

A PRIMER ON SOCIAL SECURITY DISABILITY LAW

Emily C. Russell and the Hon. Glynn F. Voisin***

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* Emily C. Russell, Tulane University School of Law '13, assisted in the research and writing of this Article as a law student and judicial intern with the Social Security Administration New Orleans Office of Disability Adjudication and Review.

** Judge Glynn F. Voisin currently serves as an administrative law judge with the New Orleans Office of Disability Adjudication and Review. Since being appointed in 2004, Judge Voisin has served as Chief Administrative Law Judge for the New Orleans Hearing Office from 2005 to 2013; Acting Regional Chief Administrative Law Judge for the Philadelphia Region from 2007 to 2008; Acting Chief Administrative Law Judge for the Metairie, Louisiana Hearing Office in 2006; and Chief Administrative Law Judge for the Jackson, Mississippi Hearing Office from 2004 to 2005. Any expressions of opinion are those of the authors and do not reflect the official position of the Social Security Administration or the United States government.

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INTRODUCTION

If you receive a paycheck, you are likely paying into the Social-Security program with the hope that you will receive monthly payments after you retire. For nearly fourteen million Americans¹ with a mental or physical impairment that prevents them from working, the Social-Security program has another meaning: payment of disability benefits. The Social-Security-disability program has reached a critical mass, in terms of the number of claims filed² and the amount of benefits paid out.³ Social-Security-disability insurance payments account for \$1 of every \$5 spent by the Social Security Administration (SSA).⁴ To further complicate issues, current projections estimate that the disability benefits fund will

1. Table 1: Number of People Receiving Social Security, Supplemental Security Income (SSI), or both, September 2016 (in thousands), *Research, Statistics, & Policy Analysis: Monthly Statistical Snapshot, September 2016*, SOC. SECURITY ADMIN. https://www.ssa.gov/policy/docs/quickfacts/stat_snapshot/2016-09.pdf (last updated Oct. 2016).

2. In FY 2009, the Social Security Administration issued 658,600 dispositions, and it issued 737,616 in FY 2010. In FY 2011, it issued over 800,000 dispositions. *Improving Social Security Disability Insurance Claim Processing in Ohio: Hearing Before the Subcomm. on Oversight of Government Management, the Federal Workforce and the District of Columbia of the S. Comm. on Homeland Security and Governmental Affairs*, 111th Cong. (2010) (statement of Hon. D. Randall Frye, President, Association of A.A.L.J.), www.hsgac.senate.gov/download/111510-randy-frye-testimony-ogm-field-hearing.

3. SOC. SEC. ADMIN., OFFICE OF POLICY, SOC. SEC. BULL. NO. 66-03, A PRIMER: SOCIAL SECURITY ACT PROGRAMS TO ASSIST THE DISABLED 53 (2005/2006) [hereinafter SOC. SEC. ADMIN., A PRIMER], <https://www.ssa.gov/policy/docs/ssb/v66n3/v66n3p53.pdf> (“The Social Security Administration (SSA) administers two of the largest disability programs in the world: the Social Security Disability Insurance (DI) and the Supplemental Security Income (SSI) disability programs. In 2005, these two programs combined paid more than \$120 billion in cash benefits to nearly 11.3 million individuals (and 1.7 million dependents).”).

4. Eduardo Porter, *Disability Insurance Causes Pain*, N.Y. TIMES (Apr. 24, 2012), <http://www.nytimes.com/2012/04/25/business/economy/disability-insurance-causes-pain.html?pagewanted=all>.

be depleted by 2034.⁵

Social-Security-disability law is rarely a topic of conversation amongst families or American workers until it has to be. Congress is similarly silent on the issue and its future, despite the fact that the program cost \$132 billion in 2011, “[M]ore than the combined annual budgets of the departments of Agriculture, Homeland Security, Commerce, Labor, Interior and Justice.”⁶ Despite public reticence on Social-Security disability, or perhaps because of it, a basic knowledge of Social-Security law is arguably more important now than ever.

The aging baby-boomer generation, in combination with the economic downturn, has catalyzed an unprecedented increase in applications for old-age and disability benefits.⁷ In 2012, former SSA Commissioner Michael Astrue told Congress that, when he leaves office in 2013, “[T]he agency will have about the same number of employees that [it] had when [he] arrived in 2007, even though . . . workloads have increased dramatically. Since FY 2007, retirement and survivor claims have increased by 26 percent and disability claims have increased by over 31 percent.”⁸ One commentator explained that the recent increase in Social-Security-disability applications, and the resulting benefit awards, has been caused by several factors, including “the baby boom demographic bump” as well as:

[R]ecurrent or sustained economic recessions; a trend toward corporate downsizing of less productive workers; the elimination or reduction of other benefit programs for people

5. Nick Timiraos, *Social Security, Medicare Face Insolvency Over 20 Years, Trustees Report*, WALL ST. J. (June 22, 2016), <http://www.wsj.com/articles/social-security-medicare-trust-funds-face-insolvency-over-20-years-trustees-report-1466605893>.

6. Brian Faler, *New Use Draining Social Security Disability Fund: Insolvency Seen in Four Years Unless Congress Acts*, BOSTON GLOBE, <http://www.bostonglobe.com/news/nation/2012/05/29/social-security-disability-insolvent-unless-congress-votes/wmG61sP4AUS0Ep28oKobJN/story.html>.

7. Since the economic recession began, the percentage of disabled workers aged twenty-five to sixty-four has increased from 4.5% to 5.3%. Janet Whitman, *Jobless Disability Claims Soar to Record \$200B as of January*, N.Y. POST (Feb. 19, 2012, 5:00 AM), http://www.nypost.com/p/news/business/pain_brings_gain_taZkGOAUhXALmhEEyMpmqJ.

8. *The Social Security Administration: Is It Meeting Its Responsibilities to Save Taxpayer Dollars and Serve the Public?*, Hearing Before the S. Comm. on Finance, 112th Cong. (2012) [hereinafter *The Social Security Administration*] (statement of Michael J. Astrue, Comm’r, Social Security Administration), <http://www.finance.senate.gov/download/astrue-opening-statement>.

with disabilities and people living in poverty; the rise in the Social Security retirement age to 66; declining access to quality ongoing and preventive health care for low-wage workers; transformations in the low wage economy; the rise in community-based alternatives to institutional care for claimants with mentally [sic] illness; outreach efforts to homeless persons with disabilities; state and local welfare agency requirements that certain persons apply for federal disability benefits; and technological, scientific, medical and psychiatric diagnostic advances that more readily reveal clinical and objective bases for impairments and their severity, among other reasons.⁹

Although the ongoing recession, the resulting increase in disability-benefits applications, and an incident with an outlier judge approving almost 100% of his cases¹⁰ complicated Astrue's tenure as SSA Commissioner, his successors will be challenged by the task of saving the entire program. As previously mentioned, current estimates project that the Social-Security disability fund will be depleted by 2034.¹¹ In the upcoming years, the SSA will have to begin looking to other avenues to make payments to America's disabled workers. A massive overhaul of the Social-Security-disability-benefits program is long overdue.

As the President of the Association of Administrative Law Judges testified before Congress: "In the context of disability adjudication, the government is the trustee of billions of taxpayer dollars."¹² Social-Security law has far-reaching and direct impacts on a large percentage of the American populace,¹³ and in recent years, the spotlight has focused on Social-Security disability. This area of the law is ripe with opportunities for law

9. JON C. DUBIN & ROBERT E. RAINS, AM. CONSTITUTION SOC'Y FOR LAW AND POLICY, *SCAPEGOATING SOCIAL SECURITY DISABILITY CLAIMANTS (AND THE JUDGES WHO EVALUATE THEM)* 10–11 (2012) (citations omitted), https://www.acslaw.org/sites/default/files/Dubin_Rains_-_Scapegoating_Social_Security_Disability_Claimants.pdf.

10. Damian Paletta, *Insolvency Looms as States Drain U.S. Disability Fund*, WALL ST. J. (Mar. 22, 2011), <http://online.wsj.com/article/SB10001424052748703752404576178570674769318.html>.

11. Timiraos, *supra* note 5.

12. *Securing the Future of the Social Security Disability Insurance Program: Hearing Before the Subcomm. on Social Security of the H. Comm. on Ways and Means*, 112th Cong. (2012) (statement of Hon. D. Randall Frye, President, Association of A.L.J.), https://aalj.org/system/files/documents/microsoft_word_-_aalj_frye_house_statement_june_27_2012.pdf.

13. See SOC. SEC. ADMIN., *A PRIMER*, *supra* note 3.

students to study, claimants' representatives to build a practice, and for Americans to educate themselves on issues that may directly affect their families. With those opportunities in mind, this primer provides an insider's view on Social-Security-disability law.

While the disability-claims process has many steps, the heart lies with the Office of Disability Adjudication and Review (ODAR) and the administrative law judges who issue decisions after an initial application for benefits is denied at the state level. Part I of this primer addresses the underpinnings of the Social-Security-disability-benefits adjudication process, consisting of: (1) the function of administrative law judges (ALJs); (2) the distinction between federal trials and administrative hearings; and (3) the path of a disability claim from the initial application to a hearing at the ODAR. Next, Part II discusses the importance of efficiency in the claims process and the ODAR's efforts to streamline hearings. Part III then provides an in-depth explanation of the sequential evaluation ALJs must use to determine whether an individual is "disabled" under the Social Security Act. Finally, Part IV lists a collection of practitioner best practices recommended by a Chief ALJ and other ALJs.

This primer concludes that Social-Security-disability law is experiencing a resurgence. Consequently, a variety of interested parties will benefit from a basic understanding of the fundamentals of the disability-adjudication process. The average American worker may use this understanding to develop his case. Social-Security-disability claimants and their representatives will benefit from this primer on the law, and can strengthen their disability practice after reading the best practices for practitioners. Finally, for those who have neither personal nor professional experience with disability law, this primer may inform future career choices and will leave such readers with a thorough understanding of the basics of this distinctive area of law.

PART I: BACKGROUND OF THE SOCIAL SECURITY DISABILITY PROGRAM

The SSA is responsible for the administration of two of the world's largest disability programs: Social-Security-Disability Insurance and Supplemental-Security Income.¹⁴ The Social-

14. SOC. SEC. ADMIN., A PRIMER, *supra* note 3.

Security-disability program is distinct from the Social-Security-old-age-benefits program, more commonly known as “retirement benefits.” When a worker is diagnosed with a physical or mental impairment that he believes prevents him from continuing to work, he may apply for Social-Security-disability insurance.¹⁵ To qualify, the worker must have paid into the Social-Security system over a specific period of time.¹⁶ This preliminary gatekeeping feature of the program has contributed to the general perception of Social-Security payments as a property right, rather than a form of welfare.¹⁷

A worker may file a paper claim with the office of Disability Determination Services (DDS) located in his state or file electronically through the SSA website.¹⁸ DDS processes each claim and makes an initial determination of whether the claimant is disabled.¹⁹ If the initial claim is denied, the claimant may appeal the determination to the ODAR.²⁰ An ALJ will then review the documents from DDS and the claimant’s medical record.²¹ Finally, the ALJ will hold a hearing to receive testimony from the claimant and any witnesses the ALJ chooses to admit.²² After the hearing, the ALJ will decide whether the claimant is disabled.²³

15. See SOC. SEC. ADMIN., A PRIMER, *supra* note 3, at 53–54.

16. See 20 C.F.R. § 404.315(a)(1) (2015) (“You are entitled to disability benefits while disabled before attaining full retirement age . . . if You have enough social security earnings to be *insured for disability*”) (emphasis in original).

17. Edward Rubin, *The Affordable Care Act, The Constitutional Meaning of Statutes, and the Emerging Doctrine of Positive Constitutional Rights*, 53 WM. & MARY L. REV 1639, 1695 (2012) (“Franklin Roosevelt famously structured [the Social Security] Act, against the advice of his economic advisors, as an insurance program funded by payroll taxes, rather than as a welfare program, to preclude its repeal or retrenchment. His political judgment, in this area as in so many others, was unerring. The usual account of why this strategy worked is that the Social Security Act’s old age payments were conceived of as a property right that people had earned rather than as a form of welfare.”).

18. *Disability Determination Process*, SOC. SECURITY ADMIN., <https://www.ssa.gov/disability/determination.htm> (last visited Jan. 6, 2017).

19. *Id.*

20. *Id.* (“Subsequent appeals of unfavorable determinations may be decided in a DDS or by an administrative law judge in SSA’s Office of Disability Adjudication and Review.”).

21. SOC. SEC. ADMIN., PUB. NO. 05-10041, THE APPEALS PROCESS 1 (2015), <https://www.ssa.gov/pubs/EN-05-10041.pdf>.

22. See *id.* (“At the hearing, the administrative law judge will question you and any witnesses you bring.”).

23. *Id.* at 2.

THE DEFINITION OF DISABILITY

The Social Security Act strictly defines “disability” for purposes of determining eligibility for disability benefits.²⁴ It is important to note that a claimant may not meet the Social-Security-Act definition of disability even if he has medically-determinable physical or mental impairments.²⁵ The SSA is not a diagnosis-driven agency; rather, it seeks to determine a person’s functional abilities to work despite medically-imposed limitations. Thus, federal regulations narrowly define disability as “the inability to do any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months.”²⁶ To make this determination, ALJs methodically examine the medical evidence and claimants’ subjective statements about their conditions using a five-step sequential evaluation.²⁷

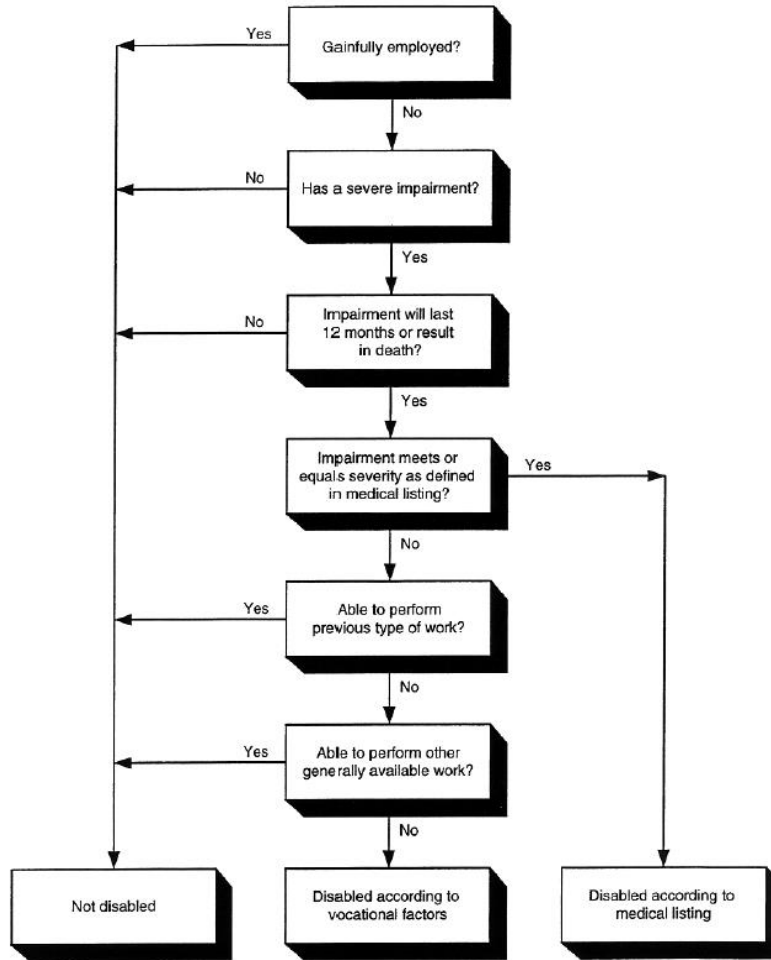
24. See Jon C. Dubin, *The Labor Market Side of Disability-Benefits Policy and Law*, 20 S. CAL. REV. L. & SOC. JUST. 1, 9–14 (2011) (discussing Congress’s development of the definition of “disability” during the 1950s).

25. See *id.* at 12–14.

26. 20 C.F.R. § 404.1505(a) (2015); SOC. SEC. ADMIN., A PRIMER, *supra* note 3, at 53–54.

27. § 404.1520(a)(4)(i)–(v).

**Figure One:
The Five-Step Sequential Process**



WHAT IS AN ADMINISTRATIVE LAW JUDGE?

All federal judges are not created equal. There are several notable differences between federal ALJs and federal district-court judges. First, federal ALJs are Article I judges, which means that they fall under the Executive Branch of the federal government.²⁸ The Senate does not confirm the appointment of Article I judges. Conversely, federal district-court judges are Article III judges, i.e., Judicial-Branch judges.²⁹ Article II of the U.S. Constitution empowers the President, “by and with the advice and consent of the Senate,” to appoint Supreme Court justices, circuit-court judges, and district-court judges.³⁰

A second difference between federal ALJs and federal district-court judges is that ALJs conduct hearings, after which the federal ALJ makes a decision.³¹ In contrast, the federal district-court judge conducts hearings on motions and trials. After a jury trial, federal district courts issue verdicts. If the judge holds a bench trial, he issues a judgment.

Procedurally and evidentially, administrative-law hearings differ from federal trials or hearings on motions. For example, there is no prohibition against hearsay in an administrative-law hearing room.³² Also, the Code of Federal Regulations guides the admission of evidence at disability hearings, rather than the

28. U.S. CONST. art. I, § 8, cl. 9 (“The Congress shall have the power to . . . constitute tribunals inferior to the Supreme Court.”); VANESSA K. BURROWS, CONG. RESEARCH SERV., 7-5700, ADMINISTRATIVE LAW JUDGES: AN OVERVIEW (2010), <http://ssaconnect.com/tfiles/ALJ-Overview.pdf> (“[ALJs] preside at formal adjudicatory and rulemaking proceedings conducted by executive branch agencies.”).

29. U.S. CONST. art. III, § 1 (“The judicial power of the United States, shall be vested in one Supreme Court, and in such inferior courts as the Congress may from time to time ordain and establish.”).

30. *See id.* art. II, § 2, cl. 2.

31. *See* BURROWS, *supra* note 28, at 1 (“In general, ALJs have two primary duties in the administrative adjudication process. The first duty is to preside over the taking of evidence at agency hearings and act as the finder of facts in the proceedings An ALJ’s other main duty is to act as a decisionmaker by making or recommending an initial determination about the resolution of the dispute.”); *see also id.* at 1 n.6 (citations omitted) (“The initial decision of the ALJ becomes the final decision of the agency if it is not appealed by the parties or if the agency itself does not seek to review the case on its own motion.”).

32. *See* 5 U.S.C. § 556(d) (2016) (“Any oral or documentary evidence may be received [by the ALJ], but the agency as a matter of policy shall provide for the exclusion of irrelevant, immaterial, or unduly repetitious evidence.”) (emphasis added); 20 C.F.R. § 404.950(c) (“The [ALJ] may receive evidence at the hearing even though the evidence would not be admissible in court under the rules of evidence used by the court.”).

Federal Code of Civil/Criminal Procedure.³³

Notably, federal administrative-agency practice is an exception to the unauthorized practice of law doctrine. As a result, in disability-benefits cases before an ALJ, representatives of claimants are *not* required to be practicing attorneys,³⁴ although 78% of claimants are represented at the hearing level by attorneys.³⁵ In general, the practice of law is restricted to attorneys admitted to a state bar after having met specific educational, examination, and moral-character requirements.³⁶ The purpose of the prohibition on the unauthorized practice of law is to promote competent representation and ethical behavior.³⁷ One commentator explains: “As administrative agencies were designed without the formalities and rules of the courts, they were ideally suited for non-attorney representatives.”³⁸ The Administrative Procedure Act (APA), which created the framework for the hearings conducted by ALJs, neither explicitly prohibited nor acquiesced in non-attorney

33. See § 404.950(c).

34. See SOC. SEC. ADMIN., OFFICE OF THE INSPECTOR GEN., CONG. RESPONSE REPORT, A-05-11-01124, ELECTRONIC SERVICES FOR CLAIMANT REPRESENTATIVES 2 n.7 (2011), <https://oig.ssa.gov/sites/default/files/audit/full/pdf/A-05-11-01124.pdf> (“Claimant representatives are attorneys, non-attorneys, and third parties who conduct business on behalf of those filing for disability benefits.”).

35. *Id.*

36. See Derek A. Denckla, *Nonlawyers and the Unauthorized Practice of Law: An Overview of the Legal and Ethical Parameters*, 67 FORDHAM L. REV. 2581, 2587 (1999) (citations omitted) (“All states have statutes that restrict the practice of law to licensed attorneys. Because these statutes are often vaguely worded, however, they fail to define [unauthorized practice of law (UPL)] succinctly. One common type of UPL statute is the so-called ‘integration act,’ which limits the practice of law to members of an integrated bar association.”).

37. See *id.* at 2593 (citations omitted) (“The rationale invoked by courts to prohibit UPL is reflected in ethical considerations (“ECs”) of the Model Code. EC 3-1 of the Model Code explains that “[t]he prohibition against the practice of law by a layman is grounded in the need of the public for integrity and competence of those who undertake to render legal services.”); see also Drew A. Swank, *Non-Attorney Social Security Disability Representatives and the Unauthorized Practice of Law*, S. ILL. U. L.J. 223, 246–47 (2012) (noting that the “twin pillars of the unauthorized practice of law doctrine designed to protect the public—measures to ensure competency and a system to ensure ethical behavior—are already provided for in the Social Security Act and the Code of Federal Regulations,” and further arguing that the language in the Code of Federal Regulations and the Social Security Administration’s Hearing Appeals and Litigation Manual (HALLEX) that requires non-attorneys to be “helpful” should be “rewritten to use verbatim the language of the Social Security Act requiring that non-attorney representatives must be ‘competent’”).

38. Swank, *supra* note 37, at 234.

representation.³⁹

In 1963, the U.S. Supreme Court addressed this congressional silence, and explained why states may not rely on the unauthorized practice of law doctrine to bar non-attorney representation before a federal administrative agency.⁴⁰ In *Sperry v. Florida*, the Court determined that the federal APA preempted Florida statutes governing the practice of law.⁴¹ As one scholar wrote, “While non-attorneys were in fact practicing law, it was deemed an exception to the unauthorized practice of law doctrine because it was limited to a federal administrative agency that had authorized it.”⁴² Because the SSA is the largest adjudicatory body in the world,⁴³ it follows that non-attorneys are more likely to appear before it than any other administrative agency. Today, non-attorney representation comprises 11%–14% of the approximately 700,000 cases heard by the SSA annually.⁴⁴

Unlike litigation, the disability-claims-hearing system is non-adversarial. At the hearing, the ALJ will typically ask questions of the claimant first and allow the representative to follow up. This questioning process is not cross-examination; rather, it helps to develop the record and allows the ALJ to hone in on key points. Through the questioning process, ALJs play an active role. ALJs serve as: (1) “advocates for the government,

39. 5 U.S.C. § 500(d)(1) (2006) (“This section does not—grant or deny to an individual who is not qualified as provided by subsection (b) or (c) of this section the right to appear for or represent a person before an agency or in an agency proceeding.”).

40. *Sperry v. Florida*, 373 U.S. 379, 388 (1963) (“Examination of the development of practice before the Patent Office and its governmental regulation reveals that: (1) nonlawyers have practiced before the Office from its inception, with the express approval of the Patent Office; (2) during prolonged congressional study of unethical practices before the Patent Office, the right of nonlawyer agents to practice before the Office went unquestioned . . . ; (3) despite protests of the bar, Congress in enacting the [APA] refused to limit the right to practice before the administrative agencies to lawyers . . .”).

41. *See id.* at 399–400 (citations omitted) (“[W]e note that every state court considering [non-attorney representation in administrative hearings] prior to 1952 agreed that the authority to participate in administrative proceedings conferred by the Patent Office and by other federal agencies was either consistent with or preemptive of state law.”).

42. Swank, *supra* note 37, at 238 (citations omitted).

43. *See* Robert E. Rains, *Professional Responsibility and Social Security Representation: The Myth of the State-Bar Bar to Compliance with Federal Rules on Production of Adverse Evidence*, 92 CORNELL L. REV. 363, 364 (2007) (citing *Heckler v. Campbell*, 461 U.S. 458, 461 n.2 (1983)) (The Social Security administrative law system is probably the largest adjudicatory system in the world.”).

44. Swank, *supra* note 37, at 234–35.

critically scrutinizing the validity of the position of the claimant . . .”; (2) “advocates for claimants . . . who do not have professional representation”; and (3) “adjudicators who must render a decision.”⁴⁵ Professor Jerry Mashaw succinctly describes the primary goal of the adjudication as “the protection of the claimant’s interest in full development and consideration of his or her claim.”⁴⁶

The administrative-review process for disability benefits is distinct from any other area of law because each step follows a formal, non-adversarial framework. Upon receiving an unfavorable initial determination regarding his application for disability benefits, a claimant may request a hearing before an ALJ.⁴⁷ ALJs review cases de novo, as if considering the claim for the first time.⁴⁸ Their review is based on the medical evidence, the claimant’s subjective complaints, and the testimony of vocational or medical experts.⁴⁹

The claimant appears at his local ODAR for a hearing before the ALJ. The SSA’s administrative-hearings process is governed by §§ 554 and 556 of the APA, the provisions for formal adjudication,⁵⁰ which are reiterated in § 205(b)(1) of the Social Security Act.⁵¹ Under these provisions, the claimant’s rights include: (1) notice and opportunity to be heard;⁵² (2) the right to

45. Jonathan P. Schneller, *The Earned Income Tax Credit and the Administration of Tax Expenditures*, 90 N.C. L. REV. 719, 777 (2012) (citations omitted) (discussing the “inquisitorial” adjudicatory process in the context of adjudication of Earned Income Tax Credit compliance).

46. See JERRY L. MASHAW, BUREAUCRATIC JUSTICE: MANAGING SOCIAL SECURITY DISABILITY CLAIMS 128 (1983).

47. See SOC. SEC. ADMIN., *supra* note 21; *Disability Determination Process*, *supra* note 18.

48. See SOC. SEC. ADMIN., *supra* note 21, at 1–2.

49. See *id.*

50. See 5 U.S.C. § 554(a) (2016) (“This section applies . . . in every case of adjudication required by statute to be determined on the record after opportunity for an agency hearing . . .”); § 556(a) (“This section applies . . . to hearings required by section 553 or 554 of this title to be conducted in accordance with this section.”).

51. See 42 U.S.C. § 405(b)(1) (2016) (“The Commissioner of Social Security is directed to make findings of fact, and decisions as to the rights of any individual applying for a payment under this subchapter.”).

52. At least one court has ruled that the SSA violates a claimant’s right to a hearing if there is an unreasonable delay between the time the claimant requests a hearing, and the actual date of the hearing. See *White v. Mathews*, 559 F.2d 852, 858–59 (2d Cir. 1977) (citations omitted) (“[U]pon request of a claimant, the [Commissioner] is directed to provide him with “reasonable notice and an opportunity for a hearing” with respect to the decision complained of. We read this as giving the claimant a right to a hearing within a reasonable time . . . Although what

an evidentiary hearing; (3) the right to findings of fact and legal conclusions based on evidence adduced at hearing; (4) following the hearing, the right to a decision containing both a statement discussing the evidence adduced as well as the Commissioner's determination and the reason(s) upon which it is based; and (5) the right to preserve the evidentiary record created before the ALJ for judicial review at the district-court level.⁵³

The hearing provides more sources of evidence for the ALJ to consider before deciding whether the claimant is disabled. As commentators have observed at a hearing before an ALJ:

Claimants have the first true opportunity to describe matters not likely apparent from the paper records before the DDS, such as the side-effects of prescribed medication, the negative synergies from the combined or cumulative consequences of multiple impairments, and the burdens and limitations of various treatment regimens.⁵⁴

Also, at a hearing, the ALJ often receives testimony from a vocational expert (VE) and sometimes from a medical expert.⁵⁵ The VE provides an impartial, vocational opinion on the claimant's ability to work, and reviews vocational exhibits and testimony at the hearing, while the medical expert provides his opinion on the claimant's impairments, even if he has not treated the claimant in the past. The claimant may also present witnesses to testify, but the ALJ is not required to hear from the witnesses.⁵⁶ Using the claimant's medical record and the information gathered at the hearing, the ALJ follows a formal five-step sequential evaluation to determine whether the claimant is disabled.⁵⁷

is reasonable depends upon a variety of circumstances, that statutory command should not be ignored. The disability insurance program is designed to alleviate the immediate and often severe hardships that result from a wage-earner's disability. In that context, delays of the better part of a year in merely affording an evidentiary hearing detract seriously from the effectiveness of the program.”)

53. § 405(b)(1).

54. DUBIN & RAINS, *supra* note 9, at 6.

55. SOC. SEC. ADMIN., *supra* note 21 (“Other witnesses, such as medical or vocational experts, also may give us information at the hearing.”); DUBIN & RAINS, *supra* note 9, at 6 (“ALJs have the discretion to call Medical Experts (MEs) and Vocational Experts (VEs) to testify at hearings on certain medical and vocational issues and sometimes are required by SSA policy or court order to do so.”).

56. *See* SOC. SEC. ADMIN., *supra* note 21; DUBIN & RAINS, *supra* note 9, at 6.

57. *See* 20 C.F.R. § 404.1520(a)(4)(i)–(v) (2015); fig.1, *supra*.

PART II: EFFICIENCY AND THE SOCIAL SECURITY DISABILITY CLAIMS PROCESS

The one-size-fits-all sequential evaluation process for adjudicating Social-Security-disability claims assists local hearing offices faced with a monumental task of processing thousands of claims every year. Recognizing the importance of expediency in this system, former SSA Commissioner Astrue aimed to reduce the disability-application and hearing backlog.⁵⁸ When a claimant is genuinely disabled, the time that he waits for a determination of his benefits is critical to his financial and physical wellbeing.⁵⁹ As Senator William S. Cohen noted in a 1983 Senate hearing, “The decisions of ALJ’s have profound effects on people’s lives, and in many cases, represent the difference between a dignified standard of living and abject poverty for a disabled worker.”⁶⁰ Waiting three years for a determination could deplete a claimant’s life savings. Worse, the wait period could catalyze the development of mental impairment, such as depression, when the initial claim was limited to a physical impairment. As one federal court observed, “The disability insurance program is designed to alleviate the immediate and often severe hardships that result from a wage-earner’s disability.”⁶¹ Consequently, efficiency is critical to Social-Security-disability law.

Approximately 1500 ALJs work for the ODAR.⁶² In 2013, the ALJs issued roughly 793,000 dispositions.⁶³ Through the SSA’s

58. Michael J. Astrue, *Press Office*, SOC. SECURITY ADMIN., <http://www.ssa.gov/pressoffice/factsheets/astrue.htm> (last visited Jan. 6, 2017) (“As Commissioner of Social Security, [Astrue] focused his efforts on reducing the disability backlog and improving service to the public, particularly through electronic services. He . . . spearheaded highly successful new systems for fast-tracking disability claims, created National Hearing Centers to reduce local backlogs with video hearings, and both expanded and overhauled the agency’s suite of electronic services to make them simpler, faster and far more user-friendly.”).

59. *See White v. Mathews*, 559 F.2d 852, 858 (2d Cir. 1977).

60. *Social Security Disability Reviews: The Role of the Administrative Law Judge, Hearing Before the Subcomm. on Oversight of Government Management of the S. Comm. on Governmental Affairs*, 98th Cong. 2 (1983) [hereinafter *Social Security Disability Reviews*] (statement of Sen. William S. Cohen, Chairman, S. Subcomm. on Oversight of Government Management).

61. *White*, 559 F.2d at 858.

62. Hearing Office Locator: Office of Disability Adjudication and Review, *Hearings and Appeals*, SOC. SECURITY ADMIN., http://www.ssa.gov/appeals/ho_locator.html (last visited Jan. 6, 2017).

63. SOC. SEC. ADMIN., COMPREHENSIVE PRINTING PROGRAM PLAN FOR FISCAL YEARS 2015–2017 (INCLUDES FY 2013 PRINTING ACTIVITY REPORTS), at 1 (2014),

establishment of production goals, ALJs demonstrated a marked increase in their rate of cases decided each month. In 1974, ALJs each disposed of roughly thirteen cases per month.⁶⁴ Today, a high percentage of ALJs hear nearly 500 cases per year.

However, ALJs must balance efficiency with providing legally sufficient decisions. They are responsible for disposing of a high volume of cases, while being held to a high level of scrutiny.⁶⁵ The five-step sequential evaluation provides a reliable, objective means of assessing large volumes of highly fact-specific claims. In recent years, even in the face of increasing volumes of hearing requests, the ODAR has become more efficient. In 2011, the ODAR cut the average waiting time for hearing decisions to less than one year for the first time since 2003.⁶⁶ The ODAR has established benchmarks for quality case processing that aim to move a case from its initial receipt to mailing of the ALJ's decision in 219 calendar days or less (i.e., seven months or less).⁶⁷ From 2011–2012, the average processing time for hearing decisions decreased, but was still higher than ex-Commissioner Astrue's goal of 270 days.⁶⁸ The New Orleans

<https://www.ssa.gov/legislation/2015-2017CPPP.pdf>.

64. *Social Security Disability Reviews*, *supra* note 60.

65. All decisions by ALJs may be appealed to the federal judiciary. See 42 U.S.C. § 405(g) (2016) (“Any individual, after any final decision of the Commissioner of Social Security made after a hearing to which he was a party, irrespective of the amount in controversy, may obtain a review of such decision by a civil action commenced within sixty days after the mailing to him of notice of such decision or within such further time as the Commissioner of Social Security may allow. Such action shall be brought in the district court of the United States for the judicial district in which the plaintiff resides, or has his principal place of business, or, if he does not reside or have his principal place of business within any such judicial district, in the United States District Court for the District of Columbia.”).

66. See *The Social Security Administration*, *supra* note 8.

67. See Organizational Structure of the Social Security Administration, *SSA Organizational Manual: Chapter TL—Office of Disability Adjudication and Review*, SOC. SECURITY ADMIN., <https://www.ssa.gov/org/orgdcdar.htm> (last visited Jan. 6, 2017) (“The Division of Workload Management[:] [1] helps the CALJ Judge to ensure timely service to the public[:] [2] [s]ets goals and performance standards for ODAR regional and hearing offices[:] [3] [a]nalyzes hearing workload needs and oversees workload transfers[:] [4] [e]valuates workflow processes and makes changes as needed[:] [5] [p]rovides management information and analyses of hearing workloads for the CALJ, other executives, and regional offices[:] [6] [i]dentifies problems and trends in the hearing workloads and proposes solutions[:] [7] [d]esigns and pilots organizational and change models; and [8] [c]oordinates with the Office of Electronic Services and Strategic Information . . . to design new reports to meet changing needs and requirements.”) (emphasis added).

68. See *The Social Security Administration*, *supra* note 8.

ODAR averages 472 days to process a case.⁶⁹ At the time of this writing, its average processing time ranked twenty-third out of 165 hearing offices and hearing centers in the country.⁷⁰

The increasing efficiency at the SSA is due, in large part, to the agency's technological advances in recent years. With the advent of the Electronic Disability Project in 2004, SSA's electronic folder replaced folders filled with paper claims that had to be lugged to hearing rooms and on airplanes during travel.⁷¹ ODARs moved into a fully-electronic realm where all paper-evidence, forms, and case-processing documents would be officially stored in an electronic record accessible to all offices across the country. The system contains a folder for every claimant who files a claim and a case-processing-management system. Other technologies include electronic hearing rooms, a digital-recording-acquisition project, and video hearings.

Going electronic provides ODARs with a more efficient and effective case-processing system. More importantly, given the large volumes of confidential information contained in each case (e.g., medical histories and Social-Security numbers), the electronic system provides a secure, centralized repository of ODAR data. Administratively, the system reduces the time it takes to receive information and facilitates automatic creation of the exhibit list. For the tech savvy claimant and representative, it also provides online access to hearing notices. Claimants who request a copy of their case files will receive it via CD. Representatives have access to this CD during hearings, but do not have general access to the system.⁷² One Louisiana non-attorney practitioner—Gary Sells—has embraced the paperless-processing system at ODAR, and advises his colleagues: “The best way for a representative to maximize the benefits of ODAR's technology is to go completely paperless.”⁷³ In his office, Mr. Sells

69. Hearing Office Average Processing Time Ranking Report FY 2016, *Hearings and Appeals*, SOC. SECURITY ADMIN., http://www.ssa.gov/appeals/DataSets/05_Average_Processing_Time_Report.html (last visited Jan. 6, 2017).

70. *Id.*

71. ALJs, including this Article's co-author Judge Glynn F. Voisin, at the Jackson, Mississippi office processed one of the first cases in a fully-electronic environment. Mississippi was one of the first states for which the electronic folder became the official folder for new disability cases filed on, or after, January 25, 2005.

72. See SOC. SEC. ADMIN, HALLEX: HEARINGS, APPEALS, AND LITIGATION LAW MANUAL, at ch. I-2-1-35, http://www.ssa.gov/OP_Home/hallex/I-02/I-2-1-35.html (last updated July 21, 2016).

73. Gary Sells, Founder, Disability Benefits Advocate, Address at Loyola University New Orleans College of Law Continuing Legal Education Course: Social

retains paper copies of only “the signed fee contract, medical releases, SSA-827s, and SSA-1696” and stores all other documents and files to his computer server.⁷⁴

PART III: THE FIVE-STEP SEQUENTIAL EVALUATION

The five-step sequential evaluation mimics the definition of adult disability in the Social Security Act line by line. The ALJ must follow the specific steps in sequence when evaluating a disability claim. At all levels of consideration, this process is designed to facilitate an accurate and consistent application of the Social Security Act’s provisions and regulations. It permits identification of the most obvious allowances and denials early in the process. Though the ALJ follows the steps sequentially, he must stop the process at any step where a finding of disabled or not disabled can be made.

The adjudication-and-review process begins at ODAR when the claimant files his appeal of DDS’s decision. The ALJ receives the claimant’s record, which typically contains medical evidence, documents the claimant filed with DDS, and sometimes statements from a third party, such as a spouse or friend who assisted with the initial disability application. Using this record, an ALJ follows the five-step sequential evaluation to determine whether the claimant meets the SSA’s definition of “disabled” and is therefore entitled to disability benefits.

STEP 1: SUBSTANTIAL GAINFUL ACTIVITY

At step one, the ALJ must determine whether the claimant has engaged in substantial gainful activity (SGA) since he filed the initial application. SGA is work that involves significant and productive physical or mental duties (the “substantial” facet), and is done for pay or profit (the “gainful” facet).⁷⁵ The ALJ will ask the claimant: “Are you working?” and “Have you worked since you filed your initial claim?”⁷⁶ Part-time work may still qualify as substantial.⁷⁷ “Gainful” means work that is typically performed for pay or profit; the claimant need not realize a profit for the

Security Disability on the Cutting Edge of Technology, (Oct. 15, 2011) (transcript on file with authors).

74. Sells, *supra* note 73.

75. 20 C.F.R. § 404.1510(a)–(b) (2015).

76. *See* §§ 404.1571, 416.971.

77. § 404.1572(a).

work to qualify as gainful.⁷⁸ The definition of disability is premised on the idea that the claimant is unable to perform *any* work activity. Therefore, the exceptions to this rule are few and far between.

One such exception is an unsuccessful work attempt. If the claimant has worked since filing the initial application, his representative will attempt to demonstrate that the claimant did not earn enough money to rise to the level of SGA.⁷⁹ Generally, if an impairment has “forced [the claimant] to stop working or to reduce the amount of work [she] do[es] so that [her] earnings from such work fall below the [SGA] earnings level,” the SSA considers that to be an unsuccessful-work attempt.⁸⁰ Aside from this exception, if an individual engages in SGA, she does not meet the Social Security Act’s definition of disabled, regardless of how severe her physical or mental impairments are.⁸¹ The inquiry ends at step one. However, if the individual is not engaging in SGA, the analysis proceeds to the second step.

STEP 2: DOES THE CLAIMANT HAVE A SEVERE IMPAIRMENT LASTING AT LEAST TWELVE MONTHS?

Next, the ALJ must evaluate whether the claimant has a severe physical or mental impairment.⁸² The impairment “must result from anatomical, physiological, or psychological abnormalities” that “can be shown by medically acceptable clinical and laboratory diagnostics techniques.”⁸³ A claimant must satisfy several requirements to proceed past this step. First, the impairment must be expected to result in death or have lasted, or be expected to last, “for a continuous period of at least 12 months.”⁸⁴ Second, the impairment must be “severe.” Courts have interpreted a severe impairment as requiring more than a slight or *de minimis* impairment.⁸⁵ Third, the impairment must

78. § 404.1572(b).

79. *See* § 404.1574(b).

80. § 404.1574(c)(1).

81. § 404.1571 (“If you are able to engage in substantial gainful activity, we will find that you are not disabled.”).

82. *See* §§ 404.1520(a)(4)(ii), 416.920(a)(4)(ii).

83. § 404.1508.

84. § 404.1509.

85. *See, e.g.,* Dixon v. Shalala, 54 F.3d 1019, 1023–25 (2d Cir. 1995) (citing Bowen v. Yuckert, 482 U.S. 137, 179–80 (1987)) (describing the *de minimis* “slightness” step-two standard, and noting that five members of the Supreme Court found that “the only valid severity regulation would be one that screened out only *de minimis* claims”).

be medically determinable. If an impairment fails to meet any of these factors, the claimant is deemed not disabled and the sequential evaluation ends.

Severe impairments that do not last twelve months are not considered disabling. For example, suppose a claimant suffers broken bones that require six weeks in a cast, but then returns to work within one year of the date of the injury. If the disability does not, or did not, last twelve months, no benefits will be awarded.

Furthermore, unrelated consecutive severe impairments, none of which last twelve months, do not qualify for benefits. For example, a claimant who breaks his leg and is in a cast for six months will not receive benefits if he falls and breaks both arms, requiring him to be in a cast for an additional seven months.⁸⁶ Although the claimant is disabled for more than one year, these are separate impairments. Independently, neither lasted for more than twelve months and benefits must be denied.

Federal regulations define the meaning of an impairment that is *not* severe as an impairment or combination of impairments that do not significantly limit the claimant's physical or mental ability to do basic work activities. Thus, a severe impairment significantly limits a claimant's physical or mental ability to do basic work activities. Such activities include physical functions like walking, standing, sitting, lifting, pushing, pulling, reaching, and the ability to see, hear, or speak. It also includes mental functions such as the ability to: (1) understand, carry out, and remember simple instructions; (2) use judgment; and (3) deal with changes in a routine work setting. A claim will be denied at step two if the impairment, or combination of impairments, does not cause more than a minimal impact on the ability to perform basic work activities.⁸⁷

86. See § 404.1522(a) (“We cannot combine two or more unrelated severe impairments to meet the 12-month duration test. If you have a severe impairment(s) and then develop another unrelated severe impairment(s) but neither one is expected to last for 12 months, we cannot find you disabled, even though the two impairments in combination last for 12 months.”).

87. See § 404.1521(a); see also SSR 85-28, 1985 WL 56856, *2 (Jan. 1, 1985) (“The principle that a denial determination may be made on the basis of medical considerations alone was first reflected in Regulations No. 4, section 404.1502(a), published in 1960. Regulations published in 1978 revised the 1960 statement concerning such determinations by replacing the phrase ‘. . . the only impairment is a slight neurosis, slight impairment of sight or hearing, or other slight abnormality or combination of slight abnormalities . . .’ with ‘. . . the medically determinable

A medically-determinable impairment exists when clinical diagnosis or testing demonstrates physical or mental abnormalities. The medical evidence must consist of signs (demonstrated through the medical evaluations), symptoms (the claimant's subjective complaints), and laboratory findings.⁸⁸ Without medical evidence, demonstrated with medically-acceptable clinical and laboratory diagnostic techniques, the impairment cannot be shown to be severe. In the Fifth Circuit, “[A]n impairment can be considered as not severe only if it is a slight abnormality [having] such minimal effect on the individual that it would not be expected to interfere with the individual’s ability to work, irrespective of age, education or work

impairment is not severe if it does not significantly limit an individual’s physical or mental capacity to perform basic work-related functions.”); SSR 96-3p, 1996 WL 374181, *1 (July 2, 1996) (“[T]he purpose of this Ruling is to restate and clarify the policy that: 1. The evaluation of whether an impairment(s) is ‘severe’ . . . requires an assessment of the functionally limiting effects of an impairment(s) on an individual’s ability to do basic work activities or, for an individual under age 18 claiming disability benefits under title XVI, to do age-appropriate activities; and 2. An individual’s symptoms may cause limitations and restrictions in functioning which . . . may require a finding that there is a ‘severe’ impairment(s) and a decision to proceed to the next step of sequential evaluation.”); SSR 96-4p, 1996 WL 374187, *2 (July 2, 1996) (“In addition, 20 CFR 404.1529 and 416.929 provide that an individual’s symptoms, such as pain, fatigue, shortness of breath, weakness, or nervousness, will not be found to affect the individual’s ability to do basic work . . . unless medical signs and laboratory findings show that there is a medically determinable physical or mental impairment(s) that could reasonably be expected to produce the symptom(s) alleged.”).

88. See § 404.1508. However, the SSA recently proposed several revisions to the medical-evidence rules contained within §§ 404.1 *et seq.*, 416.1 *et seq.* See *generally* Revisions to Rules Regarding the Evaluation of Medical Evidence, 81 Fed. Reg. 62560-01 (proposed Sept. 9, 2016) (to be codified at 20 C.F.R. pts. 404 and 416). Some of the proposed revisions include: (1) making the rules of evidence “easier to understand and use” by (a) redefining and categorizing several key-evidentiary terms, and (b) identifying “certain types of evidence” that are neither inherently valuable nor persuasive; (2) assisting representatives and adjudicators in establishing the existence of an impairment by revising the rules to state explicitly that (a) the SSA “will not use a diagnosis, medical opinion, or an individual’s statement of symptoms to establish the existence of an impairment(s),” and (b) “a physical or mental impairment must be established by objective medical evidence from an [acceptable medical source]”; (3) expanding the current categories of health-care practitioners who qualify as acceptable medical sources, “to reflect changes in the national healthcare workforce and the manner that many people now receive primary medical care”; (4) revising the rules governing who may serve as a medical or psychological consultant and who can, thus, “complete the medical portion of the case review and any applicable RFC assessment(s)”; and (5) redefining and reorganizing the factors the SSA uses in evaluating the credibility of “medical opinions and prior administrative medical findings” by emphasizing that “supportability and consistency” are the paramount considerations in determining the weight of such evidence. See *id.*

experience.”⁸⁹

Social-Security-disability law makes an important distinction between signs and symptoms. “Symptoms” are a claimant’s own description of his physical or mental impairment(s).⁹⁰ “Signs” are anatomical, physiological, or psychological abnormalities that can be observed, and are independent from a claimant’s statements about his symptoms.⁹¹ To establish a physical or mental impairment, the objective evidence (signs) must support the claimant’s subjective complaints (symptoms). In determining whether the claimant is disabled, the ALJ will consider *all* his symptoms and determine their credibility by balancing them against the objective medical evidence. After determining that the claimant is not engaged in SGA, the ALJ will consider the claimant’s symptoms to evaluate whether he has a severe physical or mental impairment at each remaining step in the sequential process.

Remember that the claimant’s impairment(s) must be medically determinable and demonstrated by medically-acceptable clinical and laboratory tests. Unsupported statements about pain or other symptoms will not establish that the claimant is disabled.⁹² Therefore, it is important for the claimant and his representative to develop the record with objective medical evidence.

At step two, an ALJ is likely to ask the claimant to describe his disabling conditions. He will then ask when the claimant stopped working and why. Finally, he may ask for the dates on which the disabling conditions were diagnosed. The claimant’s testimony supplements the record and assists the ALJ in making a disability determination at step two.

STEP 3: DOES THE CLAIMANT HAVE AN IMPAIRMENT THAT MEETS OR EQUALS ANY OF THE LISTED IMPAIRMENTS?

Once the ALJ determines that the impairment is severe, he moves to step three to evaluate whether the medical evidence alone documents an impairment, or combination of impairments,

89. *Stone v. Heckler*, 752 F.2d 1099, 1101 (5th Cir. 1985) (quoting *Estran v. Heckler*, 745 F.2d 340, 341 (5th Cir. 1984)).

90. § 404.1528(a).

91. § 404.1528(b).

92. *See* § 404.1528(a) (“Your statements alone are not enough to establish that there is a physical or mental impairment.”).

so medically severe as to be presumed disabling.⁹³ To make this assessment, the ALJ will consult the Listing of Impairments contained within the Code of Federal Regulations.⁹⁴ The listings are organized in two parts, one for adults eighteen and older (Part A) and one for children under eighteen (Part B). In evaluating disability for a child, ALJs use Part B first, and, if the criteria in Part B do not apply, then they use the criteria in Part A.⁹⁵ For example, if an adult claimant has asthma attacks at least six times per year despite prescribed treatment, and these attacks require physician intervention, her asthma meets a listing and is therefore severe.⁹⁶

The Listing of Impairments is organized by major body systems.⁹⁷ Under each body system, the listing specifies impairments that the SSA considers severe enough to prevent an individual from doing any gainful activity, irrespective of his age, education, or work experience.⁹⁸ As one scholar wrote, “Because this step authorizes a favorable decision on medical grounds alone where a claimant’s condition meets or equals the listing, listing-level impairment severity is set at a very high level.”⁹⁹

The listings are comprised of several specific parts, and each part must be medically documented to meet the listing. For example, parts of a listing may include the persistence of the condition and the number of hospitalizations over a specific period of time.¹⁰⁰ If a representative asserts that his client meets a listing and should be found disabled at step three, the representative should be prepared to provide medical documentation that proves each part of the listing is met. The ALJ’s questions will track the listing requirements. For example, if the claimant’s disabling condition is a major dysfunction of a joint, the ALJ will rely on the musculoskeletal category of impairments and will expect: (1) medical documentation proving that a gross anatomical deformity accompanied by chronic-joint

93. See §§ 404.1520(a)(4)(iii); 416.920(a)(4)(iii).

94. See § 404 subpt. P, app. 1, pts. A1–B2.

95. § 404.1525(b)(1)–(2).

96. See § 404 subpt. P, app. 1, pt. A1, at 3.03(B).

97. § 404.1525(a).

98. *Id.*

99. Dubin, *supra* note 24, at 33.

100. See, e.g., § 404 subpt. P, app. 1, pt. A1, at 3.03(B) (“Exacerbations or complications requiring three hospitalizations within a 12-month period and at least 30 days apart . . . [and e]ach hospitalization must last at least 48 hours, including hours in a hospital emergency department immediately before the hospitalization.”).

pain and stiffness exists; (2) that there is visual evidence of narrowing of the joint space; and (3) that at least one weight-bearing joint, or joint in an upper extremity, is affected.¹⁰¹

The impairment criteria under the listings are used as the basis for determining whether a claim may be allowed, considering medical and other evidence. Acceptable medical sources, such as licensed physicians, psychologists, and optometrists, may provide medical evidence to establish an impairment.¹⁰² These acceptable medical sources will likely provide medical reports that include medical history, clinical findings, laboratory findings, diagnosis, and treatment prescribed.¹⁰³ Evaluation at step three excludes consideration of the vocational factors of age, education, and work experience.¹⁰⁴ If the evidence in an individual's record is the same as the signs, symptoms, and laboratory findings in a listing, and the individual is not working, the individual will be found to be disabled on the basis of "meeting" a listing and the claim will be allowed to proceed.

If an individual's impairment, or combination of impairments, does not meet a listing, the ALJ may still determine he is disabled if the impairment(s) "equal" a listing.¹⁰⁵ An individual's impairment(s) can be considered medically equivalent to a listed impairment when "it is at least equal in severity and duration to the criteria of any listed impairment."¹⁰⁶ To establish such equivalence, the ALJ may refer to: (1) listed impairments; (2) unlisted impairments; and (3) combined impairments.¹⁰⁷

An ALJ may find that an impairment is medically equivalent to a listing if the individual has other findings that are at least of equal significance to the required criteria.¹⁰⁸ This analysis arises when an individual has an impairment that is listed, but does not exhibit one or more of the findings specified in the listing.¹⁰⁹ It

101. See § 404 subpt. P, app. 1, pt. A1, at 1.02(A)–(B).

102. § 404.1513(a)(1)–(5); *cf.* Revisions to Rules Regarding the Evaluation of Medical Evidence, *supra* note 88.

103. § 404.1513(b)(1)–(6).

104. §§ 404.1525(a), 404.1526(c).

105. See §§ 404.1525(c)(5), 404.1526.

106. § 404.1526(a).

107. See § 404.1526(b)(1)–(3).

108. § 404.1526(b)(1)(ii).

109. § 404.1526(b)(1)(i)(A).

may also arise when the claimant exhibits all the findings, but one or more is not as severe as specified in the listing.¹¹⁰

If an individual has an impairment that is not described in the Listing of Impairments, the ALJ will compare the individual's findings with those for closely-analogous listed impairments.¹¹¹ If the findings are at least of equal medical significance to those of a listed impairment, he will find the individual's impairment to be medically equivalent to the analogous listing.¹¹²

Finally, for combined impairments where none meet a listing, the ALJ will compare the claimant's findings "with those for closely analogous listed impairments."¹¹³ If the findings "are at least of equal medical significance to those of a listed impairment," the ALJ will find the individual's combination of impairments to be medically equivalent to the listed impairment.¹¹⁴

If a listing has been deleted, a claimant with that impairment is not necessarily precluded from being found disabled. The impairment may still be considered under other generalized listings, such as the cardiovascular body system listing, if it causes or contributes to the severity of an impairment for that listing.¹¹⁵ Obesity is a good example of this situation because the SSA deleted the obesity listing in 1999. The SSA and ALJs, however, are aware that obesity is a contributing factor to other body-system impairments, such as creating breathing difficulties and heart problems.¹¹⁶ As a result, an obese claimant may still demonstrate that he has severe impairments because obesity can cause other impairments to rise to the level of severe.¹¹⁷

110. § 404.1526(b)(1)(i)(B).

111. § 404.1526(b)(2).

112. *Id.*

113. § 404.1526(b)(3).

114. *Id.*

115. *See, e.g.*, SSR 02-1p, 2002 WL 34686281, *5 (Sept. 12, 2002) ("Because there is no listing for obesity, we will find that an individual with obesity 'meets' the requirements of a listing if he or she has another impairment that, by itself, meets the requirements of a listing. We will also find that a listing is met if there is an impairment that, in combination with obesity, meets the requirements of a listing.").

116. *Id.* at *3 ("Obesity is a risk factor that increases an individual's chances of developing impairments in most body systems. It commonly leads to, and often complicates, chronic diseases of the cardiovascular, respiratory, and musculoskeletal body systems.").

117. *See id.* at *4 (citations omitted) ("As with any other medical condition, we will

To make a finding that an impairment, or combination of impairments, equals a listing, an opinion by a medical expert or other “judgment of a physician (or psychologist) designated by the Commissioner” is required.¹¹⁸ The ALJ may not base such a finding on the opinion of any other physician, such as a treating physician.¹¹⁹ Finally, the ALJ must consider the opinion of a state-agency medical/psychological consultant on the issue of “meets or equals,” though he is not bound by it.¹²⁰ If the medically determinable impairment(s) does not meet, or equal in medical severity, any listed impairment, the ALJ will proceed to an intermediate step in the sequential process: the residual functional capacity determination.

“STEP 3.5”: RESIDUAL FUNCTIONAL CAPACITY

Though not an official step in the sequential evaluation, the ALJ must determine an individual’s residual functional capacity (RFC) before moving on to steps four and five.¹²¹ The RFC determination is often referred to as “step three-and-a-half.” The ALJ conducts an RFC assessment to determine (1) the level of

find that obesity is a ‘severe’ impairment when, alone or in combination with another medically determinable physical or mental impairment(s), it significantly limits an individual’s physical or mental ability to do basic work activities We will also consider the effects of any symptoms (such as pain or fatigue) that could limit functioning There is no specific level of weight or BMI that equates with a ‘severe’ or a ‘not severe’ impairment. Neither do descriptive terms for levels of obesity (e.g., ‘severe,’ ‘extreme,’ or ‘morbid’ obesity) establish whether obesity is or is not a ‘severe’ impairment for disability program purposes. Rather, we will do an individualized assessment of the impact of obesity on an individual’s functioning when deciding whether the impairment is severe.”)

118. SSR 96-6p, 1996 WL 374180, *3 (July 2, 1996) (“The [ALJ] or Appeals council is responsible for deciding the ultimate legal question whether a listing is met or equaled.”).

119. See SSR 96-5p, 1996 WL 874183, *2 (July 2, 1996) (“[T]reating source opinions on issues that are reserved to the Commissioner are never entitled to controlling weight or special significance. Giving controlling weight to such opinions would, in effect, confer upon the treating source the authority to make the determination or decision about whether an individual is under a disability, and thus would be an abdication of the Commissioner’s statutory responsibility to determine whether an individual is disabled.”).

120. See *id.* at *3 (“When a treating source provides medical evidence that demonstrates that an individual has an impairment that meets a listing, and the treating source offers an opinion that is consistent with this evidence, the adjudicator’s administrative finding about whether the individual’s impairment(s) meets the requirements of a listing will generally agree with the treating source’s opinion. Nevertheless, the issue of meeting the requirements of a listing is still an issue ultimately reserved to the Commissioner.”).

121. See 20 C.F.R. § 404.1545(a)(1) (2015); SSR 96-8p, 1996 WL 374184, *3 (July 2, 1996) (“RFC is an issue only at steps 4 and 5 of the sequential evaluation process.”).

activity the claimant can perform, and (2) whether he can perform his past-relevant work, and if not, if he can make an adjustment to other work. RFC is the individual's maximum "ability to do sustained work activities in an ordinary work setting on a regular and continuing basis," notwithstanding his impairment.¹²² A "regular and continuing" basis means "8 hours a day, for 5 days a week, or an equivalent work schedule."¹²³

When assessing RFC, the ALJ does not determine whether the claimant is disabled. Instead, the RFC formulation is a two-step process to determine the types of work activity the claimant can still do despite his impairments and related symptoms. Specifically, the ALJ will determine: (1) the limitations established by the record; and (2) the claimant's remaining functional capacity.

The ALJ phrases RFCs so that they are comprehensive, clear, and consistent. Comprehensiveness refers to the basis for making the RFC determination. ALJs base their RFC findings on *all* of the evidence of record, including both medical and non-medical evidence. The ALJ will also consider the claimant's physical, mental, and environmental abilities and the limitations imposed by all of the claimant's impairments in combination (including severe and non-severe impairments).¹²⁴ The RFC must include at least one limitation for each impairment that is found to be "severe." For example, if the ALJ finds a severe medically-determinable mental impairment, the RFC must include one or more limitation on the claimant's mental capacity to perform work activities.

To make an RFC clear, an ALJ will distinguish between the use of "impairment," "symptom," and "limitation."¹²⁵ A statement that is limited to just impairments or symptoms is not a proper

122. 1996 WL 374184, at *2.

123. *Id.* (citations omitted).

124. *See* §§ 404.1520(e), 404.1545; *see also* 1996 WL 374184, at *1 ("Ordinarily, RFC is an assessment of an individual's ability to do sustained work-related physical and mental activities in a work setting on a regular and continuing basis The RFC assessment considers only functional limitations and restrictions that result from an individual's medically determinable impairment or combination of impairments, including the impact of any related symptoms.").

125. 1996 WL 374184, at *2 (citations omitted) ("RFC is an administrative assessment of the extent to which an individual's medically determinable *impairment(s)*, including any related *symptoms, such as pain*, may cause *physical or mental limitations* or restrictions that may affect his or her capacity to do work-related physical and mental activities.") (emphasis added).

RFC. Likewise, a statement that includes some, but not all, of the claimant's limitations outlined in functional language is also improper.

To be consistent, the ALJ will explain how he considered and resolved any material inconsistencies and ambiguities. His opinion will address any conflicts between the RFC and any medical opinions, or between the RFC and the claimant's testimony. Also, when posing hypotheticals to a vocational expert, the ALJ should ensure that the RFC is consistent with the record.¹²⁶ The RFC must be the same in the "rationale" and "findings" sections of the decision.

When preparing the RFC assessment, the ALJ must consider: (1) what the claimant can still do (daily activities or functioning); (2) all established impairments and related limitations; (3) effects of medication or treatment; (4) subjective complaints; (5) medical opinions and/or medical source statements; (6) testimony; and (7) other lay evidence. Limitations that are strength-related are known as "exertional limitations." Non-strength-related limitations are "nonexertional."

Exertional limitations affect an individual's ability to meet the strength demands of a job.¹²⁷ These strength demands include lifting, carrying, standing, walking, sitting, pushing, and pulling.¹²⁸ Each of these exertional activities is further classified according to the strength demands. The various classifications are sedentary, light work, medium work, heavy work, and very heavy work.

Nonexertional limitations affect an individual's ability to meet the non-strength-related demands of a job. Nonexertional physical functions can be postural, manipulative, visual, communicative, environmental, and mental.¹²⁹ The nature of the

126. See discussion, *infra* notes 139–71.

127. See 1996 WL 374184, at *5 ("Exertional capacity addresses an individual's limitations and restrictions of physical strength and defines the individual's remaining abilities to perform each of seven strength demands . . .").

128. See § 404.1545(b); 1996 WL 374184, at *5.

129. 1996 WL 374184, at *6 ("Nonexertional capacity considers all work-related limitations and restrictions that do not depend on an individual's physical strength; i.e., all physical limitations and restrictions that are not reflected in the seven strength demands, and mental limitations and restrictions. It assesses an individual's abilities to perform physical activities such as postural (e.g., stooping, climbing), manipulative (e.g., reaching, handling), visual (seeing), communicative (hearing, speaking), and mental (e.g., understanding and remembering instructions and responding appropriately to supervision). In addition to these activities, it also

functional limitations or restrictions caused by an impairment-related symptom determines whether the impact of the symptom is exertional, nonexertional, or both.¹³⁰

After determining that a medically-determinable impairment exists, the ALJ must evaluate the intensity, persistence, and functionally-limiting effects of the claimant's symptoms. This necessarily requires that the ALJ make a credibility determination about the individual's subjective statements. Recognizing that an individual's symptoms can sometimes suggest an impairment is more severe than can be shown by the objective-medical evidence alone, the ALJ must consider certain factors in addition to the objective-medical evidence when assessing the credibility of an individual's subjective statements. Those factors include, *inter alia* the: (1) individual's daily activities; (2) location, duration, frequency, and intensity of the individual's pain or other symptoms; (3) factors that precipitate and aggravate the symptoms; (4) type, dosage, effectiveness, and side effects of any medicine the individual takes, or has taken, to alleviate pain or other symptoms; and (5) measures, other than treatment, the individual uses to relieve pain or other symptoms (such as sleeping on the floor to alleviate back pain).¹³¹

STEP 4: CAN THE CLAIMANT PERFORM PAST RELEVANT WORK?

If a claimant's impairment does not meet or equal the listing criteria, the ALJ proceeds to step four, past relevant work (PRW). Here, the ALJ must determine whether the claimant has the RFC to perform the requirements of his past work.¹³² If the claimant

considers the ability to tolerate various environmental factors (e.g., tolerance of temperature extremes.); see § 404.1545(c) ("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.").

130. SSR 96-9p, 1996 WL 374185, *5 (July 2, 1996) (citations omitted) ("For example, even though mental impairments often affect nonexertional functions, they may also limit exertional capacity affecting one of the seven strength demands; e.g., from fatigue or hysterical paralysis. Likewise, symptoms, including pain, are not intrinsically exertional or nonexertional; when a symptom causes a limitation in one of the seven strength demands, the limitation must be considered exertional.").

131. §§ 404.1529(c)(3)(i)-(v), 416.929(c)(3)(i)-(v).

132. § 404.1520(f) ("If we cannot make a determination or decision at the first three steps . . . we will compare our residual functional capacity assessment . . . with

can still do the kind of work he did in the past, the ALJ will decide he is not disabled.¹³³

For work activity to be considered “PRW,” it must meet a three-part test: (1) recency; (2) duration; and (3) earnings.¹³⁴ “Recency” means that the ALJ will consider work experience performed within fifteen years of the date of adjudication.¹³⁵ “Duration” means that the claimant must have worked at the job for a period sufficient to learn how to do it and achieve an average performance level. The Dictionary of Occupational Titles (DOT) describes the duration requirements for learning how to do certain jobs based on specific vocational and preparation ratings, which are further organized according to skill level (e.g., unskilled, semi-skilled, and skilled). An ALJ, or VE, may rely on the DOT to help determine whether the claimant can perform his PRW.¹³⁶ To meet the “earnings” requirement for PRW, the claimant must have performed his job at SGA levels.¹³⁷ The SGA is determined by earnings and the amount of time performing the job.

If the ALJ finds that the claimant may still perform his past work despite impairments, he is not disabled.¹³⁸ At this step in the sequential evaluation, the inquiry focuses on the RFC, not the availability of the past work at the present time. The Supreme Court has held that an elevator operator was not entitled to disability benefits when he could perform his past work, even though the job had become obsolete and thus no longer existed.¹³⁹

At step four, an impartial VE classifies the claimant’s PRW by skill and exertional level. Once the exertional level is

the physical and mental demands of your past relevant work.”).

133. § 404.1520(f) (“If you can still do [your past relevant work], well will find that you are not disabled.”).

134. See §§ 404.1560(b)(1), 404.1565(a) (“Past relevant work is work that you have done within the past 15 years, that was substantial gainful activity, and that lasted long enough for you to learn to do it.”).

135. § 404.1560(b)(1).

136. § 404.1560(b)(2) (“We may use the services of vocational experts . . . , or other resources, such as the ‘Dictionary of Occupational Titles,’ . . . to obtain evidence we need to help us determine whether you can do your past relevant work, given your residual functional capacity.”).

137. §§ 404.1560(b)(1), 404.1565(a).

138. § 404.1520(f).

139. *Barnhart v. Thomas*, 540 U.S. 20, 25 (2003) (“[S]tep four can result in a determination of no disability without inquiry into whether the claimant’s previous work exists in the national economy.”).

established, the VE responds to hypothetical questions posed by the ALJ.¹⁴⁰ The ALJ will ask the VE to give his opinion as to whether a hypothetical claimant, who is a mirror image of the claimant, exhibiting the same symptoms, could do the claimant's PRW.¹⁴¹

Such hypotheticals should be phrased in terms of specific work-related functional abilities, and should clearly indicate the claimant's limitations and capacities, to accurately reflect his RFC. They should not be limited to impairments and/or symptoms.

Improper: Assume a hypothetical person who is depressed and irritable.

Proper: Assume a hypothetical person who has depression and is irritable, and that as a result of this impairment and symptoms, the individual is able to interact with supervisors, co-workers, and the public on an occasional basis only.

STEP 5: CAN THE CLAIMANT PERFORM ANY OTHER JOBS AVAILABLE IN SIGNIFICANT NUMBERS IN THE NATIONAL ECONOMY?

If the ALJ finds that the claimant cannot perform any past work because of his RFC, he will then apply the same RFC to decide whether the claimant can adjust to doing other work.¹⁴² At this step, the inquiry is tailored to the claimant's subjective characteristics. The ALJ considers not only the RFC from step four, but also the claimant's age, education, and work experience.¹⁴³ If the ALJ determines that the claimant has the RFC to adjust to other jobs, the burden shifts to the ALJ to show that those jobs are available in significant numbers in the national economy.¹⁴⁴

140. See § 404.1560(b)(1).

141. § 404.1560(b)(2) (“[A] vocational expert or specialist may offer expert opinion testimony in response to a hypothetical question about whether a person with the physical and mental limitations imposed by the claimant’s medical impairment(s) can meet the demands of the claimant’s previous work, either as the claimant actually performed it or as generally performed in the national economy.”).

142. § 404.1560(c)(1).

143. *Id.*

144. See § 404.1560(c)(2) (“In order to support a finding that you are not disabled at this fifth step . . . , we are responsible for providing evidence that demonstrates that other work exists in significant numbers in the national economy that you can do, given your residual functional capacity and vocational factors.”).

At step five, the ALJ usually begins by asking the VE if there are any other jobs the claimant can perform, considering his age, education, and past work experience. These jobs must be at a lower exertional level than the claimant's past relevant work, because the ALJ determined at step four that the claimant cannot perform his PRW. The VE then responds to hypotheticals regarding existence and number of jobs in the national economy that can be performed by an individual with the claimant's RFC and vocational profile.¹⁴⁵ The VE then discusses whether the claimant's acquired-work skills are transferable to other skilled or semi-skilled occupations.¹⁴⁶ Finally, the VE discusses whether the skills are transferable with little, if any, vocational adjustment required in terms of tools, work processes, work setting, or the industry, if that is at issue.¹⁴⁷ The ALJ and VE will rely on the DOT for information about the requirements of

145. See *DiAntonio v. Colvin*, 95 F. Supp. 3d 60, 72 (D. Mass. 2015) (citations omitted) (“This Court upholds the hearing officer’s finding at step five [T]here was nothing wrong with the hypothetical questions the hearing officer posed to the [VE] The hearing officer heard the [VE’s] testimony and found that there are jobs in significant number in this economy that [the plaintiff] can perform.”).

146. See SSR 00-4p, 2000 WL 1898704, *3 (Dec. 4, 2000) (citations omitted) (“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) . . . The DOT lists a specific vocational preparation (SVP) time for each described occupation 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”); see also § 404.1568(d)(1)–(3) (“We consider you to have skills that can be used in other jobs, when the skilled or semi-skilled work activities you did in past work can be used to meet the requirements of skilled or semi-skilled work activities of other jobs or kinds of work Transferability is most probable and meaningful among jobs in which[:] (i) [t]he same or lesser degree of a skill is required; (ii) [t]he same or similar tools and machines are used; and (iii) [t]he same or similar raw materials, products, or services are involved There are degrees of transferability of skills ranging from very close similarities to remote and incidental similarities among jobs. A complete similarity of all three factors is not necessary for transferability. However, when skills are so specialized or have been acquired in such an isolated vocational setting (like many jobs in mining, agriculture, or fishing) that they are not readily usable in other industries, jobs, and work settings, we consider that they are not transferable.”).

147. See 2000 WL 1898704, at *3 (citations omitted) (“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.”).

other work in the national economy.¹⁴⁸

The ALJ also relies on a series of grids organized by the vocational factors (i.e., age, education, and work experience), which are then organized according to categories of sedentary-, light-, medium-, heavy-, and very-heavy-work RFCs.¹⁴⁹ Age is divided into three categories: (1) “[y]ounger person”; (2) “[p]erson of advanced age”; and (3) “[p]erson closely approaching advanced age.”¹⁵⁰ Education is also divided into four categories, ranging from illiterate, or unable to communicate in English, to high-school level and above.¹⁵¹ Finally, work experience ranges from unskilled to skilled.¹⁵² Certain rules require that a claimant automatically qualify as disabled if specific combinations of these factors are met. Otherwise, the ALJ must make the determination using the body of evidence before him.

As mentioned above, the ALJ has the burden of finding that

148. 2000 WL 1898704, at *2–3 (“In making disability determinations, we rely primarily on the DOT . . . for information about the requirements of work in the national economy 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.”).

149. See §§ 404.1567(a)–(e), 416.967(a)–(e); 2000 WL 1898704, at *3 (citations omitted) (“We classify jobs as sedentary, light, medium, heavy and very heavy These terms have the same meaning as they have in the exertional classifications noted in the DOT.”); see generally § 404 subpt. P, app. 2 tbls.1, 2 & 3. A thorough discussion of the utility of the grids and occupational titles in today’s labor market is outside the scope of this Article and, indeed, worthy of a separate article dedicated to that subject alone. Suffice it to say that the grids have been called “seriously outdated,” and a federal circuit court recently referred to the Dictionary of Occupational Titles as “now-defunct.” *Abbott v. Astrue*, 391 F. App’x 554, 559 (7th Cir. 2010) (citations omitted) (“At oral argument, the lawyer for the Commissioner explained that she found the listing through the Occupational Network Database (O*NET), a database that the Department of Labor developed to replace the now-defunct DOT”); *Dubin*, *supra* note 24, at 43 (“The reliance on seriously outdated labor market information means that the DOT, and ultimately the grid, is presently based on outdated assumptions that have not been established as relevant to the contemporary and dramatically different United States economy and labor market.”).

150. §§ 404.1563(c)–(e), 416.963(c)–(e).

151. §§ 404.1564(1)–(5), 416.964(1)–(5) (defining the five education levels as (1) “Illiteracy,” (2) “Marginal education,” (3) “Limited education,” (4) “High school education and above,” and (5) “Inability to communicate in English”).

152. See §§ 404.1565(a), 416.965(a) (“If you have acquired skills through your past work, we consider you to have these work skills unless you cannot use them in other skilled or semi-skilled work that you can now do. If you cannot use your skills in other skilled or semi-skilled work, we will consider your work background the same as unskilled. However, even if you have no work experience, we may consider that you are able to do unskilled work because it requires little or no judgment and can be learned in a short period of time.”).

the work the claimant is still able to perform exists in significant numbers in the national economy.¹⁵³ The ALJ is not required to find that the job is available near the claimant's home, or that the claimant could actually procure such a job if he applied.¹⁵⁴ The U.S. Court of Appeals for the Tenth Circuit (Tenth Circuit) recently addressed this issue, where a claimant argued that the ALJ had failed to provide evidence of a significant number of jobs that she could perform, based on the number of jobs "available in her local region."¹⁵⁵ The Tenth Circuit rejected the claimant's argument, specifically stating that the SSA only considers "her RFC and other vocational factors" in step five.¹⁵⁶ The court further noted that, in making the step-five determination, the SSA does not consider whether: (1) work exists in the claimant's immediate area; (2) a specific job vacancy is available to the claimant; or (3) the claimant would be hired if he applied.¹⁵⁷

At step five, there are also several combinations of medical and vocational profiles that the SSA presumes demonstrate an inability to make an adjustment to other work. When a claimant meets one of these profiles because of his medical history and job experience, he is qualified as disabled without further inquiry. First, an ALJ will consider a claimant, who has less than a sixth-grade education and work experience of thirty-five years or more of arduous, unskilled-physical labor, unable to do lighter work, and therefore disabled.¹⁵⁸ Second, if the claimant is fifty-five years or older with an eleventh-grade education or less and no

153. § 404.1560(c)(2).

154. § 404.1566(a) ("We consider that work exists in the national economy when it exists in significant numbers either in the region where you live or in several other regions of the country. It does not matter whether: (1) Work exists in the immediate area in which you live; (2) A specific job vacancy exists for you; or (3) You would be hired if you applied for work.").

155. *Boucher v. Astrue*, 371 F. App'x 917, 924 (10th Cir. 2010).

156. *Id.* (citations omitted); see § 404.1560(c)(1) ("We will look at your ability to adjust to other work by considering your residual functional capacity and the vocational factors of age, education, and work experience, as appropriate in your case Any other work (jobs) that you can adjust to must exist in significant numbers in the national economy (either in the region where you live or in several regions in the country).").

157. *Boucher*, 371 F. App'x at 924 (quoting § 404.1566(a)).

158. See § 404.1562(a) (citations omitted) ("If you have no more than a marginal education . . . and work experience of 35 years or more during which you did only arduous unskilled physical labor, and you are not working and are no longer able to do this kind of work because of a severe impairment(s) . . . , we will consider you unable to do lighter work, and therefore, disabled.").

PRW experience, the ALJ will consider the claimant disabled.¹⁵⁹

CREDIBILITY AND CONSISTENCY

In addition to the formal five-step sequential evaluation, ALJs make an informal-credibility determination based on the claimant's subjective complaints and testimony at the hearing. The consistency of the evidence may also add to, or detract from, the credibility of a disability claim. A claimant's record is credible if it includes objective medical evidence that is consistent with the subjective evidence. That is, a treating or non-treating physician or other source corroborates the claimant's subjective complaints about his pain and symptoms. Consistency and supporting evidence from medical sources will significantly impact the claimant's application for disability benefits.¹⁶⁰

CONSISTENCY AND MEDICAL OPINIONS

A common scenario plays out in medical records or in the hearing room where a claimant describes his joint pain as a nine out of ten, with ten being the worst pain, but the treating physician notes that he has a full range of motion in those joints. In this case, the evidence is not entirely consistent. To overcome the inconsistency, the ALJ must evaluate every medical opinion and assign varying weights to those opinions and determine the severity of the impairment.

In general, an opinion from a doctor who has examined the patient is given more weight than one who has not. Additionally, a treating-physician's opinion is entitled to more weight because it is more likely to provide a detailed picture of the claimant's medical impairments, than observations during a brief hospitalization or from a consultative examination conducted by the State. Specialists are also given more weight than general-primary-care doctors. As the regulations provide, "[I]f your ophthalmologist notices that you have complained of neck pain during your eye examinations, we will consider his or her opinion with respect to your neck pain, but we will give it less weight than that of another physician who has treated you for the neck

159. See § 404.1562(b) ("If you have a severe, medically determinable impairment(s) . . . , are of advanced age (age 55 or older[]), have a limited education or less . . . , and have no past relevant work experience . . . , we will find you disabled.").

160. See Revisions to Rules Regarding the Evaluation of Medical Evidence, *supra* note 88.

pain.”¹⁶¹

While medical-source opinions are important for showing the existence and severity of an impairment, certain medical opinions will not be considered in making determinations reserved to the SSA’s discretion. The SSA bestows upon ALJs the responsibility and duty of determining whether the claimant is disabled and whether the impairment(s) meets or equals a listing. The ALJ is also responsible for evaluating the claimant’s RFC and applying the vocational factors of education, age, and former work.

The ALJ will also consider all the available evidence when evaluating the intensity and persistence of the claimant’s symptoms, and how such symptoms may impact the claimant’s ability to work. Certain factors relevant to the symptoms may help quantify a claimant’s subjective complaints about the intensity and persistence of his pain and other symptoms. The ALJ will consider the following factors in evaluating the severity of the impairment in terms of persistence and intensity of the symptoms: daily activities; location, duration, frequency, and intensity of claimant’s pain or other symptoms; precipitating and aggravating factors; type, dosage, effectiveness, and side effects of any medication taken to alleviate the symptoms; and other treatment for the symptoms. In order to get disability benefits, the claimant must follow treatment prescribed by his physician. Claimants who make a personal decision to stop treatment, without consulting their doctors, will be considered non-compliant and will not receive disability benefits.

Objective-medical evidence assists ALJs in making reasonable credibility assessments.¹⁶² This evidence “is a useful indicator . . . [of] the intensity and persistence of [the claimant’s] symptoms and the effects those symptoms, such as pain, may have on [his] ability to work or, . . . [his] functioning.”¹⁶³ However, the ALJ may not reject the claimant’s statements about the intensity and persistence of pain, or other symptoms, or their effect on his ability to work “solely because the available objective medical evidence does not substantiate [his] statements.”¹⁶⁴ Rather, the ALJ must consider “all of the evidence presented,

161. § 404.1527(c)(ii).

162. See §§ 404.1529(c)(2), 416.929(c)(2) (“We must always attempt to obtain objective medical evidence and, when it is obtained, we will consider it in reaching a conclusion as to whether you are disabled.”).

163. *Id.*

164. *Id.*

including information about . . . prior work, [the claimant's] statements about [his] symptoms, evidence submitted by [his] treating or non-treating [medical] sources, and observations by [SSA] employees and other persons."¹⁶⁵ He may also consider other relevant factors, such as: (1) the claimant's daily activities; (2) the location, duration, frequency, and intensity of symptoms; (3) precipitating and aggravating factors; (4) the type, dosage, effectiveness, and side effects of any medications; and (5) treatments other than medication.¹⁶⁶

For example, if a claimant alleges he is unable to work due to problems with his hands and depression, an ALJ may find his testimony not fully credible if he fails to provide a record of hospitalization or counseling treatment, and deferred-corrective surgery for his hands. Relying on the record, the ALJ may see that the claimant's daily activities also fail to demonstrate limitations on his ability to take care of himself, drive, do yard work, and walk long distances. Thus, the hearing serves a critical function for the credibility assessment.

An ALJ's initial opinion of the case after a pre-hearing review of the record may change once he witnesses the claimant's demeanor at the hearing. Similarly, a claimant has an opportunity to elaborate on the record by testifying about his impairments and how they impact his daily life. For example, a twenty-eight-year-old male, who alleges he cannot work because of back problems, may face credibility issues because of his young age and the likelihood of his recovery. However, the ALJ may be persuaded by the claimant's genuine demeanor and testimony at the hearing.

CREDIBILITY AND UNEMPLOYMENT COMPENSATION

For the disabled worker who loses his job as a result of his disability, a conflict arises when the individual applies for both unemployment compensation and disability. When filling out the unemployment compensation application, an individual will generally certify that he is "able and available" to return to work. However, he will likely allege on the Social-Security-Disability-Benefits Application that he cannot do his PRW or any other job in the national economy. In this contradictory situation, ALJs may make a less-favorable-credibility determination for the

165. §§ 404.1529(c)(3), 416.929(c)(3).

166. §§ 404.1529(c)(3)(i)-(v), 416.929(c)(3)(i)-(v).

claimant, out of concern about an exaggerated claim of disability or fraud.

The Supreme Court has not addressed whether an ALJ may use a disabled claimant's receipt of unemployment compensation as evidence to support an unfavorable-credibility determination. In these economic times, the issue is becoming more prevalent. It is the opinion of some that unemployment compensation need not destroy a disability claimant's credibility. A good representative can maintain his client's credibility by making the right arguments before the ALJ, and examining precisely what the claimant certified when he applied for unemployment compensation.¹⁶⁷

PART IV: BEST PRACTICES FOR PRACTITIONERS

The recommendations below relate to the central theme/mission of the SSA's ODAR: to provide Social-Security claimants with timely and legally-sufficient hearings and decisions. Given the sheer number of applications to review, hearings to be held, and decisions to be rendered, efficiency and expediency are critical to the disability-review process. Unlike other federal laws, where the definition of a key term could be a cross-reference to another law entirely, the Social Security Act is a straightforward framework, and an ALJ administering that framework must be equally thorough and methodical. Prepared, knowledgeable claimants' representatives ensure that this process runs smoothly and without delay. Arguably, the best way to prepare for a hearing before an ALJ is to follow their advice. ALJs have provided all the following tips, developed over years of experience with claimants, claimants' representatives, and the hearing process.

SPECIFICITY

Disability-claims evaluation is distinct from the cases before a federal or state-court judge because an ALJ applies the same framework to every case. The evaluations, however, are entirely

167. See Jerrold A. Sulcove, *Damned If You Do and Damned If You Don't: Unemployment Compensation and the Disabled Client*, SOC. SECURITY NEWS (Fed. Bar Ass'n: Soc. Sec. Law Section, Arlington, Va.), Spring 2012, at 4, 5, <http://www.fedbar.org/Image-Library/Sections-and-Divisions/Social-Security/Spring2012.pdf> ("Typically, an ALJ will assert that the claimant who received unemployment compensation benefits made certain representations to the governmental entity issuing the payments. However, the disability record typically does not contain any statements from the claimant regarding unemployment compensation.").

tailored to the specifics of the individual claimant and his impairments. Recent court decisions have admonished ALJs for including boilerplate language in their opinions.¹⁶⁸ If the judge cannot do it, neither should you. The judge's evaluation should be tailored specifically to the claimant before him, and depends on the facts that the claimant and his medical history provide. Thus, it behooves any representative to know the medical records and claimant's case well and to support his theory by citing to the record.

Best practices for attorney and non-attorney claimant representatives:

- Submit additional evidence as early in the hearing process as possible.
- Avoid submitting evidence at the last minute.
- Number the pages on your exhibits.
- Do not file post-hearing evidence without permission. The case may already be with a writer or awaiting a judge's signature.
- Use the facts to demonstrate that your client is disabled because of his RFC, rather than manipulate his medical history to fall into a listing under the "meets-or-equals" step of the sequential evaluation.
- Avoid conclusory statements when giving the ALJ your theory of the case. The following statement is conclusory: "The impairments are severe. Therefore, the claimant's

168. Given the highly claimant-specific nature of Social Security disability, ALJs should avoid boilerplate findings. For examples of courts criticizing the use of such boilerplate language, see *Bjornson v. Astrue*, 671 F.3d 640, 645–46 (7th Cir. 2012) (citations omitted) ("Reading the administrative law judge's opinion, we first stubbed our toe on a piece of opaque boilerplate near the beginning . . . [which consisted of] a passage drafted by the [SSA] for insertion into any administrative law judge's opinion to which it pertains. This 'template' is a variant of one that this court (and not only this court) had criticized previously . . . [as] 'meaningless boilerplate' The government regards the 'template' as an indispensable aid to the [SSA's] overworked [ALJs]. Yet when we asked the government's lawyer at argument what the 'template' means, he confessed he did not know."); *Smith v. Astrue*, 467 F. App'x 507, 511 (7th Cir. 2012) (citations omitted) ("[The plaintiff] contests the ALJ's use of the boilerplate statement that 'the claimant's statements concerning the intensity persistence and limiting effects' of her symptoms 'are not credible to the extent they are inconsistent with the above residual functional capacity assessment.' [Her] argument on this point is well-taken. We have derided repeatedly this sort of boilerplate as meaningless and unhelpful to a reviewing court.").

limitations and restrictions caused by the impairment prevent him or her from doing any kind of work.” Now, a stronger statement, based on the record: “The relevant evidence in the case record demonstrates that the claimant can only stand for thirty minutes at a time, must take breaks to check blood sugar five times a day and cannot walk more than 200 feet at a time, according to the assessments of the endocrinologist and consultative examiner.” Use the medical record and build your claimant’s case with facts, rather than conclusions.

- Meet with your clients and advise them that the ALJ will ask them questions. Prepare their answers by suggesting avoidance of vague descriptions like “a while” and “a long time.” Specificity is better.
- It is not necessary to cite regulations to the ALJ.

CONCLUSION

The role of an ALJ tasked with making disability determinations has become increasingly challenging in recent years. ALJs face growing numbers of cases even as they attempt to reduce the backlog. Efficiency must be balanced against issuing legally-sufficient decisions and providing due process for each claimant. As the ALJs themselves are taught, “Preparation prevents poor performance.” In a system where time is of the essence, having a solid understanding of disability law will benefit both practitioners in their representation and American workers as they file their disability claims.

Change is in store for the Social-Security-disability program and it will surely be in the headlines in months and years to come. A new leader will assume responsibility as Commissioner of Social Security this year. The entire program may deplete its reserves in seventeen years. The law is due for amendments, and the future of the program will be closely watched through the new presidential term. The time is ripe to understand these issues and what they mean for American workers, their families, and the claimants’ representatives who represent them.