. Now it is with great pleasure that I introduce our four speakers today. They are Administrative Law Judges Marilyn Faulkner of the Downey, California Hearing Office and David Pang of the Baltimore National Hearing Center, Administrative Appeals Judge Chris Gavras, and Mary Ellen Russell from the Office of General Counsel. Judge Faulkner?
		CG	**MARILYN:** Thank you Judge Costello. Welcome to the second installment of the 2012 ODAR Continuing Education Program. The topic of today's broadcast is medical source statements. Joining me are ALJ David Pang, AAJ Chris Gavras and (b) (6) of the Office of General Counsel. Perhaps the most challenging task you face as an Administrative Law Judge, Attorney Advisor or Paralegal Specialist, is determining or explaining the weight you give to the opinions we call medical source statements. You must assign appropriate weight to all relevant opinions and articulate the reasons for the weight given in clear, concise, and accurate language. In other words, it is challenging in both decision-making and

Bookmark Title	Small Window Cues*	Large Window Cues**	Script
			decision writing. Studies show many remands result from insufficient evaluation of medical source statements. For these reasons, it is an appropriate topic for discussion in our quarterly Continuing Education Program and follows logically from our first broadcast in January 2012 on Phrasing the RFC. Let me outline the approach we'll be taking today. After discussing what constitutes a medical source statement, we will identify and discuss four recurring issues in evaluating them. Since our focus is not on identifying problems but in providing solutions, we articulate the issues by providing Four Keys for Evaluating Medical Source Statements. The keys are simple, easy-to-recall rules that provide a framework for our discussion today.
Four keys for Evaluating MSS		CG G2 Four Keys P P	**DAVID:** The four keys are: **-- First, YOU MAY GIVE A MEDICAL SOURCE STATEMENT "CONTROLLING WEIGHT" ONLY UNDER LIMITED CIRCUMSTANCES** **-- Second, YOU MAY ACCEPT A MEDICAL SOURCE STATEMENT IN PART; YOU ARE NOT REQUIRED TO ACCEPT EVERY PART OF THE OPINION**
		G3 P	**-- Third, YOU SHOULD NOT USE STOCK PHRASES ALONE TO SUPPORT THE WEIGHT YOU GIVE AN OPINION, and the fourth and final key is**

Bookmark Title	Small Window Cues*	Large Window Cues**	Script
		P	**--YOU DO NOT NEED A MEDICAL SOURCE STATEMENT TO DECIDE A CASE.**
			We'll start by defining terms. Here's a one-touch question.
One Touch Question 1		CG G4 One Touch Question 1	(b) (6) [redacted]: **Which of the following is a medical source statement?**
		P	**--A. Medical Source Statement of Ability to Do Work-Related Activities (Physical or Mental) signed by a treating physician or psychologist**
		P	**--B. Form developed by a claimant representative completed and signed by an examining physician**
		G5 P	**--C. An MRFC form completed and signed by a psychologist in the DDS**
		P	**--D. A narrative statement by a primary care physician describing a claimant's limitations, or**
		P	**--E. All of the above** **[PAUSE]**
		P	**The answer is E – all of the above.**
		CG	A medical source statement is defined at **20 CFR Sections 404.1513 and 416.913**. It is a medical opinion from an "acceptable medical source," based on medical findings, about what the individual can still do despite his or her impairments. Ideally, the medical source statement should describe the claimant's physical and mental abilities to do

Bookmark Title	Small Window Cues*	Large Window Cues**	Script
			work related activities.
		CG	**CHRIS:** For adults, the medical source statement might address the individual's exertional, manipulative, postural, special senses or environmental limitations or capacities. For claimants with mental impairments, the statement might offer an opinion on the individual's ability to understand, to carry out and remember instructions, and to respond appropriately to supervision, co-workers and work pressures in a work setting. For children, the medical source statement might offer an opinion about the child's functional limitations compared to other children of the same age in acquiring and using information, attending and completing tasks, interacting and relating with others, moving about and manipulating objects, self-care, and health and physical well-being. The best vehicles are the two Medical Source Statement of Ability to Do Work-Related Activities forms developed by Social Security:
		G6 1151	**Form-HA-1151-BK for physical impairments**
		G7 1152	**and Form HA-1152-U3 for mental impairments.**
			Each has checkboxes as well as sections for a narrative explanation by the medical source completing the report. The regulations require us to ask a treating or examining medical source to complete a medical source statement when we first seek medical records. As a matter of course, your office should furnish a medical source statement form to each provider from whom you request records. Although the provider is not obligated to

Bookmark Title	Small Window Cues*	Large Window Cues**	Script
			complete the form, many do.
			(b) (6) [redacted]: A medical source, however, is not limited to using the Social Security forms. Many representatives prepare their own forms for disability adjudication. If signed by an acceptable medical source, the information on the form is a medical source statement that you must evaluate. Likewise, a narrative statement addressing the claimant's abilities or limitations and signed by an acceptable medical source is a medical source statement. In fact, a statement in whatever form, from an acceptable medical source, regarding what the claimant can do, even if buried in treatment record notes, is a medical source statement that you must consider and evaluate. Of course, it is a medical source statement only if from an acceptable medical source. Acceptable medical sources are enumerated in the regulations and include:
		G8 Medical Sources P P P P P	**--Licensed physicians;** **--Licensed or certified psychologists;** **--Licensed optometrists for the purpose of establishing visual disorders;** **--Licensed podiatrists for the purpose of establishing impairments of the foot; and** **--Qualified speech-language pathologists**

Bookmark Title	Small Window Cues*	Large Window Cues**	Script
		G9 Common MSS P P P	**CHRIS:** The most common examples of medical source statements in a disability file include: **--The Medical Source Statement of Ability to Do Work-Related Activities forms** **--Forms prepared and provided through a claimant's representative** **--Narrative statements from an acceptable medical source**
		G10 P P P	**--Statements of the medical source regarding the claimant's limitations contained in medical records or reports prepared for workers compensation** **--Consultative examination reports, and** **--MRFC and PRFC determinations completed by State agency medical consultants.**
		CG	You should distinguish opinions from other sources from medical source statements. Nurse practitioners, chiropractors and licensed social workers, for example, are not acceptable medical sources; therefore, their opinions are not medical source statements. Likewise, opinions from non-medical sources, such as teachers, social welfare agency personnel, clergy, friends, and family are not medical source statements. You must still consider these opinions, of course, in your evaluation of the evidence. Social Security Ruling 06-3p

Bookmark Title	Small Window Cues*	Large Window Cues**	Script
			reminds us that opinions offered by these "other medical and non-medical sources" must be weighed in light of the factors enumerated in the regulations for evaluating medical opinions.
			(b) (6) [redacted]: So why distinguish between "acceptable medical sources" and the other medical and non-medical sources of record? The distinction is necessary for three reasons. First, we need evidence from an "acceptable medical source" to establish the existence of a medically determinable impairment at step two of the sequential evaluation process. Second, only "acceptable medical sources" can give us medical opinions, and Third, only "acceptable medical sources" can be considered treating sources whose medical opinions MAY be entitled to controlling weight. This is defined at **20 CFR Sections 404.1502 and 416.902**. CG CG Although the regulations and **SSR 06-3p** remind us that all opinions, from whatever source, must be considered and evaluated, we are limiting our discussion today to medical source opinions. Medical records or reports often do not contain a medical source statement. However, the regulations provide that the absence of a medical source statement will not render the medical report incomplete. You must still consider the medical report in determining whether the claimant's impairment meets or equals a listing, and in determining the

Bookmark Title	Small Window Cues*	Large Window Cues**	Script
			claimant's RFC. Let's turn our attention now to the first of our four keys. It addresses the weight to be given a treating source opinion.
Key One		G11 Key one	**DAVID:** KEY ONE is: **YOU MAY GIVE A MEDICAL SOURCE STATEMENT "CONTROLLING WEIGHT" ONLY UNDER LIMITED CIRCUMSTANCES**
			Here's a common scenario: You are reviewing a file or conducting a hearing and the file contains a medical source statement completed by the claimant's long time primary care physician. The medical source statement may appear on the social security form, or on a form developed by the representative, or in a narrative statement from the physician. It really doesn't matter. Each is a medical source statement. In our scenario, the statement indicates the claimant has very limited functional ability. If adopted, it would result in a finding of disability. The representative before you passionately argues that under the "Treating Source Rule" you must give the opinion "controlling weight" and find the claimant disabled. What do you do? Is your inquiry in the case over? Must you give the opinion controlling weight? The answer may surprise you. Whether an opinion from a treating source is entitled to controlling weight is governed by our regulations at

Bookmark Title	Small Window Cues*	Large Window Cues**	Script
		CG	20 CFR Sections 404.1527(d)(2) and 416.927(d)(2). SSR 96-2p contains additional guidance. Under the regulations, we give controlling weight to a treating source opinion only under limited circumstances. To accord controlling weight, you must satisfy a two-prong test.
		G12 Prong one	**MARILYN:** **First, the treating source opinion must be well supported by medically accepted clinical and laboratory diagnostic techniques. SSR 96-2p instructs us that whether an opinion is well supported will depend on the facts of each specific case.**
			To decide if the opinion is well supported, ask yourself these questions: --Do the treating sources' own records support the degree of limitation contained in his medical opinion? --Are the medications prescribed and the treatment provided consistent with the opinion? --Are the daily activities reported by the claimant to the treating source consistent with the opinion?
			You should examine the record closely to determine if the opinion is consistent with the physician's own records. Even if the treating source opinion is well-supported,
		G13 Prong two	**you must satisfy the second prong of the test to accord it controlling weight. Namely, the opinion must be "not inconsistent" with "other substantial evidence" in the case record.**

Bookmark Title	Small Window Cues*	Large Window Cues**	Script
			DAVID: So, what is other substantial evidence? The Supreme Court in Richardson v. Perales defined it as "more than a mere scintilla . . . [and] such relevant evidence as a reasonable mind might accept as adequate to support a conclusion."
		CG	Substantial evidence inconsistent with the treating source opinion may include other medical evidence, but may also be non-medical evidence. For example, --reported activities the claimant can perform, --opinions from other medical and non-medical sources, and -- testimony. As **Social Security Ruling 96-2p** explains, whether a medical opinion is "not inconsistent" with other substantial evidence is a judgment that adjudicators must make in each case. Sometimes the judgment is easy, because there is an obvious inconsistency. Other times, not so much. In these less obvious cases, it is especially important to examine the clinical signs, laboratory findings, and any treatment provided to determine whether there is an inconsistency between this evidence and medical opinions about diagnosis, prognosis, or functional effects. If the opinion is inconsistent with other substantial evidence, the opinion of the treating source should not be given controlling weight. Let's demonstrate this with a one-touch question

Bookmark Title	Small Window Cues*	Large Window Cues**	Script
One Touch Question 2		G14 One Touch Question 2 P P	**MARILYN:** **Assume a younger individual with past work as a cable line installer who has degenerative disc disease of the lumbar spine.** **The record contains the following:** **--A medical source statement from the treating physician showing the claimant can sit 0-1 hour total, stand or walk 0-1 hour total and lift 0-5 pounds**
		G15 P P	**--A consultative examination by a physician finding the claimant can sit 6 hours, stand or walk 2 hours and lift 15 pounds; and** **--Testimony that the claimant can lift a gallon of milk and sit or stand a total of 2 hours each in an eight hour period.**
		G16 P	**Is the opinion of the treating physician entitled to controlling weight?** **[PAUSE]** **The answer is no.**
			There is other substantial evidence of record, including the Consultative Examiner's opinion and the claimant's testimony, which is inconsistent with the treating physician's opinion, so it cannot be given controlling weight.
			DAVID: So, if a treating source opinion is not entitled to controlling weight, does this mean you must reject it completely? Of course not. It only means the opinion does not trump all

Bookmark Title	Small Window Cues*	Large Window Cues**	Script
		CG	other evidence. You still must weigh the opinion in light of the other evidence and decide how much weight to accord it. For example, you may find the opinion entitled to great weight, little weight, or no weight, depending on your analysis. Once you find the opinion is not entitled to controlling weight, determine how much weight you will give it. If you decide a treating medical source statement is not entitled to controlling weight or if you are evaluating an opinion from any other medical source, then you must consider all factors listed in the regulations at **20 C.F.R. §§ 404.1527(d) and 416.927(d)** when deciding what weight to give the opinion.
		G17 Factors P P P P P P	**These factors are:** **--Examining relationship** **--Treatment relationship** **--Supportability** **--Consistency** **--Specialization, and** **--Any other relevant factors.**
			At the hearing level, representatives and some adjudicators believe that treating source statements automatically get controlling weight or at least great weight because treating sources are at the top of a hierarchy. Representatives may refer to this as the TREATING PHYSICIAN RULE, contending the hierarchy is ironclad. Remember, the regulations do not create a "hierarchy" with

Bookmark Title	Small Window Cues*	Large Window Cues**	Script
			treating and examining relationships automatically on top. The regulations are a framework for weighing the opinion. Depending on the specific details of the case, the other factors of supportability, consistency, specialization, and program knowledge may lead you to assign less weight to a treating source opinion. On the other hand, you may find the medical source statement is indeed the best evidence and should be accorded great weight. The point is, an opinion should not "automatically" be given great weight merely because it is from a treating source.
			MARILYN: When applying the six factors to a medical opinion, keep in mind the following two points. First, supportability may be the single most important factor to consider when weighing medical source opinions. Supportability means the extent to which a source explains the reasons for the opinion and the extent to which it is supported by other evidence such as medical signs and laboratory findings. Second, consistency is not a catch-all phrase. Your decision should not merely state an opinion is "consistent with the record as a whole" and entitled to great weight. Rather, the decision must specifically identify the other evidence that is consistent with the opinion. Although the regulations do not specifically require you to articulate findings on each of these factors, a careful well-reasoned decision should briefly discuss the relevant ones.

Bookmark Title	Small Window Cues*	Large Window Cues**	Script
			This is nothing more than good reasoning and persuasive writing. Show the reader, and the appellate reviewer, that the weight you give to an opinion is reasonable and consistent with the evidence. A short explanation in a few sentences will suffice in nearly all instances. Throughout this program, we'll give you examples of how to do this. In sum, when deciding whether a treating source opinion is entitled to controlling weight, remember: --1. Give a treating opinion controlling weight only if it is WELL-SUPPORTED by clinical and laboratory techniques, AND NOT INCONSISTENT with other substantial evidence, and --2. If you do not give the opinion controlling weight, you must evaluate it and assign weight by applying the six factors set forth in the regulations. Let's turn now to KEY TWO. Once again, we'll introduce this key with a one-touch question.
One Touch Question 3			**CHRIS:** Assume the following medical source statements are in the claimant's file, then determine if the claimant's RFC must be one of those medical source statements.
		G18 One Touch Question3 P P	**-- The primary care physician limits the claimant to sedentary work with occasional reaching, handling and fingering** **-- The CE finds the claimant can lift and carry twenty**

Bookmark Title	Small Window Cues*	Large Window Cues**	Script
			pounds but can stand or walk no more than two hours and must avoid respiratory irritants
		G19 P P	**-- The DDS physician finds the claimant can do medium work, and** **-- A medical expert testifies the claimant can do the full range of light work.**
		G20 P	**Must the claimant's RFC be one of the previous medical source statements? Yes or No?** **[PAUSE]** **The Answer is NO and leads us to KEY TWO:**
Key Two		G21 Key Two	**YOU MAY ACCEPT A MEDICAL SOURCE STATEMENT IN PART; YOU ARE NOT REQUIRED TO ACCEPT EVERY PART OF THE OPINION**
			Determining RFC is not a matter of weighing the various medical source statements in the file and determining which one most closely matches the claimant's abilities. The ALJ or Senior Attorney Adjudicator determines RFC, which is the most the claimant can do given the impairments, by considering all the evidence of record. It is an administrative determination.
			MARY ELLEN: Many files contain multiple medical opinions. You may find NO opinion precisely reflects the true RFC of the claimant. As in our one-touch question, one medical source statement may say the claimant can perform a full range of medium

Bookmark Title	Small Window Cues*	Large Window Cues**	Script
			work while another opinion may limit the claimant to a severely eroded range of sedentary work. You may decide the evidence supports something in between. Are you boxed in by the four corners of the medium, or sedentary opinion when determining Residual Functional Capacity? No, you are not. The principle is clear. There is a tendency, however, particularly in complex cases with many exhibits, to simply pick one opinion and make it the RFC. Avoid this shortcut. Remember, RFC is your determination as the ALJ or Senior Attorney adjudicator. You should formulate the RFC by considering ALL the evidence. In so doing, you may adopt parts of several opinions or include limitations not specifically identified in a particular medical opinion. Of course, if a medical source statement is a complete statement of the claimant's RFC, you may adopt it in full. However, you are not required to adopt an entire opinion. You may formulate an RFC that differs from any of the medical source statements in the record. Remember, medical source statements may actually comprise separate medical opinions regarding diverse physical and mental functions. One opinion might not cover all of the claimant's functioning. You may give great weight to one element of a treating source medical opinion and no weight to other elements in the opinion, but the decision should contain reasons for the weight given to the elements adopted or rejected.

Bookmark Title	Small Window Cues*	Large Window Cues**	Script
			This is nothing more than good decision-making and persuasive writing. You should identify, briefly, in your decision, the evidence leading to the decision.
			CHRIS: This process of "articulation" – identifying the reasons for accepting or rejecting all or part of a medical opinion – is critical and need not be onerous. Let's show how it might be done with this one-touch question.
One Touch Question 4		G22 One Touch Question 4 P P P P P P P	**Assume a claimant with a right rotator cuff tear. The record shows the following:** **--The treating physician says the claimant can lift and carry no more than 15 pounds; no bilateral overhead reaching; and cannot stand or walk more than 2 hours** **--Diagnostic studies confirm a right rotator cuff tear only, and** **--Claimant testimony shows no problem standing or walking and no problem with the left arm.**
		G23 P P	**Should you adopt the treating source opinion completely? Should you give it controlling weight?** **[PAUSE]** **The answer is no.**
			Based on these facts, you might adopt part of the opinion limiting the claimant to lifting and carrying no more than 15 pounds with no overhead reaching with the right arm.

Bookmark Title	Small Window Cues*	Large Window Cues**	Script
			Your decision could state, in only a sentence or two, that you are not accepting the other limitations from the physician's opinion because you are giving greater weight to the claimant's testimony regarding his ability to walk, stand and reach with the left arm. In addition, the diagnostic tests confirm an impairment limited to the right arm and shoulder. The rest of the opinion is supported by the diagnostic test and claimant's testimony. For clarity of presentation, the facts are simplified in this example. You articulate the reasons, based on the evidence, for accepting or rejecting all or part of a medical source statement. The articulation need not be lengthy; in fact, it is better to be short, precise and pointed. But a stock phrase, such as "the opinion is consistent with the record as a whole," standing alone, is insufficient.
			MARY ELLEN: In producing the final written decision, both the ALJ and the Attorney Advisor or paralegal drafting the decision share responsibility to clearly articulate the weight given to the medical source statements. In determining RFC, the ALJ will undertake this process of weighing opinions and other evidence in determining RFC. The ALJ's instructions should guide the decision writer. Likewise, the decision writer should examine the record and articulate the evidentiary basis for rejecting all or part of a medical opinion.

Bookmark Title	Small Window Cues*	Large Window Cues**	Script
			The principle also applies to the opinion of a medical expert who testifies or answers interrogatories. You may accept all, part, or none of the opinion. Use the same criteria for weighing this opinion as you would any other medical opinion. Avoid mixing the terms RFC and medical source statement. Representatives will often submit forms signed by a treating source and identify them as an "RFC statement" or "RFC Form." Likewise, you may fall into the habit of calling these opinions "RFC statements" during the hearing or in your written decisions. Remember, RFC is an ADMINISTRATIVE determination you make as adjudicator. You should refer to statements from medical sources as medical source statements or medical opinions, not RFC statements. In sum, key two reminds us that a medical source statement may be accepted in part and rejected in part. Remember to articulate the specific reasons, based on the evidence, for the weight you assign the opinion. We'll introduce our third key with a one-touch question.
One Touch Question 5		G24 One Touch Question 5 P P P	**DAVID:** **Assume a claimant who has:** **--degenerative disc disease of the lumbar spine** **--clinical evidence of decreased motion of the lumbar spine** **--treatment only by the primary care physician with two visits in the past year, and**

Bookmark Title	Small Window Cues*	Large Window Cues**	Script
		G25 P P	**--conservative treatment for low back pain with over-the-counter medications.** **--The primary care physician submits a written statement indicating the claimant is "totally disabled."**
		G26 P P P P P	**What weight should you give this opinion?** **--A. "Controlling Weight"** **--B. Great Weight** **--C. No Weight, since it is an opinion on an issue reserved to the Commissioner, or** **--D. None of the above** **[PAUSE]** **The answer is D.**
Key Three		G27 Key 3	**This question introduces KEY THREE:** **YOU SHOULD NOT USE STOCK PHRASES ALONE TO SUPPORT THE WEIGHT YOU GIVE AN OPINION**
			Returning to our one touch question, we know from our earlier discussion we cannot accord the opinion controlling weight because it is inconsistent with other substantial evidence of record. We MIGHT find it is entitled to "great weight" but we do not have enough information at this point. Why is C not the correct answer? Whether the claimant is disabled is an issue reserved to the Commissioner. Why can't you disregard the opinion on this basis alone? You have all seen decisions in which an opinion stating the claimant is disabled is given no weight because it is an issue

Bookmark Title	Small Window Cues*	Large Window Cues**	Script
			reserved to the Commissioner. Standing alone, this statement is an insufficient basis for rejecting the opinion. Let's start our discussion by examining the regulation at issue.
		G28 Admin findings	**MARILYN:** **20 CFR Sections 404.1527(e) and 416.927(e) instruct that some issues regarding the nature and severity of theclaimant's impairments are not medical issues, but administrative findings.**
		G29 P P P P P	**These include:** **--1. Whether the impairment meets or equals a listing** **--2. Residual Functional Capacity** **--3. Whether a claimant can perform past relevant work** **--4. Applying the vocational factors of age, education and work experience, and** **--5. Whether an individual is "disabled" under the Act.**
			Under the regulations, the Commissioner decides these issues. The Commissioner delegates this responsibility to the ALJ or Senior Attorney Adjudicator at the hearing level. Some adjudicators erroneously interpret this regulation to mean that since the determination of disability is reserved to the Commissioner, an opinion from a medical source that the claimant is disabled may be disregarded for this reason alone.

Bookmark Title	Small Window Cues*	Large Window Cues**	Script
		CG	This is an incorrect interpretation of the regulations. The regulations and Social Security Ruling 96-5p require adjudicators at all levels to consider carefully opinions on any issue – including opinions about issues reserved to the Commissioner. You must evaluate all the evidence to determine the extent to which the opinion is supported by the record. Simply apply the six factors from **20 CFR Sections 404.1527(d) and 416.927(d),** and explain the weight accorded to the opinion.
			DAVID: Let's revisit the one-touch question to see how the hearing decision could have properly and fully addressed the treating source opinion in a legally sufficient manner. In our one-touch question the evidence showed: --Degenerative disc disease of the lumbar spine --Clinical evidence of decreased motion of the lumbar spine --Treatment only by the primary care physician with two visits in the past year, and --Conservative treatment for low back pain with over-the-counter medications. The primary care physician wrote that the claimant is "totally disabled." Rather than discrediting the opinion merely because this issue is reserved to the Commissioner, assess it in light of the regulatory factors. Again, these are:

Bookmark Title	Small Window Cues*	Large Window Cues**	Script
			--Examining relationship --Treatment relationship --Supportability --Consistency --Specialization, and --Any other relevant factors. In our example, you likely would give the opinion little or no weight because the objective medical evidence of record and the claimant's course of treatment just do not support it. More specifically, you might acknowledge the radiological evidence of a herniated disc, but note no evidence of nerve root impingement and only minimal clinical signs. In addition, you might cite the conservative treatment requiring only over the counter pain medications and two visits to the doctor. The revised hearing decision language could read:
		G30 Revised language	**I considered the opinion of Dr. X stating the claimant is totally disabled. This is an opinion reserved to the Commissioner and is not a medical opinion under the regulations. I also considered the opinion in light of the regulatory factors and assign it little weight.**
		G31	**The objective medical evidence shows no root impingement and only some decreased range of motion on clinical examination. In addition, the claimant receives conservative treatment and takes only over-the-counter medication for pain relief.**
			This thoroughly explains why the opinion received little weight and the explanation is tied directly to the evidence. A

Bookmark Title	Small Window Cues*	Large Window Cues**	Script
			lengthy discussion is neither necessary nor advisable. If it is an opinion reserved to the Commissioner, by all means reference this in your decision. But please accompany this statement with additional rationale referencing the evidence.
			MARILYN: The rule is simple: a stock phrase, not tied specifically to the evidence, is an inadequate basis for rejecting an opinion. We've discussed the stock phrase "the opinion is rejected because it is an issue reserved to the Commissioner" but there are similar phrases you should avoid.
		G32 phrases to avoid P P P	**For example, the following statements, standing alone, are insufficient for giving an opinion little or no weight:** **--The opinion is inconsistent with other evidence of record** **--The opinion is not consistent with the physician's treatment notes**
		G33 P P P	**--The opinion is internally inconsistent** **--The opinion is not supported by objective medical evidence, and** **--The opinion is based solely on the claimant's report**
			It is critical to understand why these reasons, standing alone, do not provide sufficient rationale. They are conclusions. You must show HOW the evidence supports the conclusion. As we showed in our one touch example, a few sentences focused and tied to the evidence should suffice. Let's turn now to **KEY FOUR:** Here's a one-touch question:

Bookmark Title	Small Window Cues*	Large Window Cues**	Script
One Touch Question 6		G34 One Touch Question 6 P P P	**CHRIS:** **Assume an unrepresented claimant applies for title II disability benefits. The relevant record consists of the following:** **--Complete medical records from the primary care physician noting lumbar disc disease** **--Complete treatment notes from a psychologist diagnosing Depressive disorder, and**
		G35 P P	**--A Single Decision Maker (SDM) report finding the claimant capable of light work with no mental health impairment.** **--There is no medical source statement or opinion from an acceptable medical source in the record even though a follow-up request was made.**
		G36 P P	**Question: Are you required to order a CE to obtain a medical source statement to adjudicate the case?** **[PAUSE]** **The answer is NO.** **And so,**
Key Four		G37	**KEY FOUR is:** **YOU DO NOT NEED A MEDICAL SOURCE STATEMENT TO DECIDE A CASE**
			MARY ELLEN:

Bookmark Title	Small Window Cues*	Large Window Cues**	Script
			Most files contain medical opinions or medical source statements from one or more sources. Occasionally, they do not. Remember, an assessment rendered by a single decision maker or SDM is not a medical opinion and must not be treated as a medical source statement. SDM evidence should appear in the "A" section of the file. Occasionally, a claimant will allege additional impairments after filing the application, and thus, the file will lack a medical source statement for these impairments. For example, a claimant may allege a new impairment of depression at the reconsideration or hearing level. Although the file may have mental health records establishing the impairment, there may not be a consultative examination report or medical source statement from the mental health care provider. Must you order a CE to address the newly-alleged impairment of depression? The answer is no. A medical source statement addressing each impairment is not required to decide whether a claimant's impairments meet a listing or to make an RFC finding. Our regulations require us to request a medical source statement as part of our initial request for medical reports; the absence of a statement does not make the report incomplete. Remember, whether a claimant's impairment meets a listing, or determining the claimant's RFC, are administrative determinations. The ALJ or Senior Attorney adjudicator makes these determinations by evaluating and weighing all the evidence. While it is often helpful to have a medical source statement,

Bookmark Title	Small Window Cues*	Large Window Cues**	Script
			it is not necessary. You are not required to order a consultative examination if the file lacks a medical source statement. Of course, to find that a claimant's impairments EQUAL a listing, the regulations require that we obtain evidence from a medical expert. So, how do you determine Residual Functional Capacity if the file does not contain a medical source statement? As with all RFC determinations, you consider all the evidence – medical reports, statements of the claimant and third parties, and testimony – to determine the MOST the claimant can do despite the impairments. Remember, formulating the RFC is an administrative determination you make as the adjudicator.
			CHRIS: So let's summarize Key Four with a few reminders:
		G38 Key 4 summary P P	**--Ensure that your office sends a medical source statement of Ability to Do Work Related Activities Form with all requests for medical records.** **--A Single Decision Maker assessment is NOT a medical opinion. It is not entitled to any weight**
		G39 P P	**--A medical source statement is not required to determine whether a claimant's impairment meets a listing or in determining a claimant's RFC, and finally,** **--Order a CE and request a medical source statement only when the evidence as a whole, both medical and nonmedical, is not sufficient to support a decision on**

Bookmark Title	Small Window Cues*	Large Window Cues**	Script
			the claim.
			With each of the four keys, we've emphasized the importance of articulating the reasons an opinion is accorded the weight you assign. Using stock phrases is not enough. The articulation, however, need not be an overwhelming task. Let's demonstrate this with three examples, taken from actual cases. We'll examine the language used in the decision, discuss the deficiencies, and show how to fix it.
			MARILYN: (b) (7)(E) State agency medical consultant opinion. The decision stated:
Decision Example 1		G40 Decision Example 1	**"The ALJ has accorded significant weight to the opinions of the State agency medical consultants because they are deemed experts and highly knowledgeable in the area of disability and because their opinions are largely consistent with the record as a whole."**
			Why is this inadequate? There are several reasons. --It uses a stock phrase stating a conclusion --It tells us what we already know – the medical consultants know our program, and --It cites no specific support for the conclusion. How do you fix it?
			DAVID: A short statement tying the conclusion to the evidence will

Bookmark Title	Small Window Cues*	Large Window Cues**	Script
			suffice. For example, you might state:
		G41	**"The record contains two medical opinions. In Exhibit 10F, the State agency consultant found the claimant limited to the full range of light work but he must avoid concentrated exposure to respiratory irritants. This is consistent with treatment records at 11F and 12F and claimant's testimony that he can walk a mile, perform household chores, and care for his two-year old child.**
		G42	**In Exhibit 14F, a State agency consultant reviewed all medical evidence, noted no evidence of congestive heart failure, a 43% ejection fraction, and opined the claimant could return to a limited range of light work. This opinion is well-supported by treatment records at 8F, page 6 and 9F, page 3. Significant weight is given each opinion in formulating the RFC."**
			This is excellent articulation for several reasons: --It identifies how many medical opinions exist --It summarizes the opinion and cites the exhibits --It shows how the two opinions are relatively consistent --It identifies specific medical findings and other evidence in support, and --It states the weight given the opinions. The decision does it all in just one short paragraph. Five points addressed in a mere six sentences.
Decision Example 2			**MARY ELLEN:** Let's turn to a second example of poor articulation. This case involves the comparative weight given to a State agency opinion and that of the treating physician.

Bookmark Title	Small Window Cues*	Large Window Cues**	Script
			The decision stated:.
		G43 Decision Example 2	**"The State agency consultant concluded the claimant would be capable of work at the light exertional level. Although this opinion is entitled to less weight, as it was given by a non-examining physician, it is considered a medical opinion and entitled to some weight.**
		G44	**Therefore, this opinion by Dr. M., (a treating physician) limiting the claimant to sedentary work is given little weight in determining the claimant's residual functional capacity."**
			You can readily see that this articulation is inadequate. Here are a just a few deficiencies: --The State agency opinion is given "less weight" than what? The decision does not say. --A State agency opinion is not necessarily entitled to less weight simply because it is by a non-examining source --There is no logical basis for the weight given the treating source opinion, and --Like our first example, it cites no specific support in the record for the conclusion.
		G45 Avoid cliches	**How can you fix it? Avoid clichés and cite the evidence**
			CHRIS: Here's how you might articulate your findings:
		G46 You might articulate	**"The State agency physician found the claimant capable of light work, with no additional limitations. The record**

Bookmark Title	Small Window Cues*	Large Window Cues**	Script
			supports this opinion, but the opinion does not account for the claimant's manipulative limitations, so I give it some weight. It is consistent with the opinion of the claimant's surgeon that the claimant can lift and carry 20 pounds
		G47	**and has no limitations standing or walking at Exhibit 7F. It is also consistent with the claimant's testimony and reported activities at Exhibit 4E. In light of this evidence, I give no weight to Dr. M's opinion that the claimant is limited to sedentary work. In addition, Dr. M's records show conservative treatment and only over the counter medication prescribed at Exhibit 10F."**
			All you need is a few sentences, tied to the evidence and citation to the exhibits, to justify the conclusion.
Decision Example 3			**MARILYN:** Let's conclude this exercise with a third example.
		G48 Decision Example 3	**This case involves the opinion of nurse practitioner D limiting the claimant to an extremely reduced range of sedentary work. As with many cases you decide, nurse practitioner D provides nearly all primary medical care to the claimant.**
		G49	**The decision stated:** **"I give no weight to the opinion of nurse practitioner D because she is not a physician. She is not an acceptable medical source under the regulations and therefore her opinion is not entitled to controlling weight."**

Bookmark Title	Small Window Cues*	Large Window Cues**	Script
			What's wrong with this? By now, you are surely seeing the pattern.
		CG	The statement misinterprets the regulations and fails to cite evidence supporting the conclusion. Remember, **SSR 06-03p** tells us that an opinion from a source not considered "an acceptable medical source" may be entitled to greater weight than even the medical opinion of a treating source.
			For example, it may be appropriate to give more weight to the opinion of a medical source who is not an "acceptable medical source". This source may have seen the claimant more often than the treating source and provided better supporting evidence and a better explanation for the opinion. So you cannot reject the opinion simply because the nurse practitioner is not a physician.
			DAVID: Here is how you might articulate the weight given:
		G50 You might articulate	**Nurse practitioner D stated in March 2009, at Exhibit 15F the claimant can perform a limited range of sedentary work with many additional non-exertional limitations. I give this opinion little weight for several reasons.** **Although D treats the claimant, a nurse practitioner is not an acceptable medical source, and the opinion is not a medical source statement.**

Bookmark Title	Small Window Cues*	Large Window Cues**	Script
		G51	**More importantly, the record does not support the opinion. When asked to identify the particular medical or clinical findings supporting the assessment, D cited the x-ray of July 24, 2008, which showed 'mild multi-level degenerative changes at L5-S1.'**
		G52	**Although D's opinion has been considered as other evidence, it is not consistent with either D's treatment notes in Exhibit 10F, or the claimant's testimony regarding daily activities."**
			This is good articulation. It does not reject the opinion simply because it is not from an acceptable medical source. It rejects the opinion because it is not consistent with treatment, diagnostic tests and the claimant's reported activities. In this example, we rejected the nurse practitioner's opinion for sound reasons. However, remember that someone who sees the claimant more often, provides better supporting evidence and a better explanation for an opinion, and whose opinion is consistent with the substantial evidence in file will be entitled to more weight than even a treating source who is a specialist in the claimant's impairment. In sum, these examples demonstrate that explaining the weight given an opinion is not an onerous task. Endless analysis is neither necessary nor desirable. Cite the evidence that supports the weight you give an opinion. Do it in just a few clear sentences. Do not rely on stock phrases and clichés.

Bookmark Title	Small Window Cues*	Large Window Cues**	Script
			We would like to thank you for your attention and participation today. Now we'll return to Judge Costello, for some final remarks.
Judge Costello Closing Remarks			**Judge Costello:** Thank you Judge Faulkner, Judge Pang, Judge Gavras and (b) (6) for your presentation today. We conclude our program with a few simple reminders. We call these the "Four Keys to Medical Source Statements." We provided you with a copy. The Four Keys are:
Four Keys to Evaluating MSS Recap		G53 Four Keys P P	**----1. You may give a medical source statement "controlling weight" only under limited circumstances** **--2. You may accept a medical source statement in part; you are not required to accept every part of the opinion**
		G54 P P	**--3. You should not use stock phrases alone to support the weight you give an opinion, and** **--4. You do not need a medical source statement to decide a case.**
Questions			Please let us know what you think of the program or if you have any questions .
		G55 OCEP mailbox	**You may reach us through the OCEP mailbox at (b) (2) or visit the OCEP website.**

Sample Cue Legend: **(G)** = Graphic | **(P)** = Pop | **(CG)** Lower 3rd – Name/Info | **(N/A)** No Image | **(VO)** Voice Over
* Three-Window Model Only | **Three-Window Model – Slides Only; One-Window Model – Slides and Presenter

Bookmark Title	Small Window Cues*	Large Window Cues**	Script
			On the website, we'll post a transcript of this presentation, answers to submitted questions, information on CLE and other material. Please use the website as a reference resource. Our next OCEP will be July 18 and the topic will be "Assessing Credibility." If you have any suggestions for future topics, please email them to our mailbox. Thank you again for your attention and participation today. We hope you found the program informative and helpful.

From: (b) (2)
Subject: ODAR Continuing Education Program Quarterly IVT Evaluating Medical Source Statements April 18, 2012
Date: Tuesday, March 20, 2012 1:45:00 PM

To All Administrative Law Judges:

ODAR Continuing Education Program A Quarterly IVT April 2012

Is this email not displaying correctly?
View it in your browser.

Assume a claimant with a right rotator cuff tear.

The record shows the following:

1. **The treating physician says the claimant can lift and carry no more than 15 pounds; no bilateral overhead reaching; and not stand or walk more than 2 hours**
2. **Diagnostic studies confirm right rotator cuff tear only**
3. **Claimant testimony shows no problem standing or walking; no problem with the left arm**

Must you adopt the treating source opinion in its entirety?
Yes or No

Learn the answer to this and other medical source statement questions on the broadcast on April 18 at 8am, 10am, 12pm, and 2pm EST

Email your questions to (b) (2)
Questions not answered in the IVT will be answered in followup

Panelists
Administrative Law Judges Marilyn Faulkner and David Pang
Administrative Appeals Judge Chris Gavras
(b) (6) ***, Office of the General Counsel***

Social Security Administration - Office of Disability Adjudication and Review

Released By: (b) (6)

Office of the Chief Administrative Law Judge

ODAR
CONTINUING EDUCATION PROGRAM

Medical Source Statements

Four Keys to Evaluating Medical Source Statements

1. You may give a MSS "controlling weight" only under limited circumstances
2. You may accept a MSS in part; you are not required to accept every part of the opinion

Four Keys to Evaluating Medical Source Statements

3. You should not use stock phrases alone to support the weight you give an opinion

4. You do not need a medical source statement to decide a case

Which are Medical Source Statements?

A. MSS of Ability to Do Work-Related Activities (Physical or Mental) signed by a treating physician or psychologist

B. Form developed by a claimant representative completed & signed by an examining physician

Which are Medical Source Statements?

C. MRFC form completed & signed by a psychologist in the DDS

D. Narrative statement by a primary care physician describing claimant's limitations

E. All of the above

MEDICAL SOURCE STATEMENT OF ABILITY TO DO WORK-RELATED ACTIVIES (PHYSICAL)

SOCIAL SECURITY ADMINISTRATION
OFFICE OF DISABILITY ADJUDICATION AND REVIEW

Form Approved
OMB No.0960-0662

MEDICAL SOURCE STATEMENT OF ABILITY TO DO WORK-RELATED ACTIVITIES (PHYSICAL)

NAME OF INDIVIDUAL SOCIAL SECURITY NUMBER

To determine this individual's ability to do **work-related activities on a regular and continuous basis**, please give us your opinion for each activity shown below:

The following terms are defined as:

- **REGULAR AND CONTINUOUS BASIS** means 8 hours a day, for 5 days a week, or an equivalent work schedule.
- **OCCASIONALLY** means very little to one-third of the time.
- **FREQUENTLY** means from one-third to two-thirds of the time.
- **CONTINUOUSLY** means more than two-thirds of the time.

Age and body habitus of the individual should not be considered in the assessment of limitations. It is important that you relate particular medical or clinical findings to any assessed limitations in capacity: The usefulness of your assessment depends on the extent to which you do this.

I. LIFTING/CARRYING

Check the boxes representing the amount the individual can lift and how often it can be lifted.

Lift	Never	Occasionally (up to 1/3)	Frequently (1/3 to 2/3)	Continuously (over 2/3)
A. Up to 10 lbs:	☐	☐	☐	☐
B. 11 to 20 lbs:	☐	☐	☐	☐
C. 21 to 50 lbs:	☐	☐	☐	☐
D. 51 to 100 lbs:	☐	☐	☐	☐

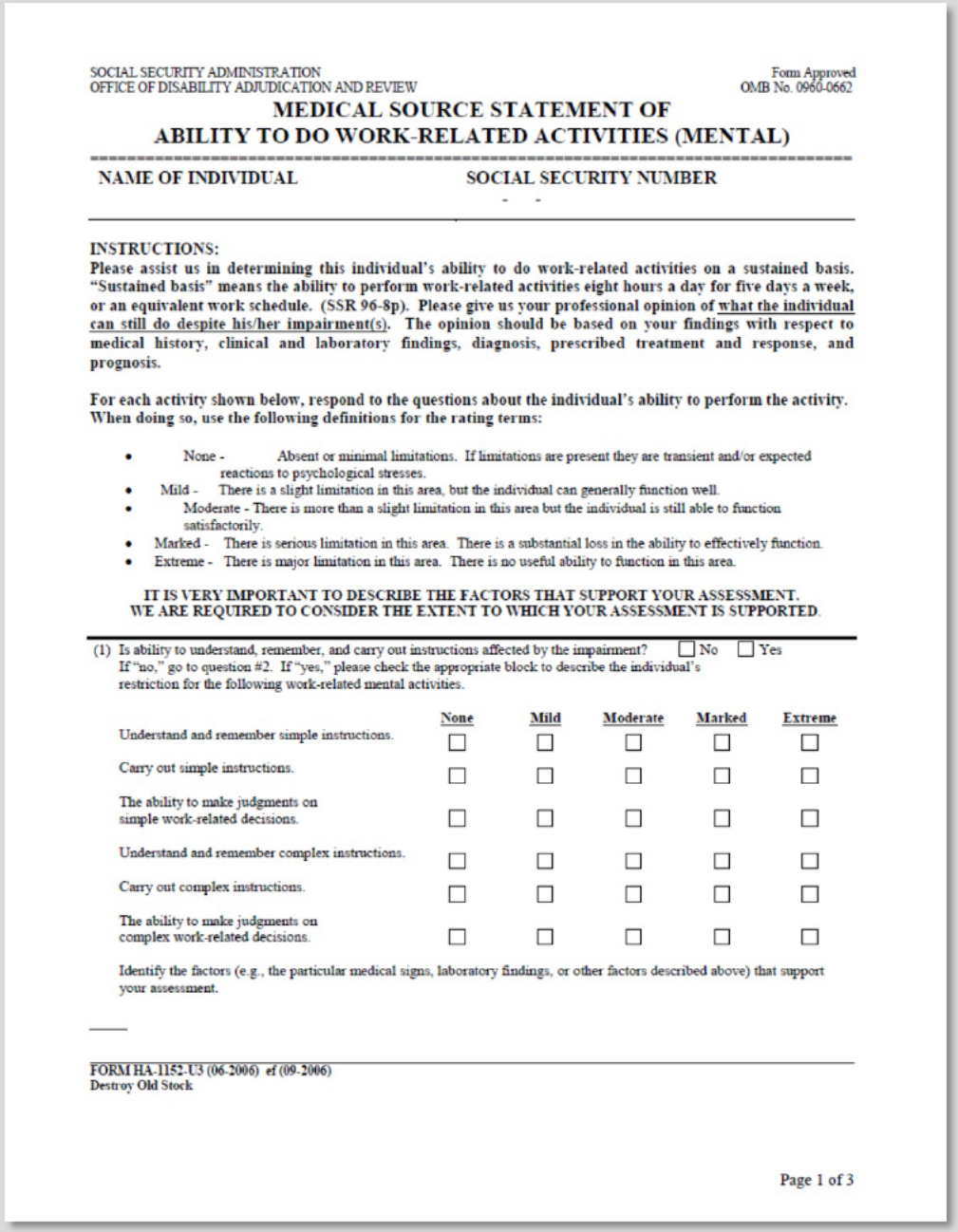
Check the boxes representing the amount the individual can carry and how often it can be carried.

Carry	Never	Occasionally (up to 1/3)	Frequently (1/3 to 2/3)	Continuously (over 2/3)
A. Up to 10 lbs:	☐	☐	☐	☐
B. 11 to 20 lbs:	☐	☐	☐	☐
C. 21 to 50 lbs:	☐	☐	☐	☐
D. 51 to 100 lbs:	☐	☐	☐	☐

Identify the particular medical or clinical findings (i.e., physical exam findings, x-ray findings, laboratory test results, history, and symptoms including pain etc.) which support your assessment or any limitations and why the findings support the assessment.

___

MEDICAL SOURCE STATEMENT OF ABILITY TO DO WORK-RELATED ACTIVIES (MENTAL)



SOCIAL SECURITY ADMINISTRATION
OFFICE OF DISABILITY ADJUDICATION AND REVIEW

Form Approved
OMB No. 0960-0662

MEDICAL SOURCE STATEMENT OF ABILITY TO DO WORK-RELATED ACTIVITIES (MENTAL)

NAME OF INDIVIDUAL

SOCIAL SECURITY NUMBER
- -

INSTRUCTIONS:
Please assist us in determining this individual's ability to do work-related activities on a sustained basis. "Sustained basis" means the ability to perform work-related activities eight hours a day for five days a week, or an equivalent work schedule. (SSR 96-8p). Please give us your professional opinion of what the individual can still do despite his/her impairment(s). The opinion should be based on your findings with respect to medical history, clinical and laboratory findings, diagnosis, prescribed treatment and response, and prognosis.

For each activity shown below, respond to the questions about the individual's ability to perform the activity. When doing so, use the following definitions for the rating terms:

- None - Absent or minimal limitations. If limitations are present they are transient and/or expected reactions to psychological stresses.
- Mild - There is a slight limitation in this area, but the individual can generally function well.
- Moderate - There is more than a slight limitation in this area but the individual is still able to function satisfactorily.
- Marked - There is serious limitation in this area. There is a substantial loss in the ability to effectively function.
- Extreme - There is major limitation in this area. There is no useful ability to function in this area.

IT IS VERY IMPORTANT TO DESCRIBE THE FACTORS THAT SUPPORT YOUR ASSESSMENT. WE ARE REQUIRED TO CONSIDER THE EXTENT TO WHICH YOUR ASSESSMENT IS SUPPORTED.

(1) Is ability to understand, remember, and carry out instructions affected by the impairment? ☐ No ☐ Yes
If "no," go to question #2. If "yes," please check the appropriate block to describe the individual's restriction for the following work-related mental activities.

	None	Mild	Moderate	Marked	Extreme
Understand and remember simple instructions.	☐	☐	☐	☐	☐
Carry out simple instructions.	☐	☐	☐	☐	☐
The ability to make judgments on simple work-related decisions.	☐	☐	☐	☐	☐
Understand and remember complex instructions.	☐	☐	☐	☐	☐
Carry out complex instructions.	☐	☐	☐	☐	☐
The ability to make judgments on complex work-related decisions.	☐	☐	☐	☐	☐

Identify the factors (e.g., the particular medical signs, laboratory findings, or other factors described above) that support your assessment.

FORM HA-1152-U3 (06-2006) *ef* (09-2006)
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Acceptable Medical Sources

- Licensed physicians
- Licensed or certified psychologists
- Licensed optometrists for the purpose of establishing visual disorders
- Licensed podiatrists for the purpose of establishing impairments of the foot
- Qualified speech-language pathologists

Common Examples of Medical Source Statements

- The Medical Source Statement of Ability to Do Work-Related Activities forms
- Forms prepared and provided through a claimant's representative
- Narrative statements from an acceptable medical source

Common Examples of Medical Source Statements, cont'd

- Statements of the medical source regarding claimant's limitations contained in medical records or reports prepared for workers compensation
- Consultative examinations
- MRFC / PRFC determinations completed by state agency medical consultants

Key One

You may give a medical source statement "controlling weight" only under limited circumstances

Two-Prong Test, Part One:

The treating source opinion must be well supported by medically accepted clinical and laboratory diagnostic techniques

Two-Prong Test, Part Two:

The opinion must be "not inconsistent" with "other substantial evidence" in the case record

- **Assume a younger individual with past work as a cable line installer who has degenerative disc disease of the lumbar spine**
- **MSS from treating physician showing claimant can sit 0-1 hour total, stand or walk 0-1 hour total & lift 0-5 pounds**

- **CE by a physician finding the claimant can sit 6 hours, stand or walk 2 hours & lift 15 pounds**
- **Testimony that claimant can lift a gallon of milk & sit or stand a total of 2 hours each in an 8 hour period**

Question:

Is the opinion of the treating physician entitled to controlling weight?

YES NO

Factors listed in 20 CFR 404.1527(d) and 416.927(d)

- Examining relationship
- Treatment relationship
- Supportability
- Consistency
- Specialization
- Any other relevant factors

The following medical source statements are in the claimant's file:

A. Primary care physician limits claimant to sedentary work with occasional reaching, handling & fingering

B. CE finds claimant can lift & carry 20 lbs but can stand or walk no more than 2 hrs & must avoid respiratory irritants

The following medical source statements are in the claimant's file:

C. DDS physician finds claimant can do medium work

D. The ME testifies the claimant can do the full range of light work

Question:

Must the claimant's RFC be one of those medical source statements?

YES NO

Key Two

You may accept a medical source statement in part; you are not required to accept every part of the opinion

- Claimant has a right rotator cuff tear
- Treating physician says the claimant
  - can lift & carry no more than 15 lbs
  - no bilateral overhead reaching
  - cannot stand or walk more than 2 hrs
- Diagnostic studies confirm right rotator cuff tear only
- Claimant testimony shows no problem standing or walking; no problem with the left arm

Question:

Should the ALJ or Senior Attorney Adjudicator adopt the treating source opinion completely, or give it controlling weight?

YES **NO**

- **Claimant has degenerative disc disease of the lumbar spine**
- **Clinical evidence of decreased motion of the lumbar spine**
- **Treatment only by the primary care physician with 2 visits in the past year**

- **Conservative treatment for low back pain with over-the-counter medications**
- **Primary care physician submits written statement indicating the claimant is “totally disabled”**

Question:

What weight should you give this opinion?

A. "Controlling Weight"
B. Great Weight
C. No Weight, since it is an opinion on an issue reserved to the Commissioner
D. None of the above.

Key Three

You should not use stock phrases alone to support the weight you give an opinion

20 CFR 404.1527(e) and 416.927(e)

Some issues regarding the nature and severity of the claimant's impairment(s) are not medical issues, but administrative findings.

20 CFR 404.1527(e) and 416.927(e), cont'd

- Whether the impairment meets or equals a listing
- RFC
- Whether a claimant can perform PRW
- Application of the vocational factors of age, education and work experience
- Whether an individual is "disabled" under the Act

Revised Decision Language for One Touch Question 5

"I considered the opinion of Dr. X stating the claimant is totally disabled. This is an opinion reserved to the Commissioner and is not a medical opinion under the regulations. I also considered the opinion in light of the regulatory factors and assign it little weight...

Revised Decision Language for One Touch Question 5

…The objective medical evidence shows no root impingement and only some decreased range of motion on clinical examination. In addition, the claimant receives conservative treatment and takes only over-the-counter medication for pain relief."

Other Stock Phrases to Avoid

Examples of statements (standing alone) that are insufficient reason to give an opinion little or no weight:

- **The opinion is inconsistent with other evidence of record**
- **The opinion is not consistent with the physician's treatment notes**

Other Stock Phrases to Avoid, cont'd

- The opinion is internally inconsistent
- The opinion is not supported by objective medical evidence
- The opinion is based solely on the claimant's report

- **Unrepresented claimant applies for Title II benefits**
- **Complete medical records from primary care physician noting lumbar disc disease**
- **Complete treatment notes from a psychologist diagnosing depressive disorder**

- **Single Decision Maker (SDM) report finding claimant capable of light work with no mental health impairment**
- **There is no MSS or opinion from an acceptable medical source in record, even though a follow-up request was made**

Question:

Are you required to order a CE to obtain a medical source statement to adjudicate the case?

YES **NO**

Key Four

A medical source statement is not required to decide a case

Key Four Summary

- Ensure that your office sends a medical source statement of Ability to Do Work Related Activities Form with all requests for medical records
- A Single Decision Maker (SDM) assessment is NOT a medical opinion. It is not entitled to any weight

Key Four Summary

- A medical source statement is not required to determine whether a claimant's impairment meets a listing or in determining a claimant's RFC
- Order a CE and request a medical source statement ONLY if necessary for a full development of the impairments

Decision Example 1

"The ALJ has accorded significant weight to the opinions of the State agency medical consultants because they are deemed experts and highly knowledgeable in the area of disability and because their opinions are largely consistent with the record as a whole."

Here is how you might articulate your findings:

"The record contains two medical opinions. The State agency consultant found the claimant limited to the full range of light work but he must avoid concentrated exposure to respiratory irritants (Exhibit 10F). This is consistent with treatment records at 11F and 12F and claimant's testimony that he can walk a mile perform household chores and care for his two year old child …

Here is how you might articulate your findings, cont'd:

…In Exhibit 14F, a State agency consultant reviewed all medical evidence, noted no evidence of congestive heart failure, a 43% ejection fraction, and opined the claimant could return to a limited range of light work. This opinion is well-supported by treatment records at 8F, page 6 and 9F, page 3. Significant weight is given each opinion in formulating the RFC."

Decision Example 2

"The State agency consultant concluded the claimant would be capable of work at the light exertional level. Although this opinion is entitled to less weight, as it was given by a nonexamining physician, it is considered a medical opinion and entitled to some weight…

Decision Example 2, cont'd

…Therefore, the opinion by Dr. M., (a treating physician) limiting the claimant to sedentary work is given little weight in determining the claimant's residual functional capacity."

How can you fix it?

Avoid clichés

and

Cite the evidence

Here is how you might articulate your findings:

"The State agency physician found the claimant capable of light work, with no additional limitations. The record supports this opinion, but the opinion does not account for claimant's manipulative limitations, so I give it some weight. It is consistent with the opinion of the claimant's surgeon that the claimant can lift and carry 20 pounds…

Here is how you might articulate your findings, cont'd:

… and has no limitations standing or walking (Exhibit 7F). It is also consistent with the claimant's testimony and reported activities (Exhibit 4E). In light of this evidence, I give no weight to Dr. M's opinion that the claimant is limited to sedentary work. In addition, Dr. M's records show conservative treatment and only over-the-counter medication prescribed (Exhibit 10F)."

Decision Example 3

- Opinion of nurse practitioner D limits claimant to extremely reduced range of sedentary work
- Nurse D provides nearly all the primary care to the claimant

Decision Example 3, cont'd

"I give no weight to the opinion of nurse practitioner D because she is not a physician. She is not an acceptable medical source under the regulations and therefore her opinion is not entitled to controlling weight."

Here is how you might articulate your findings:

"Nurse practitioner D, stated in March 2009, at Exhibit 15F the claimant can perform a limited range of sedentary work with many additional non-exertional limitations. I give this opinion little weight for several reasons. Although D treats the claimant, a nurse practitioner is not an acceptable medical source, and the opinion is not a medical source statement...

Here is how you might articulate your findings, cont'd:

…More importantly, the record does not support the opinion. When asked to identify the particular medical or clinical findings supporting the assessment, D. cited the x-ray of July 24, 2008, which showed 'mild multi-level degenerative changes at L5-S1'…

Here is how you might articulate your findings, cont'd:

… Although D's opinion has been considered as other evidence, it is not consistent with either D's treatment notes in Exhibit 10F, or the claimant's testimony regarding daily activities."

Four Keys to Evaluating Medical Source Statements

1. You may give a MSS "controlling weight" only under limited circumstances

2. You may accept a MSS in part; you are not required to accept every part of the opinion

Four Keys to Evaluating Medical Source Statements

3. You should not use stock phrases alone to support the weight you give an opinion
4. You do not need a medical source statement to decide a case

Questions?

Email (b) (2) [redacted]

ODAR Continuing Education Program

OCEP—April 2016 Quarterly IVT

FOUR KEYS TO OPINION EVIDENCE

Social Security Administration
Office of Disability Adjudication and Review

Identify opinion evidence from all sources in every decision.

- Medical opinions are statements from acceptable medical sources that reflect judgments about the nature and severity of the impairments and the resulting physical or mental restrictions.
- Other opinions are from other sources that likewise reflect on the severity of the impairments and the effect on an individual's ability to function.
- SSR 06-3p has detailed guidance on identifying and evaluating all opinion evidence.

Weigh opinions by applying the specific factors in 20 CFR 404.1527, 416.927, and SSR 06-3p.

- You may give "controlling weight" to a medical opinion only if it is from an acceptable medical source that is also a treating source. Give the opinion controlling weight only if it is well supported and not inconsistent with the other substantial evidence of record.
- Evaluate each opinion from medical and other sources in light of these factors: examining relationship, treating relationship, supportability, consistency, specialization, and other factors.
- Opinions may include multiple separate opinions. You may accept part of an opinion and reject part. Explain why in the decision.

Explain the weight given each opinion.

- Aside from the term "controlling weight," the regulations do not require the use of particular terms when assigning weight to an opinion.
- Choose an appropriate term when assigning weight and articulate the reason for the weight given, tying the reason to the evidence.

Cite specific evidence to support the weight given each opinion.

- Decisions must analyze, not simply summarize, the evidence.
- Do not rely on boilerplate phrases. Cite specific evidence in the record to support the weight given each opinion.

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		Ver. 2010.1018
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IVT Air Date: Enter a date here.	**VOD Date:** Enter a date here.	**EWD Date (VOD Techs Only):** Enter a date here.
Producer(s): (b) (6) [redacted]		
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Bookmark Title	Small Window Cues	Large Window Cues	Script
Judge Bice Introduction		G1 Titile	
		CG – L3 Debra Bice Chief Administrative Law Judge	**BICE:** Welcome to the second ODAR Continuing Education Program of 2016: "Evaluating Opinion Evidence." I'm Chief Administrative Law Judge Debra Bice. Properly identifying and weighing opinion evidence is a critical part of the disability determination process and getting it right is not an easy task. So I am pleased today's OCEP team will address both the law and it's practical application. I want to thank Judge John Costello from our Rochester New York Hearing Office for his work in leading the OCEP planning team. In a moment, he will introduce today's presenters and briefly describe the program. Let me also take a moment to mention the importance of the facilitated OCEP discussion in your office following the broadcast. it's an essential part of this training. I encourage each of you to continue asking questions – you would be surprised how many people have the same question. Your colleagues comprise the best network for answering questions. If a particular question isn't answered during the discussion, you can send the question up through your management chain. Unresolved questions at the Regional or the NHC Central Office level may be submitted to the Division of Field Procedures in the Chief Judge's Office, at (b) (2) (b) (2) Questions raised at OAO should go to the DCAAJ or Division Director, who may contact the Office of Executive Director, as needed. Enjoy the broadcast and here's Judge Costello…
Judge Costello Introduction			**COSTELLO:** Thank you, Judge Bice.

Bookmark Title	Small Window Cues	Large Window Cues	Script
		CG-L3 John Costello Administrative Law Judge	**You can make a good argument that properly evaluating opinion evidence is the single most important part of disability adjudication**. Get it right, and chances are the decision will be right and will clear appellate review. But getting it right is not as easy as it sounds. We evaluate opinion evidence so often that it's easy to fall into bad habits. Let me draw a comparison. It's Spring as we broadcast today and baseball season has just begun, so I'll borrow a lesson from the National Pastime. Baseball is played over a long season. It's a game of routine: the same nine-inning game played every day for six months. It's easy for hitters to develop bad swing habits. They call it a hitting slump. When that happens, the ballplayer needs to take a step back to find out what's wrong with his swing. He'll ask the coaches for advice and look at film to correct the flaws. In other words, he goes back to the basics that got him to the big leagues. The same holds true for us. Bad habits have a way of creeping in. It's a good idea to step back occasionally and examine the process. This broadcast is a chance to step away from your work for a moment and look at the topic of opinion evidence in a fresh light. It's a chance to go back to basics and correct the flaws that may have crept in. Our approach, as in all OCEP programs, is to reinforce essential concepts and show you a few new ones. We pull together the key regulations and social security rulings so you have one source for guidance. Don't forget the materials posted on the OCEP website. The Keys and QuickNotes from today are a ready reference and the script, with

Bookmark Title	Small Window Cues	Large Window Cues	Script
			hyperlinks to key citations, are all there. Now, let's get to the show. I'm pleased to introduce our team of instructors. Administrative Law Judges Roxanne Fuller from the Falls Church National Hearing Center and Jessica Inouye from the Evanston, Illinois Hearing Office; Administrative Appeals Judge Christopher Hargis; senior attorney advisor (b) (6) from the Columbus Ohio Hearing Office and attorney (b) (6) from the Office of the General Counsel.
Evaluating Opinion Evidence			**FULLER:** Today we examine a single topic – evaluating opinion evidence. We focus on this topic because it is so challenging, and so critical, to the disability determination. The April 2012 OCEP broadcast addressed the narrower topic of Medical Source Statements. But, a typical disability case includes opinions from many sources, and all must be considered. So today, we take a broader look at how to evaluate all opinion evidence.
			INOUYE: Our approach combines the academic and the practical. Most of you are well versed in the topic. So why do we devote a program to opinion evidence? Well, the law may be understood, but it's often misapplied. It may surprise you to learn that the top reason for remand is the failure to evaluate opinion evidence properly. Our presentation will first focus on the academic side – discussing the key regulations and Social Security Rulings (SSRs). Then we'll turn to the practical – showing you how to identify, weigh, explain and cite opinion evidence in your instructions and decisions.
			HARGIS:

Bookmark Title	Small Window Cues	Large Window Cues	Script
			As in all OCEP programs, we focus on several Key concepts. Today, the "Four Keys to Evaluating Opinion Evidence." They are:
The Four Keys		G2 Four Keys P P P P G3 Identify	**1 -- Identify opinion evidence from all sources in every decision** **2 -- Weigh the opinions by applying the specific factors in 20 CFR 404.1527, 416.927 and SSR 06-3p.** **3 -- Explain the weight given each opinion** **4 -- Cite specific evidence to support the weight given each opinion** **We can simplify the Four Keys even further. Four words summarize the evaluation of opinions: Identify, Weigh, Explain, and Cite.**
Key One			(b) (6) Let's briefly review the law on opinion evidence. It's old hat to most of you so we'll cover it quickly. But reviewing and reinforcing the basic law sets the stage for the practical discussion to follow. 20 CFR 404.1527 and 416.927, entitled "Evaluating opinion evidence," are your primary guides. The regulations for title II and title XVI contain identical language. Here's what they say: Medical opinions are statements from physicians and psychologists, or other acceptable medical sources that reflect judgments about the nature and severity of your

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			impairment(s), including your symptoms, diagnosis and prognosis, what you can still do despite impairment(s), and your physical or mental restrictions.
		G4 Acceptable P P P G5 Acceptable P P	(b) (6) : As a quick refresher, here is a summary list of acceptable medical sources. **You will find the full description in 20 CFR 404.1513(a) and 416.913(a).** • **Licensed physicians** • **Licensed or certified psychologists** • **Licensed optometrists for establishing visual disorders, with a limitation for cases in the Virgin Islands** • **Licensed podiatrists for establishing impairments of the foot, and, in some cases, the ankle, depending on the state licensing law** • **Qualified speech-language pathologists, for establishing speech or language impairments.**
			FULLER: In addition to medical opinions from acceptable medical sources, the regulations at 20 CFR 404.1513(d) and 416.913(d) say we may also consider evidence from other sources that reflect on severity of impairments and the effect on the individual's ability to function. Other sources for opinions may be medical or non-medical.

Bookmark Title	Small Window Cues	Large Window Cues	Script
			Medical sources include nurse practitioners, licensed clinical social workers, chiropractors, and others. Examples of non-medical sources are teachers, rehabilitation counselors, spouses, relatives, friends, and employers.
		G6	**Why do we distinguish between acceptable medical sources and other sources? For three reasons:**
		P	**1. Only evidence from an acceptable medical source can establish the EXISTENCE of a medically determinable impairment**
		P	**2. Only an acceptable medical source can render a MEDICAL OPINION, and**
		P	**3. Only an acceptable medical source can be a treating source whose opinion may be given controlling weight**
			The long and short of it is this: you must consider and evaluate all opinions, whether from acceptable medical sources or from other sources. And, you must explain how you considered and weighed the opinions in your decisions.
		G7	(b) (6) **: Here's a graphic representation of the key regulations and SSRs on opinion evidence.**
		P	**The regulations and SSR 06-3p are the most important and therefore shown at the top and bottom of the wheel.**
		P	**But the SSRs on the periphery are worth a brief mention.**
		G8 SSR 96-2p	**SSR 96-2p says when you may give controlling weight to a treating source medical opinion. The Ruling also**

Bookmark Title	Small Window Cues	Large Window Cues	Script
			details the articulation requirements for weighing opinion evidence.
		G9 SSR 96-5p P P P P P G10 SSR 96-6p G11 SSR 96-8p	(b) (7)(E) **:** **SSR 96-5p tells you how to address opinions on issues reserved to the Commissioner, such as:** • **Whether the individual is "disabled"** • **Whether the impairments meet or equal a Listing** • **What is the individual's residual functional capacity (RFC)** • **Whether the individual can do past relevant work or other work, and** • **How the vocational factors of age, education, and work experience apply.** Opinions on issues reserved to the Commissioner are not medical opinions and are not entitled to controlling weight or special significance. However, you cannot ignore these opinions simply because they are reserved to the Commissioner. We'll tell you how to evaluate them a bit later. **SSR 96-6p says the Administrative Law Judge (ALJ) decision must evaluate and weigh opinions by State agency consultants. It also describes the evidence we must have to make decisions based on medical equivalence.** **Finally, SSR 96-8p says if the RFC conflicts with an opinion from a medical source, the decision must explain why you did not adopt the opinion.**
			INOUYE: Here are a few tips and reminders:

Bookmark Title	Small Window Cues	Large Window Cues	Script
		G12 Make sure P P G13 Remember P P	**Make sure you distinguish between a sign and an opinion.** **A statement from the treating physician that the claimant walks with an unsteady gait is a sign, not an opinion.** **However, a doctor's statement that due to degenerative joint disease in the knees, the individual should not stand or walk more than four hours a day, is a medical opinion.** It addresses the nature and severity of the impairment and the resulting physical restrictions. **Remember, some state agencies rely on a single decisionmaker (or SDM) rather than a medical consultant, for the physical RFC evaluation.** **The finding of a single decision maker is not evidence at all**. We mention this because the Appeals Council still sees ALJ decisions referring to the SDM finding as a medical opinion. It's not. Do not weigh, or even reference, the SDM finding in your decisions.
		G14 G15	**FULLER:** The Agency has approved forms **HA-1151-BK for physical impairments and** **HA-1152 for mental impairments to solicit opinions from medical sources.** Make it your practice to include them, as appropriate, in a request for medical records. Remember to request them in consultative examinations, too.

Bookmark Title	Small Window Cues	Large Window Cues	Script
			It's easy to overlook an opinion when reviewing a file with hundreds of pages of medical records. So how can you guard against this? ALJs, here's a tip. At the start of every hearing, ask the representative to identify both medical and other opinions in the file by exhibit and page number. You have undoubtedly compiled such a list in your prehearing file review, but maybe you missed one, or the representative submitted one at the last minute. Recite the complete list of opinions into the hearing record and have the representative agree this is the complete list. Convey this list in your decision writing instructions. This short, simple step ensures you will not overlook an opinion in your decision.
			(b) (6) [redacted]: ALJs, you undoubtedly take notes on all the opinions in your prehearing review. Make sure you instruct the decision writer on the weight you give each and the reasons why. How you do this is completely a matter of personal preference but find a way to put it in one place in your instructions. This brings us to Key Two of the "Four Keys to Evaluating Opinion Evidence":
Key Two		G16	• **Weigh opinions by applying the specific factors set forth in 20 CFR 404.1527, 416.927 and SSR 06-3p.**
			(b) (6) [redacted]: We move now from identifying opinions to weighing opinions. We'll focus on formulating the RFC, but the same analysis applies when weighing medical opinions and other opinions at steps two and three of the sequential evaluation process.

Bookmark Title	Small Window Cues	Large Window Cues	Script
		G17 P P	For medical opinions from a treating medical source, you must first determine whether to give it controlling weight. We addressed this at length in our April 2012 broadcast, so we'll quickly review it now. The opinion must be: **1 -- Well-supported by medically acceptable clinical and laboratory diagnostic techniques, and** **2 -- Not inconsistent with the other substantial evidence in the record** So your first inquiry with a treating source's medical opinion is whether it is well-supported and consistent with the other evidence. If so, you give the opinion controlling weight.
		G18 P P P P P G19 P P P	**FULLER:** If you do not give the medical opinion controlling weight, then consider the opinion in light of the factors set out in the regulations. They are: • **Examining relationship** • **Treatment relationship. In this regard, consider:** o **the length of the treatment relationship** o **the frequency of examination, and** o **the nature and extent of the treatment relationship** • **Supportability** • **Consistency** • **Specialization, and**

Bookmark Title	Small Window Cues	Large Window Cues	Script
		P	• **Other factors, that tend to support or contradict the opinion**
			INOUYE: No one factor automatically gets more weight. It's easy to fall into bad habits if you forget this. A treating source opinion does not automatically trump an examining source. An examining source opinion does not automatically trump a nonexamining source. You weigh the opinion by evaluating it in light of the factors we just mentioned. Let's show how you might apply these factors to evaluate a medical opinion. We'll use a simple opinion and view it through the prism of each factor. Assume the claimant alleges impairments of lumbar disc disease and bilateral carpal tunnel syndrome. His primary care physician, Dr. Robert, says the claimant is limited to lifting 10 pounds; frequent reaching, handling, and fingering; and must briefly change position every hour. The file also includes all relevant medical evidence and opinions from medical and other sources. Since Dr. Robert is an acceptable medical source and also a treating source, first determine whether to give the opinion controlling weight. For purposes of this exercise, let's assume the opinion is not entitled to controlling weight.
			(b) (6) : Courts look closely at the weight assigned to treating source opinions given the close, ongoing relationship between doctor and patient. So use particular care when evaluating a treating source opinion. At the same time, our regulations

Bookmark Title	Small Window Cues	Large Window Cues	Script
		G20 [Here show a scale with two sides to hold the blocks we'll put on. Each block will have one word on it, e.g., Treating. Start out balanced and have the gauge arrow on the top move left or right as we add blocks]	require, and the courts regularly hold, a treating source's medical opinion is only entitled to controlling weight if the opinion is well-supported and not inconsistent with other substantial evidence. In all instances, your decision must articulate good reasons for the weight assigned a treating source opinion. Let's return to evaluating Dr. Robert's opinion in light of the regulatory factors. **We'll graphically depict the process of weighing an opinion and use the terms "Great" and "Little" on the scale for demonstrative purposes only. You're not required by the regulations to use these particular terms**.

Bookmark Title	Small Window Cues	Large Window Cues	Script
		P [Put block on right side of scale: Examining Relationship. Have scale move down on right and gauge point to "great"] P P [Put block on left side of scale that says Treating: length, frequency, nature and extent. Scale becomes balanced and gauge moves to middle.]	**HARGIS:** **The first factor we consider is examining relationship. In our example, Dr. Robert is the claimant's primary care physician and obviously an examining source. So this weighs in favor of the opinion.** **Next, consider the treating relationship. A treating source's medical opinion generally gets greater weight than an examining or nonexamining source. Dr. Robert is a treating source. Let's add another weight to the scale** The regulations require us to evaluate the treating relationship and examine the length, frequency, nature, and extent of treatment. The medical records show Dr. Robert has treated the claimant for 3 years. He sees the claimant once every 6 months, but the medical records show he has not been actively treating the back or hand conditions. He referred the claimant to a pain management specialist, Dr. Wu, who now treats and prescribes medication for the back condition. A surgeon performed carpal tunnel surgery and now treats the hand and wrist. **These facts tend to reduce the weight given based on a treating source relationship.**
			INOUYE: Supportability is our next factor. Supportability means the extent to which a medical source explains the reasons for the

Bookmark Title	Small Window Cues	Large Window Cues	Script
			opinion and the extent to which the evidence supports the opinion. Dr. Robert's records show that he examines, counsels and assists in the treatment of the claimant's impairments. His records include an MRI showing lumbar disc disease and an electodiagnostic test showing hand and abnormalities, His notes reflect physical examinations revealing signs consistent with back and hand limitations. Remember to cite specific evidence in your decision when discussing supportability. It's not enough to simply say the opinion is supported by the record. **Let's put this weight in favor of the opinion on the right side of the scale.**
		G21 P [Put block on right side: supportability. Have scale move to right toward Great]	
			FULLER: Now consider consistency. In addition to Dr. Robert's opinion, let's assume the file includes a medical opinion from a consultative examiner. The opinion finds functional limitations consistent with the full range of light work with an additional limitation of frequent handling and fingering. The file also includes an opinion from a pain management nurse practitioner saying the claimant can lift and carry 15-20 pounds. Although the nurse practitioner is not an acceptable medical source, the opinion is relevant on the key issues of impairment severity and functioning. Thus, Dr. Robert's opinion limiting the claimant to lifting no more than 10 pounds is not fully consistent with either the medical opinion from the CE or the opinion from the nurse practitioner. **Consistency is not a catch-all phrase. Your decision should not merely state an opinion is "consistent with the record as a whole" and entitled to great weight or is "inconsistent with the record as a whole" and entitled to**
		G22 Consistency	

Bookmark Title	Small Window Cues	Large Window Cues	Script
		G23 P [Put block on left side: Consistency. Move scale quite a bit so now left is lower than right and arrow points between center and "Little" weight.]	**little weight. Rather, the decision must specifically identify the other evidence that is consistent, or inconsistent, with the opinion.** **Do not neglect to consider the opinion in light of the claimant's statements, testimony, and activities of daily living.**
		P [Put block on right side: Specialization. Scale should now be weighed more heavily on left and arrow slightly moves toward "little" but is still between midpoint and little]	(b) (6) : **Next, consider specialization. Dr. Robert is a board certified internist but not an orthopedic or hand specialist. We'll add this weight to the left side**. Finally, consider other factors. The regulations give a few examples, including the medical source's understanding of our disability program. This factor typically applies to the opinion of a consultative examiner or Disability Determination Services reviewing doctor. Another example in the regulations is the extent to which the medical source is familiar with other information in the claimant's case record. This factor could apply to the opinion of a medical expert, but it could apply to other medical sources. In our example, these other factors do not apply to the opinion of Dr. Robert.
			FULLER: So there you have it. We weighed Dr. Robert's opinion in light of each regulatory factor. On first glance, it seemed we

Bookmark Title	Small Window Cues	Large Window Cues	Script
			might give great or even controlling weight based on the treating relationship. Applying all the factors, however, lessened the weight given. To demonstrate the evaluation process, we slowly addressed each factor to consider when weighing an opinion. Keep these factors foremost in mind as you evaluate an opinion. Reference these factors in your decision to justify the weight given the opinion. Even though you generally give more weight to a treating source opinion, it is not automatic. The other factors of supportability, consistency, specialization, and program knowledge may lead you to assign less weight to a treating source's medical opinion. The point is this: do not jump to a conclusion; weigh all the factors first.
		G24 Factors P P P P P P	**HARGIS:** Before we leave this topic, here is a list of the factors. Why not keep it nearby to jog your memory when you evaluate an opinion or write a decision: • **Examining relationship** • **Treatment relationship** • **Supportability** • **Consistency** • **Specialization, and** • **Other factors**
			INOUYE: Not all opinions are simple statements. SSR 96-5p notes that medical source statements may consist of multiple separate medical opinions regarding diverse physical and mental functions. You see this regularly. A typical medical source statement often is several pages long and includes opinions

Bookmark Title	Small Window Cues	Large Window Cues	Script
			on many limitations. You may accept some of these opinions and reject others. You may agree with the lifting and standing assessment, but not with the assessment regarding the use of hands for fingering and feeling. As you formulate the RFC, weigh the source statement using the factors from the regulations and explain why you accept or reject parts of medical source statement. For example, **suppose a claimant had carpal tunnel syndrome at the time the claimant's doctor completed a medical source statement, which included a limitation to only occasional fingering. Shortly thereafter, the claimant had successful surgery. It resolved all signs and symptoms of carpal tunnel syndrome up until the time of the hearing and decision.** **The decision should explain that the limitation in the medical source statement on fingering is no longer appropriate and, therefore given little weight**, (although the remainder of the doctor's opinion may still be sound.) This same analysis applies to State agency medical consultant opinions. It may be the case that the claimant has a new severe impairment at the time of your decision that the claimant did not have at the time the State agency reviewed the file. In this situation, it's appropriate to give weight to the parts of the opinion supported by the medical record and less weight to the parts of the opinion that are now obsolete.
		G25 P	
			(b) (6) [redacted]: So that covers medical opinions. What about other opinions? The regulations do not explicitly tell you how to consider opinions from other sources. However, SSR 06-3p lists the

Bookmark Title	Small Window Cues	Large Window Cues	Script
			factors to consider.
		G26	**Here's a graphic depiction of the factors to consider. In essence, they mirror the factors for weighing medical opinions. We apply the same general principles in evaluating and weighing any opinion, no matter the source.**
Key Three			(b) (6) :
			Now let's turn to articulating the weight given the opinions. We've reviewed what the law says about opinion evidence and how to evaluate and weigh it, but how do you do this in practice?
		G27 Key Three	This brings us to Key Three of the "Four Keys to Evaluating Opinion Evidence:"
			• **Explain the weight given each opinion**
			In essence, weighing an opinion is nothing more than determining, and then articulating, the degree to which the opinion influenced your ultimate decision on the claimant's limitations and abilities. Are there special or "approved" terms you should use in weighing an opinion?
		G28 Question	Let's pose the question to you in the audience.
			Which terms for assigning weight to an opinion appear in the regulations?
		P P P	**A. Great** **B. Little** **C. Controlling**

Bookmark Title	Small Window Cues	Large Window Cues	Script
		P P P	**D. All of the above** **E. None of the above** **The answer is C – controlling weight.**
		G29 P P P P P P P P	**INOUYE:** So, aside from the term "controlling" weight, the regulations do not tell you the terms to use when assigning weight. It's safe to say that most opinions are not entitled to controlling weight. So, if the regulations are silent, what terms should you use? There are no approved or certified terms of art recognized in the regulations, SSRs, or HALLEX. You are free to use any adjective that describes the weight given. **Common terms used include:** • **Great** • **Significant** • **Partial** • **Some** • **Little** • **Limited** • **Less (when comparing to another opinion)** Choose the appropriate term, of course, but devote your energy to the rationale. The rationale should tell the reader "why" you assigned the weight you did, by articulating the reason for the weight given and tying the reason to the evidence.
			(b) (6) **:** So let's focus on answering the "why" question. Be careful

Bookmark Title	Small Window Cues	Large Window Cues	Script
			here. It is not enough to give the opinion little weight because it's "inconsistent with the other evidence of record." You must tie this statement to the evidence and show how it is inconsistent. You cannot rely on boilerplate statements alone. Remember, every opinion stands on its own merits. One source does not trump another and no one factor trumps the other. In fact, SSR 06-3p says depending on the case facts and after applying the factors for weighing opinion evidence, you may give more weight to an opinion from someone who is not an acceptable medical source over one who is. You may find an opinion from a physician's assistant on the severity of the impairment or how it affects the ability to work carries more weight than the opinion from a doctor. A social worker's opinion may carry more weight than a psychologist's. For example, the source may have treated the claimant more often than another treating source, have greater knowledge of the claimant's functioning over time, or the opinion may be more consistent with the evidence as a whole.
			(b) (6) : The federal courts are strict about the evidence they will consider when reviewing a decision. The court looks at the rationale presented in the written decision; they do not go beyond this document. Even though there may be additional, important evidence in the record to support the ALJ's assessment of an opinion, if the written decision does not discuss it, the court generally will not consider it. When defending your cases in court, the Office of the General Counsel attorney is limited to the reasons offered by the ALJ in the decision. It's all the more reason you must include a specific rationale to support the weight given an opinion.

Bookmark Title	Small Window Cues	Large Window Cues	Script
			Let's go to a roundtable discussion of some common problems in drafting the opinion analysis.
			FULLER: Occasionally, I see a letter from a primary care physician outlining the diagnosis and treatment and offering the opinion that the claimant is disabled from all work. Sometimes, it's not in a letter but instead buried in the medical records. How should I treat this statement?
			INOUYE: This is a common issue and it's occasionally mishandled. Often, the representative will argue that since the opinion is from a treating source, The ALJ must give the opinion controlling weight. Here's how to address it. Whether it's in a standalone letter, medical source statement form, or buried in the medical records, the statement must be weighed and addressed in the decision. Remember, a statement that the claimant is disabled, even from a treating doctor, is not a medical opinion recognized under the regulations. Instead, it is an opinion reserved to the Commissioner because it would determine the outcome of the case. However, you cannot dismiss the opinion simply by saying it's an issue reserved to the Commissioner. You can note this in

Bookmark Title	Small Window Cues	Large Window Cues	Script
			the decision, but you must give other reasons for discounting the opinion. Consider the statement in light of all the regulatory factors and reference specifics in the evidence to support the weight given. Consider supportability and consistency. Do the doctor's records support the statement? If not, tell the reader why by citing to specific record entries. Is the statement consistent with other opinions? If not, identify the other opinions given greater weight. ALJs, help the decision writer by noting these specifics in your instructions. Decision writers, supplement the instructions with your own file review by looking for specific evidence to support the weight given.
			FULLER: Here's a twist on the first question. Suppose a treating source statement says the claimant's depressive disorder meets the requirements of listing 12.04 in the Listing of Impairments. Let's assume the evidence shows the opinion may be entitled to controlling weight. Can you give controlling weight to this opinion?
			HARGIS: The answer is no. Whether the impairment meets or equals a listing is also a decision reserved to the Commissioner, so you cannot give this opinion controlling weight. If the record includes an opinion from a medical source on an issue reserved to the Commissioner, weigh this as you would any opinion by applying the factors from the regulations.
			FULLER: Occasionally, I'll see a cursory medical opinion without a

Bookmark Title	Small Window Cues	Large Window Cues	Script
			function-by-function statement. For example, the opinion may simply say the claimant is limited to a sit-down job with an opportunity to change positions every half hour. The opinion is rather vague and non-specific. Can I discount it for this reason?
			INOUYE: No. The RFC finding should be a function-by-function assessment, but opinions from medical or other sources need not be. Remember, medical opinions are statements reflecting judgments about the nature and severity of the impairments and the physical or mental restrictions. SSR 06-3p says opinions from other sources may reflect judgments about some of the same issues addressed in medical opinions. The opinion need not include a function-by-function assessment so do not reject it for this reason. SSR 96-5p reminds us that only adjudicators, such as ALJs, determine an RFC. The RFC is a legal determination based on consideration of all evidence in the record. A medical source statement is an opinion based on the source's own knowledge. A medical source does not determine the claimant's RFC.
			FULLER: What about lay opinions from a spouse, parent, or close friend? Not only do these sources often have a close relationship to the claimant, they may stand to benefit if the ALJ finds the claimant disabled. Can we reject the opinion based on this relationship?
			HARGIS: No. SSR 96-5p says to evaluate this evidence by

Bookmark Title	Small Window Cues	Large Window Cues	Script
			considering such factors as the nature and extent of the relationship, whether the evidence is consistent with other evidence, and any other factors that support or refute the evidence. Certainly, the relationship is a factor to consider but it is not the only factor. Do not jump to a speculative conclusion. Do not impugn the integrity and credibility of the person giving the opinion simply based on the relationship to the claimant. In fact, the opportunity to see the claimant regularly may tend to support giving some weight to the opinion. Friends or family members may have special knowledge of the claimant with insight into the severity of the impairment. If you discount the opinion, avoid the temptation to dismiss it with a boilerplate conclusory statement such as "the opinion is given little weight due to the relationship between the source and the claimant" or "the opinion is not consistent with other evidence." Boilerplate statements are not enough. If the opinion is not consistent with the evidence, tell us what in the record is inconsistent. Stock or boilerplate statements without specific record references are conclusions without explanation. When weighing an opinion you must answer the question "why?" The lack of explanation is a red flag begging for a remand.
			FULLER: How do we consider disability decisions made by other governmental agencies, such as the Department of Veteran's Affairs (VA)?
			INOUYE: Well, VA decisions are not binding on social security, but you cannot ignore them. You must explain in the decision how you considered disability decisions by other agencies. The VA has its own disability rules and its decision generally has limited evidentiary value without considering the supporting

Bookmark Title	Small Window Cues	Large Window Cues	Script
		G30 P P P P	evidence on which the rating is based. Be careful. If you reject the VA decision, it's not enough to say it's because the VA relies on a different standard. This is not a reasoned explanation. A more detailed explanation of how to evaluate evidence from the VA is contained in Administrative Message (AM)-14009. If you discount the decision, AM-14009 says the rationale might include: • **a discussion of evidence inconsistent with the VA disability decision and not considered by the VA** • **a finding that the VA relied on subjective complaints found not credible by the ALJ** • **the VA decision is premised on invalid examination results or a medical opinion found entitled to less weight by the ALJ, or** • **the ALJ views the evidence differently than the VA.**
			FULLER: Here's an issue we see in almost every case. The medical source statement is three or four pages long with a combination of checkboxes and narrative completed by the source. For example, the report conveys through check box ratings that the claimant has limitations consistent with a sedentary RFC. The last page says the claimant will miss 4 days of work per month and be off-task 20% of the time. Can I accept only part of the opinion and how should I address it in the decision?

Bookmark Title	Small Window Cues	Large Window Cues	Script
		G31 P P P G32 P P	**HARGIS:** Yes, you can – and you should. Be clear in the decision writing instructions and decision. Identify what part of the opinion you accept and explain why; do the same for the part you find unpersuasive. If the opinion says the claimant will miss work or be off task an unacceptable amount of time, decide if the record supports such a finding. Specifically, you might consider: • **Whether the medical records show the claimant complains of memory or concentration problems** • **Medical treatment for concentration, memory, or related issues** • **Findings on concentration and memory in mental status examinations by consultative examiners and mental health providers** • **The effect of pain and treatment on functioning** • **Activities of daily living, including hobbies and reading** • **Whether the opinion is based on the claimant's self-report** This should help you determine whether the evidence supports this part of the opinion. Make sure you include it in the instructions and decision.
			FULLER: What about Global Assessment of Functioning, or GAF, scores.

Bookmark Title	Small Window Cues	Large Window Cues	Script
			Are they opinions and how should they be addressed?
			INOUYE: Yes, a GAF rating is an opinion. AM-13066 REVISED gives detailed guidance on how to evaluate it. The most recent revision to the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, (DSM- 5) published in 2013, does not include GAF ratings for the assessment of mental disorders. So, they pop up less frequently these days. But, here's how to address them. A GAF rating is essentially a snapshot opinion about the individual's level of functioning. Unless the clinician explains the reasons behind the rating and the period to which it applies, the GAF score does not give a reliable longitudinal picture of mental functioning. You should not rely on GAF evidence as the primary support for findings of impairment severity or mental limitations. Despite these drawbacks, the GAF rating reflects a snapshot of the claimant's functioning. Many files will have multiple GAF scores taken over a period. There is no need to assess and weigh each GAF score in your decision. Read them in context and over time and address how they reflect the individual's functioning over the period under review. Do not simply use a boilerplate general statement to dismiss their importance.
			FULLER: What about workers compensation related records? They may contain multiple opinions on the nature and extent of a particular disability.

Bookmark Title	Small Window Cues	Large Window Cues	Script
			Should I separately identify and address each one?
			HARGIS: You might approach these opinions as you do GAF ratings. Group them together to show the general trend or pattern. Then explain how they fit with the other opinions and medical evidence.
			FULLER: We see this regularly. An opinion form completed and signed by a social worker, who is NOT an acceptable medical source, countersigned by a doctor, who IS an acceptable medical source. Does this render the opinion a medical source statement from a treating source?
			INOUYE: It depends. If the doctor had a role in the care or evaluation of the claimant, whether alone or as part of an interdisciplinary team, then it's a treating source opinion. If the doctor had no role in care or evaluation, and merely co-signed the opinion, it's not a treating source opinion. Examine the record and testimony to determine the relationship with the claimant. Remember, the extent and frequency of the treatment by the doctor is important in assessing how much weight to give the opinion.
		CG-L3 CG-L3 CG-L3	**FULLER:** Psychological evaluations occasionally include a **Patient Health Questionnaire (or PHQ9)** score, a **Generalized Anxiety Disorder Screener (or GAD-7)** score, or a **World Health Organization Disability Assessment**

Bookmark Title	Small Window Cues	Large Window Cues	Script
			Score (or WHODAS). Some representatives argue that I should give these scores great weight. Are the scores opinion evidence?
			HARGIS: NO. They are not opinions. All three are self-report measures from the patient. Each is a simple questionnaire completed by the patient to help the clinician diagnose and treat mental disorders. Since they are self-report measures, they are not medical opinions and should not be evaluated or weighed as opinions. Administrative Message AM-14025 specifically addresses the WHODAS but the principles apply to all three reports. You should consider these reports along with all other evidence as part of the evaluation of symptoms. But, do not consider them opinion evidence.
			FULLER: How should I deal with this situation? Medical records often include an entry in the patient history such as “patient cannot work due to back pain” or “patient is disabled.” Sometimes the medical record includes a form asking the patient’s employment status and the entry reads “disabled.” Are these statements opinions we must weigh?
			INOUYE: It depends on the context, but for these examples, the answer is almost certainly NO, they are not medical source opinions. They are self-reports from the claimant. If you find the context shows it to be an opinion from the medical source, weigh it as you would any statement on issues reserved to the Commissioner.

Bookmark Title	Small Window Cues	Large Window Cues	Script
			FULLER: Suppose a claimant sees a surgeon for consultation and the surgeon includes an opinion on the claimant's physical limitation in the examination note. Is this a treating source opinion?
			HARGIS: No, the surgeon has not treated the claimant at this point, so it is not a treating source opinion.
			(b) (6) **:** An issue we see occasionally in court appeals is the insertion of personal views when weighing opinion evidence. It may be tempting – but don't go there. Here is an example from a recent ALJ decision and the district court's reaction. The ALJ gave little weight to a treating physician opinion and referred in the decision to "over-prescribing of medication" by the physician. To top it off, the decision said, "no doubt that the claimant's pain medications 'help', as she is taking more narcotics than most people who are in immediate recovery from surgery." The court took a dim view of this rationale, finding no medical evidence to support the conclusion and stating, "the ALJ's comments to that effect are gratuitous and wholly without merit." The ALJ decision went on to find "no rational basis" for the claimant's use of a cane, leaving open, in the court's view, the suggestion that she used it as a theatrical prop to visually support her disability. Again, the court held the finding unsupported by the evidence. In fact, the record showed the treating physician prescribed the cane due to the claimant's frequent falls.

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			Finally, the ALJ decision questioned the claimant's "alleged" need for special orthopedic shoes, especially since she did not wear them to the hearing. This despite the claimant's testimony that her podiatrist told her not to wear the shoes while wearing a brace for a recent ankle sprain. As you can imagine, the court gave short shrift to the ALJ finding, and ultimately to the decision finding the claimant not disabled. So what's the lesson? Do not speculate and do not inject your personal views when weighing opinions from medical or other sources. Make sure the evidence supports the reasons you give for the conclusions you reach.
Key Four		G33	(b) (6) : Let's turn now from our tips on weighing opinions and look at how to incorporate this information into a persuasive decision. This brings us to Key Four of the "Four Keys to Evaluating Opinion Evidence": • **Cite specific evidence to support the weight given each opinion** Simply stated, the key to a persuasive decision is the analysis, not the summary, of the evidence. It's tempting to spend more time and energy on the factual summary. It comes first in the Findings Integrated Template (or FIT) and the recitation helps shape the analysis to follow. But remember, the critical part of the decision is the analysis, not the factual summary. Focus your attention and energy there.
			(b) (6) :

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			This is an issue seen frequently in federal court appeals: summarizing the opinion evidence but not evaluating it. It is not enough to recite the opinions regarding a claimant's functional limitations without linking them to your assessment of the evidence and explaining how the evidence supports your conclusion. Your analysis should identify specific evidence that supports the weight assigned to each opinion, and explain how that evidence undermines or supports the functional assessment presented by each source.
			(b) (6) [redacted]: The regulations do not require a lengthy factual summary. But they do require an analysis of the evidence and support for the findings in your decision. How do you do this? First, make sure you avoid writer fatigue. Here is what we mean. Many files are complicated, with multiple impairments and voluminous medical records. If you spend an inordinate time summarizing the evidence in your decision, you leave the hard part for the end. Writer fatigue sets in and you push to finish the decision and move on to the next case. At this point, it's natural to reach for boilerplate or canned language to justify the weight given an opinion, without citing specific evidence to support the conclusion. For example, the decision will give little weight to an opinion because it, "is not supported by objective medical evidence and the other evidence of record." Period. The discussion ends there. Now, the statement is fine as far as it goes. It introduces the reason for rejecting the opinion. But you need more. A few sentences identifying the specific evidence relied upon and showing how it conflicts with the opinion should be enough to support the statement. How do you avoid writer fatigue? For some, it may be enough to recognize it and remember not to rely on boilerplate. For

Bookmark Title	Small Window Cues	Large Window Cues	Script
			others, it may be more efficient to identify and write the opinion evaluation first, then go back and complete the evidence summary. Or, start with a cursory record summary, address the opinions, and then return to complete the summary. It may also help to vary your approach from case to case to stay fresh and engaged.
			FULLER: ALJs, your instructions should identify all the opinions in the record. Remember our earlier tip about having the representative identify all opinion evidence at the outset of the hearing. This complements your file review and ensures you do not miss any opinions. Include the list in your instructions, then discuss the weight given each opinion and the evidence relied upon. The decision writer's independent file review should augment and amplify this in the decision. Here's another tip for decision writers. Start the factual summary with a brief overview of the event or situation that led the claimant to file for benefits. For example, it may be a work injury, motor vehicle accident or the onset of the psychological condition. Not all cases fit so neatly into these categories, but many do. The idea is to set the stage – tell the reader why the claimant filed for disability. Give the reader the context and identify the allegations. Then spend more time focused on persuasive legal analysis to support the findings.
			(b) (6) [redacted]: Save yourself time and keystrokes. Do not repeat an analysis once given. Simply incorporate well-supported findings from one part of a decision to another. Here is an example. We exaggerate the facts a bit to make the point clear. Assume the claimant alleges an inability to use either

Bookmark Title	Small Window Cues	Large Window Cues	Script
			hand due to carpal tunnel syndrome. Shortly after the alleged onset date, the claimant has carpal tunnel release surgery. Two months later, she reports to the surgeon that the symptoms have completely resolved. Now it gets interesting. At the hearing, the claimant testifies to continued inability to use either hand. A medical source statement from the primary care physician says no use of the hands bilaterally. But, the doctor's medical records show all medical treatment following the surgery focused on a separate impairment. The doctor's records include a passing reference to the claimant enjoying knitting and needlepoint. In this example, use the same analysis to discount the claimant's testimony and to show why you give little weight to the physician's opinion.
			INOUYE: Be careful not to discount an opinion simply because it does not perfectly match the RFC. The opinion may actually lend support to the decision. Here's what we mean. Let's say the ALJ finds the claimant as the RFC to do light exertional work. However, additional, non-exertional limitations lead to a finding the claimant is disabled. Suppose a treating doctor's medical source opinion is consistent with finding the claimant can do no more than sedentary work. The treating source obviously found significant limitations and the opinion is otherwise consistent with a finding of disability. It makes little sense to give this opinion little weight and analyze it at length. Instead, cite the opinion and show how it is consistent with the finding of disability. Again, we used a simple example, but the situation arises often, and the principle applies to both favorable and unfavorable decisions.
			(b) (6)

Bookmark Title	Small Window Cues	Large Window Cues	Script
			Let's conclude our discussion with an illustration. We'll start with an excerpt from an ALJ decision. I considered the opinion from Dr. Smith (Ex. 18F), but give it little weight. The opinion is unsupported by the record as a whole, and inconsistent with his contemporaneous treatment notes. You can see why this is inadequate. The decision uses only boilerplate, stock phrases to reject the opinion. It lacks any reference to the record to explain the weight given the opinion.
		G34 G35	**HARGIS:** Here's how to fix it: **I give little weight to the opinion of Dr. Smith (Ex. 18F). The opinion is unsupported by the record as a whole, and inconsistent with his contemporaneous treatment notes. As noted earlier, the claimant's objective exams are routinely normal (e.g. Ex 16F/2), he has only required conservative care (e.g. Ex 12F, p.18), and he has experienced significant symptom improvement with treatment (e.g. Ex 19F, p.5).** **Dr. Smith's treatment notes document reports of minimal pain and improvement with treatment, and do not document findings to support the limitations in Dr. Smith's opinion (Ex 15F). Moreover, as discussed above, the claimant admits to abilities exceeding the limitations Dr. Smith assessed (Ex. 3E and Hearing Testimony).**
			INOUYE: Do you see what we did? Both examples began the same.

Bookmark Title	Small Window Cues	Large Window Cues	Script
			But, the second example explained why the ALJ gave the opinion little weight by referencing the factors of supportability and consistency and citing specific evidence from the record. The analysis is easy to follow and persuasively written. A few short sentences was all it took. A boilerplate phrase is fine to introduce the factor you considered when weighing the opinion. Just make sure you back it up by citing to the evidence. Now let's return to Judge Costello for our final thoughts.
		G36 P P P P	**COSTELLO:** Thank you for your attention today. We hope the program gave you the chance to step back and reflect on how you evaluate opinion evidence in your deliberations and decisions. I leave you with the "Four Keys to Evaluating Opinion Evidence": **1 -- Identify opinion evidence from all sources** **2 -- Weigh opinions by applying the specific factors in 20 CFR 404.1527, 416.927, and SSR 06-3p.** **3 -- Explain the weight given each opinion** **4 -- Cite specific evidence to support the weight given each opinion.**

ODAR Continuing Education Program
A Quarterly IVT
QuickNotes
Opinion Evidence
April 2016

Quick Note #1: The purpose

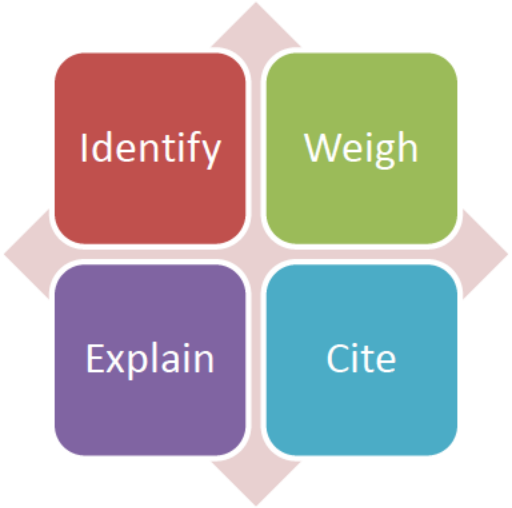
We use medical and other evidence to reach conclusions about an individual's impairment(s) when making a disability determination or decision as described in 20 CFR 404.1512, 404.1513, 416.912, and 416.913. In accordance with sections 223(d)(5) and 1614(a)(3)(H) of the Act, when we make a determination or decision of disability, we will consider all of the available evidence in the individual's case record. This includes, but is not limited to, objective medical evidence; other evidence from medical sources, including their opinions; statements by the individual and others about the impairment(s) and how it affects the individual's functioning; information from other "non-medical sources," and decisions by other governmental and nongovernmental agencies about whether an individual is disabled or blind.

See 20 CFR 404.1512, 416.912, and Social Security Ruling (SSR) 06-3p

Quick Note #2:

FOUR KEYS To Evaluating Opinion Evidence

1. Identify opinion evidence from all sources in every decision
2. Weigh opinions by applying the specific factors in 20 CFR 404.1527, 416.927, and SSR 06-3p
3. Explain the weight given each opinion
4. Cite specific evidence to support the weight given each opinion



Quick Note #3: How we define "opinion evidence" from acceptable medical sources

Medical opinions are statements from physicians and psychologists, or other acceptable medical sources that reflect judgments about the nature and severity of your impairment(s), including your symptoms, diagnosis, and prognosis, what you can still do despite your impairment(s), and your physical or mental restrictions. Here is a summary list of acceptable medical sources:

- Licensed physicians
- Licensed or certified psychologists
- Licensed optometrists for establishing visual disorders only, with a limitation for cases in the Virgin Islands
- Licensed podiatrists for establishing impairments of the foot, and in some cases the ankle, depending on the state licensing provisions
- Qualified speech-language pathologists, for establishing speech or language impairments

See 20 CFR 404.1513(a), 416.913(a), and SSR 06-3p.

Quick Note #4: Consider opinions from other medical or non-medical sources

SSR 06-3p gives specific guidance. Examples of other medical sources include nurse practitioners, licensed social workers, or chiropractors. Examples of non-medical sources are teachers, rehabilitation counselors, spouses, relatives, friends, and employers.

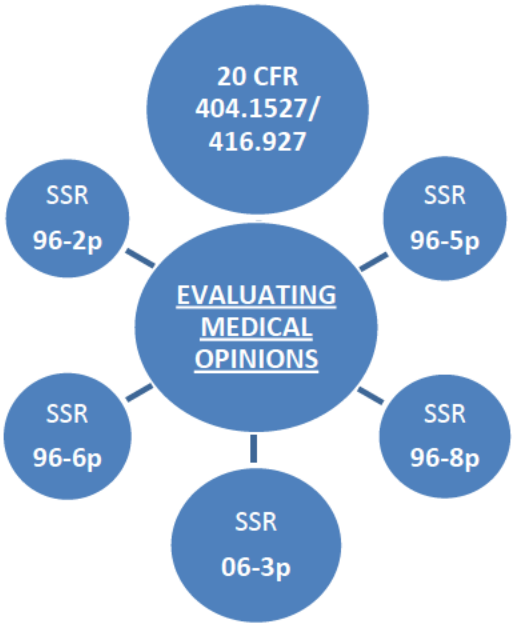
See 20 CFR 404.1513(d) and 416.913(d).

Quick Note #5: What are important distinctions between acceptable medical sources and "other sources?"

Only an acceptable medical source can:

- Provide evidence that establishes the existence of a medically determinable impairment,
- Render a medical opinion, and
- Render a medical opinion given "controlling weight" if the acceptable medical source is also a treating source

See SSR 96-2p.



Quick Note #6: SSRs that address opinion evidence

- SSR 96-2p says when you may give controlling weight to a treating source medical opinion
- SSR 96-5p tells you how to address opinions on issues reserved to the Commissioner
- SSR 96-6p says that the Administrative Law Judge (ALJ) decision must explain the weight given to opinions by State agency consultants
- SSR 96-8p says if the residual functional capacity (RFC) conflicts with an opinion from a medical source, the decision must explain why the medical source opinion was not adopted

Quick Note #7: Medical opinions vs. clinical findings

Note the difference between the two. A statement from the treating physician that a claimant walks with an antalgic gait is a clinical observation, not an opinion. However, that same physician's assessment that degenerative joint disease in the knees limits a claimant to standing or walking no more than four hours a day is a medical opinion.

Quick Note #8: Single decisionmakers

Remember that some State agencies continue to rely on single decisionmakers (SDM) rather than medical consultants for the RFC evaluation. Findings of a SDM do not constitute a medical opinion or

other opinion and should not be addressed in decisions.

Quick Note #9: Tips for ALJs

To help avoid missing an opinion of record, ask the representative at the beginning of the hearing to identify all of the medical and non-medical opinions. In addition, your instructions to the decision writer should identify all of the opinions of record, the weight given, and why.

Quick Note #10: Ways by which we weigh opinions

The factors to consider when weighing medical opinions are:

- Examining relationship
- Treatment relationship
- Supportability
- Consistency
- Specialization
- Other factors that tend to support or contradict the opinion

Remember, the regulations do not create a "hierarchy" with treating and examining relationships automatically on top. Depending on the specific details of the case, other factors may lead you to assign lesser weight to a treating source opinion.

Quick Note #11: Assigning weight

You may accept part and reject part of a medical opinion. Give greater weight to parts of an opinion supported by the evidence, with an explanation. Assign less weight to parts of the medical opinion that are unsupported by the record, with an explanation.

Quick Note #12: Providing an adequate explanation

Weighing an opinion requires you to determine and articulate the degree to which the opinion influenced your decision regarding the claimant's limitations and capabilities.

Avoid canned language without further analysis. It is not enough to give an opinion little weight and state, "it is inconsistent with the overall evidence of record." You must explain by tying this statement to the evidence and show how it is inconsistent. This will make your decision legally defensible.

On appeal, the Office of the General Counsel attorney is limited to the reasons offered by the ALJ in the decision. Therefore, you must thoroughly articulate the rationale in support of the weight assigned to an opinion.

Quick Note #13: Other than "controlling weight," the regulations do not specify how an adjudicator can or should articulate the weight given to an opinion. There are no magic words.

A treating medical source opinion will only receive controlling weight if it is well supported by medically acceptable clinical and laboratory diagnostic techniques and not inconsistent with the other substantial evidence in the record.

Quick Note #14: Common errors

1. Assigning controlling weight or giving special significance to a medical source opinion that states a claimant is disabled. Remember, this is a finding reserved to the Commissioner because it is dispositive of the case.

2. Assigning controlling weight to a treating medical source that opines a claimant meets a listing. Whether the severity of an impairment meets or equals a listing is also a decision reserved to the Commissioner. Thus, you cannot give the opinion controlling weight. However, you should evaluate and weigh the opinion in light of the factors for weighing opinions.

3. Not addressing medical and non-medical opinions because they are not articulated in a function-by-function fashion.

4. Rejecting a lay opinion from a spouse, parent, or close friend with a conclusory statement and no analysis. Weigh such lay opinions by applying the factors discussed earlier.

5. Disregarding disability determinations by other governmental agencies. These determinations are not binding on Social Security but you must explain how you considered disability decisions by other agencies. Consult the Administrative Message (AM) 14009 and Social Security Ruling 96-5p.

6. Failing to address Global Assessment of Functioning (GAF) scores. Consult AM-13066 REV, which provides

detailed guidance on how to evaluate GAF scores. There is no need to assess and weigh each GAF score in your decision, but assess them in context and over time. Doing so will give you an idea of the claimant's overall functioning during the relevant period.

7. Ignoring workers' compensation related functional assessments. Approach your analysis as you would with GAF scores.

8. Playing doctor or relying on your personal experience. Do not substitute your judgment for a competent medical opinion.

Quick Note #15: Make sure your writing is persuasive

The key to a persuasive decision is the analysis, not the summary of the evidence. It is never enough to recite the opinions regarding a claimant's functional limitations without linking them to the residual functional capacity assessment and explaining how the evidence supports the findings. Remember that if you use boilerplate language it should only be used to introduce the analysis; it is not a substitute for analysis.

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IVT Air Date: Enter a date here.	**VOD Date:** Enter a date here.	**EWD Date (VOD Techs Only):** Enter a date here.
Producer(s): (b) (6) [redacted]		
Client(s): ODAR		
SME(s) Judge John Costello		
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Bookmark Title	Small Window Cues	Large Window Cues	Script
Introduction		G1 Title Slide **Christopher Dillon**, Deputy Chief Administrative Law Judge	DILLON: I'm Deputy Chief Administrative Law Judge Christopher Dillon. Welcome to today's OCEP presentation, "Evaluation of Medical Evidence: A Guide to the Revised Rules." Today's topic is a timely one. Most of the regulatory revisions are effective with disability claims filed on or after March 27, 2017. As a result, we have many cases at the hearing level that fall under the revised rules. It's critically important that we understand the revisions and apply them correctly. Today's presentation includes an in depth analysis and practical advice about these comprehensive changes to our regulations. Now let me turn to Judge John Costello who will introduce today's presenters. Judge Costello . . .
		John Costello, Administrative Law Judge	COSTELLO: Thanks Judge Dillon. As we broadcast today, the baseball World Series is just around the corner. So let's start with a baseball story. Longtime fans will remember this former star – Jose Canseco. Colorful player, fearsome hitter, armchair philosopher. In his prime, he may have been the best hitter in baseball. In the course of an interview, a writer once

Bookmark Title	Small Window Cues	Large Window Cues	Script
		Caroline Siderius Administrative Law Judge **Joel Krafsur** Administrative Appeals Judge (b) (6) Senior Attorney Advisor (b) (6) Attorney, OGC	asked him, "What's the key to hitting?" "See the ball, hit the ball," Canseco replied. Now, I'm not sure if Canseco coined the phrase, or Pete Rose, or Chevy Chase in the movie "Caddyshack" but the point is this – understand the essence and you understand the subject. This is our approach today – to accurately and concisely explain the revisions in a way that is useful to you, and do so in less than an hour. Here's how we'll do it. We'll start with a bit of history to show why we revised the regulations and to put the changes in context. We'll then point out the major revisions, followed by an in-depth discussion of the changes that will most affect you at the hearings and appeals levels. We'll narrow the discussion further to concentrate on the most important change – how to evaluate medical opinion evidence. We'll conclude with examples showing you how to put the changes into action, in your written instructions and decisions. We have an outstanding team of instructors today. I'm pleased to introduce Administrative Law Judge Caroline Siderius from the Spokane hearing office, Administrative Appeals Judge Joel Krafsur, Senior Attorney Advisor (b) (6) (b) (6) from the West Des Moines hearing office and attorney (b) (6) from the Office of the General Counsel. Judge Siderius –
Sets of Rules			SIDERIUS:

Bookmark Title	Small Window Cues	Large Window Cues	Script
			Let me start with a word on terminology. There are now two different sets of rules to follow, depending on the filing date for the claim.
		G2	**Claims filed before March 27, 2017 follow what we will call the "prior rules." Claims filed on or after March 27, 2017 follow what we will call the "current rules."**
			These are the terms used in our program instructions and we'll use them throughout this broadcast.
		G3 P	**The regulations include both sets of rules. You'll find the prior rules for evaluating medical opinion evidence principally at 20 C.F.R. 404.1527 and 416.927;**
		P	**You'll find the current rules principally at 20 C.F.R. 404.1520c and 416.920c.**
			It's distracting to continually cite legal authority, so we'll limit further references. The current rules apply to adjudication at all levels of the administrative process.
			The adjudicators at the hearing level are ALJs and senior attorney advisors, and at the Appeals Council level they are administrative appeals judges (AAJs). We'll use the term ALJ instead of adjudicator throughout this program, but the instructions also apply to senior attorney advisors and AAJs.
			As always, we focus the discussion on several key concepts. Today – the "Five Keys to Evaluating Medical Evidence under the Current Rules."
		G4 P	**They are:** 1. **The Current Rules Reorganize and Clarify Our Evidence Regulations and Reflect Changes in The Way Individuals Receive Medical Care**

Bookmark Title	Small Window Cues	Large Window Cues	Script
		P P G5 P P	**2. The ALJ Decision Must Evaluate and Discuss the Persuasiveness of Medical Opinion Evidence from Medical Sources** **3. Supportability and Consistency Are the Most Important Factors For Evaluating the Persuasiveness of Medical Opinion Evidence. The ALJ Decision Must Address These Two Factors When Evaluating the Persuasiveness of Medical Opinion Evidence** **4. The ALJ Decision Must Not Provide an Analysis of Decisions by Other Governmental Agencies or Non-Governmental Entities, Disability Examiner Findings, or Statements on Issues Reserved To The Commissioner** **5. Put the Principles Into Practice: Concisely Articulate the Persuasiveness of All Medical Opinions by Citing Specific Evidence in the Record**
Key One		G6 P P P	(b) (6) [redacted]: **Let's begin our analysis with Key One –** **The Current Rules reorganize and clarify our evidence regulations for ease of use. They also:** ▪ **Redefine several key terms** ▪ **Revise our list of acceptable medical sources (AMS)** ▪ **Revise how we consider and articulate our consideration of medical opinions and prior administrative medical findings** ▪ **Revise who can be a medical consultant (MC) and psychological consultant (PC), and** ▪ **Revise our rules about treating sources.**

Bookmark Title	Small Window Cues	Large Window Cues	Script
		P P P	The current rules also conform our rules to the requirements of the Bipartisan Budget Act of 2015, reflect changes in the national healthcare workforce and in the manner that individuals receive primary medical care, emphasize the need for objective medical evidence in disability and blindness claims, and allow us to continue to make accurate and consistent decisions.
			(b) (6) : You may be wondering - why so many changes? Well, before the Medical Evidence final rules, we had not made comprehensive changes to our evidence regulations since 1991. Much of the terminology and organization of our rules remained the same as when we adopted them in 1991. Since we first adopted the "treating source rule" in 1991, the healthcare delivery system changed in significant ways, so we revised our rules to reflect this reality. Today, many people receive health care from multiple medical sources instead of one treating source. Patients less frequently develop a sustained relationship with one treating physician. In fact, many of the medical sources who evaluate, examine, or treat patients do not even qualify as "treating sources" under the prior rules because they are not AMSs. Nurse Practitioners are a good example. The current rules recognize these changes in healthcare delivery.
			KRAFSUR: The final rules also reflect our adjudicative experience, legal precedents, and recommendations from the Administrative Conference of the United States (ACUS).

Bookmark Title	Small Window Cues	Large Window Cues	Script
			For example, our experience applying the "treating source rule" shows that when Federal courts apply our prior rules, they tend to focus more on the quality of an ALJ's articulation in evaluating a treating source's opinion and less on whether substantial evidence supports the decision. What's more, the complexity of the "treating source rule," including the articulation requirements, caused the rule to be one of the most common causes of federal court remands in our disability litigation cases.
		G7	**In 2013, ACUS studied SSA's experience applying the treating source rule and recommended that we revise our regulations to eliminate the controlling weight aspect of the rule in favor of a more flexible approach that gives adjudicators greater discretion.**
		G8	**ACUS also recommended that we consider expanding our list of AMSs to include additional medical sources like nurse practitioners and physician assistants, to reflect today's healthcare system.**
			SIDERIUS:
			With this backdrop, we made comprehensive revisions to our rules about medical evidence in disability claims. In particular, we revised our rules to move away from assigning a specific weight to medical opinions and to clarify that adjudicators should focus on how PERSUASIVE they find all medical opinions and prior administrative medical findings in the case record.
		G9	**We also expanded the list of AMSs to include licensed advanced practice registered nurses, physician assistants, and licensed audiologists for impairments of**

Bookmark Title	Small Window Cues	Large Window Cues	Script
			hearing loss, auditory processing disorders, and balance disorders. You may be wondering why there are different rules for evaluating medical opinion evidence based on the filing date of the claim. The answer is that we adopted a different implementation process than usual for this regulation. The current rules recognize that some claimants with pending claims may have requested and obtained treating and other medical source opinions based on our prior regulations. In light of this, we continued our prior rules on evaluating opinion evidence, including the rule on giving controlling weight to treating source opinions, for those claims filed before March 27, 2017. Generally, use the prior rules for claims filed before March 27, 2017 and use the current rules for claims filed on or after that date. By filing date, we generally mean the protective filing date, if there is one.
		G10	(b) (6) : Of course, nothing is ever simple and neither are filing date scenarios. A claimant may have concurrent claims with different filing dates, or a claimant may be undergoing a continuing disability review (CDR), or have some other situation where the proper rule to apply is not obvious. You'll find complete guidance for determining the filing date for evaluating evidence in the Program Operation Systems Manual (POMS) at DI 24503.050.

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		P P P G11 P P P P	**Here are common filing date scenarios and the proper rules to apply:** - **For concurrent claims, generally use the earliest possible filing date to determine which rule to follow.** - **For example, if the Title II claim filing date is February 15, 2017 and the Title XVI filing date is April 2, 2017 use the February 15 filing date and decide both claims using the prior rules.** - **For reopening, if you reopen a prior claim, use the original filing date of the earlier claim to determine which rule to follow for the reopened claim.** Thus, if you reopen a prior claim and consolidate it with a subsequent application, use the filing date of the reopened claim to determine which rule to follow. For CDRs, the current rules apply in most cases, with one exception. **The exception is a bit wordy but here it is.** **Use the prior rules if all the following apply:** **(1) This is the first CDR for the claim after March 27, 2017; and,** **(2) There is no medical improvement related to the ability to work; and**

Bookmark Title	Small Window Cues	Large Window Cues	Script
		P	**(3) All full medical determination(s) made in the claim(s) under review were made using the prior rules.** **For age 18 redeterminations, use the date the claimant attained age 18 as the filing date.**
		G12 P P P P P P P *Screen Shots G13 P	KRAFSUR: Now let's see how well you've learned the concept. **Assume a claim for Title II disability benefits, filed in April 2015 has been remanded and consolidated with a subsequent application filed in June 2017.** **Which rules apply to the claims?** **A. The current rules** **B. The prior rules** **C. The prior rules for the remanded claim; the current rules for the subsequent application** **D. Never mind the rules.** **The correct answer is B.** The prior rules apply to both claims. Use the earliest possible filing date to determine which rules apply. In this case, since the prior application was filed before March 27, 2017, the prior rules apply to both claims. **Here's a quick way to know which rule applies.** **An indicator "MEDEV" in the upper right hand corner of eView shows whether the Disability Determination Services (DDS) used the "current rules" or "prior rules." It's not fool proof, but it should be an accurate guide, particularly in the more complicated scenarios we just discussed.**

Bookmark Title	Small Window Cues	Large Window Cues	Script
			(b) (6) : The main differences between the prior rules and the current rules involves the list of AMSs, which we will discuss later, and how we evaluate medical opinion evidence. For claims filed before March 27, 2017, you should continue to weigh all medical opinions, and when appropriate, give controlling weight to treating source opinions. We also rescinded four Social Security Rulings (SSRs) because they were inconsistent with or duplicative of the Medical Evidence final rules.
		L3: SSR 96-2p, 96-5p, 06-3p rescinded 3/27/17	**Three of these SSRs,** 96-2p, 96-5p **and** 06-3p **were rescinded effective March 27, 2017, but we revised the regulations to include the main the policy content of these SSRs.** Do NOT cite these SSRs in your decisions anymore; cite the regulations instead. Our hearing level decision-writing template should take care of this, but double check to make sure you are not citing the rescinded SSRs in your decisions.
		L3: 20 C.F.R. 404.1527 and 416.927, not SSR 06-3p	Here's an example. If you are adjudicating a claim filed before March 27, 2017 that involves an opinion from a medical source who does not qualify as an AMS. **You should consider the opinion under paragraph (f) of 20 C.F.R.** 404.1527 **and** 416.927, **not SSR** 06-3p. The Medical Evidence final rules added Paragraph (f). It reflects some of the guidance previously found in SSR 06-3p and explains how we consider opinions from medical

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			sources who are not AMSs in claims filed before March 27, 2017. Cite the regulation, not the SSR, in your decision.
		L3: SSR 17-2p rescinded and replaced SSR 96-6p G14	KRAFSUR: SSR 17-2p rescinded and replaced SSR 96-6p and applies to all claims ADJUDICATED on or after March 27, 2017. SSR 17-2p addresses the evidence needed by adjudicators to make findings about medical equivalence at the Hearings and Appeals Council Levels. In short, it says you cannot rely upon the medical expert's (ME's) conclusory statement that the claimant's impairments medically equal a Listing to make this disability determination. This is a statement on an issue reserved to the Commissioner and is inherently neither valuable nor persuasive to us. **If the ME states that the individual's impairment(s) medically equal a Listing, the ALJ must ask the ME to identify medical evidence in the record that supports the ME's statement.** The ALJ considers this evidence and ultimately determines whether the claimant's impairments medically equal a Listing. It is the ALJ, not the ME, who ultimately determines whether the claimant's impairments medically equal a Listing. The decision should discuss the evidence that supports the ALJ finding.
Definitions			(b) (6) :

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		G15 P P P P P	Let's turn our attention now to definitions. Knowing the definition of a few key terms is essential to understanding how to apply the current rules. The current rules organize evidence in disability claims into defined categories of evidence. We evaluate the evidence according to the rules pertaining to that category of evidence. **The five categories of evidence are:** **(1) Objective medical evidence** **(2) Medical opinions,** **(3) Other medical evidence,** **(4) Evidence from nonmedical sources, and** **(5) Prior administrative medical findings.**
		L3: 20 C.F.R. 404.1513 and 416.913.	SIDERIUS: Each category has a specific definition and purpose in our administrative process. We categorize evidence from medical sources as objective medical evidence, medical opinions, or other medical evidence. Evidence from nonmedical sources, includes, for example, evidence from the claimant, family, friends, and employers. **You can find the full list of definitions at 20 C.F.R.** 404.1513 and 416.913. Objective medical evidence means signs, laboratory findings, or both. All medical sources can make evidence we can categorize as objective medical evidence. And, of

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		G16 20 C.F.R. 404.1502(a) and 416.902(a)	course, we need objective medical evidence from an AMS to establish the existence of an a medically determinable impairment (MDI). For claims filed on or after March 27, 2017, the current rules expand the definition of AMSs. **We added licensed audiologists for impairments of hearing loss, auditory processing disorders, and balance disorders; licensed advanced practice registered nurses; and licensed physician assistants to the AMS list.** For claims filed on or after March 27, 2017, these sources can provide the objective medical evidence needed to establish the existence of an MDI. **You'll find the complete AMS list at 20 C.F.R.** 404.1502(a) and 416.902(a)**.**
		G17 P P	(b) (6) : Perhaps the most significant change in the current rules is how we define the term "medical opinion" for claims filed on or after March 27, 2017. **In adult claims, the regulations define a medical opinion as -** **A statement from a medical source about what you can still do despite your impairment(s) and whether you have one or more impairment-related limitations or restrictions in the following abilities:** **(i) Your ability to perform physical demands of work activities;**

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		P P P G18	**(ii) Your ability to perform mental demands of work activities;** **(iii) Your ability to perform other demands of work; and** **(iv) Your ability to adapt to environmental conditions.** You can see how these relate to the residual functional capacity (RFC). You'll notice that a medical opinion is one rendered by a "medical source." The current rules retain the definition of medical source from the prior rules. 20 C.F.R. 404.1502 and 416.902 defines a "**medical source" as a licensed healthcare worker working within the scope of practice, or a certified speech-language pathologist or school psychologist acting within the scope of practice.** The current rules clarify that statements reflecting judgments about the nature and severity of impairment(s), including symptoms, diagnosis, and prognosis are not "medical opinions." We classify these as "other medical evidence" because they do not describe a claimant's functional abilities and limitations.
			KRAFSUR: By the way, we no longer use the term "medical source statement" under the current rules. So scratch that term from your lexicon. In fact, it might be a good idea to run a word search for the term "medical source statement" on decisions drafted under the current rules to make sure it

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			does not appear inadvertently. The correct term is medical opinion. This is also a good time to remind everyone not to refer to medical opinion evidence as a "RFC Statement," "RFC medical opinion," or something similar. It's important to use the correct terminology and these are imprecise and incorrect terms. Remember, a medical source provides a medical opinion; an ALJ determines an RFC. The terms are not interchangeable.
			(b) (6) [redacted]: You'll recall that only objective medical evidence from an AMS can establish a medically determinable impairment. Under the current rules, however, both AMS and other medical sources can render a medical opinion. A few examples, by no means exhaustive, of other medical sources include licensed mental health therapists, certified social workers, physical therapists, and chiropractors. Finally, the current rules define a statement on an issue reserved to the Commissioner as a statement that would direct the determination or decision of disability. We'll examine this in detail a bit later.
			SIDERIUS: Now let's see how well you understand these key definitions. Consider this situation in a claim filed on or after March 27, 2017.

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		G19 P P P P P P P	**In a treatment note section titled "prognosis," the doctor entered "Good. Condition expected to resolve by June." This is:** **A. A medical opinion** **B. A statement on an issue reserved to the Commissioner** **C. Other medical evidence** **D. None of the above** **The answer is C, other medical evidence.** It is not a medical opinion because it is not a statement about what the claimant can still do despite the impairment(s) nor is it a statement about whether the claimant has one or more impairment-related limitations or restrictions in a work related ability. The current rules define a prognosis from a medical source as "other medical evidence." The ALJ decision may certainly discuss the prognosis, but should not evaluate its persuasiveness since it is not a medical opinion.
Key Two		G20 Fade to black	**This brings us to Key Two -** • **The Disability Decision Must Evaluate and Discuss the Persuasiveness of Medical Opinions from Medical Sources** **Let me join Judge Costello and Judge Krafsur to discuss this further.**
		3 person panel, Costello, moderator; Siderius; Krafsur panelists	COSTELLO: Thank you both for joining me.

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			Judge Siderius, can you briefly talk about this change, before we address it in detail? SIDERIUS: Sure. For claims filed on or after March 27, 2017, we have eliminated the treating source rule and no longer assign weight to medical opinions. Instead, we focus on the PERSUASIVENESS of the medical opinion. We do not defer or give any specific evidentiary weight, including controlling weight, to any medical opinion or prior administrative medical finding, including those from the claimant's own medical sources. G21 **Instead, we evaluate the persuasiveness of medical opinions using the factors listed in paragraph (c) of sections** 404.1520c and 416.920c**, with particular emphasis on the factors of supportability and consistency.**
			KRAFSUR: The current rules for evaluating the persuasiveness of medical opinions also apply to prior administrative MEDICAL findings. I mention it once now, so we don't need to repeat it as we discuss the evaluation of medical opinions. A prior administrative medical finding is a factual finding, other than the ultimate determination about whether a claimant is disabled, made by an MC or PC at the initial or reconsideration level of review. An example is the RFC completed by the DDS MC at the initial level of adjudication.

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			Under the prior rules, the ALJ assigned "weight" to each opinion in the record and explained the basis for the weight given. Under the current rules, the ALJ must instead evaluate and discuss the persuasiveness of medical opinion evidence.
		G22 P P G23 P P P P P P G24 P	COSTELLO: Sounds like a simple enough change. Just substitute persuasiveness for weight and presto, you're done, right? SIDERIUS: Wrong. We're not simply swapping out terms. The terms have changed and so has the analysis. Let's start the discussion by going through the major changes to evaluating medical opinion evidence under the current rules. **1. Do NOT give any weight to a medical opinion. This also means no medical opinion is entitled to controlling weight.** **2. Do not consider medical sources to be either "treating" or "nontreating" sources. The current rules value the quality of the content of the evidence more than the status of the person who provides the evidence.** **3. Evaluate the persuasiveness of medical opinions using the following factors:** **a. Supportability** **b. Consistency** **c. Relationship with the claimant** **d. Specialization, and** **e. Other Factors** **4. Supportability and consistency are most important factors to consider when you evaluate a**

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		P P	**medical opinion. You must articulate how you considered these two factors in the decision.** **5. You may consider multiple medical opinions from the same medical source together in a single analysis. You are not required to evaluate each medical opinion in a separate discussion** **6. If two or more medical opinions on the same issue are equally well-supported and consistent with the record but not exactly the same, explain how you considered the other most persuasive factors**
			KRAFSUR: The current rules actually borrow many concepts used for evaluating medical opinions from the prior rules. But, the emphasis has changed. Rather than emphasizing the medical source's relationship to the claimant and generally giving more weight to a treating source opinion, the current rules require us to evaluate the persuasiveness of all medical opinions, with supportability and consistency being the key factors.
			COSTELLO: Ok, I understand the focus is on the quality of a medical opinion, not the status of the person rendering the opinion. But how do you evaluate persuasiveness? SIDERIUS: Well, let's first go a bit deeper. Under the prior rules for evaluating medical opinions, the ALJ first determined whether to give controlling weight to a treating source opinion. If not given controlling weight, then

Bookmark Title	Small Window Cues	Large Window Cues	Script
			the ALJ evaluated and weighed this opinion along with all other opinions to reach a final determination. The current rules recognize that there is no inherent persuasiveness to evidence from a particular medical source, be it a claimant's own medical source, an AMS or non-AMS, a consultative examiner, or a medical consultant. Disability decisions under the current rules should never assign weight, and certainly never assign controlling weight to any medical opinion.
			COSTELLO: Is the treatment relationship still a factor to consider in evaluating a medical opinion? SIDERIUS: Yes, the medical source's relationship to the claimant is still one factor we consider in evaluating a medical opinion. But, it is less important than the factors of supportability and consistency. Remember, use the terminology "claimant's own medical source" and not "treating source" or "nontreating source".
			KRAFSUR: We mentioned the five factors for evaluating medical opinion evidence a moment ago. Sharp viewers may have noticed that these factors sound very much like the factors used in weighing a medical opinion under the prior rules. In fact, the factors under the prior and current rules are nearly identical; the definitions have changed slightly, but essentially the prior and current factors are the same. The real change is in

Bookmark Title	Small Window Cues	Large Window Cues	Script
Key Three			emphasis – from the source to the content of the medical opinion. **This brings us to Key Three –** • **Supportability and Consistency Are the Most Important Factors For Evaluating the Persuasiveness of Medical Opinion Evidence. The ALJ Decision Must Address These Two Factors When Evaluating the Persuasiveness of Medical Opinion Evidence**
		G26 G27	COSTELLO: So, what do the terms supportability and consistency mean? KRAFSUR: Here is how the regulations define supportability: **The more relevant the objective medical evidence and supporting explanations presented by a medical source are to support his or her medical opinion(s) or prior administrative medical finding(s), the more persuasive the medical opinions or prior administrative medical finding(s) will be.** So, supportability is a two-prong analysis. First, consider how well the objective medical evidence relied upon by the medical source supports the medical opinion. Here's an example. **Consider a medical opinion from the primary care physician for a claimant who alleges disabling back pain. For the first prong of the analysis, examine the**

Bookmark Title	Small Window Cues	Large Window Cues	Script
		G28	**doctor's own records. What objective evidence does the doctor report in the examination notes? Did the doctor order diagnostic tests or x-rays? What do they show? The stronger the objective evidence the better supported the opinion.** **Second, consider the explanation for the medical opinion provided. The more relevant the objective evidence and explanation presented by the medical source, the more well supported and persuasive the opinion.** Do not neglect to include this analysis in the decision. Judges, a few words in the instructions addressing the supportability factor will lead to a much better draft decision.
Examples		G29	COSTELLO: Let's put this into practice. Can you show me how to do this in a decision? KRAFSUR: Here are two basic examples focused solely on the supportability factor. We've kept the example short for purposes of the broadcast. You should certainly consider adding more detail to ensure a well-supported explanation. For a well-supported opinion, you might say: **Dr. Robert provided a three-page medical opinion assessing the claimant's functional ability (Exhibit 7F). He said the claimant could sit for 6 hours, stand/walk for 2 hours, and lift/carry up to 10 pounds but had additional limitations,**

Bookmark Title	Small Window Cues	Large Window Cues	Script
			including an ability to only occasionally handle and finger. I find this medical opinion persuasive. It is supported by his examination reports, the EMG showing marked abnormalities (Exhibit 8F), and the detailed explanation by Dr. Robert in the opinion.
		G30	SIDERIUS: Conversely, for a poorly supported medical opinion, you might say: **Dr. Robert provided a three-page medical opinion assessing the claimant's functional ability (Exhibit 7F). I find this medical opinion unpersuasive. His examinations report generally normal findings (see pages 7 and 10). He has ordered no diagnostic tests such as x-ray or MRI, and has not referred the claimant to a specialist for treatment of the back complaints. His medical opinion consists of a series of checked boxes on a form. The lines on the form allowing for an explanation are blank. In essence, Dr. Robert does not explain his medical opinion. Finally, Dr. Robert began treating the claimant 6 months ago and has seen him twice.**
			COSTELLO: All right. That covers the factor of supportability. What about the second factor, consistency? SIDERIUS:

Bookmark Title	Small Window Cues	Large Window Cues	Script
		G31	"Consistency" means how consistent the medical opinion is with all the other evidence in the record from all other sources. This includes evidence from both medical and non-medical sources. Here, we also consider whether there are internal conflicts within the evidence from the same source. A boilerplate statement, such as "I find the medical opinion of Dr. Robert persuasive because it is consistent with the record as a whole," is not adequate, standing alone. You must cite to specific evidence in the record that is consistent or inconsistent with the medical opinion. You might introduce the consistency discussion with the boilerplate introductory sentence we just showed you, but follow it with an explanation. For example, when addressing consistency in an unfavorable decision you might say, **The medical opinion of Dr. No at exhibit 7F is not persuasive. It is not consistent with the evidence of record. As noted in this decision, three other doctors submitted medical opinions indicating the claimant is less limited (Exhibits 11 to 13F). The MRI showed mild lumbar stenosis and was otherwise unremarkable (Exhibit 9F). The claimant receives no ongoing treatment for his low back. He takes Advil and Flexeril intermittently for pain. He does gardening and cuts his own lawn.** For all medical opinions, the decision MUST discuss the factors of supportability and consistency. It's not optional. If it's not done, it's an error of law. So pay very close attention to this. Make sure, particularly in unfavorable decisions, the

Bookmark Title	Small Window Cues	Large Window Cues	Script
			discussion of these two factor is clear and cites specific evidence.

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			COSTELLO:
			
			So does this mean we can skip over the other factors?
			
			KRAFSUR:
			
			No. You MUST consider all the regulatory factors when evaluating a medical opinion.
			
			The difference is between what you must consider and what you must articulate in the decision. You must consider all the factors; you must articulate how you considered supportability and consistency. Ultimately, consideration of all the factors will inform the determination of persuasiveness. You'll recall that the remaining factors include:
			
			• **Relationship with the claimant, which includes**
			  ○ **Length of the Treatment Relationship**
			  ○ **Frequency of examinations**
			  ○ **Purpose of the treatment relationship**
			  ○ **Extent of the treatment relationship**
			  ○ **Examining relationship**
			• **Specialization, and**
			• **Other factors**
			  ○ **Such as familiarity by the medical source with other evidence in the claim, or an understanding of our disability program's policies and evidentiary requirements.**

			SIDERIUS: The ALJ decision may refer to these remaining factors but, with one exception we'll discuss shortly, it's not required.

Bookmark Title	Small Window Cues	Large Window Cues	Script
			The remaining factors may tip the scale when determining the persuasiveness of a medical opinion. For example, consider two divergent opinions, one from the primary care physician and the other from a consultative examiner. Applying only the factors of supportability and consistency, you may find the two opinions equally persuasive. However, considering the factor of "relationship with the claimant" shows the primary care physician treated the claimant every three months for the past five years, while the other doctor examined the claimant once. This may tip the scale to the primary care physician's opinion. If so, say so, by citing the additional factors in the decision.
			COSTELLO: Let me ask you to discuss two other changes in the current rules: Multiple opinions from one source and two or more opinions equally supported and consistent with the record but not exactly the same. We said earlier that – You may consider multiple medical opinions from the same medical source together in a single analysis; you are not required to evaluate each medical opinion separately How should you do this if there are three separate and significantly different medical opinions from the same medical source? KRAFSUR: With so many possible variations, it's hard to give a simple answer.

Bookmark Title	Small Window Cues	Large Window Cues	Script
		G33 P P P P P	Here are a few general principles that might help with the analysis, and help you address the opinions in the decision: • **Is there common thread in all the medical opinions?** • **Did the claimant's medical condition change over the period covered in the several opinions?** • **Do the medical source opinions reflect this?** • **Does the support for each medical opinion vary?** • **How consistent are the medical opinions with the evidence of record?** The decision may warrant a lengthier, or separate, evaluation of the multiple opinions from one source. The choice is yours. The point is to have a complete, cogent, persuasive analysis.
Medical Opinions		G34	COSTELLO: Judge Siderius, what about equally well supported and consistent medical opinions that are not exactly the same. SIDERIUS: **The current rules say -** • **If two or more medical opinions on the same issue are equally well-supported and consistent with the record but are not exactly the same, you must explain how you considered the other most persuasive factors** We touched on this a bit earlier. The regulation reminds us to consider all factors when evaluating a medical opinion.

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			Different, but equally well-supported medical opinions on the same issue require a more thorough written articulation. You must articulate how you considered the remaining most persuasive factors –namely relationship with the claimant, specialization, and other factors – and explain how these factors led you to find one medical opinion more persuasive.
			COSTELLO: Now that we've discussed medical opinions, what about statements from nonmedical sources, say, an affidavit from a spouse discussing the claimant's limitations? KRAFSUR: Under the prior rules, the ALJ generally must evaluate and weigh virtually any opinion found in the record. This includes statements submitted by non-medical sources, including friends and relatives. The prior rules also generally require that ALJ decisions address decisions by other governmental agencies and nongovernmental entities (such as and the Department of Veterans Affairs (VA) and statements on issues reserved to the Commissioner, such as whether the claimant is disabled. The current rules change all this.
			COSTELLO: Why don't we look at each of these other categories of evidence? Judge Siderius, tell us about evidence from non-medical sources.

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		L3: 20 CFR 404.1527(f) and 416.927(f)	SIDERIUS: When the Agency published the Medical Evidence final rules, it simultaneously rescinded SSR 06-3p, which generally required the ALJ to evaluate and weigh evidence from non-medical sources. In cases under the prior rules, you should still evaluate and weigh this evidence under the guidance of the 20 CFR 404.1527(f) and 416.927(f). In contrast, the current rules neither prohibit nor require you to do so. In some situations under the current rules, you may want to assess certain statements from non-medical sources. For example, a former employer may submit a statement on the impact the claimant's impairments had on work performance. This is an insight that is not likely to be available from other sources. It may be appropriate to address the statement in the decision. Other examples of evidence from non-medical sources are evaluations included in an individualized education plan (IEP), and functional reports prepared by teachers and counselors. Remember our definition of medical source. A teacher is not a medical source. Under the current rules, a teacher's statement is not a medical opinion we must evaluate for persuasiveness. Still, the teacher's statement is highly probative and useful in determining disability. DO NOT ignore this type of evidence, especially from a teacher in a child disability case. It could be highly probative on the claimant's functional ability.
Key Four			COSTELLO: **This brings us to Key Four:**

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		G35	• **The ALJ Decision Must Not Provide an Analysis of Decisions by Other Governmental Agencies or Non-Governmental Entities, Disability Examiner Findings, or Statements on Issues Reserved to the Commissioner.** Judge Siderius, could you explain this. SIDERIUS: As the regulations note, this evidence is neither inherently valuable nor persuasive. These may include, for example, decisions on disability made by the VA, a state workers compensation board or a private insurer. For claims filed on or after March 27, 2017, the ALJ decision should not include an analysis of disability determinations by other agencies or entities concerning whether an individual is disabled, blind, employable, or entitled to any benefits. Let's say, for the example, the VA found the claimant 100% disabled under their disability program. This determination is neither inherently valuable nor persuasive to us. The ALJ decision should not include an analysis of the determination made by the VA. **The ALJ decision should not say, for example, "The VA determined the claimant to be 100% disabled under their program. Although their criteria for determining disability differs from Social Security, I find the VA decision persuasive."**
		G36	

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			However, the ALJ decision must articulate how the ALJ considered the evidence underlying the VA rating, such as a VA doctor's medical opinion. In short, do not assess the persuasiveness of DECISIONS by other agencies or entities but do assess the persuasiveness of the underlying medical opinion evidence.
		G37 P P P P G38 P	COSTELLO: Finally, let's look at Statements on Issues Reserved to the Commissioner. SIDERIUS: The current rules make clear that statements on issues reserved to the Commissioner are neither inherently valuable nor persuasive. For claims filed on or after March 27, 2017, the ALJ decision should not provide an analysis of statements by medical or other sources on issues reserved to the Commissioner. **Examples of issues reserved to the Commissioner include statements indicating:** • **Whether or not a claimant is disabled, blind, able to work, or able to perform regular or continuing work;** • **Whether or not a claimant has a severe impairment;** • **Whether or not an impairment meets the duration requirement;** • **Whether an impairment meets or medically equals a listed impairment;** • **What the claimant's RFC is using our programmatic terms about functional exertional**

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Key Five		P P P G39 Fade To Black	**levels (instead of descriptions about the claimant's functional abilities and limitations);** • **Whether or not the claimant's RFC prevents performance of past relevant work;** • **Whether a claimant does or does not meet a medical-vocational rule; and,** • **Whether or not the claimant's disability ends or continues when we conduct a CDR.** **This brings us to Key Five:** • **Put the Principles Into Practice: Concisely Articulate the Persuasiveness of All Medical Opinions by Citing Specific Evidence in the Record** **Judge Costello, we'll let attorney's (b) (6) and (b) (6) take it from here.**
		Change panel to Costello, (b) (6), and (b) (6).	COSTELLO: Thanks Judge Siderius and Judge Krafsur. Now let's spend time discussing and demonstrating how you should apply the current rules. I imagine many of you out there are thinking, "Does this mean the analysis in our decisions will be even more time consuming and lengthy?" (b) (6) what do you think? (b) (6) It shouldn't be. In fact, once we gain some experience applying the current rules, the ALJ decisions should end up being more focused and concise.

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			The amount of time spent in addressing the persuasiveness of medical opinions should not differ drastically from the analysis under our prior rules. Of course, the amount of articulation will depend on the complexity of the case. General statements regarding supportability and consistency DO NOT satisfy our articulation requirements under the prior rules – or the current rules. Articulating the specific evidence that speaks to supportability and consistency should result in a concise and strong analysis. The articulation should also shift the focus of judicial review by the federal courts from how the ALJ articulated the weight given each opinion to whether substantial evidence supports the decision.
		G40	COSTELLO: I see how this sounds great in theory. But, how about in practice? There is a time-honored advice to fiction writers that seems apt here – "show, don't tell." So, show me. (b) (6): Sure. The easiest way to demonstrate this is by example. Let's look at how our decisions addressed medical opinions under the prior rules compared to how our decisions under the current rules would address those same medical opinions. Again, the examples are bare-bone, given the constraints of this broadcast. Use them as a starting point. The better the articulation, the better the decision. **Consider this abbreviated set of facts:**

Bookmark Title	Small Window Cues	Large Window Cues	Script
		P P P G41 P P G42	**Dr. Wilson submitted a statement that the claimant is able to lift and carry 15 pounds occasionally and 5 pounds frequently.** **The claimant can occasionally balance, stoop, kneel, crouch, and crawl.** **The medical evidence contains MRIs and x-rays confirming degenerative disc disease of the lumbar spine, with neural foraminal narrowing.** **Further, the claimant routinely attended physical therapy and medication management sessions at a pain clinic, and underwent a discectomy.** **Dr. Wilson provided an explanation describing how objective testing and other evidence were congruent with his medical opinion.** Under the prior rules, we would assign Dr. Wilson's opinions a specific weight within the decision. For example, under the prior rules the decision might say, **"I give great weight to the opinion of Dr. Wilson. He is a treating physician and board certified in neurology. Furthermore, he performed surgery for the claimant's degenerative disc disease in an attempt to relieve his pain. Treatment records show the claimant continued to exhibit pain when lifting in follow-up visits with Dr. Wilson."** COSTELLO: Ok, I see how to evaluate under the prior rules. How would you approach Dr. Wilson's medical opinions using the current rules? (b) (6) :

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			The first impulse might be to simply switch out the terms "great weight" with something likely "highly persuasive." Don't do it. There is a better approach, which is consistent with the reasoning behind the changes in the regulations. Articulate how you considered the required factors of supportability and consistency, followed by additional factors if necessary. Compare the objective medical evidence to the medical opinion. Identify treatment records, objective testing, continued reports of symptoms, changes in treatment, and other keys that illustrate supportability, and consistency or inconsistency with the medical opinion. This analysis shifts the focus away from the source of the medical opinion, and emphasizes the quality of the content. This is a key conceptual change under the current rules. G43 **The analysis using the current rules might look like this:** **Dr. Wilson's medical opinions are supported by objective medical testing and are consistent with other evidence throughout the record. Imaging performed in December 2017 showed advanced degenerative disc disease at multiple levels, with neural foraminal narrowing and nerve root encroachment.** **Dr. Wilson provided specific examples of test results and failed treatment attempts in support of his medical opinion. Medical records document consistent follow-up treatment with the primary care doctor, physical therapy, and a pain clinic.** G44

Bookmark Title	Small Window Cues	Large Window Cues	Script
		G45	**Conservative treatment failed to provide any pain relief.** **The claimant demonstrated decreased strength in her lower extremities on multiple examinations from January to March 2018. (Exhibit 10F) Dr. Wilson eventually performed a discectomy in March 2018. Despite his intervention, the claimant continued to report significant pain, which increased with lifting or carrying items greater than 15 pounds.**
			COSTELLO: I see several differences in our examples. When applying the current rules, the example did not refer to the factors of specialization or treating status. As required, it explained how the ALJ considered the two factors of supportability and consistency in determining persuasiveness. It was not necessary to discuss the additional factors in this example. (b) (6) : That's right. Of course, the decision may address the other factors and in some cases it may be helpful to do so, particularly in cases where a more detailed explanation will give the claimant and appellate reviewers a clear understanding of the considerations leading to the final decision.
			COSTELLO: I notice the example did not explain how persuasive the ALJ found Dr. Walker's medical opinion. It did not say the medical opinion was "very" persuasive or "highly"

Bookmark Title	Small Window Cues	Large Window Cues	Script
			persuasive, or use any modifier. It just said the medical opinion was persuasive. Why no modifier? (b) (6) : Neither the regulations nor our policy interpretation say you must not use modifiers when discussing persuasiveness. But approach the use of modifiers with caution when discussing persuasiveness. We used modifiers like "great," "little," or "partial" weight when evaluating a medical opinion under the prior rules. But, the terms were never well defined, except the term "controlling" weight. The current rules shift the emphasis from support for the modifiers to articulation of the underlying evidence. You are not required to use modifiers when discussing the persuasiveness of a medical opinion, nor are you prohibited from doing so. Our advice – approach with caution.
			COSTELLO: We mentioned earlier that you should address multiple medical opinions from one medical source in one analysis. How about an example? (b) (6) Sure, the current rules are simpler. Under the current rules, the ALJ may aggregate and summarize multiple medical opinions using "source level" analysis when evaluating persuasiveness.

Bookmark Title	Small Window Cues	Large Window Cues	Script
Analysis		G46 G47 P P G48	**Specifically, the regulation states,** **When a medical source provides multiple medical opinion(s) or prior administrative medical findings, we will articulate how we considered the medical opinions or prior administrative medical findings from that medical source together in a single analysis. We are not required to articulate how we considered each medical opinion or prior administrative medical finding from one medical source individually.** Now let's see how to do this in a decision. **Here are the facts:** **Dr. Mitchell states in July 2017 that the claimant can lift and carry up to 25 pounds occasionally and 15 pounds frequently and can stand and walk for up to six hours of an eight-hour workday (Exhibit 10F).** **A later medical opinion from Dr. Mitchell in October 2017 says the claimant can lift and carry only 10 pounds occasionally, cannot lift or carry any weight frequently and can only stand and walk for two hours total in a workday (Exhibit 12F).** **Finally, Dr. Mitchell said in March 2018 the claimant could lift and carry up to 20 pounds occasionally and 10 pounds frequently and can stand or walk up to six hours total in a workday, but would need to change position for two**

Bookmark Title	Small Window Cues	Large Window Cues	Script
			minutes every hour, at the workstation and while remaining on task.
			Under the prior rules, the ALJ decision generally assigns weight to each of Dr. Mitchell's opinions, and discusses those parts accepted or rejected. Under the current rules, the decision could address the multiple medical opinions in one analysis.
			The facts, of course, will dictate the analysis. But all Dr. Mitchell's medical opinions could be addressed at the source level in a single analysis, assessing the supportability and consistency with the record.
		G49	**Here's how one analysis might look:**
		P	**In considering the persuasiveness of Dr. Mitchell's medical opinions, the undersigned finds the proposed limitations of standing and walking for up to six hours total in an eight-hour workday, and lifting up to 20 pounds occasionally and 10 pounds frequently to be supported by his own testing and examination records.**
		P	**Objective imaging performed in June 2017 and February 2018 showed only mild to moderate degenerative disc disease, without nerve root encroachment. The claimant walked with a normal gait and had full strength in her lower extremities.**
		G50 P	**Further, these limitations are consistent with the testing and medical opinions of a consultative examiner, Dr. Jenner. Additionally, the claimant**

Bookmark Title	Small Window Cues	Large Window Cues	Script
		P	**reported to providers she experienced improvement with treatment and had resumed a walking program three times per week.** **Dr. Mitchell's October 2017 medical opinions are inconsistent with this evidence, and the record does not show changes in objective tests or reports of symptoms to support these greater limitations.**
		Fade To Black	COSTELLO: You can see how the decision addressed and reconciled the several medical opinions. The explanation shows why some of the medical opinions were supported by the doctor's own records and consistent with other evidence. In contrast, the other, more limiting, medical opinion was not as well supported or consistent. Let's get everyone together and brainstorm a few final thoughts.
Conclusion		Change scene to 3-shot, plus Siderius and Krafsur green screen singles Use Triple Boxes edit effect	COSTELLO: As we conclude our program today, why don't we leave our viewers with a few tips to help streamline their work? Let's keep them simple and easy to remember. Judge Siderius let me start with you. How about advice for the ALJs. SIDERIUS: Ok, how about this?

Bookmark Title	Small Window Cues	Large Window Cues	Script
			When drafting instructions, identify specific evidence to help guide the decision writer especially on the factors of supportability and consistency. Decision writers should supplement this with their own file review. The decision writer should take the time and carefully articulate the medical opinion analysis, always citing to specific evidence affecting the factors of consistency and supportability. This may be the most critical part of the decision, especially on appeal. Refer to other factors as appropriate. Let me remind everyone again – it is not enough to say a medical opinion is supported and consistent. You must identify specific evidence leading to this conclusion.
			COSTELLO: (b) (6) your turn. A tip for attorney advisors and paralegal assistants? (b) (6) Sure. Remember, although the articulation requirements have changed under the current rules, the decision must still address all medical opinions. Make sure you do not overlook any. At the same time, for claims filed on or after March 27, 2017, do not articulate how you considered evidence that is inherently neither valuable nor persuasive. This includes statements on issues reserved to the Commissioner and decisions by other governmental agencies and nongovernmental entities.

Bookmark Title	Small Window Cues	Large Window Cues	Script
		L3: 20 CFR 404.1520b(c) and 416.920b(c)	Here's a suggestion. Let the reader, and a reviewing court, know WHY you did not discuss this evidence in the decision. For example, you might consider writing in all decisions, "I did not provide articulation about the evidence that is inherently neither valuable nor **persuasive in accordance with 20 CFR** 404.1520b(c) and 416.920b(c)**."** Finally, the attorney advisor or paralegal specialist should also review the file and, in conjunction with the general instructions from the ALJ, identify the evidence that further supports the ALJ finding on the medical opinion evidence.
			COSTELLO: Judge Krafsur, anything you'd like to add? KRAFSUR Sure, here's an easy one. Run a final word check on the decision draft for the word "weight." on cases under the current rules. We do not use the term "weight" when evaluating opinion evidence under current rules and this simple check may avoid an unfortunate remand.
			COSTELLO: (b) (6) what's your tip? (b) (6) Generally, avoid modifiers in articulating persuasiveness. We noted earlier that the regulations do not prohibit the use of modifiers but you do not want to fall into a pattern of using

Bookmark Title	Small Window Cues	Large Window Cues	Script
			modifiers always, as we did when weighing medical opinion evidence under the prior rules. Instead, focus on identifying the specific evidence that addresses the supportability and consistency factors.
			COSTELLO: Judge Siderius, any final advice? SIDERIUS: Sure, we didn't talk about it a lot, but don't forget SSR 17-2p. If you have persuasive medical expert evidence and find a claimant equals a listing, you must identify the evidence in the record that supports your conclusion, and the decision must reflect this. You cannot simply rely on the medical expert's conclusory statement that the claimant meets or equals a listing. That evidence is a statement on an issue reserved to the Commissioner. By the way, the same principle applies if you find the claimant's impairments meet a listing, although this is not specifically a part of the SSR.
		Costello turns to single camera, address audience	COSTELLO: Thank you for your participation today. I want to thank our presenters for their work in helping to make the current rules easier to understand and apply. We want you to feel confident when you use the current rules, so we emphasized the most important changes that will affect your work at the hearing and appeals levels. For this, I think the Five Keys may be very helpful. I encourage you to keep a hard copy of

Bookmark Title	Small Window Cues	Large Window Cues	Script
			the Keys and the QuickNotes handy as you begin to decide cases under the current rules.

OHO Continuing Education Program

OCEP—October 2018 Quarterly IVT

Five Keys to Evaluating Medical Evidence Under Current Rules

Social Security Administration
Office of Hearings Operations

IVT

The Current Rules Reorganize and Clarify Our Evidence Regulations and Reflect Changes in the Way Individuals Receive Medical Care

- March 27, 2017 is the effective date of the revised regulations. Use the "current rules" for claims filed on or after this date; use the "prior rules" for claims filed prior to this date.

The ALJ Decision Must Evaluate and Discuss the Persuasiveness of Medical Opinion Evidence from Medical Sources

- The "current rules" for evaluating medical opinion evidence are principally at 20 CFR 404.1520c and 416.920c; the "prior rules" are principally at 20 CFR 404.1527 and 416.927.
- A **Medical Opinion** is "[A] statement from a medical source about what you can still do despite your impairment(s) and whether you have one or more impairment-related limitations or restrictions in the following abilities: (i) Your ability to perform physical demands of work activities; (ii) Your ability to perform mental demands of work activities; (iii) Your ability to perform other demands of work; and (iv) Your ability to adapt to environmental conditions.
- Under current rules, adjudicators should focus on how PERSUASIVE they find all medical opinions and prior administrative findings rather than assign weight to particular opinions.
- Evaluate the persuasiveness of medical opinions using the factors in paragraph (c) of 20 CFR 404.1520c and 416.920c.

Supportability and Consistency Are the Most Important Factors. The ALJ Decision Must Address These Two Factors When Evaluating the Persuasiveness of Medical Opinion Evidence

- Supportability – consider the objective medical evidence relied upon and supporting explanations provided by the medical source.
- Consistency – consider how consistent the medical opinion is with other evidence in the record from other sources.

The ALJ Decision Must Not provide an Analysis of Decisions by Other Government Agencies or Non-Governmental Entities, Disability Examiner Findings, or Statements on Issues Reserved to the Commissioner

- These determinations are neither inherently valuable nor persuasive to us.

Put the Principles into Practice: Concisely Articulate the Persuasiveness of All Medical Opinions by Citing Specific Evidence in the Record

OCEP FY 19

Evaluating Medical Evidence Under the Current Rules

Claims: Before and After

Claims filed before March 27, 2017 follow what we will call the "prior rules." Claims filed on or after March 27, 2017 follow what we will call the "current rules."

Regulations

- Prior Rules
  - 20 C.F.R. 404.1527 and 416.927
- Current Rules
  - 20 C.F.R. 404.1520c and 416.920c

Five Keys

1. The current rules reorganize and clarify our evidence regulations and reflect changes in the way individuals receive medical care.
2. The ALJ decision must evaluate and discuss the persuasiveness of medical opinion evidence from medical sources.
3. Supportability and consistency are the most important factors for evaluating the persuasiveness of medical opinion evidence. The ALJ decision must address these two factors when evaluating the persuasiveness of medical opinion evidence.

Five Keys

4. The ALJ decision must not provide an analysis of decisions by other governmental agencies or non-governmental entities, disability examiner findings, or statements on issues reserved to the Commissioner.

5. Put the principles into practice: concisely articulate the persuasiveness of all medical opinions by citing specific evidence in the record.

Key One

- The current rules reorganize and clarify our evidence regulations for ease of use
- Redefine several key terms
- Revise our list of Acceptable Medical Sources (AMS)
- Revise how we consider and articulate our consideration of medical opinions and prior administrative medical findings
- Revise who can be a Medical Consultant (MC) and Psychological Consultant (PC)
- Revise our rules about treating sources

ACUS Study

In 2013, ACUS studied SSA's experience applying the treating source rule and recommended that we revise our regulations to eliminate the controlling weight aspect of the rule in favor of a more flexible approach that gives adjudicators greater discretion.

ACUS Study

Also recommended that we consider expanding our list of AMSs to include additional medical sources like nurse practitioners and physician assistants, to reflect today's healthcare system.

Additional AMSs under Current Rules

Licensed advanced practice registered nurses, physician assistants, and licensed audiologists for impairments of hearing loss, auditory processing disorders, and balance disorders.

Scenarios

- For concurrent claims, generally use the earliest possible filing date to determine which rule to follow.
  - For example, if the Title II claim filing date is February 15, 2017 and the Title XVI filing date is April 2, 2017 use the February 15 filing date and decide both claims using the prior rules.
- For reopening, if you reopen a prior claim, use the original filing date of the earlier claim to determine which rule to follow for the reopened claim.

CDRs

Current rules generally apply -

Except, use the prior rules if all the following apply:

1. **This is the first CDR for the claim after March 27, 2017**
2. **There is no medical improvement related to the ability to work**
3. **All full medical determination(s) made in the claim(s) under review were made using the prior rules**

For age 18 redeterminations, use the date the claimant attained age 18 as the filing date.

Question 1

Assume a claim for Title II disability benefits, filed in April 2015, has been remanded and consolidated with a subsequent application filed in June 2017.

Which rules apply to the claims?

A. The current rules

B. The prior rules

C. The prior rules for the remanded claim; the current rules for the subsequent application

D. Never mind the rules

(b) (7)(E)

(b) (7)(E)

ME Statement

If the ME states that the individual's impairment(s) medically equal a Listing, the ALJ must ask the ME to identify medical evidence in the record that supports the ME's statement.

Five Categories Of Evidence

1. Objective medical evidence
2. Medical opinions
3. Other medical evidence
4. Evidence from nonmedical sources
5. Prior administrative medical findings

Objective Medical Evidence

- Signs, laboratory findings, or both
- All medical sources can make evidence we can categorize as objective medical evidence
- Need objective medical evidence from an AMS to establish the existence of an MDI

Expanded Definition

Added licensed audiologists for impairments of hearing loss, auditory processing disorders, and balance disorders; licensed advanced practice registered nurses; and licensed physician assistants to the AMS list.

Medical Opinion Definition

A statement from a medical source about what you can still do despite your impairment(s) and whether you have one or more impairment-related limitations or restrictions in the following abilities:

1. Physical demands of work activities
2. Mental demands of work activities
3. Other demands of work
4. Ability to adapt to environmental conditions

Medical Source

A licensed healthcare worker working within the scope of practice, or a certified speech-language pathologist or school psychologist acting within the scope of practice.

Question Two

In a treatment note section titled “prognosis,” the doctor entered “Good. Condition expected to resolve by June.”

This is:

A. A medical opinion

B. A statement on an issue reserved to the Commissioner

C. Other medical evidence

D. None of the above

Key Two

The disability decision must evaluate and discuss the persuasiveness of medical opinions from medical sources.

Persuasiveness

Evaluate the persuasiveness of medical opinions using the factors listed in paragraph (c) of sections 404.1520c and 416.920c, with particular emphasis on the factors of supportability and consistency.

Major Changes

- Do NOT give any weight to a medical opinion. This also means no medical opinion is entitled to controlling weight.

- Do not consider medical sources to be either “treating” or “nontreating” sources. The current rules value the quality of the content of the evidence more than the status of the person who provides the evidence.

Major Changes

Evaluate the persuasiveness of medical opinions using the following factors:

A. Supportability

B. Consistency

C. Relationship with the claimant

D. Specialization

E. Other Factors

Major Changes

- Supportability and consistency are most important factors to consider when you evaluate a medical opinion. You must articulate how you considered these two factors in the decision.
- You may consider multiple medical opinions from the same medical source together in a single analysis. You are not required to evaluate each medical opinion in a separate discussion.
- If two or more medical opinions on the same issue are equally well-supported and consistent with the record but not exactly the same, explain how you considered the other most persuasive factors.

Key Three

Supportability and consistency are the most important factors for evaluating the persuasiveness of medical opinion evidence. The ALJ decision must address these two factors when evaluating the persuasiveness of medical opinion evidence.

Supportability

The more relevant the objective medical evidence and supporting explanations presented by a medical source are to support his or her medical opinion(s) or prior administrative medical finding(s), the more persuasive the medical opinions or prior administrative medical finding(s) will be.

Example

- Consider a medical opinion from the primary care physician for a claimant who alleges disabling back pain.
- For the first prong of the analysis, examine the doctor's own records. What objective evidence does the doctor report in the examination notes?
- Did the doctor order diagnostic tests or x-rays? What do they show? The stronger the objective evidence the better supported the opinion.

Example

- Consider the explanation for the medical opinion provided.
- The more relevant the objective evidence and explanation presented by the medical source, the more well supported and persuasive the opinion.

Well-Supported Opinion (Example)

Dr. Robert provided a three-page medical opinion assessing the claimant's functional ability (Exhibit 7F). He said the claimant could sit for 6 hours, stand/walk for 2 hours, and lift/carry up to 10 pounds but had additional limitations, including an ability to only occasionally handle and finger. I find this medical opinion persuasive. It is supported by his examination reports, the EMG showing marked abnormalities (Exhibit 8F), and the detailed explanation by Dr. Robert in the opinion.

Poor-Supported Opinion (Example)

Dr. Robert provided a three-page medical opinion assessing the claimant's functional ability (Exhibit 7F). I find this medical opinion unpersuasive. His examinations report generally normal findings (see pages 7 and 10). He has ordered no diagnostic tests such as x-ray or MRI, and has not referred the claimant to a specialist for treatment of the back complaints. His medical opinion consists of a series of checked boxes on a form. The lines on the form allowing for an explanation are blank. In essence, Dr. Robert does not explain his medical opinion. Finally, Dr. Robert began treating the claimant 6 months ago and has seen him twice.

Addressing Consistency – Unfavorable Decision

The medical opinion of Dr. No at exhibit 7F is not persuasive. It is not consistent with the evidence of record. As noted in this decision, three other doctors submitted medical opinions indicating the claimant is less limited (Exhibits 11 to 13F). The MRI showed mild lumbar stenosis and was otherwise unremarkable (Exhibit 9F). The claimant receives no ongoing treatment for his low back. He takes Advil and Flexeril intermittently for pain. He does gardening and cuts his own lawn.

Remaining Factors

- Relationship with the claimant, which includes:
  - Length of the treatment relationship
  - Frequency of examinations
  - Purpose of the treatment relationship
  - Extent of the treatment relationship
  - Examining relationship
- Specialization
- Other factors
  - Such as familiarity by the medical source with other evidence in the claim, or an understanding of our disability program's policies and evidentiary requirements

General Principles

- Is there common thread in all the medical opinions?
- Did the claimant's medical condition change over the period covered in the several opinions?
- Do the medical source opinions reflect this?
- Does the support for each medical opinion vary?
- How consistent are the medical opinions with the evidence of record?

Current Rules

If two or more medical opinions on the same issue are equally well-supported and consistent with the record but are not exactly the same, you must explain how you considered the other most persuasive factors.

Key Four

The ALJ decision must not provide an analysis of decisions by other governmental agencies or non-governmental entities, disability examiner findings, or statements on issues reserved to the Commissioner.

ALJ Decision Example – Should Not Say

"The VA determined the claimant to be 100% disabled under their program. Although their criteria for determining disability differs from Social Security, I find the VA decision persuasive."

Examples Of Issues Reserved to COSS

- Is disabled, blind, able to work, or able to perform regular or continuing work
- Has a severe impairment
- Impairment meets the duration requirement
- Impairment meets or medically equals a listed impairment

Examples Of Issues Reserved to COSS

- What the claimant's RFC is using our programmatic terms about functional exertional levels (instead of descriptions about the claimant's functional abilities and limitations)
- RFC prevents performance of past relevant work
- Does or does not meet a medical-vocational rule
- Disability ends or continues when we conduct a CDR

Key Five

Put the principles into practice: concisely articulate the persuasiveness of all medical opinions by citing specific evidence in record.

Set Of Facts

- Dr. Wilson submitted a statement that the claimant is able to lift and carry 15 pounds occasionally and 5 pounds frequently.
- Claimant can occasionally balance, stoop, kneel, crouch, and crawl.
- Medical evidence contains MRIs and x-rays confirming degenerative disc disease of the lumbar spine, with neural foraminal narrowing.

Set Of Facts

- Claimant routinely attended physical therapy and medication management sessions at a pain clinic, and underwent a discectomy.

- Dr. Wilson provided an explanation describing how objective testing and other evidence were congruent with his medical opinion.

Prior Rules

"I give great weight to the opinion of Dr. Wilson. He is a treating physician and board certified in neurology. Furthermore, he performed surgery for the claimant's degenerative disc disease in an attempt to relieve his pain. Treatment records show the claimant continued to exhibit pain when lifting in follow-up visits with Dr. Wilson."

Analysis Using Current Rules

Dr. Wilson's medical opinions are supported by objective medical testing and are consistent with other evidence throughout the record. Imaging performed in December 2017 showed advanced degenerative disc disease at multiple levels, with neural foraminal narrowing and nerve root encroachment.

Analysis Using Current Rules

Dr. Wilson provided specific examples of test results and failed treatment attempts in support of his medical opinion. Medical records document consistent follow-up treatment with the primary care doctor, physical therapy, and a pain clinic. Conservative treatment failed to provide any pain relief.

Analysis Using Current Rules

The claimant demonstrated decreased strength in her lower extremities on multiple examinations from January to March 2018 (Exhibit 10F). Dr. Wilson eventually performed a discectomy in March 2018. Despite his intervention, the claimant continued to report significant pain, which increased with lifting or carrying items greater than 15 pounds.

Regulation States

When a medical source provides multiple medical opinion(s) or prior administrative medical findings, we will articulate how we considered the medical opinions or prior administrative medical findings from that medical source together in a single analysis. We are not required to articulate how we considered each medical opinion or prior administrative medical finding from one medical source individually.

Facts

- Dr. Mitchell states in July 2017 that the claimant can lift and carry up to 25 pounds occasionally and 15 pounds frequently and can stand and walk for up to six hours of an eight-hour workday (Exhibit 10F).

- A later medical opinion from Dr. Mitchell in October 2017 says the claimant can lift and carry only 10 pounds occasionally, cannot lift or carry any weight frequently and can only stand and walk for two hours total in a workday (Exhibit 12F).

Facts

- Finally, Dr. Mitchell said in March 2018 the claimant could lift and carry up to 20 pounds occasionally and 10 pounds frequently and can stand or walk up to six hours total in a workday, but would need to change position for two minutes every hour, at the workstation and while remaining on task.

Analysis

- In considering the persuasiveness of Dr. Mitchell's medical opinions, the undersigned finds the proposed limitations of standing and walking for up to six hours total in an eight-hour workday, and lifting up to 20 pounds occasionally and 10 pounds frequently to be supported by his own testing and examination records.

- Objective imaging performed in June 2017 and February 2018 showed only mild to moderate degenerative disc disease, without nerve root encroachment. The claimant walked with a normal gait and had full strength in her lower extremities.

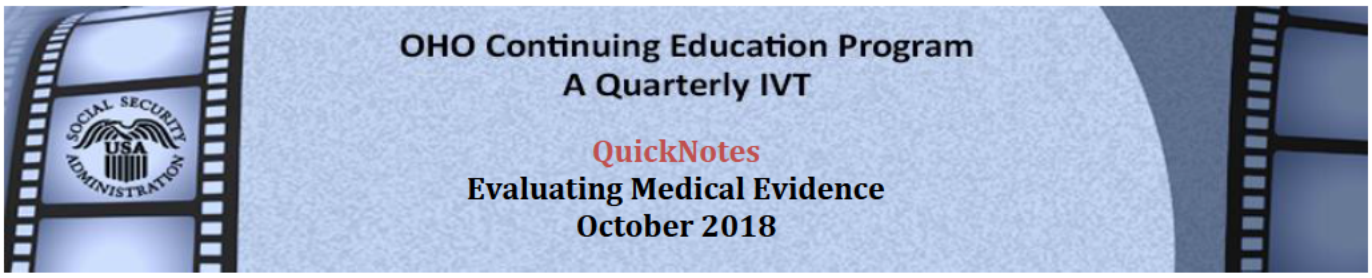
Analysis

- Further, these limitations are consistent with the testing and medical opinions of a consultative examiner, Dr. Jenner. Additionally, the claimant reported to providers she experienced improvement with treatment and had resumed a walking program three times per week.

- Dr. Mitchell's October 2017 medical opinions are inconsistent with this evidence, and the record does not show changes in objective tests or reports of symptoms to support these greater limitations.

Example

“I did not provide articulation about the evidence that is inherently neither valuable nor persuasive in accordance with 20 CFR 404.1520b(c) and 416.920b(c).”



1 *The Current Rules Reorganize and Clarify Our Evidence Regulations and Reflect Changes in the Way Individuals Receive Medical Care.*

There are two sets of rules for evaluating medical evidence depending on the filing date for the claim. Claims filed before March 27, 2017 follow what we call the "prior rules." They are found principally at 20 CFR 404.1527 and 416.927. Claims filed on or after March 27, 2017 follow the "current rules," found principally at 20 CFR 404.1520c and 416.920c.

The current rules:

- Redefine several key terms
- Revise our list of acceptable medical sources (AMS)
- Revise how we consider and articulate our consideration of medical opinions and prior administrative medical findings
- Revise who can be a medical consultant (MC) and psychological consultant (PC), and
- Revise our rules about treating sources.

The current rules also conform our rules to the requirements of the Bipartisan Budget Act of 2015, reflect changes in the national healthcare workforce and in the manner that individuals receive primary medical care, and emphasize the need for objective medical evidence in disability and blindness claims.

We revised our rules to move away from assigning a specific weight to medical opinions and to clarify that adjudicators should focus on how PERSUASIVE they find all medical opinions and prior administrative medical findings in the case record.

We also expanded the list of AMSs to include licensed advanced practice registered nurses, physician assistants, and licensed audiologists for impairments of hearing loss, auditory processing disorders, and balance disorders.

Generally, use the prior rules for claims filed before March 27, 2017 and use the current rules for claims filed on or after that date.

Other common filing date scenarios and the proper rules to apply (POMS DI 24503.050) -

- For concurrent claims, generally use the earliest possible filing date to determine which rule to follow.
- If you reopen a prior claim, use the original filing date of the earlier claim to determine which rule to follow for the reopened claim.
- For CDRs, the current rules apply in most cases, with the following exception:
  (1) It is the first CDR for the claim after March 27, 2017 and
  (2) There is no medical improvement related to the ability to work
  (3) All full medical determination(s) made in the claim(s) under review were made using the prior rules.
- For age 18 redeterminations, use the date the claimant attained age 18 as the filing date.

Social Security Rulings (SSRs) 96-2p, 96-5p, 96-6p and 06-03p were rescinded effective March 27, 2017. These SSRs should not be relied upon or cited in any decision.

SSR 17-2p rescinded and replaced SSR 96-6p and applies to all claims adjudicated on or after March 27, 2017. SSR 17-2p addresses the evidence needed by adjudicators to make findings about medical equivalence at the Hearings and Appeals Council Levels.

The five categories of evidence are:
(20 CFR 404.1513; 416.913)

- objective medical evidence,
- medical opinions,
- other medical evidence,

- evidence from nonmedical sources, and
- prior administrative medical findings.

Objective medical evidence means signs, laboratory findings, or both.

You must have objective medical evidence from an AMS to establish the existence of a medically determinable impairment (MDI).

A **Medical Opinion is** a statement from a medical source about what you can still do despite your impairment(s) and whether you have one or more impairment-related limitations or restrictions in the following abilities:

I. Your ability to perform physical demands of work activities;
II. Your ability to perform mental demands of work activities;
III. Your ability to perform other demands of work; and
IV. Your ability to adapt to environmental conditions.

A **Medical Source** is a licensed healthcare worker working within the scope of practice, or a certified speech-language pathologist or school psychologist acting within the scope of practice **(**20 CFR 404.1502 and 416.902**).**

The current rules clarify that symptoms, diagnosis, and prognosis are not "medical opinion." We classify these terms as "other medical evidence" because these concepts do not describe a claimant's functional abilities and limitations.

We no longer use the term "medical source statement" under the current rules.

🗝 2 *The Disability Decision Must Evaluate and Discuss the Persuasiveness of Medical Opinions from Medical Sources*

Under the current rules, we have eliminated the "treating source rule" and no longer assign weight to medical opinions. Instead, we focus on persuasiveness of the medical opinion.

The current rules for evaluating the persuasiveness of medical opinions also apply to prior administrative medical findings.

A **prior administrative medical finding** is a factual finding, other than the ultimate determination about whether a claimant is disabled, made by an MC or PC at the initial or reconsideration level of review. An example is the RFC completed by the DDS MC at the initial level of adjudication.

The major changes to evaluating medical opinion evidence under the current rules -

- Do not give any weight to a medical opinion
- Do not consider medical sources to be either "treating" or "non-treating" sources
- Evaluate the "persuasiveness" of medical opinions using the following factors
    a) Supportability
    b) Consistency
    c) Relationship with the claimant
    d) Specialization
    e) Other Factors
- Supportability and consistency are most important factors. You must articulate how you considered these two factors in the decision
- You may consider multiple medical opinions from a medical source together in a single analysis
- If two or more medical opinions are equally well-supported but not exactly the same, explain how you considered the other most persuasive factors

🗝 3 *Supportability and Consistency Are the Most Important Factors For Evaluating Medical Opinion Evidence. The ALJ Decision Must Address These Two Factors When Evaluating the Persuasiveness of Medical Opinion Evidence*

Supportability is essentially a two-prong analysis:

- Consider how well objective medical evidence relied upon by the medical source supports the medical opinion
- Consider the explanation for the medical opinion provided by the medical source

Consistency means how consistent the medical source opinion is with all the other evidence in the record from all other sources.

You must consider all the regulatory factors when evaluating a medical opinion. You must articulate how you considered supportability and consistency.

You may consider multiple medical opinions from a medical source together in a single analysis; you may, but are not required, to evaluate each opinion separately.

If two or more medical opinions are equally well supported but not exactly the same, you must explain how you considered the other most persuasive factors. The remaining factors include:

- **Relationship with the claimant,** which includes
  - Length of the treatment relationship
  - Frequency of examinations
  - Purpose of the treatment relationship
  - Extent of the treatment relationship
  - Examining relationship
- **Specialization,** and
- **Other factors**
  - Such as familiarity by the medical source with other evidence in the claim, or an understanding of our disability program's policies and evidentiary requirements.

We have rescinded SSR 06-3p, which generally required the ALJ to evaluate and weigh evidence from non-medical sources. In cases under the prior rules, you should still evaluate and

weigh this evidence under the guidance of the 20 CFR 404.1527(f) and 416.927(f). The current rules neither prohibit nor require you to weigh evidence and opinions from non-medical sources.

🗝 4 *The ALJ Decision Must Not Provide an Analysis of Decisions by Other Governmental Agencies or Non-Governmental Entities, Disability Examiner Findings, or Statements on Issues Reserved To The Commissioner.*

This evidence is neither inherently valuable nor persuasive.

Decisions by other governmental agencies or non-governmental entities, disability examiner findings may include, for example, decisions on disability made by the VA, a state workers compensation board or a private insurer.

Issues reserved to the Commissioner (20 CFR 404.1520b and 416.920b), may include:

- Whether or not a claimant is disabled, blind, able to work, or able to perform regular or continuing work;
- Whether or not a claimant has a severe impairment;
- Whether or not an impairment meets the duration requirement;
- Whether an impairment meets or medically equals a listed impairment;
- What the claimant's RFC is using our programmatic terms about functional exertional levels (instead of descriptions about the claimant's functional abilities and limitations);
- Whether or not the claimant's RFC prevents performance of past relevant work;
- Whether a claimant does or does not meet a medical-vocational rule; and,
- Whether or not the claimant's disability ends or continues when we conduct a CDR.

🗝 5 *Put the Principles into Practice: Concisely Articulate the Persuasiveness of All Medical Opinions by Citing Specific Evidence in the Record*

General statements regarding supportability and consistency do not satisfy our articulation requirements under the prior rules – or the current rules. Articulating the specific evidence that speaks to supportability and consistency should result in a concise and strong analysis.

This analysis shifts the focus away from the source of the medical opinion, and emphasizes the quality of the content-. a key conceptual change under the current rules.

You must address the factors of supportability and consistency. Of course, the decision may address the other factors. In some cases, a more detailed explanation of other factors will give the claimant and appellate reviewers a clear understanding of the considerations leading to the final decision.

Final Tips:

ALJs, when drafting instructions, identify specific evidence to help guide the decision writer, especially on the factors of supportability and consistency.

Although the articulation requirements have changed under the current rules, the decision must still address all medical opinions.

Do not articulate how you considered evidence that is inherently neither valuable nor persuasive. This includes statements on issues reserved to the Commissioner and decisions by other governmental agencies and nongovernmental entities. You may consider including in the decision a statement such as, "I did not provide articulation about the evidence that is inherently neither valuable nor persuasive in accordance with 20 CFR 404.1520b(c) and 416.920b(c)."

Under SSR 17-2p, if you have persuasive medical expert evidence and find a claimant equals a listing, you must identify the evidence in the record that supports your conclusion, and the decision must reflect this.