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Social Security Disability Programs: Improving the Quality of Benefit Award Decisions

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United States Senate

PERMANENT SUBCOMMITTEE ON INVESTIGATIONS

Committee on Homeland Security and Governmental Affairs

**Social Security Disability Programs:
Improving the Quality of Benefit Award Decisions**

MINORITY STAFF REPORT

**PERMANENT SUBCOMMITTEE
ON INVESTIGATIONS**

UNITED STATES SENATE



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SOCIAL SECURITY DISABILITY PROGRAMS: IMPROVING THE QUALITY OF BENEFIT AWARD DECISIONS

In April 2012, the Social Security Trustees estimated the Social Security Disability Trust Fund, which supports the Social Security Disability Insurance (“SSDI”) program, could be exhausted by 2016.¹ Under a “high-cost” scenario, a less-likely but still realistic possibility, the Trustees estimated the Disability Trust Fund could be exhausted as early as 2015. To stave this off, the Trustees suggested that “legislative action is needed as soon as possible.”

Significant stress on the trust fund is due in part to the fact that the number of individuals receiving disability benefits continues to rise at an unprecedented rate. Understanding this phenomenon is a complicated analysis. Researchers at the Center for American Progress assert the “program provides strong incentives to applicants and beneficiaries to remain permanently out of the labor force, and it provides no incentive to employers to implement cost-effective accommodations that enable employees with work limitations to remain on the job.”² These researchers determined that “too many work-capable individuals involuntarily exit the labor force and apply for and often receive,” Social Security Disability Insurance.³ Such a conclusion raises questions as to whether benefits are going to those Congress intended when it created the disability programs.

The stress to the disability system was likely exacerbated when the financial crisis hit in 2008, resulting in a number of individuals losing jobs and, in turn, employer sponsored health insurance benefits. Census data indicated that between October 2008 and June 2010, job losses among workers with disabilities far exceeded those of workers without disabilities.⁴ Without health insurance, it is possible that chronic conditions held in check by medicine and treatment worsened and became more difficult to manage or even became disabling. Those workers potentially turned to federal disability insurance. In other cases, workers with disabling conditions who had refrained from applying for disability insurance because they were able to manage their impairments and sustain work, lost those paychecks, and then applied for disability insurance payments.

Whatever the reason, the result is that 5.9 million Americans have been awarded SSDI benefits since January 2009.⁵ Economists estimate that Americans added to the disability rolls could account for as much as a quarter of the two percent drop in the labor force participation rate since

¹ The 2012 Annual Report of the Board of Trustees of the Federal Old-Age and Survivors Insurance and Federal Disability Insurance Trust Funds, <http://www.ssa.gov/oact/tr/2012/tr2012.pdf>.

² Center for American Progress, Autor and Duggan, Supporting Work: A Proposal for Modernizing the US Disability Insurance System, January 2010, <http://www.americanprogress.org/wp-content/uploads/issues/2010/12/pdf/autordugganpaper.pdf>.

³ Id.

⁴ H. Stephen Kaye, Ph.D., The impact of the 2007-09 Recession on Workers with Disabilities, Vol. 133, No. 10, October 2010, <http://www.bls.gov/opub/mlr/2010/10/art2exc.htm>.

⁵ Award statistics collected from Social Security Administration, Office of the Chief Actuary, Beneficiary Data, Benefits Awarded by Type of Beneficiary, <http://www.ssa.gov/OACT/ProgData/awards.html>. Information does not account for beneficiaries leaving the SSDI rolls.

2007.⁶ Reports also show that the country's population between the ages of 25 and 64 receiving SSDI benefits rose to a record-high of 5.3 percent in March 2012, compared to 4.5 percent in 2007. Applications for disability benefits filed by this age group rose to 18 per 1,000 last year, up from 8 per 1,000 in 1990.⁷ Amid all the statistics, one thing is clear: more Americans than ever are turning to the disability programs to make ends meet and more work is needed to ensure scarce benefits go only to the disabled.

The flood of Social Security disability applications over the past few years has tested the agency's resources and personnel. As a result, disabled Americans are waiting longer and longer before receiving the benefits they deserve. Many now wait as long as two years before having their application finalized.

Oversight of these programs by Congress, however, is critical to the long-term vitality of this important safety net. Congress and SSA need to ensure that benefits are protected for those who would choose to work, but cannot do so because of their disability. Every person who is wrongfully added to the disability rolls by the agency takes money out of the pockets of the disabled.

If Congress fails to ensure the financial sustainability of our nation's disability programs, everyone loses. Taxpayers will bear heavier costs; the Social Security Administration will have to do more with less; and most worrisome, there will be nothing left to give to those who need it most.

Over the past two years, the U.S. Senate Permanent Subcommittee on Investigations has conducted several bipartisan inquiries into aspects of the Social Security Administration's (SSA) disability programs, including how it processes applications. To increase its understanding, the Subcommittee undertook a review of the quality of disability claims approved by the agency at the initial application stage and each level of appeal. This Report describes the investigation's review, findings, and recommendations.

⁶ Daniel Hartley, Federal Reserve Bank of Cleveland, *The Labor Force: To Work or Not to Work* (Fall 2011), http://www.clevelandfed.org/Forefront/2011/fall/ff_2011_fall_06.cfm.

⁷ Alex Kowalksi, *Disabled Americans Shrink Size of U.S. Labor Force*, Bloomberg, May 3, 2012, <http://www.bloomberg.com/news/2012-05-03/disabled-americans-shrink-size-of-u-s-labor-force.html>.

I. EXECUTIVE SUMMARY

A. Investigation Overview

On March 1, 2011, the Subcommittee requested that SSA provide case files, with personal information removed, for SSA beneficiaries accepted into the SSDI or Supplemental Security Income (SSI) program from three specific counties in Virginia, Alabama, and, Oklahoma, reflecting different levels of *per capita* enrollment in the SSDI and SSI programs. After the Subcommittee provided selection criteria, SSA randomly selected 300 electronic case files, 100 from each specified county that met the criteria.⁸ The cases provided a cross-section of applicants who were awarded disability benefits at different stages of review within SSA: initial application, reconsideration, appeal before an administrative law judge (ALJ), or appeal before the Social Security Appeals Council.

The Subcommittee requested only cases in which disability benefits were awarded, and not any cases in which benefits were denied, in order to focus on the process and analysis performed by the agency (at each level of review and appeal) in determining when a claimant met the program's definition of disability. The Subcommittee was interested, in particular, in how the agency handled a claimant's available medical evidence and the evidence needed to support an award of benefits under existing program rules. The investigation examined the decisions reached, rationale used, subjective claimant testimony, objective medical evidence, any expert or physician opinions rendered, and other relevant evidence contained in the case files provided by SSA.

In conducting its investigation, the Subcommittee consulted with SSA, disability experts, SSA Administrative Law Judges, and others. It reviewed not only the 300 case files, but also SSA policies, procedures, guidelines, regulations, administrative decisions, and court cases.

By limiting its review to 300 case files from three counties, the Subcommittee was able to drill down into the specifics of each case. The resulting findings are representative of each county and provide a detailed case study of how disability approval decisions are made, their weaknesses, and how they can be improved. While the resulting findings cannot be statistically extrapolated into a nationwide analysis of SSA disability cases, the same types of issues affected decisions across all three counties, suggesting they may be a factor elsewhere in the nation.

B. Findings of Fact

Based upon its review of the 300 disability case files, the Report makes the following findings of fact.

- (1) **Low Quality Decisions.** The investigation's review of 300 disability case files found that more than a quarter of agency decisions failed to properly address

⁸ The SSA Office of the Inspector General reviewed SSA's proposed sampling methodology and stated to Subcommittee staff they had "no comment" with regard to the methodology.

insufficient, contradictory, or incomplete evidence. The report's findings corroborate a 2011 internal quality review conducted by SSA itself, which found that on average nationwide, disability decisions made at the ALJ level had errors or were insufficient 22 percent of the time. The three counties examined by the Subcommittee are in regions with even higher individual error rates, according to SSA, of between 23-26 percent. It is likely that the three counties had error rates in excess of their regional averages, raising serious questions about the quality of their decisions. ALJs also failed in some cases to adequately analyze the effect of factors such as obesity and drug and alcohol abuse on a claimant's impairment.⁹

- (2) **Insufficient and Contradictory Medical Evidence.** In many cases, at both the initial and appellate levels of review, the state-based Disability Determination Services (DDS) examiners and SSA Administrative Law Judges (ALJs) issued decisions approving disability benefits without citing adequate, objective medical evidence to support the finding; without explaining the medical basis for the decision; without showing how the claimant met basic listing elements; or at times without taking into account or explaining contradictory evidence.
- (3) **Poor Hearing Practices.** Some SSA ALJs held perfunctory hearings lasting less than 10 minutes, misused testimony provided by vocational or medical experts, and failed to elicit hearing testimony needed to resolve conflicting information in a claimant's case file.
- (4) **Late Evidence.** Some case files showed that disability applicants, usually through their representatives, submitted medical evidence immediately before or on the day of an ALJ hearing or after the hearing's conclusion, a practice leading to confusion about the supporting evidence and inefficiencies in case analysis.
- (5) **Inconsistent Use of Consultative Examinations by ALJs.** In many cases before ALJs, consultative examinations (CEs) submitted on behalf of either SSA or a claimant were either summarily dismissed or heavily relied upon, with little to no explanation. In addition, the CEs themselves often consisted of little more than conclusory statements with insufficient reference to objective medical evidence or how the CE's findings related to other evidence in the case file.
- (6) **Misuse of Medical Listings.** In many case files, ALJ opinions failed to demonstrate how a claimant met each of the required criteria in the SSA's Medical Listing of Impairments to qualify under "Step Three" in the application process. Awards at Step Three are reserved for those who have medical conditions SSA has determined to be severe enough to qualify an applicant for benefits.

⁹ Given the high number of questionable decisions, a similar review of claimants the agency denies is needed to ensure that benefits are not being denied to individuals that are disabled.

- (7) **Reliance on Medical-Vocational Guidelines.** The majority of disability awards reviewed by the Subcommittee at the ALJ level utilized SSA medical-vocational grid rules. A recent SSA analysis found that benefit awards were made under these grid rules at a rate of 4 to 1, compared to awards made due to a claimant's meeting a medical listing. At times, these decisions were the result of a claimant's representative and the ALJ negotiating an award of benefits by changing the disability onset date to the claimant's 50th or 55th birthday.
- (8) **Outdated Job List.** Some case files showed DDS examiners and ALJs relied on the Department of Labor's outdated Dictionary of Occupational Titles (DOT), which SSA is in the process of replacing with a new Occupational Information System, to identify jobs open to claimants with limited disabilities. The last major revision to the DOT occurred in 1977, yet the new database is not expected to be ready until 2016. In the meantime, SSA disability decision-makers will continue to rely on the DOT which does not reflect current labor market trends or jobs available in the national economy.

C. Recommendations

The Report makes the following recommendations:

- (1) **Require Government Representative at ALJ Hearings.** To ensure key evidence and issues are properly presented, reduce instances in which SSA ALJs overlook evidence indicating a claimant is not disabled, and increase consistency and accountability in ALJ decision-making, a representative of the agency should participate in all ALJ disability hearings and decisions. Including a government representative at the ALJ Level has long been a recommendation of both the Association of Administrative Law Judges and the Social Security Advisory Board.¹⁰ Congress should specifically designate funds for such a program.
- (2) **Strengthen Quality Review Process.** The new ALJ review process initiated by the Quality Division of the Office of Appellate Operations should be expanded and strengthened by conducting more reviews during the year and developing metrics to measure the quality of disability decisions. Such information should be made available to Congress.
- (3) **Close the Evidentiary Record.** To eliminate the confusion, inefficiencies, and abuses associated with the current practice of allowing medical evidence to be submitted at any point in a disability case, the evidentiary record should close one

¹⁰ See Social Security Advisory Board, Charting the Future of Social Security's Disability Programs: The Need for Fundamental Change, January 2001, <http://www.ssab.gov/publications/disability/disabilitywhitepap.pdf>; Testimony of Association of Administrative Law Judges, Committee on Ways and Means, Subcommittee on Social Security and The House Committee the Judiciary, Subcommittee on Courts, Commercial and Administrative Law, July 22, 2011.

week prior to an ALJ hearing, with exceptions allowed only for significant new evidence for which exclusion would be contrary to the public interest.

- (4) **Strengthen Use of Medical Listings.** SAA should provide additional training to ALJs on the use of SSA Medical Listings, and direct ALJ decisions to identify how a claimant meets each required element of a listing, citing objective medical evidence and not just conclusory statements by an expert.
- (5) **Expedite Updated Job List.** SSA should move more quickly to ensure the Occupational Information System can serve as a usable replacement for the Dictionary of Occupational Titles to identify jobs that claimants with limited disabilities can perform in the national economy.
- (6) **Focused Training for ALJs.** The Office of Appellate Operations, Quality Division, should provide training to all ALJs regarding adequate articulation in opinions of determinations that involve both obesity and drug and alcohol abuse. This training should emphasize the proper way to analyze and address these issues as required by law, regulation and agency guidance.
- (7) **Strengthen Consultative Examinations.** Because many disability claimants do not have sufficient funds to obtain detailed medical evidence of their conditions, SSA should determine, with input from ALJs, how to improve the usefulness of agency-funded Consultative Examinations (CEs), including by requiring an explanation of any significant disparity between the CE's analysis and other evidence in the case file.
- (8) **Reform the Medical-Vocational Guidelines.** The medical-vocational guidelines should be reviewed to determine if reforms are needed. Additional study should be conducted to evaluate whether the current guidelines utilize the proper factors and if they appropriately reflect a person's ability to work.

II. BACKGROUND INFORMATION ON SOCIAL SECURITY DISABILITY INSURANCE AND SUPPLEMENTAL SECURITY INCOME

Social Security Disability Insurance (SSDI). Congress enacted the SSDI program in 1956 to provide a safety net for individuals who, after working for a time, become disabled and no longer able to provide for themselves. These individuals are awarded disability benefits when certain program qualifications are met, but are too young to qualify for retirement benefits. SSDI provides monthly cash payments to beneficiaries from the SSDI Trust Fund (financed through payroll taxes) based on a beneficiary's past wages. These payments are indexed to reflect changes in national wage levels. To take advantage of the program, a worker must have worked a minimum amount of time to be covered or "insured" by the program.

By the end of December 2010, 10.2 million people were receiving SSDI payments.¹¹ In total in FY2010, the SSDI Trust Fund paid \$124.2 in benefits. In FY2011, payments grew to almost \$129 billion and for FY2012, SSA estimates that it will pay \$134 billion.¹² In sharp contrast, in FY2011, the SSDI Trust Fund will only take in \$114 billion.¹³ In August 2012, the agency reported 10.8 million individuals were receiving SSDI benefits.¹⁴

Annual Number of SSDI Beneficiaries in Current Payment Status

Year	Total Number of Beneficiaries	Total Benefits Paid
2006	8.615 million	\$92.384 billion
2007	8.918 million	\$99.086 billion
2008	9.274 million	\$106.301 billion
2009	9.696 million	\$118.329 billion
2010	10.185 million	\$124.191 billion
2011	10.614 million	\$128.900 billion

Source: Information provided by Congressional Research Services

Note: Numbers include all workers, spouses, and children receiving SSDI payments.

Once an individual's application for SSDI is approved, there is a five-month waiting period before he or she begins to receive benefits. SSDI beneficiaries also qualify for Medicare coverage 24 months after SSDI eligibility begins. Benefit payments continue as long as the beneficiary remains disabled, or until the beneficiary reaches the full retirement age. Very few individuals leave the disability rolls by returning to work or medical improvement; most simply convert automatically to retirement benefits at the federal retirement age (FRA).

¹¹ Information provided by Congressional Research Service.

¹² Social Security Administration, Office of the Budget, *FY2012 President's Budget, Budget Overview*, February 2012, <http://www.ssa.gov/budget/2012BudgetOverview.pdf>.

¹³ Social Security Administration, Office of the Chief Actuary, *The 2011 OASDI Trustee's Report*, <http://www.ssa.gov/oact/TRSUM/index.html>.

¹⁴ Social Security Administration, *Benefits Paid by Type of Beneficiary*, <http://www.ssa.gov/OACT/ProgData/icp.html>.

Reasons for SSDI Worker Benefit Terminations, 2011

Reason for Termination	Number of Beneficiaries	Percentage of Terminations
Reached Full Retirement Age	338,222	51.7%
Death	235,734	36.1%
Medical Improvement	23,271	3.6%
Return to Work	39,813	6.1%
Other	14,743	2.7%
Total Terminations/Suspensions	653,877	100.0%

Source: Social Security Administration, *Benefits Terminated for All Disabled Beneficiaries*, Table 50, Number, by reason for termination 2011, http://www.ssa.gov/policy/docs/statcomps/di_asr/2011/sect03f.html#table50.

Supplemental Security Income (SSI). Unlike SSDI, SSI (established in 1972) is a means-tested benefit paid to the disabled poor, elderly, and blind who have limited income and resources. To qualify for the SSI program, an individual must meet the same definition of “disability” as under the SSDI program, but also only have a maximum of \$2,000 of countable resources (\$3,000 for a married couple). An individual may qualify for both SSI and SSDI.

Under program regulations, a number of items are excluded from what is considered an individual’s resources, including: a house and the land it is on; a vehicle, regardless of value; household goods and personal effects; and cash accounts with certain designations.¹⁵ An individual does not need to meet the same work history requirements as the SSDI program to receive benefits, only maintain countable resources below the \$2,000 limit. SSI payments change with a beneficiary’s monthly earnings, resources, and living conditions. Individual financial circumstances often change, requiring SSA to frequently reassess recipients’ eligibility for benefits.

The SSI program is funded through the government’s General Fund, which is financed by tax payments from the American public. In most states, SSI recipients also receive Medicaid and food assistance. In FY2012, SSA expects to pay out almost \$51 billion in Federal and State Supplementation benefits to about 8.3 million SSI recipients.¹⁶

SSI benefits and administrative expenses are considered mandatory spending. According to SSA, the actual amount dispersed in FY2011 was \$52.4 billion in federal benefits and \$3.8 billion spent in beneficiary services.¹⁷ In FY2012, the program is estimated to spend \$48.1 billion in benefits and cost \$3.7 billion in beneficiary services, administration, and research.

¹⁵ All examples provided by SSA. For a comprehensive list of excludable resources, see <http://www.ssa.gov/ssi/text-resources-ussi.htm>.

¹⁶ Information provided by Social Security Administration.

¹⁷ Social Security Administration FY2013 Presidents Budget, Key Tables, Table 6, <http://www.ssa.gov/budget/2013KeyTables.pdf>.

Annual Number of SSI Beneficiaries in Current Payment Status

Year	Number of Recipients	Total Benefits Paid
2006	5,829,765	\$30.783 billion
2007	5,959,794	\$32.771 billion
2008	6,118,824	\$34.475 billion
2009	6,322,253	\$38.130 billion
2010	6,556,915	\$40.076 billion
2011	6,930,667	\$41.464 billion

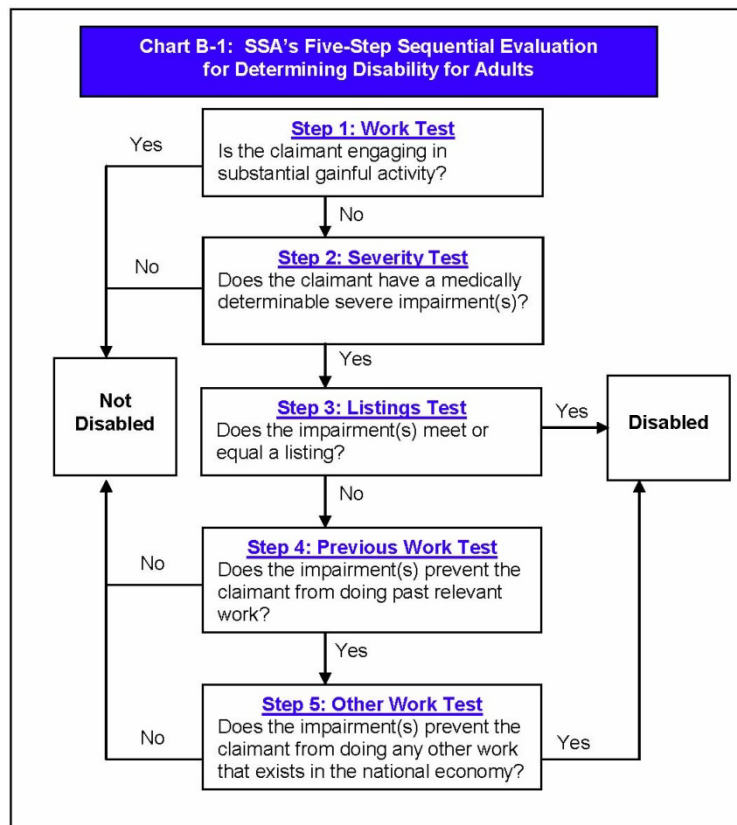
Source: Information prepared by Congressional Research Service

Note: Numbers include all blind and disabled receiving SSI payments.

Due to complex program rules and inadequate program administration, SSA made \$4 billion in overpayments to SSI recipients in 2009, who did not properly report assets.¹⁸

Definition of “Disability.” To qualify for SSDI or SSI a claimant must meet SSA’s definition of disability, which is defined as the inability to engage in substantial gainful activity (SGA) due to a medically determinable physical or mental impairment expected to result in death or last at least 12 months. SGA is essentially determined by the amount of money a claimant makes per month. If a claimant is earning over \$1,000 a month, they are generally deemed to be performing SGA.

In order for the agency to award benefits, SSA must find the claimant unable to perform any kind of work that exists “in the national economy,” taking into account age, education, and work experience. For many years, SSA has used a guidebook called the Dictionary of Occupational Titles (DOT), previously maintained by the Department of Labor,



¹⁸ SSA Inspector General O’Carroll also reported that SSA made \$800 million in underpayments to SSI recipients, putting the program as a whole at a 10 percent improper payment rate. This is based on the fact that in 2009, SSA paid \$48.3 billion to SSI beneficiaries. See Testimony of SSA Inspector General Patrick O’Carroll before the United States House of Representatives, Subcommittee on Social Security, Committee on Ways and Means (June 14, 2011), <http://waysandmeans.house.gov/UploadedFiles/ocarroll222.pdf>.

in determining the types of jobs that exist for individuals alleging disability.¹⁹ The last major revision to the DOT by the Department of Labor was in 1977. In 2008, SSA determined to replace the DOT with a new database called the Occupational Information System (OIS). In July 2011, SSA determined that it could replace the DOT with the new OIS by 2016, but at a cost of \$108 million. A 2012 GAO report stated that, by February 2012, SSA had made progress on this effort, but it was too early to tell if the 2016 deadline would be met.²⁰

The Application and Appellate Process. Once a claimant files an application for disability benefits with SSA, it is forwarded to a central office in the person’s home state, called the state disability determination service (“DDS”). There is one DDS office in each state, which provides an initial determination based on the medical evidence in the claimant’s file. Due to an historical anomaly, DDS employees are employees of the various state governments, though they are paid by funds from SSA. Each state’s DDS contracts with SSA to adjudicate medical eligibility for disability benefits under SSDI and SSI rules and regulations.

If the claimant does not provide all of his or her own medical evidence, DDS will contact the claimant’s doctor(s) to request the medical evidence on behalf of the claimant. The DDS then conducts a five-step sequential evaluation (outlined in the graphic above) to determine if an applicant is disabled. An applicant can be denied at any step, even if they meet a later criterion.

Functional/Vocational Grids (Step 5 Analysis). While a claimant’s medical condition may be severe enough to qualify for benefits at step three, under SSA’s current rules most claimants qualify for benefits at step five under an analysis of their residual functional capacity (“RFC”). An RFC measures what an individual can still do despite their functional limitations caused by alleged medically determinable mental or physical impairments. The RFC is determined by the adjudicator at each level of decision. The RFC is an individual’s maximum remaining ability to perform sustained work on a regular and continuing basis for eight hours a day for five days a week or an equivalent work schedule.²¹ The agency then determines if the claimant can do any other work that exists, considering the individual’s RFC, age, education, and work experience.

In 1979, SSA issued regulations aimed at standardizing decision-making at step five where the agency considers whether the claimant can perform any job that exists in the national economy. To implement those regulations, SSA also developed Medical-Vocational Guidelines for DDS examiners and ALJs to use when analyzing a particular case.

The Medical-Vocational Guidelines include three charts or “grids.” Each grid corresponds to a claimant’s ability to perform certain types of work determined by the decision-maker: sedentary; light; or medium. Columns related to a claimant’s age, education and work history are also

¹⁹ Information provided by the Social Security Administration.

²⁰ Government Accountability Office, Modernizing SSA Disability Programs, Program Made, but Key Efforts Warrant More Management Focus, GAO-12-420, <http://gao.gov/assets/600/591701.pdf>.

²¹ SSR 96-9R: Policy Interpretation Ruling, Titles II and XVI: Determining Capability to do Other Work – Implications of a Residual Functional Capacity for less than a full range of sedentary work, effective/publication date: 07/02/96.

factored into these grids.²² Once the DDS or ALJ adjudicator determines the level of work a claimant is capable of performing and assigns the person to the sedentary, light, or medium grid, the adjudicator can then use the additional factors in the grid involving age, education and work experience, to determine whether SSA policy indicates that the examiner or ALJ should find the individual to be disabled. The vocational grids direct a finding of disabled or not disabled only when all of the criteria of a specific rule are met. The analysis can be complicated. The Social Security Advisory Board has explained

The medical-vocational guidelines, which are based solely on the capacity for physical exertion, function as reference points, or guiding principles, for cases involving severe non-exertional impairments. If a claimant's impairment is non-exertional (e.g., postural, manipulative, or environmental restrictions; mental impairment) or if the claimant has a combinational of exertional and non-exertional limitations, the vocational rules will not direct the conclusion of the claim. Instead the adjudicator will use the guiding principles to evaluate the case. This is often a difficult area for adjudicators and results in more subject decision making.²³

These guidelines provide standardized guidance intended to eliminate the time, costs, and inconsistencies associated with SSA decision-makers analyzing specific claimant circumstances. With regard to age, under the grids, once an individual reaches 50 years old (categorized as “closely approaching advanced age”), the vocational guidelines make it easier for those persons to meet the disability standard. The rules provide even more favorable outcomes for persons 55 years old or older (categorized as “advanced age”). SSA has determined that at those ages, it is less likely an individual will be able to learn a new skill to perform new types of jobs.

²² See 20 C.F.R. Appendix 1 to Subpart P or Part 404 – Listing of Impairments.

²³ Social Security Advisory Board, Aspects of Disability Decision Making: Data and Materials, February 2012, http://www.ssab.gov/Publications/Disability/GPO_Chartbook_FINAL_06122012.pdf.

The portion of the grid governing disability determinations for individuals that are 55 and older (or advanced age) that are limited to sedentary work is excerpted below:

Table No. 1—Residual Functional Capacity: Maximum Sustained Work Capability Limited to Sedentary Work as a Result of Severe Medically Determinable Impairment(s)				
Rule	Age	Education	Previous work experience	Decision
201.01	Advanced age	Limited or less than high school	Unskilled or none	Disabled
201.02	Advanced age	Limited or less than high school	Skilled or semiskilled—skills not transferable	Disabled
201.03	Advanced age	Limited or less than high school	Skilled or semiskilled—skills transferable	Not disabled
201.04	Advanced age	High school graduate or more—does not provide for direct entry into skilled work	Unskilled or none	Disabled
201.05	Advanced age	High school graduate or more—provides for direct entry into skilled work	Unskilled or none	Not disabled
201.06	Advanced age	High school graduate or more—does not provide for direct entry into skilled work	Skilled or semiskilled—skills not transferable	Disabled
201.07	Advanced age	High school graduate or more—does not provide for direct entry into skilled work	Skilled or semiskilled—skills transferable	Not disabled
201.08	Advanced age	High school graduate or more—provides for direct entry into skilled work	Skilled or semiskilled—skills not transferable	Not disabled

“Less than Sedentary” RFC. The agency has ruled that to be categorized as able to perform sedentary work, an individual must be able to sustain sitting six hours of an eight hour work day and be able to occasionally lift ten pounds. If the adjudicator determines the claimant cannot perform those functions, or their equivalent, the adjudicator can find the individual has a “less than sedentary” residual functional capacity (RFC). The agency, in Social Security Ruling 96-9p, explained that “an RFC for less than a full range of sedentary work reflects very serious limitations resulting from an individual’s medical impairment(s) and is expected to be relatively rare.” The same ruling made clear that the ability to perform less than sedentary work “does not necessarily equate with a decision of ‘disabled.’”

Social Security Ruling 96-8p. DDS examiners and ALJs may also rely on Social Security Ruling 96-8p in approving claims related to an individual’s ability to engage in an eight hour work day.²⁴ This ruling provides that an individual must be able to sustain work-related physical and mental activities in a work setting on a regular and continuing basis. A “regular and continuing basis” is defined eight hours a day, for five days a week, or an equivalent work schedule. If the individual’s alleged impairments prevent participation in a full workday, the agency may award disability benefits.

²⁴ See SSR 96-8p: Policy Interpretation Ruling, Titles II and XVI: Assessing Residual Functional Capacity in Initial Claims, Effective/Publication Date July 2, 1996, http://www.ssa.gov/OP_Home/rulings/di/01/SSR96-08-di-01.html.

The guidelines regarding how to treat claimants who are 50 or 55 years of age or older in the three Medical-Vocational Guideline grids have not been revised in more than 25 years. Several years ago, SSA considered raising the ages to reflect “adjudicative experience, advances in medical treatment and healthcare, changes in the workforce since [SSA] originally published [the] rules for considering age in 1978, and current and future increases in the full retirement age under Social Security law,” but no action was actually taken.²⁵

A Denial Can Be Appealed. If an individual is denied benefits at the DDS evaluation or “Initial Application,” in most states, a claimant has four opportunities to appeal the denial: (1) reconsideration, a *de novo* re-evaluation by another DDS examiner; (2) a *de novo* hearing by an Administrative Law Judge (ALJ) in SSA’s Office of Disability Adjudication and Review (ODAR); (3) a request for review by the Social Security Appeals Council (SSAC); and (4) an appeal to federal district court.²⁶

Continuing Disability Reviews (CDRs). After an individual is determined to be disabled, SSA is required to conduct periodic medical and work reviews to ensure that beneficiaries continue to qualify for the program.²⁷ By regulation, these reviews are set for between six months and seven years based on the beneficiary’s likelihood of medical improvement.²⁸ Due to growing numbers of beneficiaries, budget constraints, and the agency’s choice to focus resources on the application backlog, however, the agency has not performed all of the required reviews on a timely basis, resulting in a 1.5 million CDR backlog. If the agency were to perform these reviews in accordance with current law, it would result in \$15.8 billion in lifetime federal benefits savings, according to the SSA inspector general.²⁹

SSA Quality Reviews. The decisions made by SSA’s DDS examiners and ALJs are subject to SSA’s Office of Quality Review (OQR).³⁰ SSA’s OQR is charged with assessing the integrity and quality of the administration of SSA programs in headquarters and in the field. Its responsibilities include conducting broad-based studies of SSA’s SSDI and SSI programs. OQR shares information about recurring errors, common deficiencies, and policy inconsistencies through its reports.

OQR’s key functions include providing support and guidance to program and integrity field staff, ensuring proper case documentation, and delivering quality review feedback to operating

²⁵ In 2005, under Commissioner Jo Anne Barnhart, SSA attempted to raise the ages in the vocational grids on that basis. See *Age as a Factor in Evaluating Disability*, 70 Fed. Reg. 67101 (Nov. 4, 2005). Almost four years later, under Commissioner Astrue, without explanation, the proposed increase in ages was withdrawn. See *Age as a Factor in Evaluating Disability*, 74 Fed. Reg. 21563 (May 8, 2009).

²⁶ In ten states, the first level of appeal, reconsideration by another DDS examiner, is unavailable. See POMS DI 12015.100, *Disability Redesign Prototype Model*, listing the states in which Reconsideration currently does not exist.

²⁷ 20 C.F.R. §§ 404.1589 and 416.989.

²⁸ 20 C.F.R. §§ 404.1590 and 416.990.

²⁹ Social Security Administration, Office of Inspector General, “Full Medical Continuing Disability Reviews,” Report A-07-09-29147 (March 2010).

³⁰ SSA Organizational Manual, Subchapter TK, Office of Quality Performance, <http://www.socialsecurity.gov/org/orgdcqp.htm#oqr>.

components. In addition, OQR's Division of Disability Initial develops disability policy and procedures for conducting quality reviews. Those key functions include analyzing data to identify significant errors, targeting areas needing study to determine corrective action, and issuing prepayment and quality review reports. OQR's Division of Appeals has overall responsibility for the development, coordination, analysis, and reporting of quality review and feedback data at the DDS examiner level and can address similar issues at the ALJ or Disability Determination Board levels.

OQR also works with the Office of Appellate Operations (OAO) to develop a statistically significant sample, most recently of about 3,500 cases, to conduct annual prepayment reviews of SSDI and SSI payments. If the review finds a problem with a particular payment, SSA will withhold payment until adequate information has been provided.

In addition, in 2011, OAO established a Division of Quality (DQ) and instructed DQ staff to begin conducting post-payment "focused quality reviews" (FQRs) to identify recurrent decisional issues in disability cases, problematic patterns in the adjudication of disability cases, and where policy or procedural changes may be needed.³¹ As of January 2012, DQ had completed about 16 such reviews for specific ALJs and about three for entire hearing offices. A team of DQ staffers conducts the FQR, which takes about four to five days to complete. Once a team selects a FQR subject, it screens a sample of 60 to 80 cases for a random period against several criteria. Criteria may include: (1) how many decisions were on the record, (2) how many were bench decisions, (3) how long a hearing lasted, (4) whether claimants submitted additional evidence after a DDS examiner decision, (5) whether a case file included opinion evidence after the DDS determination, or (6) whether case files included opinion evidence from treating, examining, or non-examining sources. DQ staff then conducts a more in-depth review of about 25% of the screened cases and issues a report on its findings. The report and its findings are discussed with the ALJs that were the subjects of the review and could be used by SSA when taking formal disciplinary action against an ALJ for consistently issuing disability decisions that are legally insufficient.

A 2011 report summarizing the DQ reviews reported that DQ staff found, after reviewing disability decisions across the country, that 22 percent contained errors, meaning the DQ reviews identified a quality problem in more than one out of five disability cases.³² At the same time, it is important to note that DQ reviews may identify a quality error in a decision without also finding that the decision on whether to award disability benefits was incorrect.³³ Of the cases

³¹ When DQ finds, based on its sampling of pre-payment cases, that there is a much higher-than-average rate of review for an ALJ or hearing office, then it may conduct an FQR to evaluate what may be a problematic pattern in the adjudication of disability cases. The Office of Appellate Operations also selects subjects for FQRs based on various analyses. The Office of Appellate Operations also works with the ODAR Division of Management Information and Analysis, as well as the SSA Office of Quality Performance, to develop algorithms to improve the selection process for additional FQRs. Office of Appellate Operations, Executive Director's broadcast, 1/13/12.

³² See Fiscal Year 2011, Final Actions Report, Division of Quality, February 8, 2012, provided to the Subcommittee by the Social Security Administration. The Appeals Council took own motion review on 22 percent of the 3,692 decisions reviewed. Six hundred sixty-five of those cases were remanded to hearing offices for further development because the record was not sufficient to render a decision.

³³ *Id.* at 2.

identified by DQ as containing an error, the Office of Appellate Operations, on its own motion, remanded 82 percent to the originating hearing office for further development because the record was not sufficient to render a decision.³⁴ The cases selected for review were selected using a random selection sampling process.

The 2011 DQ report not only reported a national error rate of 22 percent for SSA decisions as a whole, it also provided a chart identifying the extent of problematic cases found in each SSA regional office. When broken down by region, the rate ranged from a low of 15.5 percent (Region 8) to a high of 26.2 percent (Region 6).³⁵

Own Motion Rate by Region					
As stated above, the Council took own motion on 22% of the 3692 decisions reviewed. The regional own motion rate ranged from 15.5% (Region 8) to 26.2% (Region 6), with an average rate of 22% and an overall rate of 22%.					
Region	EFF	Own Motion		OM Rate	Total Cases
		REM	DEC		
1	160	34	8	20.8%	202
2	259	75	10	24.7%	344
3	279	72	15	23.8%	366
4	278	72	12	23.2%	362
5	305	57	11	18.2%	373
6	256	77	14	26.2%	347
7	259	61	17	23.1%	337
8	273	39	11	15.5%	323
9	272	60	20	22.7%	352
10	269	53	11	19.2%	333
NHC	270	65	18	23.5%	353
Total	2880	665	147	22.0%	3692

The three ODAR hearing offices examined in this Report are encompassed within the chart's statistics. The ODAR hearing office in Oklahoma City, Oklahoma is part of Region 6, which had the highest error rate of 26.2 percent. The ODAR hearing office in Montgomery, Alabama is part of Region 4, which had a 23.2 percent error rate. Finally, the ODAR hearing office in Roanoke, Virginia is located in Region 3, which had a 23.8 percent error rate.

The Office of Appellate Operations DQ staff reports its data and findings (but no recommendations) to the Office of the Chief Administrative Law Judge and ODAR executives for whatever educational or other action they deem appropriate.

³⁴ Id.

³⁵ Id. at 6.

After receiving the DQ data collected in 2011, ODAR responded by developing and implementing mandatory continuing education training for ALJs beginning in January 2012. The first three training topics address the following issues in detail:

- Assessing Credibility;
- Phrasing the Residual Functional Capacity; and
- Evaluating Medical Source Statements.

These issues were also identified by the Subcommittee investigation as problems, as further discussed with regard to specific case files below.

III. BACKGROUND ON SELECTION OF 300 DISABILITY CASE FILES

To examine the process used by SSA to award benefits to individuals in both the SSDI and SSI programs, the Subcommittee developed a case study based upon detailed analysis of 300 specific case files. The case files were selected to reflect certain common diagnoses asserted by disability applicants, as well as decisions made at the initial application and each subsequent level of appeal.

Selection of Counties. To ensure that the 300 case files reflected different types of counties, the investigation examined data to determine whether disability benefits were concentrated in certain parts of the United States. To determine the percentage of individuals receiving disability benefits, the Subcommittee compared U.S. Census Bureau data on the population size of each county in the United States to the data maintained by SSA on the number of SSDI and SSI recipients in each county in the United States.³⁶ This comparison provided the percentage of the population in each county receiving SSDI or SSI benefits in 2009.

Based on this data, three counties were selected to represent three different levels of population density with regard to individuals enrolled in the SSDI and SSI programs (high, low, and mid-range):

- Low-Density Disability Population: Oklahoma (3.20 percent on SSDI; 2.31 percent on SSI);
- Mid-Range Density Disability Population: Alabama (8.54 percent on SSDI; 12.14 percent on SSDI, SSI, or both); and
- Highest Density Disability Population: Virginia (19.27 percent on SSDI; 20.7 percent on SSDI, SSI, or both).

The county in Virginia had the highest percentage of individuals receiving disability benefits in the country in 2009.

Disability Case Files Requested. In cooperation with the investigation, SSA agreed to obtain 100 case files from each of the specified counties in response to selection criteria specified by the Subcommittee. The first selection criterion was designed to reflect how disability benefits were awarded at the initial application stage and at each subsequent stage in the appellate process in each of the three counties. To ensure a cross-section of the decision-making process, the Subcommittee requested the selection of approximately 20 cases approved to receive disability benefits at the initial application process and then at each of the four subsequent levels of appeal: reconsideration; ALJ hearing; Social Security Appeals Council; and federal district court. The selection criteria excluded review of any case file in which benefits were denied.

³⁶ Social Security Administration, Annual Statistical Report on the Social Security Disability Insurance Program, 2009; http://www.ssa.gov/policy/docs/statcomps/oasdi_sc/index.html compared to U.S. Census Bureau; State and County QuickFacts; <http://quickfacts.census.gov/qfd/index.html>.

Secondly, to ensure the case files reflected typical disability applicants, the Subcommittee requested that the bulk of the case files be divided among the three most common specific diagnoses, using national percentages for diagnoses of individuals on the disability rolls. The three most common 2009 diagnoses were: musculoskeletal system and connective tissue problems (24.9 percent); mental disorders (27.5 percent); and mental retardation or developmental disabilities (8.9 percent).³⁷ To ensure consideration of all potential diagnosis groups, the Subcommittee also requested that at least some of the case files reflect all of the remaining diagnosis categories.

Using these selection criteria, SSA developed criteria to randomly select 100 case files from each of the three counties for Subcommittee review.

Redaction of Personally Identifiable Information. Prior to the disability case files being provided to the Subcommittee, SSA removed all personally identifiable information from each case file. The redactions included removing all claimant names, addresses, telephone numbers, dates of birth, tax information, and any other information that could be used to specifically identify a particular claimant. SSA then assigned an identifying number to each case file, such as Oklahoma Case 101.

Contents of the Case Files. The contents of each disability case file were generally uniform. The file generally included a SSA disability application form and associated subjective questionnaire documents completed by the applicant (i.e., questionnaires about a claimant's pain or activities the claimant performed on a daily basis), agency-generated documents relating to case process or appeals, correspondence between the agency and the claimant (or the claimant's representative), and any medical evidence or consultative exams related to the applicant. The quantity and type of medical evidence submitted with each case file varied greatly. Duplicative pieces of medical evidence were frequently provided in applications where the claimant was represented by an attorney or claim representative. The size of each case file varied greatly, ranging from just over 100 pages of documents to over 1,500 pages.

Review of Agency Process to Award Disability Benefits. In reviewing the 300 disability case files, the Subcommittee investigation focused on the process utilized by the agency, at all levels, to determine the award of disability benefits. The Subcommittee's review examined the agency's evaluation of evidence, both medical and other, available to support a claim of disability. The amount of medical evidence in each case file varied widely, but when available, generally included medical testing results, physician or therapy progress notes and reports, and general hospital and physician records. The case file also included SSA's evaluation of reports issued by consultative examiners and claimants' subjective allegations made on SSA application forms supplementing disability applications (e.g., reports by claimants of pain, third-party reports of claimant activity, reports on a claimant's ability to perform activities of daily living, and work history).

³⁷ Social Security Administration, Annual Statistical Report on the Social Security Disability Insurance Program, 2009, Table 6, Distribution by sex and diagnostic group, December 2009, http://www.ssa.gov/policy/docs/statcomps/di_asr/2009/index.html.

By reviewing these 300 case files in detail, patterns emerged suggesting areas of weakness and ways in which SSA could improve its awards of disability benefits.

IV. PROBLEMS WITH DECISIONS MADE BY ADMINISTRATIVE LAW JUDGES

Administrative Law Judges (ALJs) play a significant role in the adjudication of disability claims filed with the Social Security Administration (SSA). As a group, ALJs decide approximately 700,000 cases every year, and each ALJ is expected to process at least 500 cases per year.³⁸ This volume of cases represents nearly a quarter of all of the disability claims filed with SSA in a typical year, all of which must be examined by less than two percent of SSA's workforce.³⁹ Importantly, in most cases, ALJs effectively provide the final opportunity for claimants who have been denied to make their case for disability benefits.

In the three counties examined by the investigation, benefit award decisions at the ALJ level were fraught with significant problems. These problems ranged from basing decisions on evidence of questionable value, to citing insufficient evidence to support the decision made, misusing expert testimony, and holding perfunctory hearings. The result was a large number of poor quality decisions, raising questions about whether they were decided correctly.

A number of ALJs who spoke with the Subcommittee suggested that at least part of the problem lay in the heavy workload that comes with the job. In recent years, as a concerted effort was made to reduce the growing backlog of undecided disability applications, ALJs were encouraged to decide no fewer than 500 cases per year. Since most cases contain several hundred pages of documents – many over 1,000 pages, including complex medical documents – making a proper decision and producing a high quality written description of that decision on more than one case per day is difficult.

Others pointed out how quality can suffer in some offices because the program's rules have become so complex that applying them correctly is also difficult. There are more than a dozen categories of "medical listings" for which disabled Americans can qualify, each containing subcategories of ailments, which themselves also have subcategories. For claimants that do not have a disability that fits into a medical listing, they can also qualify under the "Medical-Vocational" guidelines. Using lengthy and complex "grids," ALJs must determine if a person's medical condition is severe enough to qualify for benefits based upon age, education and past work history. Keeping all of these rules, options, and guidelines straight, and applying them correctly, is a challenge for even the most conscientious and experienced judges.

In addition, even when large numbers of poor quality decisions are identified, senior SSA officials explained that there is little the agency can do to correct the underlying problems, because of the Administrative Procedures Act (APA). The APA, which applies more broadly than to disability programs and the SSA, establishes the principle of "qualified judicial

³⁸ Statement of Michael J. Astrue, Commissioner, Social Security Administration before the Committee on Ways and Means Subcommittee on Social Security, June 27, 2012, http://www.ssa.gov/legislation/testimony_062712.html

³⁹ Social Security Administration, Hearings and Appeals, Information about Social Security's Office of Disability Adjudication and Review, http://www.ssa.gov/appeals/about_odar.html

independence” for the work of administrative law judges.⁴⁰ This law ensures that, while ALJs remain employees of the Executive Branch, and therefore work for SSA, they retain significant freedom in how they conduct their work.

For claimants, this independence is intended to assure them of a fair and impartial hearing if their initial applications are denied by agency personnel. According to agency officials, however, it can also create an accountability problem in which the agency has little recourse if it disagrees with the manner in which a judge conducts business or makes decisions.⁴¹

In an interview, the SSA Chief Administrative Law Judge Debra Bice acknowledged the tension between independence and accountability for ALJs.⁴² Judge Bice, who has nearly 30 years’ experience with Social Security disability programs, much of the time at the agency and some as a claimant representative, is responsible for overseeing over 1,400 ALJs. Having become an ALJ in 2008, Ms. Bice rose to the position of Chief Judge in January 2011.

She told the Subcommittee that one particular concern that has surfaced during her tenure is so-called “high producers” – ALJs that decide a disproportionately large number of cases each year. When asked whether she was concerned about the poor quality of work being done by some of the high-producing ALJs, she said she was. She added, however, that she was not sure what the agency could do about it because of the independence ALJs are afforded. In 2011, the Commissioner unofficially capped the number of cases each ALJ can decide at 1,200, which he did by limiting their assignments to no more than 100 per month.⁴³

Absent a change in law or program rules, however, Judge Bice told the Subcommittee that she is limited to emphasizing the role of training to better prepare new judges and refresh senior ones. Noting that some judges “hadn’t been trained in years,” she explained that she now holds quarterly discussions with small groups of judges to talk about their work. Her top advice for judges, she said, is to “never abdicate the role of judge.” She explained that the job of a judge is not “just taking a case and paying it,” but striving to “make sure they are impartial,” and decide each case on its merits.

⁴⁰ See 75 Fed. Reg. §§39154, 39156, Final Rules Setting the Time and Place for Hearing Before an Administrative Law Judge (discussing qualified judicial independence).

⁴¹ A March 2012 report of the SSA Inspector General explained: “While the APA and the Act permit SSA to review ALJ decisions, the Agency cannot review ALJ decisions in any manner it chooses. For instance, in October 1981, SSA instituted the Bellmon Review Program where the Appeals Council reviewed pre-effectuation decisions of ALJs with high allowance rates. Under the program, the AC reviewed these ALJs’ decisions to determine whether the decisions were correct, and, if they were not, the AC issued final decisions or returned cases to ALJs with instructions for additional actions. The Association of Administrative Law Judges filed suit against SSA and alleged that the Bellmon Review Program violated ALJs’ decisional independence. When the district court issued its decision in 1984, it used the Bellmon Review Program. The court did not find that the Bellmon Review Program violated the law, but it did find that focusing review on ALJs with high allowance rates created an ‘atmosphere of tension and unfairness which violated the spirit of the APA, if no specific provision thereof.’” SSA Office of Inspector General, “The Social Security Administration’s Review of Administrative Law Judge’s Decisions,” A-07-12-21234, March 2012, <http://oig.ssa.gov/sites/default/files/audit/full/pdf/A-07-12-21234.pdf>.

⁴² Subcommittee interview of Debra Bice (8/3/2012).

⁴³ *Id.*

The Subcommittee also interviewed Judge Patricia Jonas, Executive Director of the Office of Appellate Operations (OAO).⁴⁴ Judge Jonas discussed the Division of Quality (DQ) recently established by the OAO. She explained that the DQ is responsible for reviewing unappealed decisions by ALJs and hearing office senior attorney adjudicators. She disclosed that in its first full fiscal year of operation, FY2011, the division found errors in 22 percent of the cases it reviewed, which resulted in OAO's issuing, on its own motion, remand orders or corrective decisions in numerous cases that had not been appealed.⁴⁵ In an agency newsletter, the OAO noted the following "top 10 reasons for remand of the unappealed hearing decisions:

- RFC – exertional limitations inadequately evaluated;
- RFC – mental limitations inadequately evaluated;
- Claimant credibility – failed to discuss appropriate credibility factors;
- Drug or Alcohol Abuse – insufficient articulation of [drug and alcohol abuse] rationale;
- RFC – non-mental non-exertional limitations inadequately evaluated;
- Incomplete/inadequate record – record inadequately developed;
- Onset date/closed period/[continuing disability review];
- RFC – effect of combination or impairments inadequately evaluated;
- Treating source – recontact necessary.”⁴⁶

A number of the issues identified by OAO as top concerns mirror the concerns identified by the Subcommittee investigation in this case study.

The following cases illustrate a number of the problems identified by the Subcommittee investigation in its review of the 300 case files.

A. Misuse of Vocational Experts

ALJs rely on vocational experts (VEs) to provide independent third-party analysis during hearings on the capacity of claimants to perform work. In fact, approximately 76 percent of all SSA hearings in FY2010 involved VEs.⁴⁷ In the cases reviewed in the investigation, ALJs often cited the testimony of these experts to award disability benefits. However, instead of simply relying on the independent judgments of the VE present at the hearing, a few ALJs at times appeared to ask leading questions and even manipulate the process in a manner that resulted in a finding of disability.

SSA guidance for the use of vocational experts is provided for ALJs in a detailed manual called the “Hearings, Appeals and Litigation Law Manual,” or HALLEX. All ALJs are supposed to

⁴⁴ Subcommittee interview of Patricia Jonas (7/30/12 and 8/9/2012).

⁴⁵ Office of Appellate Operations, Executive Director's Broadcast, Vol. 3, Special Edition – Quality Review, January 13, 2012.

⁴⁶ Id.

⁴⁷ Office of the Inspector General, Social Security Administration, Availability and Use of Vocational Experts, May 2012, <http://oig.ssa.gov/sites/default/files/audit/full/pdf/A-12-11-11124.pdf>.

follow HALLEX guidelines, which were drafted by the SSA Deputy Commissioner for Disability Adjudication and Review for that purpose.⁴⁸

Vocational experts (VEs) are not employees of SSA, but are private contractors paid by the agency for each hearing they attend. Frequently, they work in the field of vocational rehabilitation, developing expertise in helping individuals find work or retraining people looking to get back into the workforce. Most of the ALJ hearings reviewed by the Subcommittee had a Vocational Expert present to testify regarding whether there were jobs the claimant could potentially perform that exist in the national economy. The VE's role is to provide an opinion about whether a claimant's limitations are severe enough to limit their ability to work.

HALLEX provides basic procedures for the use of VEs, but notes: "The ALJ should take care to elicit useful and objective testimony from the VE."⁴⁹ ALJs elicit this testimony by asking the VE questions about the claimant, or instead, "The ALJ may use hypothetical questions to elicit the VE's opinion about the availability of jobs that an individual could perform given certain factual situations."⁵⁰ The second option allows an ALJ to craft various scenarios to which a VE is required to respond. A vocational expert is not supposed to independently review any claimant's medical records to ensure that the hypothetical they are given match the claimant in the hearing room.

In the cases reviewed in the investigation, VE testimony was usually provided in response to the ALJ posing "hypothetical" questions about claimants with the same disabling conditions as the actual claimant, rather than asking directly about claimant. Under HALLEX guidelines, these hypothetical disabling conditions are supposed to be garnered from the medical evidence of record, going no further.⁵¹ Considering only the hypothetical conditions set by the judge, the VE then opines on whether jobs exist that the claimant could perform. The VE can also testify regarding the number of those jobs that exist in the nation, and sometimes the region.

In some instances, the investigation found ALJs using VEs in inappropriate ways or in ways that failed to yield useful results. In a few cases, the ALJ construed a hypothetical situation so narrowly that it elicited testimony from a VE that no jobs were available. In a number of cases, the hypothetical situations were not supported by the medical evidence of record for the relevant claimant, or were contradicted by the available evidence. At other times, a VE was asked only a single question, seemingly to obtain a pre-determined result. In one instance, when a judge received testimony that jobs were available for the claimant, the ALJ kept asking questions – adding hypothetical limitations each time – until the VE said that no jobs could be found. Using the testimony provided in response to the final question asked, the judge ruled fully favorable for

⁴⁸ See Social Security Administration, HALLEX I-1-0-1, Purpose. http://www.ssa.gov/OP_Home/hallex/I-01/I-1-0-1.html.

⁴⁹ Social Security Administration, HALLEX I-2-5-55. The Vocational Expert's Testimony. http://www.ssa.gov/OP_Home/hallex/I-02/I-2-5-55.html.

⁵⁰ Social Security Administration, HALLEX I-2-6-74. Testimony of a Vocational Expert. http://www.ssa.gov/OP_Home/hallex/I-02/I-2-6-74.html.

⁵¹ Established case law is clear that a hypothetical must match the claimant's medical record. It is not intended to examine a variety of scenarios that are unrelated to a claimant. <http://caselaw.findlaw.com/us-9th-circuit/1608455.html>.

a claimant's disability application. In still another instance, an ALJ misreported the testimony provided by a vocational expert, claiming it supported a decision to award benefits when it did not. Sometimes, testimony from medical experts present at the hearing received similar treatment.

These actions gave the appearance that the ALJs at times were manipulating the use of expert witnesses to obtain a pre-determined answer. To the extent this happened, expert witnesses were used to give the appearance of independent third-party corroboration of determinations that may not otherwise have been supported by evidence in the case file. Examples of cases raising these issues follow.

Virginia Case 278. ALJ Richard Swartz awarded disability benefits to a claimant for "disorders of back," though two prior DDS examiners had found the claimant was able to work. A functional assessment study conducted by the claimant's physical therapist even suggested the claimant may have exaggerated his pain to restrict his work. Whether or not the claimant was credible, however, this case highlights how the testimony of a vocational expert was used to find a claimant disabled, despite a VE testifying several times during a hearing that jobs were available that the claimant could perform, and never appeared to conclude there was no work for the claimant.

Having applied for disability alleging chronic back pain, the claimant was denied by DDS at both the initial application stage and upon reconsideration. He then appealed to have his case heard by an ALJ.

His case file contained conflicting medical evidence about whether his condition was serious enough to keep him from working. One physical therapist who conducted an exam, for example, stated that based solely on how the claimant presented at the exam, he could do only sedentary work and could not immediately return to his former job. This same therapist, however, found evidence that his claimed symptoms did not properly match his claimed illness. She reported the claimant could not sit during the exam for more than 15 minutes, but wrote, "It should be noted that he drove approximately 1[.5] hours to the clinic this morning" In another place, the physical therapist wrote: "Utilizing Waddell's Non-organic physical signs of low back pain, the patient tested positive in 1 of 5 categories." Waddell's tests are performed sometimes to determine if a patient is exaggerating, though they can also simply indicate non-physical reasons for pain. Testing positive in any one of the five areas, as the claimant did, is an indication that some of the pain was not physical and that his claims may not be credible.

The physical therapist concluded this exam by finding some evidence of "inappropriate illness behavior," because of inconsistencies between the physical exam and the claimant's answers to a questionnaire. She also wrote: "The patient's activities qualify him for a sedentary physical demand level of work." After making that determination, however, she also wrote: "Based on the objective findings of the Functional Capacity Evaluation it would appear that the patient could not return to work at this time. With observed demonstration of the inability to sit greater than 15 minutes or stand greater than 15 minutes, the patient would be ineffective in an office situation. However, this decision as always is left to the discretion and judgment of the referring physician"

Several months later, medical records related to a worker's compensation claim, dated February 7, 2007, found the claimant continued to allege pain, prompting discussion of a surgical remedy, but also that the claimant "can return to work tomorrow." His doctor wrote: "[Another doctor] had contemplated a fusion and I concur that this was a reasonable option. The patient declined surgery and continues to decline surgery as of this day's dateHe can return to work tomorrow with restrictionsI do not see any reason what so ever to escalate or increase his narcotic requirement and do believe that he should be referred to a pain management group so they can wean him from Lortab to anti-inflammatories over-the-counter alone."

On April 2, 2007, both a psychologist and a physician at the DDS level reviewed the claimant's records, each separately noting possible problems related to the claimant's credibility: "Based on the evidence of record, the claimant's statements are found to be partially credible."

At the ALJ hearing, the following exchange between ALJ Richard Swartz and a vocational expert (VE) present at the hearing transpired:

ALJ: Would you give us your assessment of his past relevant work experience?

VE: Yes, sir. The work he did as a welder/fabricator is SVP: 5, which is skilled, and it's classified as heavy exertional level.

ALJ: That basically covers it all?

VE: Yes, it does. He's just a, he's a skilled welder.

ALJ: Okay. Are there any welding jobs at a sedentary, light level so he could transfer these skills to such a thing?

VE: No, most of the welding jobs are between medium and heavy.

Claimant's Attorney: You can stand up long as you need to.

ALJ: If the claimant is about 36 or 37 years old, in that neighborhood. If, with his education level and this past work experience, if he were limited to do the sedentary or light work where he would need some sort of an occupation where he could change positions throughout the workday, more than, more than most standard breaks and lunch, in order to relieve discomfort, can you suggest any jobs at either one of those exertional levels?

VE: As long as he's able to sit, and stand and walk six hours in an eight-hour day, and be productive, there's some unskilled, light exertional level jobs. We have, there's a, a storage rental clerks, storage facility rental clerk. Do you need a DOT numbers on these?

ALJ: No.

VE: On the DOT number, you don't need – 80,500 nationally; 6,400 in the Mid-Atlantic. We have unskilled sales clerk, which is at the light level. There's 164,600 nationally; there's 5,800 in the Mid-Atlantic. We have assembler small parts, there's a – and that's under skilled, light. There's 30,500 nationally, and 4,700 in the Mid- Atlantic region. Do you need more than that, Your Honor?

ALJ: No. How about at the sedentary level? Are there any there for you where you would have the opportunity to change positions occasionally if you wanted to?

VE: Yes.

ALJ: Other than the regular breaks, and so forth.

VE: Yes, your Honor. Again you'd have to be able to set six hours out of an eight-hour day and be productive. There's a charge account clerk. There's 380,000 nationally, and there's 34,000 in the Mid-Atlantic region. There's an order clerk, 587,000 nationally; 27,400 in the Mid-Atlantic. There's an office clerk with addresser, there's 343,000 nationally, and 17,500 in the Mid-Atlantic. Would you need more than that, sir?

ALJ: No, I guess that would do. Are there any hazards involved in these jobs so if a person had some sort of problem they were required to avoid hazardous situations. Would that be a difficulty in any of these?

VE: No, Your Honor.

ALJ: How about if they were limited to only occasional stooping and crouching? Could they do that, with all of these, with these jobs, would that, would that be a problem?

VE: No, Your Honor.

ALJ: If your discomfort limited you to, to the extent that you were required to change positions from sitting to standing, or standing to sitting, at least briefly in order to relieve discomfort for about every 15 minutes, could you still perform any of these jobs?

VE: It would be, I mean, you, you've got to be productive in an eight-hour work day. I guess it goes with the, the frequency and duration. If he's able to sit and stand every 15 minutes and still be productive, then that would work but if, if he basically having problems staying on task then that would take those jobs away.

ALJ: Okay. He's described to us frequently why he has to just, has to sleep during the day. Could he do that on any of these jobs?

VE: No, Your Honor. The -- you get a 15 minute break in the morning, a lunch break, and 15 minute break in the afternoon, and if he's having to take more than that, then it would probably result in being discharged.

ALJ: He's also testified so some ongoing depression or anxiety that has developed since the time of his accident. If this affects his ability to perform all of the different parts of employment or at least ..., would it compromise any of these jobs?

VE: Not these jobs, your Honor. These are unskilled jobs, but probably unskilled jobs or jobs...30 days...

ALJ: Would he have to be able to work eight hours a day in order to do these jobs, with at least some position or other.

VE: He would have to work eight hours a day.

ALJ: That's all the questions I have. Counsel, do you have any?

Claimant's Attorney: I don't think so, Judge.

During the hearing, ALJ Swartz posed and then continued to limit the hypothetical, which is supposed to mirror the claimant's condition, until the VE testified there were no jobs the claimant could perform. Further, all hypotheticals presented to VEs that the ALJ eventually relies on to award benefits are supposed to be supported by the claimant's medical records, but no medical record supported the ALJ's hypothetical that the claimant needed to nap during the day. During the hearing, the ALJ asked the claimant whether he took naps during the day. The claimant responded:

Oh, yeah. Yeah, I, some days, you know, I might take a nap for a hour or something, you know, it, you know, I do that if, like if I don't sleep good at the night or something, it hits me during the day. If I can get comfortable, I'll take a nap, you know?

This testimony does not indicate that the claimant needed regular or lengthy naps during the workday. Nonetheless, the ALJ used this testimony, with no supporting medical records or evidence, to narrow the hypothetical posed to the VE in such a way that the VE testified that no jobs existed the claimant could perform.

ALJ Swartz ruled fully favorable for SSDI in a decision dated April 24, 2008, which was written by a staff attorney. In the decision, Judge Swartz selectively cited the testimony of the VE: "The vocational expert testified that claimant's past relevant work as a [job title withheld], a

skilled job performed at the heavy level of exertion, provides no skills that are transferable to sedentary work.” He also wrote: “Limitations imposed by back disorder preclude performance of even sedentary work on a regular and continuing basis....Considering the claimant’s limitations, he cannot make an adjustment to any work that exists in significant numbers in the national economy....The claimant’s description of his limitations is consistent with the medical evidence of record, and his testimony is credible.”

Alabama Case 69. In this case, ALJ Vincent Intoccia approved SSDI and SSI benefits for a woman based on “arthritis; obesity; hypertension; GERD [acid reflux]; asthma; degenerative disc disease L4-L5; spinal stenosis; and glaucoma.” Her initial claims for benefits had been denied, because DDS determined she lacked sufficient medical evidence and had too many resources to qualify for SSI. She was ultimately awarded benefits under both the SSI and SSDI programs, however, based in part upon a pain assessment from her doctor that arrived hours prior to the start of her ALJ hearing. At the hearing, Judge Intoccia presented the pain form to the medical expert (ME) and vocational expert (VE) present at the hearing, neither of whom had a prior opportunity to review it, and then announced a fully favorable decision from the bench.

In August 2008, the 59-year old claimant filed for SSDI benefits, claiming a disability that began on August 15, 2007. In its Notice of Disapproved Claim on September 26, 2008, the DDS examiner wrote:

We have determined that your condition is not severe enough to keep you from working. We considered the medical and other information, your age, education, training, and work experience in determining how your condition affects your ability to work.

You state that you are disabled because of high blood pressure, a bad back, arthritis in your knees and hand, acid reflux, eye problems, and chest pain. The evidence shows that you have some restrictions. Your restrictions prevent you from performing your past work as a [JOB TITLE WITHHELD] as you describe this work. However, your restrictions do not preclude you from performing that type of work as it is normally performed in the national economy.

In reviewing the available medical records, the examiner noted how the claimant’s own description of her “activities of daily living” revealed “mod[erate] limitations due to pain and requires some assistance; however, [signs or symptoms] appears to be partially consistent w/ findings” that the claim should be denied.

The claimant’s file contained conflicting evidence regarding the severity of her medical conditions. Among the various records SSA reviewed before denying the case at the DDS level were at least 10 notes from her doctor stating the claimant would be absent from work for medical reasons on certain days between 2005 and 2007. In each case she was cleared to return to work. According to one note from her doctor, she sustained, “multiple injuries connected with job fall on 12-21-06,” but was allowed to return to work on February 12, 2007.

On July 18, 2007, the claimant experienced chest and body pain, and was admitted to the hospital for two days, forcing her to miss work. Doctors ruled out a heart attack and discharged her, but diagnosed her with, “Uncontrolled hypertension” and “Arthritis,” while also noting her condition had “improved.” In August 2008, the month she filed for disability, medical records show the claimant complained of hand pain, but her other medical conditions appear to have improved, with medical records indicating her lumbar spine had returned to normal, she had only mild stenosis (a narrowing of blood vessels), and an ankle injury had healed.

In September 2008, the claimant was examined at a family medical center regarding her application for disability benefits. The report concluded: “She can perform all activities without assistance. She needs to have some physiotherapy for lower back problems as well as wrist and knee problems.” There was no mention of complications from glaucoma or problems with her sight.

Following SSA’s initial denial of both claims, the woman hired an attorney on October 10, 2008, and appealed the same day requesting a hearing before an administrative law judge, noting that she would submit additional evidence into the record. The key piece of new evidence was submitted on January 6, 2010, the day before her hearing with Judge Intoccia. It was a one-page form titled “Clinical Assessment of Pain,” filled out by her doctor at the request of the attorney.

The form contained four questions, each listing options for the doctor to circle. The first three listed four possible options, labeled A through D, with A indicating pain that was insignificant and D indicating pain that was severe. For the first two questions, the doctor placed a mark between the C and D options, indicating that the claimant’s level of pain was between “distracting” and “virtually incapacitating.” In the third question, about whether any medications would produce side effects limiting work, the doctor circled C, indicating the patient could experience limitations due to “distraction, inattention, drowsiness, etc.” The form provided no other information about the source of the pain.⁵²

After calling the hearing to begin at 8:44 a.m. the following morning, on January 7, Judge Intoccia entered the “pain assessment” form from the claimant’s doctor into the record. After directing questions to the claimant, Judge Intoccia asked the vocational expert (VE) a single hypothetical that involved the new piece of evidence:

Let’s assume a hypothetical individual, same vocational profile as during the period at issue. Let’s assume that such an individual could perform a full range of sedentary work activity and then let’s superimpose on top of that the pain assessment by Dr. [] otherwise set forth at Exhibit 5F, dated 1/6/2010. If we superimpose those non-exertional limitations by the pain on top of the, the full range of sedentary work activity, could someone under those facts and circumstances go back to any of those three jobs or any other jobs?

⁵² In the Subcommittee’s interview with Roanoke, Virginia Hearing Office Chief Administrative Law Judge Thomas Erwin, he indicated this form was originally created by one of the disability attorneys that frequently appears before ALJs in the office representing claimants. Other claimant representatives were now utilizing this form to provide proof of a claimant’s pain.

The VE replied, “No, sir, neither.”

The judge then turned to the medical expert present for an evaluation of the doctor’s “pain assessment.” The medical expert explained that the pain assessment from the day before showed the claimant, who was present for the hearing, had pain that was “intractable and virtually incapacitating.” The medical expert interpreted the assessment as yielding a more severe diagnosis even than the claimant’s doctor that indicated:

Well, on [claimant doctor’s] pain assessment he, on, on the first and second factor he gave a, a C and a D. D says pain is present and found to be intractable and virtually inc[ap]acitating to the individual. On the, the second factor he also listed a C and a D. D says the increase of pain to such an extent that bed rest and/or a medication is necessary upon physical activity. And then the third factor, the, he indicated a, a C evaluation. To what extent will side effects impact upon the ability? The drug side effects can be expected to be severe and to limit effectiveness due to distraction, inattention, and drowsiness, etcetera. So that would preclude employment.

It appears the medical expert mischaracterized what the document said. While he noted that the doctor circled both the C and D options on the form for the first two questions, he only explained the more extreme pain description found in D. In reality, the doctor had clearly placed a mark *between* the two options, seemingly in an attempt to split the difference, although he did not provide any written explanation of what he meant. The meaning of the document was also ambiguous because it was little more than a basic questionnaire containing no original analysis from the treating physician. Had the evidence not been created, submitted, and analyzed in less than 24 hours, it might have allowed more opportunity for the medical and vocational experts to review it and contact the doctor for an explanation, leading to a more informed, and perhaps different conclusion.

At the hearing, however, after receiving the medical and vocational expert testimony, ALJ Intoccia immediately concluded the proceedings by announcing, “after review of the available evidence of record it appears that a wholly favorable Bench Decision can be issued in this particular claim.” In a bench decision the judge announces his decision at the hearing in the presence of the claimant, which is followed typically by a brief written statement sent in the mail. His bench decision concluded the claimant met vocational listing 201.06, which he “based on VE testimony.” Listing 201.06 finds someone is disabled if they are “limited to sedentary work” for a severe impairment, but also are past the age of 55 and do not have “transferable” skills.

Oklahoma Case 105. Judge Wayne Falkenstein awarded SSDI and SSI benefits to a man alleging chronic knee pain based on knee surgery that occurred in 1984, shoulder pain, coronary artery disease, and obesity. During a brief ALJ hearing, the claimant was not asked a single medical question about his ailments, and the attorney told the judge several times that he was unsure the medical evidence was sufficient to qualify for disability. Yet, using a hypothetical

scenario discussed with the medical expert and a vocational expert, the judge found the claimant disabled under the agency's Medical-Vocational Rules.

Medical Evidence of Record. The claimant's sparse medical records consisted only of notes from a hospital visit on August 5, 2006, and a 2007 consultative examination performed at the request of DDS following his application.

Notes from the 2006 hospital visit described the claimant as "a 49 [year] old who complains of chronic left knee [following] surgery in 1984 and right shoulder pain, no [history] of injury." The claimant stated that he used no over-the-counter medications for his pain, but was prescribed Naproxen, if needed, for pain relief. The physician noted that the claimant's "left knee without inflammation or deformity, no effusion + good ligament stability, scar consistent with [history]. Right shoulder +TTP, no deformity noted. Decrease [range of motion]."

The physician's findings in the consultative exam performed in March 2007, with regard to the claimant's allegations of knee and shoulder pain, noted:

The patient is able to walk without an artificial device. The patient's gait is normal, safe, and stable. The patient can do heel walking normally. Toe walking is weak. Straight-leg raise test is negative on both sides Motor strength is 5/5 in the quadriceps and hamstrings. Dorsiflexion and plantar flexion of the feet are in the normal range. Cervical spine with flexion, extension, lateral flexion and rotation is within normal limits. Dorsolumbar flexion, extension and lateral flexion is decreased associated with pain and stiffness. Hip joints with internal rotation, external rotation, abduction, adduction, forward flexion and backward flexion are within normal limits associated with some stiffness without any significant pain. Knee joints with flexion and extension are within normal limits bilaterally.

There is pain and stiffness on the left side, only stiffness on the right side Shoulder joints with forward elevation, abduction, adduction, external rotation and internal rotations are within normal limits bilaterally....By palpation, none of the joints are tender. There is no swelling or erythema noted in any of the joints.

Initial Application. The claimant submitted his initial application for benefits on July 9, 2007. DDS reviewed the claimant's application for both SSDI and SSI based on diagnoses of "osteoarthritis and allied disorders" and "disorders of back discogenic and degenerative."

DDS denied the claim at initial application on September 10, 2007, and explained:

The claimant is a 50 year old male with a 12th grade education. He alleges knee and back pain. The claimant's impairments have been determined to be non-severe in nature. His consultative examination revealed that he has full range of motion in both upper and lower extremities. He is [status post] arthroscopic surgery from 1984, with no inflammation or effusion. Right shoulder had TTP,

decreased [range of motion] with abduction. [Activities of daily living] are not limited to pain.

The claim was again denied on November, 13, 2007 after reconsideration, which explained its decision by noting: “He has no recent [testing]. He is on no med[ication]s, according to his 3373. He has no recent [doctor] visits...He drives, shops in stores, cooks 3 meals per day. After review of the medical evidence, this case appears non-severe.”

ALJ Hearing. On February 11, 2009, nearly two years after the date of his last known medical appointment, the claimant appeared for a hearing before Judge Falkenstein. In the interim period, no new medical evidence of the claimant’s condition was provided.

At the start of the 12-minute hearing, Judge Falkenstein asked the claimant’s attorney, “what’s your theory on how you’re going to win.” The claimant’s attorney responded:

[W]ell, that’s a good question, Your Honor. I don’t, I don’t know if, if the, you know, if you feel that an orthopedic evaluation would, would help. Or I know that’s not, you know, necessarily, you know, your duty of that *but I know we are really lacking in the medical* [emphasis added].

The Judge immediately turned to the medical expert present at the hearing, who opined: “[T]here’s nothing here that I can marshal that would meet or equal a listed impairment.” The ALJ then questioned the vocational expert regarding available jobs for the claimant. The VE found, under the limitations expressed by the judge, the claimant had no skills that were transferrable to the type of work the claimant could perform. With regard to the type of work the claimant previously performed, the VE found that “jobs utilizing transferable skills would not be appropriate.” The VE went on to say “in looking at unskilled work [the hypothetical person based on the claimant’s alleged limitations] suggests a full range of sedentary work and a reduced range of light, unskilled work.” The VE went on to agree with the ALJ that “there are no skills transferrable to sedentary” work.

The judge then asked the claimant’s attorney “how do you think you stand?” The attorney replied

ATTY: [W]ell, your honor, I know the medical, you know, evidence is, is weak, you know. It’s, may not even support a medically determinable, determinable problem. I know that – well, it’s, you know, it’s old, what, I think, oh, a couple of years since he’s been there and had any treatment and –

ALJ: Record closed.

The transcript shows that the ALJ interrupted the attorney, closed the record, and awarded benefits.

In his decision, issued on March 4, 2009, the ALJ wrote: “[T]he claimant has the following severe impairment(s): degenerative joint disease, status post left knee surgery, coronary artery

disease, and obesity.” No medical evidence in the record mentioned degenerative joint disease and the only reference to coronary artery disease called it “mild coronary artery disease without significant symptoms” rather than “severe.”

To support his decision, the Judge cited the testimony of the medical expert to determine the claimant could only perform sedentary work and wrote that “the vocational expert at the hearing stated [the claimant’s] capabilities *essentially* limited the claimant to sedentary work. [emphasis added].” The judge concluded: “[C]onsidering the claimant’s age, education and work experience, a finding of ‘disabled’ is directed by Medical-Vocational Rule 201.14,” or the vocational grid. Essentially, in this case, the judge cited the medical and vocational expert testimony to justify a decision that had virtually no medical support in the case file.

Oklahoma Case 104. In this case, Judge Lance Hiltbrand awarded SSI benefits to a claimant based on “deafness in both ears, degenerative joint disease of the right hip, degenerative disc disease of the cervix and lumbar spine, bilateral carpal tunnel and hypertension.” In his opinion explaining the decision, he put significant weight on the testimony of a vocational expert at his hearing. The hearing transcript discloses, however, that the judge asked the VE only one question, based upon a hypothetical situation that was not supported by the medical evidence. The VE, who is not trained or expected to ensure that a hypothetical matches the circumstances of the actual claimant, opined under the hypothetical scenario given that the person would be unable to perform work.

On April 4, 2008, the claimant filed for SSDI and SSI benefits, alleging that her disability began at various times between 1999 and 2003. At the ALJ hearing, she asked that her onset date be amended to the date of her application – April 4, 2008 – due to a lack of medical evidence prior to 2008. Because she was not insured for SSDI benefits through that new date, however, she was, technically, not eligible for SSDI benefits.

Prior to reaching the ALJ level, however, both the SSDI and SSI claims were denied by DDS on August 1, 2008, due to insufficient medical evidence. In the SSI denial, the agency explained, “We have determined that your condition is not severe enough to keep you from working.” While the claimant suffered a degree of deafness, it began when she was a child and had not prevented her from working. The SSDI denial concluded, “your condition was not disabling.” In its Explanation of Determination, DDS wrote that the claimant, “has a RFC for a wide range of light work with limited hearing She can communicate with coworkers and supervisors Vocational Rule 202.11 directs a decision of not disabled.”

On September 17, 2008, the claim was again denied, this time under reconsideration, which DDS explained in the following way:

We have determined that your condition was not disabling on any date through 3/31/2008, when you were last insured for disability benefits. ... Your arthritis causes you some pain and discomfort; however, you can still move well enough to do some types of work. With hearing aids you can hear well enough to work in jobs that do not require perfect hearing. Medical evidence does not show any impairments which keep you from working.

The claimant, a 54-year-old woman, testified she had moved from California to Oklahoma so her sister could care for her. She explained that her disability required her sister to take complete care of her, and her sister did all the cooking, cleaning, yard work, laundry, driving, shopping, and caring for their dogs. However, in medical records from August 26, 2008, she told her doctor she: “Moved to Oklahoma 8 m[onths] ago to take care of her mother who had a stroke.” Her SSA Form 3368, dated April 4, 2008, filled out by disability claimants, also explained that, “I stopped working because I came to OKC. And the pain.”

The claimant also alleged disabling hearing loss. However, in doctor notes from May 20, 2008, the physician noted that the claimant had some hearing ability: “The patient states that she was born deaf but states that she reads lips very well; however, throughout the examination I noticed on multiple occasions that she seems to hear me without looking at my face, but when we are further away from each other she does have a significant amount of difficulty hearing me and I have to repeat myself on several occasions.”

DDS sent her for a hearing test and the resulting consultative exam record from July 17, 2008, stated she had worn hearing aids since the age of 21 due to hearing loss beginning at age five. The consultative examiner found her “hearing aid on the right is non functional” and “her present hearing aid on the left is approximately eight or nine years old” and “was not functioning real well.” He used a stock hearing aid from the office and put it into her right ear, observing, “You will notice that she got much better function from her stock aid on the right than with her own hearing on the left.” The examiner concluded, “She basically needs new binaural hearing aids.”

Judge Hiltbrand held a hearing for the claimant on August 18, 2009, at which the claimant asked that her disability onset date be amended to April 4, 2008, the date of her application. Her attorney explained to the judge, “As you can see from the record, we don’t have any medical going back.” Judge Hiltbrand responded, “Okay. So, we’re looking at basically from May the 21st 2008 to the present”

During the hearing, the woman explained that when she was working in 2005, she stopped working because she, “stepped off the back of a ladder and whatever I did, I really didn’t hurt myself, but I guess I did because after my hip really started hurting a lot and my back. And so – and I really – I wanted to leave California and come back to Oklahoma and live with my family. So, I quit [the job] and moved back to Oklahoma.” The judge asked if she received workers compensation for the fall, but she responded, “I never even went to the hospital, the doctor.”

She continued to explain to the judge that she was currently living with her sister, who “just recently got on” Social Security Disability as well. Her sister, she said, took care of her to such an extent that she even had to help her dress in the morning, including pulling up her pants. When the judge questioned how the sister could do this with her disability, the woman responded, “You know she’s dealing with hers quite well.” She added that her sister did her laundry and was the “worker in the house.”

In his September 9, 2009, fully favorable decision, ALJ Hiltbrand disagreed with the DDS determination regarding Vocational Rule 202.11, which should find the claimant “not disabled.”

He based his disagreement on the testimony of the vocational expert at the hearing. The testimony of the vocational expert, however, was based on a hypothetical created by the judge that was not based on evidence in the medical record. In the hypothetical, the judge described the claimant's various conditions, but added the assumption the claimant would experience "a mild to severe level of fatigue and discomfort affecting her ability to work in a competitive environment." This fatigue symptom was not mentioned or supported in the available medical evidence in the case file.

Moreover, in the same July 2008 document generated by a DDS doctor used by the judge to identify and support restrictions on the claimant's ability to lift, sit and stand, a separate section called "Postural Limitations," contained no limitations on the ability of the claimant to engage in a variety of physical activities. This section provided options for a DDS physician to identify any limitations with respect to climbing, balancing, stooping, kneeling, crouching, or crawling. When presented with the option for each activity to select whether the limitations were a factor "frequently," "occasionally" or "never" – the examiner chose "None established." The document did not refer to any issues involving fatigue or discomfort.

During the hearing, Judge Hiltbrand offered the following hypothetical to the vocational expert to analyze:

ALJ: Assume a hypothetical the same education and work experience as that of the claimant has the following exertional and nonexertional limitations, which I will give you at this time. This hypothetical individual can occasionally lift and carry objects no more than 20 pounds, frequently lift or carry objects up to 10 pounds, stand and/or walk at normal pace, six hours in an eight-hour workday and sit with no breaks for a total of six hours in an eight-hour workday. **As to all postural limitations as to climbing, balancing, kneeling, crouching and crawling, all those are going to occasional.** She is going to have limited hearing. She should avoid loud background noises. She may have difficulty hearing, dealing with the general public, or working on the telephone or dealing with people on the telephone. As to environmental limitations as to any loud noises, avoid concentrate exposure and experiences a **mild to severe level of fatigue** and discomfort affecting her ability to work in a competitive environment. Based on these exertional, non-exertional limitations can this hypothetical individual perform any of her past relevant work as she previously performed it or how it shall be performed in the national and national economy, please? [emphasis added]

VE: No, Your Honor.

ALJ: Okay. Any other work?

VE: No, Your Honor.

The judge based his decision to award benefits in large part on the VE's testimony. His opinion did not address the contradictory medical evidence in the record or perform a credibility analysis of the claimant's testimony.

Moreover, the judge did not address the credibility of her testimony that her disabled sister was capable of meeting all of the claimant's physical needs, including dressing and feeding her. Finally, he found her disabled beginning in April 2008, despite the fact that he mentioned during the hearing that the relevant medical records were dated from May 2008, the following month.

B. Questionable Hearing Conduct and Use of Hearing Evidence

Administrative Law Judges determine some of the most challenging disability cases that come before the Social Security Administration. By the time a case reaches an ALJ, claimants have already been denied benefits, in most states twice. Hearings provide an opportunity for claimants to make their case personally before an impartial judge. They also allow the judge to get answers to questions about potentially lacking or conflicting evidence, whether a claimant is credible, or whether a condition has worsened.

Similar to other judicial venues, the ALJ hearing is not simply an informal meeting between the agency and a claimant. Rather, hearings are intended to be run as judicial proceedings that allow claimants the opportunity for due process and for the judge to obtain all relevant facts. SSA guidelines are clear: "The ALJ must inquire fully into all matters at issue and conduct the administrative hearing in a fair and impartial manner."⁵³

During an interview, SSA's Chief ALJ, Debra Bice, was adamant about the high standards applicable to the conduct of disability hearings.⁵⁴ When asked about how to conduct a good hearing, she reiterated what she described as her constant message to ALJs: "Don't abdicate your role as judge." She said that disability ALJs were responsible to "know the law" and "know your case" well enough to "provide a full and fair hearing." She added that she instructed the judges: "Don't just look at the physician's records and pay a case."

The role of the judge at the hearing, she went on, is to ask questions that present the issues in the case: "Claimants should get a chance to tell their story." With few exceptions, a good hearing takes 45 to 60 minutes to conduct, sometimes longer, according to Judge Bice.

Asked about extremely short hearings, Judge Bice responded that there are "serious problems with a three minute hearing." She indicated that short hearings can erase the appearance, if not the reality, of a process that is independent and impartial, making them look instead like stagecraft. Moreover, she added, "If a claimant doesn't speak, that's not a hearing."

⁵³ SSA identifies the elements of a hearing as an introduction; an opening statement; oaths or affirmations; adducing the evidence; receipt of oral testimony; presentation of written or oral argument; and a closing argument. Each of these elements of the hearing is accompanied by detailed procedures. Social Security Administration, HALLEX I-2-6-1. Hearings – General. http://www.ssa.gov/OP_Home/hallex/I-02/I-2-6-1.html.

⁵⁴ Subcommittee interview of SSA Chief Administrative Law Judge Debra Bice (8/3/2012).

The chief judge spoke even more strongly about the problem of judges having off-the-record conversations with claimant representatives, calling it a matter of ethics. While making provision for the way judges and representatives can develop friendly relationships after years of seeing each other on a regular basis, she stressed the importance of maintaining professionalism. “My policy is you don’t want to talk to a representative anywhere outside of a hearing room. ALJs should not go off the record,” explained Judge Bice. In federal courts, such off-the-record conversations are considered *ex parte* – meaning a conversation between a judge and only one of the parties involved – and a violation of the code of conduct for United States Judges.⁵⁵ Despite SSA hearings being set up as “non-adversarial” proceedings involving only a single party, off-the-record conversations threaten the impartiality of the ALJ hearing and render the hearing record incomplete.

Chief Judge Bice told the Subcommittee that, at all times, ALJs need to “make sure they are impartial” in fact, while also “presenting impartiality.” In particular, she warned that judges and claimant representatives should not meet prior to hearings to talk about cases, a practice she called, “very dangerous.” “Very rarely should judges call representatives to talk on the phone” about cases, she explained, insisting that it only take place when there is no other option. Citing an example of something even more off-limits, Judge Bice said judges “shouldn’t be having lunch with representatives.”

The Subcommittee investigation found that in a significant number of the 300 cases it reviewed, ALJs held hearings that failed to meet the standards laid out for them by agency rules and Chief Judge Bice. Problems included perfunctory hearings that were less than 15 minutes long, including some that lasted only three minutes. In some hearings, the transcript showed that the ALJ did not ask the claimant a single medical question. In others, the ALJ turned over all questioning to the claimant’s representative. In those cases, the judge rarely cross-examined the claimant or asked follow-up questions to clarify the answers. In many cases, the judge did not address or resolve issues involving conflicting evidence in the case file. In some cases, the judge issued a decision citing evidence that was either not in the case file or was directly contrary to the records or hearing testimony that did exist. In one instance, a judge appeared to coach a claimant about how to get higher benefits by making his financial condition look worse than it was. Still other hearing transcripts mentioned off-the-record conversations between judges and attorneys that were never explained on the record. The following cases illustrate some of the troubling practices identified during the investigation.

The problem encountered most frequently by the Subcommittee was that of short hearings in which the ALJ failed to properly address the relevant issues. In ***Oklahoma Case 148***, for example, the claimant alleged a disability related to depression and anxiety. On March 21, 2007, she was sent for a mental evaluation to determine whether she met the criteria for medical listing 12.04, related to “affective mood disorders.” While the examining doctor found she did have some moderate mental impairments, the claimant’s condition was determined to be non-severe and not to have met the listing criteria. After a five-minute hearing on June 16, 2008, however,

⁵⁵ See United States Courts, Rules and Policies, Codes of Conduct for United States Judges, Canon 3: A Judge Should Perform the Duties of the Office Fairly, Impartially, and Diligently, <http://www.uscourts.gov/RulesAndPolicies/CodesOfConduct/CodeConductUnitedStatesJudges.aspx>.

ALJ Wayne Falkenstein awarded benefits to the woman. The judge opened the hearing by asking the claimant only three questions, each to obtain administrative details about her birthdate, home address, and level of high school education. He then turned to a medical expert, who had not personally examined the claimant, asking for a review of the medical file. The medical expert said the claimant met the medical listing for 12.04, and without further questions the judge closed the hearing.

Oklahoma Case 153 is a case involving a woman who alleged crippling hand pain from carpal tunnel syndrome, yet also worked as a bartender. One doctor found she had “adequate dexterity” with her hands and fingers; another described her as disabled. ALJ Wayne Falkenstein held a 17-minute hearing which failed to address the conflicting medical evidence. Moreover, most of the time in the hearing was spent trying to call a medical expert whom the judge had asked to testify by telephone. After several wrong number attempts, he sent his assistant to find the number. When the correct number was eventually found, the judge spoke briefly with the expert and closed the hearing.

Virginia Case 267, decided by ALJ David B. Daugherty, involved a hearing that lasted only three minutes, from 9:18 a.m. to 9:21 a.m. The claimant alleged back pathology, shoulder arthritis, left knee arthritis, depression, and anxiety, and was examined on October 21, 2007. A consultant’s report from the examination states:

The number of hours the claimant could be expected to sit, stand and walk will be 4 to 5 hours in an 8-hour workday with normal breaks. The claimant does not require any assistive devices for ambulation. The amount of weight the claimant could lift and carry is 15 to 20 pounds frequently. Slight limitation in bending, stooping, crouching and crawling. No limitations in reaching, handling, fingering or grasping. No other relevant visual, communicative, workplace or environmental limitations.

This and other medical evidence weighing against the claimant was dismissed by ALJ Daugherty. Instead he based his favorable decision on a checklist form filled out by a doctor (Doctor One), apparently at the request of the claimant’s attorney. On July 22, 2008, at his three-minute hearing, Judge Daugherty elicited evidence to support Doctor One’s characterization of the claimant’s limitations and at one point had to remind the claimant that he had seen Doctor One. The following is the hearing testimony in its entirety.

ALJ: Mr. --

CLMT: Yeah.

ALJ: -- my name is David Daugherty and I'll be judge for the hearing. All right, Bill do you have any objections to me admitting the exhibits.

REP: No, Your Honor.

ALJ: Okay, so you would admit all of the exhibits.

ALJ: Now, Mr. [NAME REDACTED], raise your right hand and I'll swear you in. You, too, [VOCATIONAL EXPERT]

ALJ: Mr. [NAME REDACTED], what are your primary health problems; what keeps you from working?

CLMT: I was born with scoliosis; I have pain, anxiety, and depression.

ALJ: High blood pressure?

CLMT: Yes.

ALJ: You have pain every day?

CLMT: Yes.

ALJ: Pain right this minute?

CLMT: Yes.

ALJ: Who's your doctor?

CLMT: [DOCTOR Two] and [Doctor Three].

ALJ: You seeing Doctor One?

CLMT: Yes.

ALJ: Okay, let the record show that I'm trying to find some information (INAUDIBLE).

[VOCATIONAL EXPERT SWORN IN]

ALJ: MR. [NAME REDACTED], as a result of this claimant's impairments (INAUDIBLE) is limited to lifting 10 pounds occasionally, less than 10 pounds frequently; he can stand and/or walk less than three hours a workday; sit less than three hours in a workday; never climb, crouch, crawl or kneel. How does the combination of those limitations affect his ability to work and hold down a full-time job?

VE: (INAUDIBLE).

ALJ: I agree with that. I'm going to write a favorable decision (INAUDIBLE). You may be excused.

ATTY: Thank you, Your Honor.

The differences between the medical evidence in the file and hearing testimony as presented by the judge are difficult to reconcile. The consultant's examination report in the case file states the claimant could lift "15 to 20 pounds frequently," but at the hearing the judge said the claimant could lift "10 pounds occasionally, less than 10 pounds frequently." The consultant's examination report states the claimant could "stand and walk ... 4 to 5 hours in an 8-hour workday with normal breaks"; the judge said the claimant could "sit less than three hours in a workday." The consultant's examination describes a "[s]light limitation in bending, stooping, crouching and crawling," but the judge said the claimant could "never climb, crouch, crawl or kneel." The hearing record and subsequent written opinion contain no explanation for the judge's recitation of facts that contradict the contents of the case file.

Oklahoma Case 151. During another hearing, ALJ Peter Keltch appeared to coach a claimant about how he might increase the amount of his benefit check by saying that he was renting a room from his partner, rather than living there for free. The judge gave this advice before he knew the claimant's living arrangements, raising questions about his impartiality and adherence to program rules in this instance.

In addition, this case raises concerns about how the judge justified awarding SSDI benefits to a claimant who could not establish the onset of his disability during a period in which he was insured. The primary issue needing resolution at the hearing involved whether the claimant's disability onset date occurred prior to the claimant's "date last insured," or DLI. Anyone found to have become disabled after his or her DLI does not qualify for SSDI benefits.⁵⁶

The claimant applied for disability benefits based on symptomatic human immunodeficiency virus (HIV) infection.⁵⁷ He alleged a disability onset date of April 15, 2003, nearly two years before his DLI of March 31, 2005. The claimant provided, however, medical records supporting his claim of disability dated no earlier than 2007, two years after his DLI.

DDS Review of Claim. DDS determined that the claimant had failed to prove he was disabled before his DLI. Upon reconsideration of the initial application, DDS sustained the denial and sent the claimant a letter explaining:

We have determined that your condition was not disabling on any date through 03/31/05, when you were last insured for disability benefits [Y]ou said that you were unable to work because of acquired immune deficiency syndrome, joint pain with neuropathy, asthma, allergies, and anxiety. The medical evidence shows the following: Although you sometimes had problems with asthma and allergies, you were able to breathe adequately most of the time. While your joint pain and neuropathy caused discomfort, you could still move around and walk

⁵⁶ Someone that does not qualify for SSDI, for example due to a DLI problem, could still qualify for SSI, assuming they meet the resource and disability requirements.

⁵⁷ While many individuals with HIV infection have a condition that prevents them from being able to work, an HIV diagnosis alone does not guarantee an award of benefits. As with other impairments, the allegations must meet program requirements. Therefore, individuals with HIV infection who are asymptomatic or who have less severe HIV manifestations, may not meet program requirements to be awarded benefits. Need cite

well enough to do some types of work. Your anxiety kept you from doing stressful and complex work, but you could do simple, routine work. Although you tested positive for HIV, the medical evidence does not show any other impairments which kept you from working on or before the date you were last insured for disability benefits.

ALJ Review of Insured Status. The hearing transcript shows that ALJ Keltch was well aware of the disability onset issue. In fact, the judge stated:

I'm showing here the date last insured of March 31, 2005. So, you're not currently insured from Disability. So, you apparently stopped paying in the first quarter in 2000. I don't have any record of any payments in and then that means that your insurance expired March 31st of 2005, which is fine if you are disabled as of the date you said, which was April 15, 2003. So, if you're actually disabled in '03, then you still had coverage. However, if I find that you were not disabled until 2006, '07, '08, '09, sometime later, then you wouldn't have any insurance coverage.

Judge Keltch made clear that he needed to find the claimant disabled prior to March 31, 2005, the claimant's DLI. No medical evidence in the file, however, supported such a finding. Medical evidence from a treating physician stated that the claimant had been "his patient since 2004," but made no mention of disabling health issues dating that far back. The statement by the physician only confirmed the claimant was a patient; it made no mention of a disabling condition. Medical evidence from another doctor stated the doctor saw the claimant five times in six months between October 2008 and February 2009, but those dates were long after the DLI expiration date. While both doctors stated the patient was *currently* disabled, neither doctor provided evidence of disability to support the alleged onset date of 2003.

A medical treatment note dated August 16, 2007, noted that the claimant, a hairdresser, complained he was in such pain that "he cannot even finish one person's haircut." This note was again, after the DLI. It also indicated the claimant was working until at least 2007, which the judge did not ask about during the hearing. Another treatment note dated January 19, 2009, a date that is, again, years past the DLI, reported "his symptoms are improving." One of his doctor's noted, "chronic pain syndrome is nearly controlled at this point."

Despite the lack of medical evidence establishing the disability onset date, Judge Keltch found the claimant disabled beginning April 2003, the claimant's alleged onset date, and well before his DLI, making him eligible for disability benefits. His opinion did not explain the basis for that onset date.

ALJ Coaching of Claimant. A second set of issues involves the judge's conduct during the hearing, when Judge Keltch appeared to coach the claimant on how to secure a higher monthly disability check than he may have been entitled to. The hearing transcript shows how Judge Keltch advised the claimant, who had no income and lived rent-free with his partner, in the following way to receive full benefit checks each month.

Judge Keltch: Do you have income from any source?

Claimant: No.

Judge Keltch: How are you living?

Claimant: [My roommate] supports me. He buys my medications.

Judge Keltch: If you get your benefits do you and [your roommate] have an agreement that you're going to pay [your roommate] back some money?

Claimant: Yes, sir.

Judge Keltch: I'll tell you and a little secret about that. If you go in, if you're approved and they say now where've you been living and if you say I've been having a free apartment, they say oh well we'll deduct a third off of your benefits because you didn't have any rent to pay. But if you go in and say I've been living with a friend and I'm going to pay him back, then they give you the full check. I mean it's between you and him to pay him back if he's been paying the rent and bills.

Claimant: Yes, sir.

Judge Keltch: If you go in there and say well I've just been provided a place to stay and they say oh well for Supplemental Security Benefits then you don't get it, or the check.

Claimant: Yes, sir.

Judge Keltch: You knew that didn't you (to claimant's attorney)?

Attorney: Yes, sir.

While the claimant and attorney responded affirmatively when Judge Keltch asked if the claimant had an agreement to pay a portion of the rent to his roommate, even the suggestion of the judge to advise the claimant on how to maximize his monthly benefit payments potentially violated the ALJ's obligation to remain impartial.

Oklahoma Case 102. ALJ Ralph L. Wampler awarded SSDI and SSI benefits to a 26 year-old woman who alleged that she was disabled because she had poor reading and spelling skills as well as a learning disorder. The claimant supported her allegations with statements on her application documents, but the case file contained no objective medical evidence to support her claim. Judge Wampler held a three-minute hearing during which he questioned the medical expert regarding whether the claimant met a medical listing 12.05 for mental retardation. In response, the medical expert indicated that the claimant did not meet all of the listing criteria in 12.05(D). Despite this testimony, Judge Wampler ended the hearing, awarded benefits under listing 12.05(C), and wrote that the award was supported by the expert's hearing testimony, even though the expert had not discussed 12.05(C).

Initial Application and Reconsideration. When the claimant first applied for benefits, DDS requested a consultative exam be performed. The evaluator that performed the Mental Residual Functional Capacity examination found the claimant was “markedly limited” in her ability to understand and remember detailed instructions, as well as in her ability to carry out detailed instructions. The evaluator found the claimant “can perform only simple tasks with routine supervision [and] can relate on a superficial work basis.”

DDS also had a psychiatric review technique performed. The evaluator found:

26 years old alleges poor reading, spelling, developmental delay and learning disorder. No known mental health treatment past or current. CE exam shows verbal scores of 66, performance of 78 and full scale of 69. Claimant retain[s] ability do simple work.

The evaluator noted the claimant had a “12th grade education attended special education throughout school year, alleges poor spelling skills, poor reading, developmental delay and learning disability. No medical sources provided by claimant.”

The psychological evaluator met with the claimant and determined:

Affect and behavior were observed to be fairly talkative, fidgety and serious. She was cooperative with the examiner. Attention was focused. Effort and motivation were good. Results are interpreted as being valid. Observations of adaptive behavior and interpersonal style suggest a level of functioning that is consistent with the obtained IQ score.

The examiner’s primary diagnosis was that the claimant had a learning disorder; there were no other diagnoses of note. The examiner noted the claimant had four children and was pregnant with her fifth. He noted the claimant’s “medical problems include hypertension She is supposed to take medication for hypertension but she doesn’t.”

The examiner provided no other details as to the claimant’s activities of daily living or her social interactions. The examiner noted the claimant “last worked at a call center for less than one week. The job ended because was told she wasn’t fit for job.” The claimant stated on her disability application forms that she primarily stays home and cares for her four children with the help of her boyfriend.

DDS denied the initial application and request for reconsideration. In the explanation of determination DDS found:

26 years old alleges poor reading and spelling skills, developmental and learning disorder. Claimant received a mental [psychiatric review technique form] and a [medical residual functional capacity] assessment for simple work.

The claimant appealed.

ALJ Hearing. At the hearing stage, Judge Wampler held a hearing lasting three minutes. At the hearing, a medical expert testified she had reviewed the medical documents in the file. No medical records were included in this file, however, except the brief CE report and IQ test results of 66, 69, and 78.

The medical expert opined the claimant generally met the criteria of Listing 12.05, the listing for mental retardation. A claimant meets the criteria of this listing if they meet any one of four tests, labeled A through D. Under 12.05(D), a claimant meets the requirements if a single test shows they have an IQ between 60 and 70 resulting in at least two of the following: (1) marked restriction of activities of daily living; (2) marked difficulties in maintaining social functioning; (3) marked difficulties in maintaining concentration, persistence, or pace; or (4) repeated episodes of decompensation, each of extended duration.⁵⁸

The medical expert testified that the claimant generally met the 12.05 listing, but under questioning from the judge was able to identify a “marked” limitation in only one instead of the listed areas.

Judge:	What do[es the medical record] show the claimant suffers from?
ME:	This individual has a diagnosis of mild mental retardation and a diagnosis of a learning disorder. It’s my opinion that she meets 12.05.
Judge:	12.05. Okay. Now, can you address the B criteria?
ME:	Yes, your honor. In restrictions of daily, daily living activities, I believe there’s a mild restriction.
Judge:	Uh-huh.
ME:	In maintaining social function, I believe there is a moderate limitation.
Judge:	Uh-huh.
ME:	In maintaining concentration, persistence, or pace, there’s a marked to extreme restriction.
Judge:	Okay. And then episodes of deterioration?
ME:	I don’t have – Your Honor, she’s living in a pretty restricted environment –

⁵⁸ Social Security Administration, Medical Listing 12.05(D), http://www.ssa.gov/disability/professionals/bluebook/12.00-MentalDisorders-Adult.htm#12_05.

Judge: Uh-huh.

ME: -- and, not doing things that are, are causing these to occur and don't have any -- I have very limited documentation, actually, but I don't have documentation.

Judge: Okay.

ME: So, I'd just say I don't have enough information.

The medical expert's testimony established a marked limitation in only one area, maintaining concentration, persistence, or pace. After a question regarding the duration of the claimant's alleged impairment, Judge Wampler stated that he didn't "see a need to of going any further," and ended the hearing.

In his written opinion, Judge Wampler stated that he was awarding benefits to the claimant based on listing 12.05(C), which has different criteria and was not even referenced during the three-minute hearing. His opinion cited the medical expert as having testified that the claimant met the requirements of "12.05(C)," even though she had testified about 12.05(D) and did not find that the claimant met the criteria in that listing. While the claimant may well have met the requirements of the 12.05(C) listing and should have received benefits, the judge incorrectly cited the hearing testimony as support for his finding.

Alabama Case 73. In 2010, ALJ Frederick McGrath awarded SSDI benefits to a 49 year-old veteran for "disorders of the back and chronic headaches." Judge McGrath's decision finding the claimant disabled relied in part on a perfunctory eight-minute hearing that took place by video instead of in person and in which the judge spoke only to the attorney, without eliciting testimony from the claimant. The claimant's case file contained a number of conflicting medical records, some showing a possible disability and others showing he could work. During the hearing, Judge McGrath did not discuss any of the conflicting evidence regarding his disability, asking only for an opening statement from his attorney.

A review of the records shows the claimant had a history of painful headaches, though the same records also show he worked despite them for several decades. Complicating the case, his long-term use of prescription drugs for the headaches led doctors to raise concerns that he overused certain medicines – which one said worsened his condition – and that he may have been "drug seeking." And while he claimed that low back pain kept him from working, a consultative exam more than a year after his alleged onset date determined he could do "light work."

His claim for SSDI was denied on October 15, 2009, because DDS found his medical records showed he was still capable of work:

You state you are disabled because of degenerative disc disease and chronic headaches. The evidence shows you have some restrictions and are not able to perform work that you have done in the past. However, based on your age,

education and past work experience, you are still able to perform certain types of work.

On December 14, 2009, the claimant appealed the denial and requested a hearing with an ALJ.

Medical and Work History. The claimant's medical records showed that he had struggled with depression since 1982 and with headaches "since he was 15," but also worked for more than three decades with these same conditions. A review of the records he supplied to SSA show that he complained also of back pain, but that he was never kept from working for extended periods of time.

Records covering the period 2007 to 2009 indicate that the claimant worked off and on at various jobs, despite severe headaches. On August 17, 2007, the claimant underwent a neurological exam for his headaches, at which the doctor wrote: "[O]ver the years he has self medicated with over the counter remedies including Goody Powders, etc. He reports that for the past 15 years he estimates he has taken Goody Powders on a daily basis – he can take up to 6 to 18 per day." Regarding the frequent headaches, he wrote: "Certainly, medication overuse has been a contributing factor."

During a clinic visit the following week, again for headaches, the claimant became agitated when he did not receive the prescription he wanted, which the doctor attributed to him being "drug seeking":

"He was recommended to taper off BC aspirin powders. [Another doctor] recommended using Lortab for his headache and handed him a prescription of Topamax. Patient states that Topamax prescription *has* not been beneficial and that in fact has caused him numbness to right lower extremity. Patient grabbed prescription bottle and threw it across the room into the trash can. Patient missed trash can and then got up and threw it again in the trash can. ...

I personally feel that this patient is drug seeking and I did not feel comfortable with this patient in the room throwing his prescription across the room and into trash can. Patient left office visit extremely frustrated"

Notes from October 12, 2007, showed the claimant continuing to work, which he explained was possible because of a Valium prescription. His doctor recommended lowering the dose, but noted how the claimant resisted: "[H]e is now working in Jacksonville Florida. He is trying to find jobs here and there, but he always comes back home to Selma....He reports that as long as he takes [his] medications, his pain is relatively well controlled....We were discussing last time maybe the possibility of decreasing the Valium to one a day, but he reports that since he has to be traveling so much to work, he feels that the Valium will need to be kept at the same dosage."

A medical progress note from May 8, 2008, reported the patient complained of back pain, but that, "He was laid off his job so he is basically not lifting or carrying anything heavy." Another medical note over a year later, from October 12, 2009, stated: "Currently he is in so much pain

that he cannot do a good job at keeping up with his work so he quit his job last year and is pursuing on disability benefits.”

Numerous records from the Veterans Administration noted the claimant also struggled with cocaine addiction. One from November 21, 2008, recorded how, “[Patient] denies cocaine use, but is on VA papers.” On February 6, March 24, May 19, 24 and September 28, 2009, medical progress notes state that an “active problem” was “cocaine depend[ence].”

On May 22, 2009, the patient visited the VA for an evaluation of his “ambulatory status,” which would later be a central piece of evidence discussed in the short hearing. While the evaluation was described by the claimant’s attorney during the hearing as containing a “prescription” for a walker, the notes show it was the claimant who requested it: “Patient arrived clinic ambulatory without assistive device....Prosthetics service issued the claimant a dolomite Four Wheel Rollator, as requested.”

Following his application for disability, the claimant underwent a consultative exam at the request of DDS on October 12, 2009. The examining doctor found he “walks [with] obvious pain, limps both ways but tolerates it well.” The doctor also noted the claimant “would definitely benefit using a walker to help [with] balance as well as ease [with] walking.”

On October 15, 2009, another DDS consultative examiner reviewed the claimant’s records and called the findings into question, saying his “statements about his allegations are partially credible.” This examiner found that the claimant could perform in the “light work range,” or several degrees of difficulty more than the “less than sedentary” range of work. Also according to this examiner, the applicable vocational rule in this case was 202.21, which provided a determination of “not disabled.”

Perfunctory Video Hearing. On August 13, 2010, ALJ Frederick McGrath held an eight-minute video hearing in which he indicated to the claimant he would rule favorably. During the brief hearing, the judge did not ask a single question of the claimant, and only asked the attorney for an opening statement. The hearing left a number of issues unresolved, including: (1) how to handle records giving conflicting accounts of cocaine and barbiturate abuse; (2) whether the claimant was fired from his job or quit because of his disability; and (3) how to handle the October 2009 consultative exam which found him fit for light work and not disabled.

ALJ McGrath opened the hearing by saying, “I note you’re going to be using a walker today and I note that for the record. I’m going to speak to your attorney for a few minutes.” He then turned to the claimant’s attorney for an opening statement. The attorney responded: “Thank you, Your Honor. We submit that this gentleman is unable to work on a competitive basis due to the pain in his low back, some in his neck and of course his chronic headaches. The walker that you mentioned was prescribed by the VA on May 22 of ‘09....” He added the claimant “just contacted us a couple of weeks ago, and so we haven’t had time to further develop the case, but if need be I’ll certainly obtain those records.”

Judge McGrath responded; “[I]f he can’t meet the full range of sedentary work I’m going to find him disabled. You’ll get a decision. Any additional records you have available you need to barcode in just so that he has a complete record. That concludes the hearing.”

On September 14, 2010, ALJ McGrath issued a fully favorable decision, finding the claimant disabled for “disorders of the back and chronic headaches.” As in the hearing, the decision did not discuss any of the unresolved issues or conflicting evidence, as required by program rules. Among his findings of fact was that the claimant “has the residual functional capacity to perform a limited range of sedentary unskilled work,” based in part on the use of a walker and because he “is illiterate.”

Judge McGrath’s finding of illiteracy was not, however, supported by the evidence, and even contradicted what little evidence on this issue was in the file. The only reference to the claimant’s literacy was in a consultative exam on August 4, 2009, in which the examiner found he had no difficulty with reading.

Alabama Case 72. In 2010, ALJ David Horton awarded SSI child benefits to a teenage girl a month before her 18th birthday, concluding she had several “severe impairments,” including “morbid obesity; severe degenerative disc disease; diabetes mellitus; and chronic anemia.”

At a 17-minute hearing, Judge Horton explained that he would hold a shorter hearing than usual because he wanted to get a decision out quickly. He noted that if the decision were issued after her 18th birthday, the claimant would also be required to undergo evaluation as an adult. Under SSA program rules, this evaluation would require the agency to consider whether as an adult she was able to work. Children, in contrast, are not required to be evaluated on their ability to work, but only on whether they have “marked” limitations in two of six “domains of functioning.”

In this case, the doctors and examiners who evaluated the claimant did not find marked limitations in two domains. ALJ Horton determined, however, that she had marked limitations in: (1) moving about and manipulating objects, and (2) health and physical well-being, and awarded her SSI benefits. In his fully favorable decision, Judge Horton relied on the claimant’s brief hearing testimony to make these findings. His opinion did not address conflicting information in the case file; in particular, two key pieces of evidence that specifically addressed the child’s abilities in each of the six domains of functioning and concluded she had mild limitations, but was not disabled.

One of these records came from her teacher. A March 5, 2009 assessment from the claimant’s 11th grade English teacher found the child not only had few limitations, but was succeeding in school. The teacher, who taught the claimant 1.5 hours each day, completed a detailed questionnaire at the request of the agency, describing the child’s capacity in all six “domains.” In the two areas found by Judge Horton to have “marked” limitations - “Moving about and manipulating objects” as well as “Health and physical well-being” – the teacher reported for the first “no problems observed in this domain; functioning appears age-appropriate” and for the second, “[n]one of which I am aware.” The teacher even went on to write:

Prior to this survey, I had no indication that there was any problem with this student. Compared with the “general” population of our school, this child’s behavior is far preferred to that of most students her age.

The ALJ opinion does not address this evidence.

The second key record is a consultative examination performed at the request of the agency. On March 17, 2009, the consultative examiner for the agency found marked limitations for the claimant in only one domain of functioning, “Moving about and manipulating objects.” In the domain of “Health and physical well being,” the CE determined the child’s limitations to be “Less than marked.” The ALJ dismissed the CE’s opinion, however, writing later in his decision:

The State agency medical consultant’s assessment regarding health and well being is given little weight because evidence received at the hearing level shows that the claimant is more limited in this domain than determined by the State agency consultant. Furthermore, the State agency consultant did not adequately consider the combined effect of the claimant’s impairments.

During the hearing, though, ALJ Horton asked the claimant only to confirm facts already in the medical record, drawing out no new information. He began the hearing announcing that he had read the materials in the record so that there was little need for a normal-length hearing:

Okay. I'm going to try to keep the testimony fairly short this morning because I reviewed the medical evidence pretty thoroughly in here. I'm just going to kind of ask you some questions about your treatment. I normally like to get testimony from just one person at a time, but in this particular case, since again I think the medical evidence kind of speaks most of what's here, if at some time you need to chime in, [Claimant] it's okay, but normally I don't allow that, but in this particular case, again, just because I think the medical evidence is what it is, I just want to verify some things in here in the quickest way we can get it in there.

His remarks contain no indication that the file contained conflicting information regarding her disability, nor does the judge examine that issue during the hearing.

The ALJ hearing concluded after 17 minutes, and the judge issued a decision two days later – unusually fast compared with other agency decision times. Before adjourning, he explained why he was issuing the decision so quickly:

Okay. Both what I'm going to do in a case like this because again I pretty well reviewed the medical record is I'm going to review it one more time, issue a decision in this case. We're going to try to get that decision out fairly quickly since your daughter is going to turn 18 here next month. But it sometimes takes a little while to get out in the mail and get to you and so forth, but you will get a decision in the next few months based on everything that I see in the record.

And if you should be awarded benefits, one of the things you may want to make sure is to take care of any medical needs as quickly as possible because should she be awarded benefits there'll be an age 18 redetermination coming up very quickly. So just keep that in the back of your mind about medical treatment and so forth. But anyway, I appreciate you all coming out today and giving me your testimony. I hope you get doing better because you're awfully young to have such severe problems, so again I hope things get going better for you, but appreciate it.

By moving so quickly and disregarding the conflicting evidence in the case file, the judge enabled the claimant to obtain SSI benefits under criteria designed for children and avoid having to be evaluated under adult criteria, as required for all claimants 18 years of age and older.

C. Improper Application of Medical Listings

As noted above, in many cases, SSA issues disability benefits based upon finding a “medical allowance” at step three of the five-step disability analysis. Making an award of disability benefits at step three of the sequential process and finding the claimant meets a medical listing requires an exact and object level of proof. This is the only step in the process where benefits can be awarded solely on the basis of medical factors. If an individual is not working and provides proof of one of the listed impairments, or an impairment of equal severity, the agency will award disability benefits without considering vocational factors (i.e., the claimant’s age, education, or previous work history).⁵⁹

To be found disabled at step three, a claimant must meet the criteria for at least one illness on a “Listing of Impairments,” developed by SSA. The Listing of Impairments is broken down into 14 body systems. For each “listing,” SSA specifies very specific medical criteria that must be met before a claimant is deemed to “meet a listing” and qualify for disability benefits. SSA developed these medical listings and more importantly, their required elements, to insure disability payments are only made for particular conditions under particular circumstances. The Listings are also intended to promote national uniformity and consistency at all adjudicative levels.⁶⁰

Since the 1990s, the Government Accountability Office (GAO), the SSA Office of Inspector General, and Social Security Advisory Board “have expressed concerns that the medical listings being used [by SSA] no longer provide current and relevant criteria to evaluate disability applicants’ inability to work.”⁶¹ In fact, in 2003, GAO placed SSA’s disability programs on the high-risk list “in part because their programs continue to emphasize medical conditions in assessing work capacity, without adequate consideration of work opportunities afforded by

⁵⁹ Social Security Advisory Board, Aspects of Disability Decision Making: Data and Materials, February 2012, http://www.ssab.gov/Publications/Disability/GPO_Chartbook_FINAL_06122012.pdf.

⁶⁰ Id.

⁶¹ Government Accountability Office, Modernizing SSA Disability Programs, Program Made, but Key Efforts Warrant More Management Focus, GAO-12-420, July 2012, <http://gao.gov/assets/600/591701.pdf>.

advances in medicine, technology, and changes in the labor market.”⁶² In July 2012, GAO noted that SSA has made some progress in updating the medical listings for eight of the 14 body system medical listings. The agency continues to experience delays, however, with the remaining six body systems. GAO also noted that two of the six remaining body system listings to be updated were mental and neurological disorders, which were among the most frequently used in the eligibility determination process. GAO also determined that SSA would likely miss its targeted time frames for four of these six body systems. Therefore, GAO recommended that SSA explicitly identify the resources needed to fund the work needed to complete these updates.⁶³

Some of the ALJ decisions reviewed by the Subcommittee relied upon a medical listing to award disability benefits. In a number of those cases, the ALJ merely provided the listing number and stated that the claimant “met the listing” at Step 3 of the sequential decision process, because the claimant alleged a particular diagnosis. At times, the ALJs failed to explain how the objective medical evidence in the case file demonstrated that the elements of the particular listing were met.

A second set of issues involved medical listing 12.05, which identifies the medical criteria for “mental retardation.” To meet this listing as an adult, a person must not only provide evidence such as low scores during IQ testing, but must also demonstrate that the condition existed prior to the age of 22 years old, and that the claimant also had certain other limitations restricting the ability to work.⁶⁴ Frequently, ALJs relied heavily on IQ testing results, but failed to demonstrate how a person met the age-related requirement or other required limitations. The Subcommittee investigation also detected a strange pattern in some cases in which the claimant applied for disability benefits related to musculoskeletal or other physical ailments, but after getting denied and obtaining an attorney, applied for and were found to have met the medical listing for mental retardation.⁶⁵

In an interview with ALJ Thomas Erwin, the Hearing Office Chief Administrative Law Judge from Roanoke, Virginia, he noted that cases like this are difficult. He explained that he sometimes has to take additional steps to make sure he has all the information he needs when a claimant changes allegation in the middle of the application process. “If a claimant says back pain, but suddenly there is a record for depression and anxiety from a psychologist, I may send the person for an independent exam.”⁶⁶

⁶² Government Accountability Office, Modernizing SSA Disability Programs, Program Made, but Key Efforts Warrant More Management Focus, GAO-12-420, July 2012, <http://gao.gov/assets/600/591701.pdf>.

⁶³ Government Accountability Office, Modernizing SSA Disability Programs, Program Made, but Key Efforts Warrant More Management Focus, GAO-12-420, July 2012, <http://gao.gov/assets/600/591701.pdf>.

⁶⁴ Social Security Administration, Medical Listings, 12.00: Mental Disorders, http://www.ssa.gov/disability/professionals/bluebook/12.00-MentalDisorders-Adult.htm#12_05.

⁶⁵ Indeed, Roanoke, Virginia Hearing Office Chief Administrative Law Judge Thomas Erwin noted this was a frequent occurrence with regard to claimants that appeared before ALJs in his office.

⁶⁶ Subcommittee Interview of Judge Thomas Erwin (9/7/12)

SSA guidelines allow for an ALJ to request an additional consultative exam, which will be arranged through the State DDS office.⁶⁷ By going through the DDS office, this reduces the chances any interested parties might sway the results for or against the claimant. Judge Erwin noted that some attorneys will try to provide a “store bought opinion,” which he said were more frequent for mental exams than for physical exams. “If it’s clear the attorney just sent the person out, my Spidey sense goes off a little,” he added.

Oklahoma City ALJ Dell Gordon sounded a similar note, explaining that mental impairments were the most difficult to deal with, requiring more of his time and attention. The difficulty, he said, was in sorting through good evidence and “evidence that doesn’t seem genuine.” The problem is that “canny attorneys can buy an extremely favorable description that finds someone extremely disabled,” even if they do not have a long-term relationship with the claimant.⁶⁸

Virginia Case 249. In 2010, ALJ William Russell awarded SSDI benefits to a 55 year-old woman finding she met the criteria of Listing 12.05(C) for mental retardation. To meet this listing, a person is required to show the condition began before the age of 22; to demonstrate an IQ between 60 and 70; and to demonstrate a “significant work-related limitation.”

This case highlights the difficulty for ALJs as they weight all relevant evidence. While the case file contains sufficient records to support the 12.05(C) listing, it also fit a pattern that several judges raised as suspect. In the claimant’s original application for benefits, the only work-related limitation she alleged was COPD, a severe breathing condition. The ALJ awarded benefits, however, finding the claimant met the listing for “mental retardation” with a second “significant work-related limitation” of anxiety.

Moreover, during the ALJ hearing, the judge noted that she needed more evidence, and so requested an additional consultative exam. Only, the exam was arranged by the claimant’s attorney, rather than by the judge. When asked about the doctor to whom the client was sent, Judge Erwin noted that he was familiar with the person. He explained how this particular doctor “only does those for attorneys,” referencing consultative examinations for disability claims.

In his opinion, the Judge pointed to no specific medical evidence supporting his finding, and simply restated the medical listing:

The claimant’s impairments meet listing 12.05(C). The “paragraph C” criteria of this listing are met because the claimant has mental retardation initially manifested before age 22 with a valid verbal, performance, or full scale IQ of 60 through 70 and a physical or other mental impairment imposing an additional and significant work-related limitation of function.

Medical Evidence of Record. Progress notes in the claimant’s file were from her treating physician and dated between 2007 and November 2009. The claimant was treated for seasonal

⁶⁷ HALLEX I-2-5-20. Consultative Examinations and Tests. http://www.ssa.gov/OP_Home/hallex/I-02/I-2-5-20.html

⁶⁸ Subcommittee Interview of Judge Dell Gordon (9/7/12)

allergies, high cholesterol, headaches, and hypertension, all of which were controlled with medication. After she applied for disability benefits, she complained of sleep apnea, which was successfully treated with a Continuous Positive Airway Pressure (“CPAP”) machine.

DDS sent the claimant for a consultative examination on October 29, 2008. The physician found:

The claimant’s appearance, behavior and speech were normal. Thought process and content were normal. Concentration and attention were normal. Judgment and insight were normal. Attitude and degree of cooperation was normal. Fund of information seems adequate.

DDS denied the claim and reasoned:

The evidence shows that you have pain in your back, but you are still able to sit, stand, walk, and move about within an adequate range without assistance. You have breathing problems, but a recent breathing study has shown that you return a sufficient ability to breathe. There are many jobs in the economy that do not require much education. Migraines are very bothersome, but generally respond well to treatment and medication. There is no evidence that you have significant difficulty with vision. Your hypertension has not caused you any severe complications.

Attorney Procured Mental Opinion Inconsistent with Medical Records. Following SSA’s denial of the claimant’s initial application, her attorney sent the claimant for a mental evaluation on September 27, 2010. Having only a 7th grade education, the doctor found the claimant “produces IQ scores of VCI 66, PRI 60, WMI 71, PSI 68, and FSIQ 60.” Despite her low IQ, the claimant had never before complained of a mental impairment. In the report from that doctor, it was noted that the claimant’s “Standardized test scores (Lorge-Thorndike) from fourth grade report Total IQ 53, but the referenced standardized test results were not present in the claimant’s file. The same physician also diagnosed her with generalized anxiety disorder and mild mental retardation.

No evidence indicated the claimant ever complained of a mental condition prior to the 2010 medical evaluation arranged by her attorney. There are no references in the progress notes that she suffered from mental retardation or a low IQ. She arrived to all appointments alone, “wanted to know her lab results” and asked questions directly of the doctor, and “verbalized understanding [of] all instructions and agree[d] with treatment plan[s].” Her 2008 consultative examination found her thought process, concentration, and judgment to be “normal.”

She applied for disability in 2009, and progress notes indicated she suggested to her physician that she might qualify for benefits based on chronic obstructive pulmonary disease (“COPD”). Nowhere in the physicians notes is such a condition discussed prior to the claimant’s suggestion. The physician indicated he would obtain the records SSA procured during the claimant’s CE, if any existed, regarding a COPD evaluation. The ALJ opinion does not reference this condition.

Despite conflicting medical evidence of record, the ALJ apparently relied solely on the mental evaluation procured by the claimant's attorney and found the claimant qualified for benefits based on Listing 12.05(C).

Alabama Case 57. In 2010, ALJ Vincent Intoccia awarded SSDI and SSI benefits in a bench decision during a four-minute hearing to a 35-year-old man complaining of "mental problems and seizures." The Judge determined the claimant met the criteria of listing 12.05(C). While the case file contained records indicating that the claimant had a low IQ, it did not demonstrate an "onset of the impairment before age 22" or existence of a second, significant work-related limitation that took effect prior to the expiration of the individual's disability insurance.

DDS denied the claim on May 30, 2008, explaining:

We have determined your condition was not disabling on any date through 7/12/06, when you were last insured for disability benefits. In deciding this, we considered the medical records, your statements, and how your condition affected your ability to work.

When applying for disability benefits, you must meet certain eligibility requirements. The information in your file shows that you last met the insured status requirements for consideration of disability was 6/30/07.

Two months later on July 23, 2008, the claimant obtained representation and appealed the denial.

The majority of the medical records in his case file pertain to treatment related to a November 2007 accident when the claimant was hit by a car. The claimant sustained a broken tibia and clavicle and a cerebral hemorrhage. The accident occurred five months after the claimant's DLI and therefore, could not be used to award benefits to the claimant.

In addition, medical evidence indicated the claimant's limitations as a result of the accident would not create work-related limitations that would persist beyond a year, as required to meet the criteria of Listing 12.05(C). Medical records dated February 4, 2008 show that following surgery, the claimant had no clavicle pain and was healing. His physician cleared him to bear weight on his injured leg as much as he could tolerate, and x-rays showed "excellent alignment of his fracture."

At the February 3, 2010, four-minute hearing, Judge Intoccia did not ask the claimant any questions, and the claimant did not speak. Only the judge, the claimant's attorney and a vocational expert provided testimony for the record. The key exchange discussing the claimant's medical listing was as follows:

ALJ: And it's my understanding, [claimant's attorney], essentially your position is that [claimant] meets 12.05C?

ATTY: Yes, sir.

ALJ: Okay. I would, I really have to agree with you on that position. I really have no questions for him unless you do.

Judge Intoccia immediately issued a bench decision and provided only the following explanation:

To summarize briefly, I found you disabled as of July 1, 2006 because of mild mental retardation, Fetal Alcohol Spectrum Disorder (FASD) and 22a11 Deletion Syndrome so severe that your impairment(s) meet the requirements of (C) listed in the Listing of Impairments.

Here, the claimant's verbal, performance and full-scale IQ scores were rated as 69, 68 and 73. The medical record, however, contained little concrete evidence of a second severe impairment prior to the claimant's DLI of June 2007. The only evidence in the claimant's file that mentioned the secondary impairments listed above only speculated they were issues for the claimant. A medical record from a mobile clinic on August 19, 2009 stated

[Claimant] with a long history of neurodevelopmental abnormalities as well as a behavioral associated with material drinking. His manifestations are likely to be due to prenatal exposure to alcohol, but additional medical work up is needed and in this context chromosome analysis as well as DNA analysis for Fragile X syndrome and a CGH array will be requested today. [Claimant's] father was encouraged to continue with current interventions and therapies...

Chromosome analysis was reported as normal (46XY) and a DNA study for Fragile X was negative. However, a CGH array revealed a 22q11 deletion of 2.4Mb typical of the DiGeorge Syndrome deletion. This finding was discussed with [claimant's] father by phone. 22q11 deletion is among the most common chromosomal abnormality in humans and its is associated with neurodevelopmental disabilities including cognitive deficiencies associated medical problems and mental illness later in life. In this context, the family was encouraged to follow up in our clinic for further discussions and additional recommendation. This laboratory result suggests a dual diagnosis Fetal Alcohol Spectrum Disorder (FASD) and 22q11 deletion syndrome.

The examining physician only speculates as the claimant's potential diagnoses. No other medical record in the file indicated the claimant returned to confirm the potential diagnoses, or for the suggested treatment.

The Judge also failed to address the claimant's extensive history of alcohol abuse. A consultative exam stated the claimant "began drinking alcohol around the age of eighteen. At one time, he drank an estimated 'one or two' cases of alcohol [per] week." It also noted he "has gotten into a car to drive in front of police while drinking. He bought paper to roll marijuana cigarettes in front of a policeman and was subsequently charged with possession." The physician noted the claimant "has been arrested twice for DUI and once for possession of marijuana."

Virginia Case 287. In 2009, ALJ Geraldine Page made a fully favorable award of SSI and SSDI benefits effective August 31, 2005, under listing 12.05(C) due to obesity, migraine headaches, chronic fatigue syndrome, anxiety, and mild mental retardation. The ALJ determined the claimant met the criteria of medical listing 12.05(C) – cited above – due to an IQ between 60 and 70 and the other listed ailments, which the judge determined to be so severe as to limit her ability to work. Objective medical records, however, inconsistently referred to those other impairments and failed to support a finding that they were severe enough to cause work-related limitations. The claimant worked as a custodian part-time and on an as needed basis.

Medical Listing Requirements. Judge Page cited a report that found “the claimant obtained a verbal IQ score of 70, a performance IQ score of 65, and a full scale IQ score of 65” to satisfy the first criterion of 12.05(C).

Under the listing, the Judge must also find “a physical or other mental impairment imposing an additional and significant work-related limitation of function.” To satisfy that part of the listing, the judge provided only the following conclusory statement:

Thus, the claimant’s obesity, migraine headaches, chronic fatigue syndrome, and anxiety impose additional and significant work-related limitation on her ability to function mentally and physically. Consequently, the Administrative Law Judge finds that, taking into consideration the additional mental and physical impairments the claimant possess, both of the criteria in Section 12.05(C) are satisfied.

The ALJ did not explain how the additional impairments limited the claimant’s ability to work, especially in light the claimant’s continuing to work even after alleging a disability.

Claimant’s Work Record. Evidence in the claimant’s file indicated she was able to work for more than seven years despite her disability, although her wages did not rise to the level of SGA, according to agency documents. A vocational rehabilitation report noted that the claimant is “on the substitute list for the [] County Public School as a custodian and cook” and “hoped she could get a permanent job with the school system.” On her application, the claimant reported she worked for the school from 2000-2007, one day a week for six hours a day as both a substitute custodian and kitchen worker.

Psychological Evaluations. In a consultative exam dated May 27, 2008, the examiner found the following:

The results of this psychological evaluation revealed a woman who has had a work history that extended for five or six years. Apparently, she must have been functioning reasonably well to have sustained employment for that long. She does a wide variety of tasks around the house and socializes with various people. She has a wide variety of avocations that she enjoys thoroughly. Her communication skills are good. She showed no real problems with either memory deficits or concentration [but] is somewhat anxious and is overreactive to stressors. It is

perplexing that the claimant has never really sought any extensive psychotherapy to assist her in dealing with her periodic anxiety and periodic episodes of transient depression. Neither of these appears to be incapacitating.

From a psychological point of view, it is the examiner's opinion that [the claimant] is capable of functioning in a 40-hour per week job, depending upon the circumstances. It is felt that she could be an effective worker, sustain her employment, get along reasonably well with fellow employees, supervisors, and even the general public. It is likely that she would need to work around somebody who watches over her to some extent but this does not have to be extensive after she learned the ropes and demands of the employment.

The examiner also noted the claimant had a Global Assessment of Functioning, or GAF, of between 65 and 70. The GAF is a tool used by mental health professionals to determine a person's capacity for social or professional engagement. It runs from 0-100, and a score between 60 and 70 is given to those with mild limitations. A prior exam in September 2007 found the claimant with a GAF of 57.

In yet another psychological evaluation, dated May 10, 2007, the examiner noted that, despite a 2006 GAF score of 54, he rated her with a GAF of 70. He went on to explain how the claimant had attended community college classes for several years, and:

denies that she has been depressed and states that her mood is usually 'good.' She states that she sleeps well and energy is adequate; appetite is good; she is irritable at times. She enjoys socializ[ing] and is not withdrawn or agoraphobic. She reports no acute anxiety or panic attacks but states that she is afraid to drive herself to work and has never driven alone. She is able to drive when accompanied by her mother.

The examiner determined that he did "not believe that any pharmacological treatment or medications are indicated at this time" and recommended that the claimant begin counseling to "work towards becoming more independent."

In a psychological evaluation on October 20, 2006, the claimant noted "she is currently working for [employer]" and "she has worked in the past with JPTA and WIA. She is uncertain of any employment problems." The claimant also noted "her income helps with the household income, and this is mainly her step-father's income." The claimant reported "she spends her time working."

ALJ Hearing. At the ALJ hearing in April 2009, the claimant testified she was seeking treatment for her anxiety and saw a therapist for the first time earlier that week. Because she had so recently begun treatment, no treatment records existed documenting the extent to which the claimant suffered from anxiety and none were included in her case file. In addition, no documentation supported the conclusion that the claimant's obesity, migraine headaches or fatigue prevented her from working, in light of her actual work record.

In the fully favorable decision explaining her reasons for finding the claimant met listing 12.05(C), Judge Page referred to one of the records discussing the claimant's GAF score. The judge cited only the oldest GAF score of 54, even though later scores for the claimant ranged from 57 to 70, and even the doctor who assigned the score of 54 had concluded the "prognosis for placement in an employment position comparable to her skill level would appear to have a fair prognosis."

While the judge's decision to award benefits may have been the correct one, her opinion failed to provide a reasonable explanation of how the claimant's other ailments significantly limited her ability to work, given the claimant's work history.

Virginia Case 282. In this case, ALJ Karen Peters awarded benefits to a claimant under the affective disorder listing 12.04 for bipolar disorder, stating that the requirements of the listing were met, though her decision did not explain why. Moreover, the file contained evidence from a medical exam in which the doctor determined the claimant *did not* meet 12.04, and in fact called her impairments "non-severe."

Under listing 12.04, the SSA regulations lay out the requirements needed for this impairment. For someone diagnosed with bipolar disorder, such a person must also meet the following to be awarded benefits (in pertinent part):

12.04 Affective disorders: Characterized by a disturbance of mood, accompanied by a full or partial manic or depressive syndrome. Mood refers to a prolonged emotion that colors the whole psychic life; it generally involves either depression or elation.

The required level of severity for these disorders is met when the requirements in both A and B are satisfied, or when the requirements in C are satisfied.

- A. Medically documented persistence, either continuous or intermittent, of one of the following:
- 3. Bipolar syndrome with a history of episodic periods manifested by the full symptomatic picture of both manic and depressive syndromes (and currently characterized by either or both syndromes);

AND

- B. Resulting in at least two of the following:

- 1. Marked restriction of activities of daily living; or
- 2. Marked difficulties in maintaining social functioning; or
- 3. Marked difficulties in maintaining concentration, persistence, or pace; or
- 4. Repeated episodes of decompensation, each of extended duration;

Prior to the claim being denied by SSA, a consultative examiner reviewed her records on August 12, 2008 and found that they showed her to have a non-severe mental impairment and even questioned whether her claims were fully credible:

In assessing the credibility of the claimant's statements regarding symptoms and their effects on function, her medical history, her activities of daily living and the type of treatment she received were considered. Based on the evidence of record, the claimant's statements are found to be partially credible.

Another doctor looked over the material two days later and concurred:

Consequently, while the MER indicates the likelihood of diagnoses of Depressive Disorder NOS and Anxiety Disorder NOS, the associated symptoms would not appear to be severe enough to prevent the performance of all levels of work. Therefore, the claimant's disability allegations cannot be viewed as fully credible.

The claimant was then seen in a consultative examination on January 5, 2009, to evaluate whether she met the criteria of either listing 12.04 or 12.05. The physician determined she did not and indicated that her impairments were "not severe."

On June 3, 2010, Judge Peters conducted a hearing by video at which the claimant appeared with her attorney. During the hearing it was discussed that the claimant had previously received SSI benefits, but was dropped from the program when she got married because she no longer met the resource test. During this discussion, however, the woman became unable to speak or answer questions, only able to nod. Judge Peters cut the hearing short after 14 minutes, deciding that she would have to send the claimant for a second consultative exam.

In July 2010, the claimant's attorney arranged for her to see a psychologist, but this exam was also cut short because of a similar incident. The psychologist wrote:

Upon trying to administer her the third subtest to the WAIS-IV [the claimant] fell into a total silence and seemed unable to speak or move. The examiner made several efforts to draw her out of this 'spell' but was rather unsuccessful. Then help was sought from her son in the waiting room. He immediately came and recognized this pattern and began to comfort her and talk with her. We got her something to drink, which she did through a straw. He reports that this Conversion Disorder pattern has been worsening of late, and she is having it almost every three days at this point in time. He also noted that they almost always try to have someone around her all of the time if not most of the time.

Eventually, while her son monitored her, the examiner went and talked with the facility guard who is also the head of the facility. We inquired with the son about calling 9-1-1, but he insisted that that would really not do any good. It was then offered to him that we would help him get her to the car, and he believed that was a good idea, which we did. Her son as well as the guard and facility head helped her to the car with the use of a rolling chair. She was successfully loaded in the

car and then left. During this episode, she spoke only single words such as “help” and “drink.” Her son seemed very familiar with this pattern and was very comforting toward her during the time that it occurred. Therefore, obviously, the testing was truncated.

Judge Peters’ fully favorable decision referenced the July consultative exam and stated that claimant met the 12.04 listing. Instead of explaining how any of the evidence in the file supported this decision, however, the judge simply wrote:

The claimant’s impairments meet the criteria of section 12.04. The paragraph A criteria are satisfied because the claimant has bipolar disorder. The paragraph B criteria are satisfied because the claimant’s impairments cause marked difficulties in maintain social functioning, and marked difficulties in maintaining concentration, persistence, or pace.

ALJ Peter’s failed to explain how the marked difficulties the claimant experienced any marked difficulties with regard to social function. In fact, the claimant told the physician at her consultative exam that “she goes to the grocery store with someone,” “she does attend church,” and she “socializes with family members.”

Virginia Case 291. ALJ Gordon Malick awarded disability benefits to a claimant under a listing for Crohn’s Disease, but lacked the necessary medical evidence to support the award.⁶⁹ The listing states, in pertinent part:

5.06 Inflammatory bowel disease (IBD) documented by endoscopy, biopsy, appropriate medically acceptable imaging, or operative findings with:

- A. Obstruction of stenotic areas (not adhesions) in the small intestine or colon with proximal dilatation ... requiring hospitalization for intestinal decompression or for surgery, and occurring on at least two occasions at least 60 days apart within a consecutive 6-month period; or
- B. Two of the [following specific medical conditions] despite continuing treatment as prescribed and occurring within the same consecutive 6-month period[.]⁷⁰

⁶⁹ The judge awarded the decision under listing “5.07(B),” but since there is no such listing, he likely meant to refer to “5.06(B).”

⁷⁰ A claimant must prove two of the following: (1) Anemia with hemoglobin of less than 10.0 g/dL, present on at least two evaluations at least 60 days apart; (2) Serum albumin of 3.0 g/dL or less, present on at least two evaluations at least 60 days apart; (3) Clinically documented tender abdominal mass palpable on physical examination with abdominal pain or cramping that is not completely controlled by prescribed narcotic medication, present on at least two evaluations at least 60 days apart; (4) Perineal disease with a draining abscess or fistula, with pain that is not completely controlled by prescribed narcotic medication, present on at least two evaluations at least 60 days apart; (5) Involuntary weight loss of at least 10 percent from baseline, as computed in pounds, kilograms, or BMI, present on at least two evaluations at least 60

It is important to note that in meeting the requirements of listing 5.06(B), a claimant must be found to have met *two* of the listed criteria. Further, each of the criterion is based on objective medical testing, containing little if any room for subjective judgment from an ALJ. The claimant appears to lack the secondary medical criteria necessary for disability benefits.

Medical Evidence of Record. The claimant complained of several days of fatigue following injections she took six times per year to treat her Crohn's disease. These injections appear to have successfully controlled the claimant's condition. A physician's note dated October 12, 2006 read: "[S]he has had no hospitalizations or flares during the last year. She is currently in maintenance with Remicade 7.5 mg every 8 weeks without any complications." On that same date, the physician determined the claimant's Crohn's disease was "currently in remission."

Attorney Procured Examining Physician Opinion. The claimant's attorney sent her to a physician, who provided an opinion on the claimant's ability to work. He concluded she would have difficulty holding down a job, but identified only one reason – fatigue.

With regard to the standard residual functional capacity, I think that the fatigue is her only limiter. Her ability to walk 6 hours in an 8 hour day is probably limited but most of the other things would not be a problem. I also don't think this is psychological, she said that you [her attorney] had suggested she may need to see a therapist but she and I both feel that this is probably not necessary

With respect to disability, it sounds as if her primary problem is fatigue. She doesn't have any actual focal deficits that would be causing a problem with work, but definitely fatigue is a side effect both of Remicade and of Crohn's disease.

Fatigue, even if significant, is not, however, one of the criteria for Listing 5.06. Indeed, at reconsideration, DDS determined:

The evidence shows that you are treated for Crohn's disease and that you experience joint and muscle pain at times. However, you have not become malnourished nor underweight from digestive troubles. You remain able to stand, walk, and move about adequately without assistance. You have good use of your hands and arms. We realize that you may continue to experience difficulties, but your condition is not so severe as to be considered disabling.

In his fully favorable decision, Judge Malick awarded benefits based on "5.07B," but based his findings primarily on the severity of the claimant's fatigue, rather than on her meeting one of the specified medical conditions. Citing the exam document noted above as Exhibit 1F, he wrote:

days apart; or (6) Need for supplemental daily enteral nutrition via a gastrostomy or daily parenteral nutrition via a central venous catheter.

Based on the medical evidence and statement from the claimant's physician (Exhibits 1F, 3F, 6F), the Administrative Law Judge finds that the claimant's impairments are severe and meet the criteria of section 5.07B

Also cited were Exhibit 3F, which explained the Crohn's disease to be "[c]urrently in remission," and Exhibit 6F, which related to complaints of shoulder pain.

While the claimant may have experienced significant fatigue and perhaps could have qualified for disability benefits by meeting the required criteria, Judge Malick justified the award by citing the Crohn's Disease medical listing, without explaining how the claimant met any of the specific requirements.

Oklahoma Case 186. In this case ALJ Lance Hiltbrand awarded a 7 year-old child SSI benefits for an "affective mood disorder" under medical listing 112.02, which he determined began on the day the child was born. Listing 112.02 does not, however, have any criteria for children under the age of one. Medical records were also not provided for any time prior to when the child was five years old.

The child was denied SSI benefits when he was in Kindergarten, but his mother reapplied while he was in first grade after a series of suspensions from school the year before. The documents in the file contained conflicting evidence regarding whether the child met the criteria for listing 112.02.

Since to meet the listings, the criteria require feedback from "parents or other individuals who have knowledge of the child," the child's teacher filled out a detailed Teacher Questionnaire on September 24, 2007, shortly after the application was filed. She described the child as having few limitations, citing as the most serious problem for the first-grader, "organizing own things or school material."

On November 29, 2007, SSA sent the claimant to a consultative examiner for allegations of mood disorder, ADHD, "intermittent explosive traits," and a learning disorder. The examiner found some the impairments to be severe, but also determined they "[do] not meet, medically equal, or functionally equal the listings." The teacher evaluation and CE, thus, agreed that while the child had some issues, he did not meet the requirements of the affective mood disorder listing.

On February 27, 2008, a DDS doctor reviewed the claimant's file after a request for reconsideration. Out of six major domains of functioning, the DDS doctor found the child with three areas in which there were "no limitations" and three in which they were "less than marked." As such, he concluded the child did not meet the requirements of a listing and the claimant was denied benefits.

Judge Hiltbrand held a hearing on March 24, 2009, at which the child appeared along with his mother and her boyfriend. Discussion about the child's disruptive classroom behavior consumed much of the time, but his mom explained that he was different at home.

MOM: And she writes comments like he's finally calmed down and sat down and started working by 11:00, which means from the time he got there until 11:00 he's been bouncing off the wall. He's been up walking round the classroom, bothering the other children. She has again, very disruptive in the morning, calms in the afternoon. She has disruptive during film. Sent to the hall. And it's not really a week goes by he's not sent to the hall or ISR. His desk is away from the rest of the children in the classroom because he gets up, walks around the classroom. He talks out loud. Laughs to himself. When he's supposed to be doing work he'll fiddle and push the pencil somewhere else.

ALJ: Will that be tolerated at home if he did something like that at home?

MOM: No. He's a –

BOYFRIEND: He doesn't do it at home.

MOM: -- totally different person at home.

His mom went on to explain how the child's school principal believed the behavior problems were related to immaturity, "the principal at [the child's elementary school] said that it's his maturity level. That he has a -- because he's the youngest second grader at the school because he turned seven in August."

In addition to being the second youngest child in his grade, the mom also explained he had a disruptive daily schedule. She woke her four children up every morning at 4 a.m. because, having only one car, her boyfriend drove her and the children to her work at 4:45 a.m. While the children would come home and try to get some additional sleep, they were taken most mornings to before-school care and stayed for after-school care.

Near the end of the half-hour hearing, the judge noted how, "it seems like he's extremely well behaved here." ALJ Hiltbrand then ordered an additional consultative exam before making his decision. This consultative exam took place several months later on June 24, 2009, at which the doctor found the child met listing 112.02, finding severe impairments in almost every possible category.

Judge Hiltbrand issued a fully favorable decision relying heavily on the June exam. While the CE noted the child met the medical listing, it also stated the claimant

did not demonstrate any hyperactive or impulsive behavior during the evaluation. He looked around the room more as the evaluation proceeded but never got out of his seat. He followed instructions without having them having to be repeated and worked carefully. He smiled frequently and appropriately and only sometimes frowned when he was trying to figure out an answer. He put forth good effort and his test results are thought to be a valid assessment of his current functioning.

The judge also determined that the child's mood disorder began the day he was born in 2001, citing his "premature birth and low birth weight." The opinion did not reference any medical records prior to 2006, when the child was five years old, in reaching that determination. Therefore, the ALJ determined the claimant was disabled five years prior to the availability of supporting medical evidence.

D. Failure by ALJ to Conduct a Proper Credibility Analysis

One of the main reason identified by the DQ for remand, was the failure of the ALJ to perform a proper credibility analysis of the claimant. In at least two cases, the investigation discovered evidence of the ALJ failing to conduct such an analysis. In both cases, claimants were awarded disability benefits, but the evidence questioning credibility was not mentioned or discussed by the ALJs in their decisions.

Oklahoma Case 109. In this case, Judge Lance Hiltbrand awarded SSDI benefits to a woman who claimed she was unable to work due to an injury to her right shoulder. The injury was so severe, she claimed that she could not use her right arm. Though a doctor observed her using the same arm without any problem, the ALJ awarded full disability benefits based on her ailment.

The ALJ noted the claimant said her disability began when she “was injured on the job while working as a cake decorator” in late 2003. In July 2004, the claimant underwent surgery for a tear to her rotator cuff in her right shoulder.

She applied for disability benefits in November 2005, but was denied by DDS following her initial application and after reconsideration. She filed a request for an ALJ hearing on January 12, 2007.

On October 24, 2007 the claimant’s attorney sent her for a consultative exam for an evaluation “of injuries which [the claimant] stated occurred...while working.” The claimant told the examining doctor that she was stacking boxes and “she felt a ‘pulling sensation’ in her right arm and shoulder.” She explained how she never reported the injury, but instead continued to work. In May 2004, the claimant “took a leave of absence so she could find out what was wrong with her right shoulder.” After both surgery and physical therapy, the claimant stated “she has no relief of the pain in the fingers of her right hand or her right forearm.” Further, the claimant stated:

She has pain in the right shoulder with raising her arm above her head. She states she has pain in the right shoulder with lifting a can of vegetables. She states she has pain in the right shoulder with turning or twisting at the elbow. She states she has pain in the right should with pushing and pulling. She states she has numbness and tingling in the right shoulder. She states she has popping, clicking, and locking of the right shoulder. She denies other complaints to the right shoulder.

Once the claimant was out of the doctor’s office, however, things changed. The doctor noted the claimant:

was observed leaving the office today unlocking her truck door and opening it with her right arm. She was also observed extending her right arm to place a bag in to the right front passenger seat. She was observed utilizing both of her arms to steer the wheel of her vehicle.

The doctor concluded the claimant “has sustained no permanent partial impairment to the right arm or the right hand as a result of the above stated accident.” The doctor also opined the claimant’s “period of temporary total disability has long since ended and she may return to employment. She is in no further need of medical care or continuing medical maintenance.” As such, the doctor stated “based on age, education, training, and work experience [the claimant] is not permanently and totally disabled or in need of vocational rehabilitation.”

Despite the CE doctor stating the woman used both hands to drive the car, at the hearing, the claimant testified “I drive one-handed, unless it’s real windy and then I keep that one down there.” She also testified that she goes to casinos with family members.

Despite this evidence from the claimant’s own attorney showing the claimant had full use of her right shoulder and arm just five months before her hearing, Judge Hiltbrand awarded the 44-year old claimant benefits without addressing any of the issues raised by these inconsistencies.

Oklahoma Case 145. This next case involved a veteran who sought disability benefits for post-traumatic stress disorder (PTSD), which he said arose from his military service. Throughout his medical files, however, his doctors noted not only how he was prone to exaggeration, but at times even directly accused the claimant of malingering.

He applied for disability in August 2005 for back pain and anxiety, but in January 2006 was denied at the initial level by DDS. Among the medical evidence DDS considered in making its determination was a consultative exam to assess the claimant’s physical condition, which was done on October 18, 2005. The doctor conducting the exam was a primary care physician not a psychologist, but nonetheless noted the claimant “has a history of social anxiety.” Another medical record reviewed by DDS was a “mental status exam” held on November 7, 2005. The psychologist, who was not a treating physician, diagnosed the claimant with “schizophrenia” and “paranoid type Posttraumatic Stress Disorder.” He added: “Prognosis is judged to be fair. There is a moderate probability that treatment will result in substantial improvement over the next twelve months.”

Then in December 2005, a second consultative examiner reviewed all of the claimant’s medical records, making particular mention of the diagnosis of “schizophrenia” at the November mental status exam. She wrote: “This [diagnosis] of Schizophrenia is not consistent with any of the [medical evidence of record], current or distant.”

The initial claim was denied in January 2006, and again upon reconsideration in August 2006, but ALJ Peter M. Keltch approved the case in June 2008, relying heavily on the same two exams from October and November 2005. Judge Keltch determined the claimant suffered from “Schizophrenia, post traumatic stress syndrome, and a history of polysubstance abuse.” Judge Keltch concluded the claimant met the criteria for medical listings 12.03(A), (B) and (C) related to “Schizophrenic, paranoid and other psychotic disorders.”

A more thorough review of the file, however, might have raised questions about whether benefits should have been awarded. In 1997, eight years prior to his disability application, the claimant

applied for veterans benefits related to PTSD. On September 30, 1997, a psychiatrist conducted an examination, but failed to make a final diagnosis because of the claimant's "malingering."

The differential diagnosis is so broad because I find the veteran to not be a very credible historian. He generally endorsed the presence of almost all symptoms asked of him. Reference should also be made to the admission and discharge notes regarding his 1997 psychiatric hospitalization which also raises issues of credibility. If the veteran's history was accurate, it would be my opinion that he does have a post-traumatic stress disorder related to his [military] experiences. However, I do not believe that his history is accurate based on his clinical presentation.

Then in October 2006, nearly a year after the consultative examinations, the claimant again underwent a mental evaluation. During the exam, the man discussed his military service and how he had recently lost his cousin, who "was his closest friend." In the conclusion of the evaluation, the examiner determined: "[The] results were not valid. His profile was similar to the profiles of others who try to present themselves with more serious pathology than they have. Over reporting psychopathology is common for negative and defiant personality types...."

His medical records mentioned, as well, that he applied for service-connected disability benefits from the Department of Veterans Affairs on multiple occasions, but was turned down each time.

On June 9, 2008, Judge Keltch held a hearing to consider the case, but the claimant did not appear to testify. Judge Keltch explained he had a prior conversation with the man's attorney and concluded it would be dangerous to have him in the hearing room: "The reason he is not in the hearing room is that the gentleman has a severe mental problem, and it is thought to be safer, number one, for him not to be in the hearing room...."

At the hearing, which lasted approximately 10 minutes, the judge asked the medical expert present to consider the mental evaluation from November 2006, which resulted in a diagnosis of schizophrenia. The medical expert present, who had not met or examined the claimant, said she concurred and that he met medical listing 12.03, at which point the hearing was closed.

In his fully favorable decision, ALJ Keltch relied heavily on the November 2006 mental status exam (MSE), as well as the medical expert at the hearing. He failed, however, to mention how the December 2006 exam said the MSE was inconsistent with the rest of the medical record. Moreover, his decision made no mention of the multiple references to malingering, and that other doctors had called the claimant's truthfulness into question.

E. Poorly Drafted On-The-Record Decisions by Senior Attorney Adjudicators

Administrative Law Judges are supported by staffers to help organize case files, write decisions and deal with claimants. Among them are attorneys – called “senior attorney adjudicators” – who help draft their decisions once an ALJ has determined a case. In recent years, however, senior attorneys have also been allowed to write favorable, on-the-record decisions that do not need the approval of an ALJ. By allowing senior attorneys to screen cases to write favorable decisions the senior attorney determines meet program requirements, the agency has intended to move “payable” cases through the system more quickly, leaving the more difficult decisions for the judges.⁷¹

In the cases reviewed by the Subcommittee, however, some of the opinions written and approved only by senior attorneys contained a number of problems.

Oklahoma Case 149. In this case, the claimant applied for back pain, but was awarded benefits under medical listing 12.05(C) for mental retardation. The 2008 written opinion by an SSA senior attorney included only the information favorable to the claimant, while failing to explain or acknowledge conflicting evidence in the file.

To qualify for this medical listing, a claimant must report an IQ of between 60 and 70, show that the impairment has been present since at least age 22, and have an additional impairment severe enough to restrict work. In this case, the claimant was determined to have an IQ score of 70, but two doctors remained unconvinced that the listing criteria were met.

On October 11, 2006, a DDS doctor reviewed the claimant’s file to determine if she met medical listing 12.05, and found she did not. His determination apparently stemmed in part from the fact that the woman did not claim to have any mental impairments.

47 yr. old female does not allege mental. She has not had psychiatric treatment. She has pain due to physical problems and there is associated depression. She was in Special Ed from the 6th grade on. She lives with her two sons. She was cooperative at the psych CE. [IQ] scores V 72 P 73 and FS 70. ADL’s She is able to do the cleaning, cooking and laundry. She is able to drive and shop for groceries. She goes to church. Some restrictions are present due to pain.

One of the considerations the agency must make is whether a claimant can manage their own funds, if awarded benefits. Patients found to meet medical listing 12.05 nearly always are found incapable of doing this, resulting from their mental condition. Here as well, the record contained conflicting information. On August 31, 2006, a state consultative doctor said the woman could not manage her funds. One month earlier, on July 8, 2006, however, a psychiatrist evaluated her in his office and concluded that she did not suffer from mental retardation and could manage her

⁷¹ See Amendment to the Attorney Advisor Program, 72 Fed. Reg. 44763 (August 9, 2007); Extension of Sunset Date for Attorney Advisor Program, 76 Fed. Reg. 18383 (April 4, 2011).

own funds. The psychiatrist's determination matched the one reached three months later, in October 2006, when the doctor described previously found that the claimant did not qualify under the 12.05 listing.

The June 3, 2008, decision written by the senior attorney found that the claimant had an IQ score of 70, and a secondary condition of back pain that significantly limited her ability to work. To establish the second condition, the attorney cited a "medical source statement" from the claimant's doctor, which was a questionnaire filled out at the request of her attorney. The questionnaire said the woman suffered from a degenerative lumbar spine, even though another medical record from October 27, 2006 had found: "No traumatic or degenerative abnormality of the lumbar spine is present."

In the final decision, the SSA senior attorney determined the claimant suffered from "mental retardation" and "degenerative disc disease." The opinion did not acknowledge or explain the conflicting evidence in the case file on both points.

Oklahoma Case 114. In this case a SSA senior attorney awarded benefits to a woman for back pain and obesity, but failed to explain how the medical evidence supported the alleged onset date. Moreover, the opinion's brief analysis of the objective medical evidence consisted primarily of a paragraph cut-and-pasted from a letter written by the claimant's attorney.

The claimant applied for benefits after having back surgery, alleging that her disability began on September 5, 2007, "due to Crohn's disease, neck and back problems, and arthritis."

She received payments under a private disability insurance policy, and saw a rheumatologist for only the second time on January 4, 2008. The first visit had been prior to her surgery three months earlier. In a record in the case file describing the visit, the doctor explained there had been a "misunderstanding" and that he had been asked "to write for disability without seeing her." He noted that he would need some information from her employer, adding:

I told her that I think she is best served working to maintain her activity level. However, she has been off work. I recommend physical therapy ... for three weeks. To Whom It May Concern: The patient is unable to work until July 4, 2008. At that time, she will have no restrictions.

In early July, the rheumatologist saw her again and extended the disability until September, but noted that this was in order to collect additional information.

On July 30, 2008, the claimant visited her regular doctor to help deal with her back pain. The notes from her doctor said that one of the activities she enjoys is "bicycling."

She states she has difficulty sitting and standing for more than 10 minutes. She has difficulty performing laundry, vacuuming, baking, and getting into the lower shelves at the grocery store. She enjoys sewing, crocheting, reading, bicycling, cooking, and baking.

It is unclear from the notes whether she was continuing to bicycle or had enjoyed it in the past.

On August 4, 2008, her initial application was denied. She was denied again by DDS under reconsideration on December 23, 2008, which noted: “You are recovering well from your back operation and should be able to return to work within twelve months.”

A note in the file indicated the claimant saw her rheumatologist again on November 18, 2008, but got into a dispute with him about failing to comply with his prescribed treatment. He concluded the note saying that he would no longer see her as a patient: “Will discharge the patient for noncompliance.” She found a new rheumatologist, but the records show she visited her only one time on November 26, 2008. That rheumatologist found that the claimant was disabled and could not work.

On April 21, 2009, the claimant’s attorney wrote a letter to the Oklahoma City Office of Disability Adjudication and Review asking for an on-the-record decision. The letter also referenced a form filled out by the claimant’s new rheumatologist the month before on March 18, and asked that it be given “controlling weight,” despite the fact that she had only seen the patient one time. The letter from the attorney contained the following paragraph:

[DOCTOR 1] is the claimant’s treating rheumatologist. She completed the enclosed physical capacities dated March 18, 2009 indicating the claimant cannot perform the requirements of even sedentary work. The claimant needs to alternate her sitting and standing at will throughout the day. She cannot use her hands adequately for simple grasping, fine manipulation, and repetitive motion tasks. The claimant can lift/carry occasionally up to 5 pounds but should never lift/carry over that amount. [DOCTOR 1] writes the claimant is in constant pain and her condition is chronic and incurable. The claimant requires daily pain medication and prolonged periods of rest due to fatigue and pain. [DOCTOR 1] writes the claimant has chronic pain and inflammation in the joints, diffuse musculo-skeletal pain which is causing fatigue, inability to concentrate and potential absences from a job due to disease exacerbation. The pain, according to [DOCTOR 1], would be disabling to the extent that it would prevent the claimant from working full time at even a sedentary position.

One month later on May 21, 2009, the SSA senior attorney issued a fully favorable on-the-record decision. It concluded that the claimant’s disability began on September 5, 2007, as she alleged, but did not cite any evidence prior to October 14, 2008 – nearly a year after the fact.

More significantly, the decision contained a brief section analyzing the medical records used to conclude the woman was disabled. Not only was the March 18, 2009, doctor form given controlling weight as requested, the SSA senior attorney simply copied and pasted the above excerpted paragraph from the letter of the claimant’s attorney into the official opinion. The opinion also did not acknowledge or explain the conflicting evidence in the file indicating the claimant was recovering from her back surgery and her initial rheumatologist did not view her as having severe or lasting problems. The SSA senior attorney’s opinion raises questions about whether the medical evidence was properly reviewed and analyzed.

Oklahoma Case 127. In 2010, an SSA senior attorney awarded benefits to a man for degenerative disc disease and depression, finding the claimant could perform “less than sedentary” work despite a State consultant finding he was not disabled and could perform “light” work.

In the senior attorney’s opinion, he discounted the opinion of doctors who performed examinations at the request of SSA, saying: “The State agency medical consultants’ physical assessments are given little weight because the State agency consultants did not adequately consider the claimant’s subjective complaints or the combined effect of the claimant’s impairments.” In contrast, the SSA senior attorney placed significant weight on the claimant’s subjective complaints, while failing to acknowledge that those complaints did not always match the medical records.

One central issue involved the claimant’s ability to walk. The claimant said that his disability began when he was 48 years old in December 2006, which is when he stopped working due to back pain which he described as so severe that he could barely walk. Over the course of the next several years, though, his medical records show that he could walk much further than he described.

During a doctor visit on February 16, 2007, two months after he alleged his disability began, his doctor wrote: “The patient, two weeks ago, joined the [gym] and has been exercising regularly since that time.” On May 11, 2007, the same doctor wrote: “The patient has been walking four times per week.” On August 6, 2007, his doctor wrote: “The patient’s been walking 1-mile 3 to 4 time per week.” He was reported to be “walking 1 mile per day 5-days per week,” again by his doctor on October 31, 2007. Nine months later, on July 30, 2008, the doctor once more noted: “The patient is walking one mile a day at least five times per week.”

During a doctor visit in October 2008, he said, “His wife lost her insurance so he’ll be transitioning to a new insurance company soon.” The next month, in November 2008, he applied for disability insurance. In January 2009, he filled out paperwork for SSA writing, “I have problems walking, standing, bending, sitting for any length of time.” In a second form from February 3, 2009, filled out by his wife, she answered a question about how far he could walk writing, “end of drive way.” However, the records that followed said he could still walk and work.

During a consultative exam with the State agency doctor in April 2009, the doctor concluded he could do light work, adding, “The claimant appears to ambulate in a safe and stable gait at an appropriate sp[eed] without the use of assistive devices.”

On July 22, 2009, he visited his own doctor, complaining of back pain, but the doctor again noted that he and his wife had been making a regular practice of taking walks: “The patient seems to be doing much better on the Cymbalta. We are still dealing with pain issues....He’s been walking a mile and a quarter with his wife every day over the past 2 ½ months.”

The claimant's initial application was denied by DDS, which explained that he was "given a residual functional capacity rating for light work with occasional stooping, and a mental status rating for unskilled labor. ... Using the Medical Vocational Guidelines and Rule #202.14, which directs a decision of not disabled, this case is denied at step 5, for other work." He was denied again upon reconsideration in November 2009.

On March 2010, his attorney for the claimant wrote a letter to the SSA senior attorney working on the case in the Oklahoma City SSA office. It read: "This letter is to advise you that based upon new medical records received and income verification, we wish to amend our onset date to February 28, 2008." Two weeks earlier, the claimant's attorney had faxed five pages of medical records to the office. While the letter said that he wanted to change the onset date because of "new evidence," some of the records were already included in the file. Moreover, only one of the records was dated after the denial at reconsideration. Two were from December 2003 and March 2006 – outside the relevant time frame. None of the "new" records or the existing records in the file explained why the new onset date should be February 28, 2008, which was only a few days before the claimant's 50th birthday.

On April 2, 2010, eight days after receiving the letter from the claimant's attorney, the SSA senior attorney issued a fully favorable opinion finding the claimant disabled. The decision failed to acknowledge or explain why the determination was inconsistent with the records in the file showing the claimant's regular walking routine.

F. Poor Quality Opinions from ALJ Howard O'Bryan

The 16 disability opinions reviewed in the investigation from ALJ Howard O'Bryan, age 87, of Oklahoma City, Oklahoma stand out for their numerous problems and require their own analysis. Judge O'Bryan's opinions not only lacked sufficient judicial analysis or evidentiary support, but were at times incomprehensible. However, as one of the agency's highest producing ALJs in the nation, the impact of his opinions on the disability program has been larger than most.

Since at least 2006, Judge O'Bryan has issued more than 1,000 decisions each year – several years approaching 2,000. The highest three years were 2007 to 2009 in which he decided 1,833; 1,846; and 1,722 cases, respectively. Many of the decisions reviewed in the investigation were written during this time period. His rate for approving the award of disability benefits in the cases he reviewed was similarly high, ranging each year between 90 and 100 percent.

While the investigation questions whether all of these cases were properly awarded, the opinions were most notable for their decidedly poor quality. First, his opinions contained substantial amounts of agency-approved "boilerplate" language. Most of this language was not specific to an individual case, but rather explained how the disability programs worked. In sections that appeared to apply to a specific claimant, however, the opinions also contained a pervasive use of boilerplate. Commonly, Judge O'Bryan used the following sentence after several pages of medical images, seemingly to explain why disability benefits should be awarded: "Various physicians, treating and non-treating, have written that the claimant suffered from various

medical problems and that the claimant has significant work restrictions.”⁷²

Second, instead of providing an analysis of the information contained in an individual case file, Judge O’Bryan typically included partial images of medical records from the case file that he electronically copied into his opinion without explanation. For example, he routinely copied part of a doctor’s examination report describing a claimant’s medical condition and inserted it into his opinion on the case with no attribution or explanation. At times, the images he pasted into the record had nothing to do with the case, or directly contradicted his award of benefits. For example, in *Oklahoma Case 135*, a woman alleged various ailments ranging from hip pain to PTSD and depression. Judge O’Bryan awarded her full disability benefits, but also copied into his decision another doctor’s opinion that her claims were not always credible: “[Claimant] was very manipulative and an unreliable historian.”

Third, instead of precisely identifying a claimant’s disabling condition, the judge typically wrote a long list of maladies, followed by “etc., etc., etc.” He used this technique whether he found a person disabled under the Medical-Vocational Rules or the medical listings. In some cases, he found claimants met three or more medical listings – followed by “etc., etc., etc.” – something the Subcommittee did not encounter in any other ALJ opinion. In one extreme case, *Oklahoma Case 135*, Judge O’Bryan made the following “finding of fact:”

The severity of the claimant's affective (mood) disorders, classed as major depression(2960), anxiety related disorders, post traumatic stress disorder (3000), disorders of backdiscogenic and degenerative (7240), chronic liver disease and cirrhosis, i.e., Hepatitis C,(5710), history of broken left femur, broken hip left side, **etc., etc., etc.**, meets the criteria of section(s) **12.04, 12.06, etc.**,

Agency Directive to Judge O’Bryan. The agency was aware of Judge O’Bryan’s inadequate opinions and reprimanded him several times over the past four years. An internal agency document produced to the Subcommittee stated that in 2008, Regional Chief Administrative Law Judge Joan Parks Sanders verbally counseled Judge O’Bryan regarding the content of his opinions. Two years later in 2010, Oklahoma City Hearing Office Chief Administrative Law Judge (HOCALJ) Douglas S. Stults verbally counseled Judge O’Bryan twice about the content of his opinions.

On September 14, 2011, HOCALJ Stults went farther and sent Judge O’Bryan a formal directive, which explained:

a review of 168 decisions issued by [Judge O’Bryan] in FY2011 shows that, in 153 of those decisions, [Judge O’Bryan] included significant amounts of superfluous information, including unnecessary and lengthy citations to legal and medical authority. In addition, [Judge O’Bryan] inserted images of the claimant’s medical records in [his] findings of fact and conclusions of law, instead of

⁷² See, e.g., Oklahoma Cases 132 and 166.

analyzing the information. Furthermore, instead of making specific findings, [Judge O'Bryan] simply state[d], “etc. etc. etc.,” at some points of the decision.

The directive went on to remind Judge O'Bryan of his obligations:

[As a] Social Security Administration (SSA) Administrative Law Judge (ALJ), you are responsible for conducting hearings and issuing legally sufficient and defensible decisions. See HALLEX I-2-0-5.B. A legally sufficient and defensible decision requires that you comply with SSA's laws, regulations, rulings, and policies. In order for SSA to continue to meet its obligations to the public, it is essential that ALJs discharge their duties in a timely manner that reflects a high degree of responsibility, professionalism, and integrity. You are expected to provide hearings and decisions to claimants in a timely and judicious manner. Satisfying these responsibilities requires an ALJ to follow both the letter and the spirit of the policies he is bound to follow.

The formal directive stated that while it was not a disciplinary action, should Judge O'Bryan continue to fail to follow agency policy, it “may lead to disciplinary action.” To date, the Subcommittee is aware of no disciplinary action taken by the agency against Judge O'Bryan.

When interviewed regarding the directive to Judge O'Bryan, HOCALJ Stults told the Subcommittee that he felt the directive he sent to Judge O'Bryan was probably “too harsh” and “discussed more than it needed to.”⁷³ Judge Stults explained that the catalyst for sending the directive related to Judge O'Bryan's inserting active links to internal agency documents into his decisions, which caused problems when the decisions were effectuated. The letter, however, contains no mention of a concern regarding pasting these links into a decision.

With regard to Judge O'Bryan's decision writing, Judge Stults stated that Judge O'Bryan had taken it upon himself and volunteered to review and write the on-the-record decisions to help process the disability cases awaiting action in the Oklahoma City hearing office. Further, Judge Stults told the Subcommittee that Judge O'Bryan “was good at it.” Judge Stults explained that Judge O'Bryan reviewed “raw” cases that had not undergone any review or preparation by office staff, which made them more difficult to review. He said that allowed the other ALJs in the Oklahoma City hearing office to divide up the remaining cases that had been prepared by office staff for ALJ review, which enabled those judges to act more quickly. Judge Stults explained that the Oklahoma City office lacked adequate staff to properly support its ALJs, so Judge O'Bryan's actions provided welcome assistance to the other judges.

Interview of Judge O'Bryan. Judge O'Bryan was also interviewed.⁷⁴ When asked about his unusual approach to deciding cases, he explained that a lot of what was seen by the Subcommittee was the result of a particularly busy period between 2006 and 2009. “I did an

⁷³ Subcommittee interview of Oklahoma City Hearing Office Chief Administrative Law Judge Douglas S. Stults (8/31/2012).

⁷⁴ Subcommittee interview of Judge Howard O'Bryan, (8/31/2012).

awful lot of cases in those years,” said Judge O’Bryan, referencing the years he often decided more than 1,800 cases.

It was in this time period, he went on, that the agency developed a significant backlog, but “did not have adequate resources to do cases.” To play his part and help, the judge did as much of the work he could to free up others. “Rather than utilize personnel, I would review raw cases to see what could be allowed on-the-record,” he explained. The term “raw cases,” he said, referred to cases that no one had yet looked at or prepared for a judge. He added, “I was the only one who would agree to review raw cases.”

“I was trying to keep up the number of dispositions for the office,” Judge O’Bryan went on, noting, “I wrote all of them myself.” He was able to dispose of so many cases during this time, he said that SSA began shipping him cases from around the nation. He said that, at one point, he was sent 500 cases from Little Rock, Arkansas – equivalent to a single judge’s workload for a whole year. “I was asked to review those cases to see if they could be allowed,” he said. According to Judge O’Bryan, he was able to get through so many cases, that SSA sent him huge blocks of cases from such cities as Houston, Texas; Atlanta, Georgia; Baton Rouge, Louisiana; Greenville, South Carolina; and Yakima, Washington. He said he also received cases from Missouri.

Asked how he was able to get through so many cases from other states in such a short period of time, Judge O’Bryan explained that he only handled the cases that he thought should result in the award of disability benefits, and sent the rest back to the states they came from for hearings. He explained that in a typical case, the possible denial of benefits mandated a hearing and written opinion, which took more time than writing an opinion granted disability benefits based upon the records already in the case file.

According to Judge O’Bryan, he saw plenty of cases that did not require much time to decide. “You could take one look at them and see the person was dying,” he said. Judge O’Bryan explained as well that he did not “always need an ME [medical expert], because you can read the medicals as well as a medical advisor.”

When asked about the problems with his opinions, he defended his approach as acceptable practice. He stated that SSA encouraged the way he wrote his decisions, and claimed that he rarely ever had decisions reversed by the Social Security Appeals Council. “I’m very, very careful about what I put into decisions,” he said.

Regarding the frequent use of “etc., etc., etc.” when identifying a claimant’s conditions, Judge O’Bryan explained it was for times when a person has, “a whole bunch of other things wrong with them and I didn’t feel it was necessary to list them. I was just trying to rule on the major impairments.”

On the issue of inserting images from medical records in place of describing the claimant’s medical conditions and analyzing them, he said that his technique helped him get the opinions done more quickly. “In spite of the numbers,” said Judge O’Bryan, “our office was still running low in the region. In order to help get these out, I reviewed for OTRs [on-the-record opinions].”

And so, he said, “I used a little different technique. The rules don’t say how you have to set up a case.” Judge O’Bryan rejected the notion that he failed to include case-specific analysis in his opinions, saying, “I thought I put analysis in. I really did ... I would cut and paste images followed by rationale.”

Judge Stults supported Judge O’Bryan’s statements and noted that Judge O’Bryan’s opinions “passed muster with the Appeals Counsel,” meaning they were never remanded for legal insufficiency. Judge Stults asserted that pasting images into ALJ opinions was a widely-used technique by many ALJs, including him, after SSA switched to electronic medical files in 2006.

Judge O’Bryan also pushed back at first when asked about why he used boilerplate language in his opinions, explaining: “It wasn’t boilerplate at all. ... I may have used similar language.” He later conceded, however, “I may have taken a few shortcuts. I maybe should have written them better.” But with the time constraints on ALJs, he said, “You do whatever you can do to make them go. You try to get through them the best you can.” Later in the interview, he said: “In the past we all used boilerplate. At one time, the agency encouraged boilerplate. We could cut and paste and had a ball doing it, because it saved so much time.”

When asked about how much time he spent deliberating on each case, Judge O’Bryan said it varied. Some cases, he said, he “can review in a matter of a few minutes. You can take one look and know they meet a medical listing.” For others, he said, “I’ve spent an hour or two, some took days,” while others took as little as 30 minutes. Asked about a typical case, he said he typically took one or two hours to review it and reach a decision. The reason he could proceed so quickly for the cases decided between 2006 and 2009, he said, was because he chose cases that were “clear cut, no questions about them.”

“In the end,” Judge O’Bryan concluded, “I feel I have made the right decisions.” Judge Stults told the Subcommittee that he was sure “Judge O’Bryan looked at every page of every file.”

Judge O’Bryan told the Subcommittee that he no longer produces decisions at the rate he did during the time frame, 2006 to 2009. One reason may be that SSA now limits disability ALJs to deciding no more than 1,200 cases per year. Judge O’Bryan indicated that in 2010 and 2011, he decided 1,343 and 1,164 cases per year, respectively. He also noted that in 2012, to date, he had decided 502 cases. In addition, Judge Stults told the Subcommittee that Judge O’Bryan no longer writes his own decisions, reviews raw cases, or decides cases sent from other states; instead Oklahoma City SSA staff writers prepare the decisions for Judge O’Bryan to approve and sign. It is unclear whether this arrangement was established in response to the September 2011 letter criticizing the poor quality of the judge’s opinions.

Another relatively recent change is that, according to Judge O’Bryan, he now approves the award of disability benefits in only about 54% of the cases he reviews, which is close to the SSA average for disability ALJs. Judge O’Bryan continues to decide disability cases, and continues to be one of the most active judges in the Oklahoma City hearing office.

During the course of the investigation, under the random case selection process used by SSA, the Subcommittee reviewed 16 opinions issued by Judge O'Bryan, all of which raised concerns about the poor quality of the case description and analysis. Several examples follow.

Oklahoma Case 111. In 2007, Judge O'Bryan awarded disability benefits to a truck driver who alleged a back-related work injury from September 22, 2005. The claimant's case file contained records from several doctors indicating the man could return to work, one of whom wrote that he could return to work with "no restrictions," but Judge O'Bryan found him disabled. In his opinion, the judge wrote that the claimant could do only work that was "less than sedentary" and utilized the formulation of "etc., etc., etc.," for which he claimed support from "various doctors."

On September 22, 2005, the claimant sustained a work injury after falling from the top of a railroad car ladder. Records from five hours after the incident state: "Patient states: 'Slipped coming down hand rail injuring right shoulder, right knee and neck.'" The claimant also told the doctor he had previously injured his shoulder and knee, and had: "Two surgeries [on his] right shoulder and arthroscopy [on his] right knee."

Medical notes from October 6 and 14, 2005, several weeks after the injury, show the patient had returned to work with light duty restrictions. According the records, "Patient has been working within the duty restrictions. He states that his right knee is fine, but his right shoulder is still hurting."

He had neck surgery in December 2005 and shoulder surgery in March 2006, followed by rehabilitation until June. Throughout the first half of 2006, the claimant's medical records show steady progress toward recovery, ending with his clearance to return to work with no restrictions.

These records, starting from January 24, 2006, following his neck surgery but prior to his shoulder surgery, showed him "temporarily totally disabled," but that, "His neck and right-arm radicular pain have abated ... [the patient] is very pleased with the results of surgery."

Records from February 28, 2006, completed by same treating physician, show "the patient has had excellent results from his surgery, and, at present, has no symptoms of an active radiculopathy or myelopathy." The surgeon also fully cleared him to return to work at this point, stating, "the patient can return to gainful employment at any time. He will be on a 25-pound permanent weight [restriction] in lifting, bending, pulling, tugging, etc. The patient tells me that he has decided not to return to work as a truck driver in the future." His doctor instructed him to "continue his home exercise program and is to stay active."

In early March, prior to shoulder surgery, the claimant indicated he was eager to proceed, explaining to his doctor, "He is left hand dominant. He thinks he can protect the right shoulder and continue to be fairly functional." On March 21, 2006, the claimant underwent the shoulder surgery. Six days after the surgery, he told his orthopedist, "I feel great." The orthopedist wrote in response, "I can tell a big difference. He has no pain or popping reported. His wounds are benign. He is only six days following the surgery. Physical therapy for a couple of weeks recommended."

A follow up appointment with an orthopedist on May 22, 2006, reported: "Range of motion [in his shoulder] is steadily improved. He is doing very well. ... He is reporting no pain The patient has reached maximum medical improvement. He is released today without restrictions in regards to his shoulder. He will take over the counter anti-inflammatories on an as needed basis." Regarding his "Work Status" the doctor wrote, "No restrictions." No medical records exist in the file after this date.

Seven months later, the claimant filed for SSDI benefits. His initial application was denied at the DDS level on February 21, 2007, which the agency explained was because of conclusions made by two separate doctors at evaluations from February 6, 2007. The agency explained:

We have determined your condition is not severe enough to keep you from working Although you have pain and discomfort in your neck and shoulder, you can move them well enough to do some types of work We realize that your condition keeps you from doing any of your past work, but it does not keep you from doing other work which is less demanding.

He requested reconsideration on March 12, 2007, explaining, "I am unable to work." In May, he filled out a form for the agency explaining his limitations, adding at the end: "I can not go back to work, I'm on pain meds, I've got restrictions for life and I've not had any income since 9/22/05 - because of that I'm not real happy about you all keeping me from receiving SSA disability." DDS again denied benefits under reconsideration, and he appealed to have his case heard before an ALJ.

The claimant's attorney followed up by writing directly to an SSA senior attorney working with the ALJs in the ODAR office in Oklahoma City on November 9, 2007, saying: "[D]ue to [the claimant's] age and his medical condition, I would request that you as a Senior Attorney please review the file for the possibility of an on the record favorable decision."

ALJ Review. On December 26, 2007, Judge O'Bryan issued a sparsely worded "on-the-record" fully favorable decision for the claimant, awarding him SSDI benefits. Despite having been medically approved to return to work with no work-related residual impairment by his treating physician, Judge O'Bryan found the claimant disabled because of: "Other and unspecified arthropathies (7160), etc., etc." and "Disorders of back discogenic and degenerative (7240), etc., etc., etc., etc.,".

He found that the claimant: "is functional below the sedentary level for any sustained, continual or regular activity." In the section explaining his findings, he cut and pasted various portions of medical evidence from the case file into his decision, one of which was a consultative examination used to deny the initial claim. He then wrote: "Various physicians, treating and non-treating, have written that the claimant suffered from various medical problems and that the claimant has significant work restrictions."

Judge O'Bryan concluded: "Considering the claimant's age, education, work experience, and residual functional capacity, there are no jobs that exist in significant numbers in the national economy that the claimant can perform."

Oklahoma Case 134. Here, a 52-year-old man applied for SSDI and SSI benefits alleging osteoarthritis in his knee, legs, and back, as well as depression. The claimant asserted that he was becoming “more and more house-bound,” “had no interest in anything,” “could barely function,” and could not drive. In October 2007, Judge O’Bryan made a fully favorable award of benefits after an on the record review and determined no hearing was needed. He awarded benefits beginning in November 2004, finding the claimant’s condition met the criteria for the following grid listings: 12.04 (affective disorder); 1.04A (spine disorder); and 12.06 (anxiety disorder), “etc.” The opinion failed to acknowledge or discuss evidence in the case file of possible malingering and a higher activity level by the claimant than he admitted. In addition, his decision failed to discuss any of the specific elements required to meet each listing or to identify the evidence of record that proved the listings were met.

Evidence of Physical and Mental Health. Despite the claimant’s subjective assertions that he could barely function and was house-bound, the evidence of record contained hundreds of pages of medical records from the Veterans Affairs (VA) clinic chronicling treatment between August 2004 and October 2006. The medical records documented the claimant was physically active in a number of ways. Further, in a December 2006 evaluation, the physician examining the claimant reported actions by the claimant which countered his claims of chronic pain.

The majority of the claimant’s records related to his weekly therapeutic Hepatitis C support group notes. These records documented the claimant engaged in a wide variety of physical activities, as well as tracking his mental health.

In December 2004, a psychologist noted the claimant “retold his story of losing his job about 5 weeks ago and how much struggle he has been having over this.” The physician notes indicated “he is extremely anxious over this because of its cyclic nature and for what he was terminated over.” The claimant reported that he was “drawing unemployment and he has enough money saved to get by on.” The psychologist noted the claimant’s responses were not, in fact, reflective of someone “extremely anxious,” but were, “suggestive of an individual in a very relaxed state and low [an]xiety.” As the session concluded, the psychologist “asked [the claimant] how he felt and he said ‘great.’”

In January 2005, the claimant reported that he had “started going to the [health club] and swimming laps twice a week now.” The claimant stated: “I feel good but it wears me out quite easily.” At the same session, the claimant discussed going back to work, but “stated that he frequently will procrastinate when it comes to looking for a job which he has also done in the past.” The next month, February 2005, the claimant stated that “his mornings are quite full every day and he is slowly trying to expand into the afternoons.” He also discussed that he was “concerned that if he goes on a job interview in the afternoon that he will not be up to his full potential and not make a favorable first impression.” Therefore, the therapist “discussed the possibilities of moving the interviews to the morning or reducing his morning activities for the day of the interview to preserve more energy for later on in the day.”

At a meeting on April 14, 2005, the claimant “was very supportive of other group members facing crises” and “shared that he has found exercising in the VA’s health wing very beneficial.”

He also “reports that he continues to exercise and to spend time volunteering.” The next week, on April 21, the claimant reported “he continues to look for employment and participate in [the] upward bound program,” which provides support for individuals preparing to attend college.⁷⁵

On May 5, 2005, the claimant expressed that “he experienced two occasions where he felt somewhat depressed,” but “he was able to challenge his negative thoughts and reframe his situation, thus elevating his mood and continuing to move forward.” He also “reported that he continues to stay very active and revealed that he has applied for employment at the VA.” The therapist reported the claimant’s condition had improved. On May 12, 2005, the claimant reported “that he continues to volunteer at the VA, participate in the Upward Bound program, and to challenge his negative thoughts.” By May 19, 2005, the claimant stated “he has gotten much of his strength and energy back following [his Hepatitis] treatment” and “continues to volunteer at the VA.”

On June 9, 2005, the claimant “reports that he has been feeling good and has made progress on his home projects” and gave a good deal of advice during today’s group.” The next week, on June 16, the claimant had a “bright affect with upbeat mood” and “reports that he continues to volunteer 25 hours per week, but he is too tired to look for a job.” On June 23, the claimant “pointed out that his schedule is quite busy.” The next month, on July 19, 2005, the claimant was seen for a rash on his arms “likely starting after exposure to outdoor plants.” He reported that “he is doing well and discussed his physical activity as well as active participation in VA programs such as volunteering and Upward Bound program” on August 11, 2005. At the same time, blood tests confirmed prescribed treatment was successful, and no sign of Hepatitis C was detected in his RNA, even six months after treatment.

On August 29, 2005, the claimant reported to his counselor that his current leisure interests were “working with Upward Bound, exercise, work on the house, movies, reading computers, volunteering, and water aerobics.” In September 2005, the claimant “denies any significant neck or low back pain but says that he is involved with therapeutic recreation 5 times a week [at the VA] doing comprehensive abdominal [exercises], stretches as well as he [is] personally doing swimming [exercises] at the local [gym] 5x/week.” The progress notes repeatedly stated the claimant had “a bright affect with upbeat mood.”

Records throughout 2006 continued to document the claimant’s active lifestyle, which included pottery, drumming, a walking-sticking making group, and yoga classes, as well as a college-level course. In January 2006, the therapist noted the claimant “is positive and encouraging of others and appears to benefit from the social interaction” of his group.” In the spring of 2006, he stopped attending his Hepatitis support group, but instead participated in a weight management support group. In July 2006, the claimant developed a “rash [on his] lower legs after he went out on his farm.”

⁷⁵ United States Department of Education, Upward Bound Program, <http://www2.ed.gov/programs/trioupbound/index.html>.

In late summer 2006, the claimant stopped exercising and complained to his physician of fatigue and liver pain. On September 21, 2006, the claimant's physician confirmed the claimant's pain was "NOT liver related." The physician noted "we cured his virus" and "[claimant] is clearly poorly conditioned cardiovascular wise and needs to start exercising to reverse his fatigue rather than obsess about 18 months ago. He need not return to liver clinic."

In the same month, October 2006, the claimant applied for disability.

Potential Evidence of Malingering. In December 2006, a physician reviewed the claimant, whose chief complaint was "chronic bilateral knee pain, left ankle pain, neck pain, and low back pain." The physician noted the claimant "ambulates with crutches" and "has chronic pain behaviors." He stated the claimant "exhibits chronic pain with attempts to manipulate the shoulders." The physician noted, however, the claimant acted much differently when he got to the parking lot. The doctor stated he:

observed the patient in the parking lot. He drives a small traditional Volkswagen. He was able to get into the Volkswagen without difficulty. This required flexing his knees to at least 90 degrees. He fastened his seat belt and turned his head 90 degrees to the right to look over his right shoulder to back out. He had no trouble using his left shoulder to slam the car door.

DDS Review. The DDS determined the claimant failed to meet program qualifications and wrote in its explanation of determination:

52 year old male [complains of] knee problems, hepatitis C and mental problems. He has the residual functional capacity to lift/carry 20 lbs occasionally, 10 lbs frequently and to stand/sit/walk 6 hours in an 8 hour workday. One of his past relevant jobs was as a retail sales worker where he lifted 50lbs occasionally. He cannot do the job as he describes it. In the DOR the job is Sales Attendant, 299.577-010, which carries a light strength rating. He has the residual functional capacity to do this job as it exists in the national economy.

DDS affirmed the denial on reconsideration. The claimant retained an attorney and requested a hearing before an administrative law judge.

Judge O'Bryan's Decision. ALJ O'Bryan made a fully favorable decision for the claimant on the record without holding a hearing – a practice reserved for cases that are obvious and do not require hearings. Judge O'Bryan cited no specific evidence and performed no analysis, but found:

The severity of the claimants affective (mood) disorders (2960), anxiety related disorders (3000), hepatitis C, disorders of the back discogenic and degenerative (7240), knee and leg problems, obesity and hyperalimentation (2780), etc., etc., etc., meets the criteria of section(s) 12.04, 1.04A, 12.06, Social Security Ruling 02-01p, etc., etc., etc., of 20 CFR Part 404, Subpart P, Appendix 1 (20 CFR 404.152(d)).

Judge O'Bryan awarded benefits based on the claimant's meeting the grid listings for anxiety and affective disorders, as well as a spinal condition, but identified no medical evidence from the record that supported his decision. Instead, he just stated "etc.," specifying only that "various physicians, treating and non-treating, have written that the claimant suffered from various medical problems and that the claimant has significant work restrictions."

Judge O'Bryan also dismissed the doctors at the DDS-level who denied the claim, stating:

The State agency medical opinions are given little weight because other medical opinions are more consistent with the regard as a whole and evidence received at the hearing level shows that the claimant is more limited than determined by the state agency consultants. ... The Administrative Law Judge affords greater weight to the opinion of the examining (nontreating) source. The opinion is well supported by medically acceptable clinical and laboratory findings and is consistent with the record when viewed in its entirety. ... The State agency did not adequately consider the entire record, including the subjective complaints and other allegations of the claimant.

The ALJ did not identify what new medical evidence proved this statement, or the opinion of the examining physician he relied on to award benefits.

Oklahoma Case 144. In 2009, ALJ O'Bryan awarded disabled widow's benefits and SSI to a claimant for affective mood disorders and anxiety disorders. While an award of benefits may have been warranted, in drafting his fully favorable decision, Judge O'Bryan included many of the problematic features described earlier. The opinion also failed adequately to address significant evidence of drug and alcohol abuse, as well as the significance of claimant's past work record. Finally, the case file contained few, if any, medical records to support the claimant's allegation of disabling anxiety.

In her application, the claimant wrote she became disabled in August 2003, but also that she worked until 2004. According to her paperwork, she quit her job, "because I have been taking care of my husband who recently passed away." After her husband, who was also on disability, died in 2008, she decided to apply for disability benefits even though she had been denied three times in the past. On the application she wrote: "So when he passed in August 12, 2008, I'm left in an awful place, so I thought – now its time – its proper, its my right to apply for disability – which I am doing again and again."

One key issue was that the claimant did not have many medical records available to support her claim. A case manager from a mental health clinic noted on May 10, 2009, that the claimant: "is in a difficult spot without having ample records to back her claim of being disabled due to mental illness. [The claimant] has been denied three times and from the way she puts it, her attorney is reluctant to take her case at this point."

Her application was denied at the first two levels of review, and she appealed the case to appear before an administrative law judge.

Claimant's Work History. On her Request for Reconsideration – a form filled out by those denied benefits at the DDS level – the claimant said she worked briefly in February 2009 as a waitress, six months after filing her original disability application. The job did not last more than a few weeks, but raised questions about her ability to work. Asked on the form to explain why she requested reconsideration, she wrote:

I got turned down – I am broke – I attempted to work. Worked 9 days 1/30-2/16.
 Couldn't cope – small diner – I could only handle about 2 tables – they weren't happy with me – and I couldn't handle it.

On another form, she was asked if there was any change in her disability since she applied in August 2008, to which she replied “yes.” She elaborated: “When you denied my disability – I had no money – I attempted to work, started 1/30/09 – quit 2/16/09. Diner waitress – too nervous – couldn't cope. ... Small diner, they all said I'm too stressed – need to improve – need to get faster, I couldn't concentrate. Getting 2 tables overwhelmed me.”

A medical evaluation undertaken at SSA's request just a few months earlier, in December 2008, noted that the claimant had indicated she had “worked for many years despite ... anxiety and polysubstance abuse.” The opinion awarding benefits contains no analysis of the claimant's work history to determine whether, in the past, she was able to work despite experiencing anxiety and what, if anything, had changed.

Evidence of D&A Abuse. In addition, the claimant's file contained significant evidence that the claimant had a serious drug and alcohol addiction. The presence of drug or alcohol abuse requires the decision-maker to determine whether the claimant's drug addiction or alcoholism is a contributing factor material to the determination of disability. The decision maker must determine the claimant would be disabled independent of their drug or alcohol addiction.⁷⁶ The records reflect that various doctors struggled to determine whether the addiction was related to her depression and anxiety, and whether she would suffer those mental impairments if she discontinued her drug and alcohol dependence, as the following demonstrates. Judge O'Bryan's opinion, however, simply concluded this information was “not material,” failing to offer any explanation as to why.

The claimant was referred by the state DDS office for a psychological exam in October 2008, at which the doctor reported that she had been drinking heavily and taking her deceased husband's anxiety medication, Xanax.

[The claimant] stated that she drinks beer, ‘more these past two years,’ estimating that on average she drinks, ‘eight beers a night, up to three cases a week.’ She considers herself to have been a problem drinker, ‘from 2004 until the present time.’

⁷⁶ See 20 CFR §416.935, “How we will determine whether your drug addiction or alcoholism is a contributing factor material to the determination of disability,” http://www.ssa.gov/OP_Home/cfr20/416/416-0935.htm.

During the same evaluation she “reported that she has been taking Xanax all of her life,” adding “I take my husband’s, .5 mg. every day.”

One of the agency doctors, writing a “case analysis” on December 12, 2008, asked another doctor, “Do you agree DAA [drug and alcohol abuse] material?” She added this case was “[a] bit complicated. Get 3rd party [assessment] from the neighbor who sees her often. Then we’ll deal with the [alcohol] use. Right now I can’t say DAA because I don’t know if sober she would do better.”

A subsequent evaluation by a DDS consultant on December 31, 2008, raised similar questions, saying the claimant: “has suffered anxiety with panic attacks for many years but has not sought [mental health] treatment in about 5 years and no [medical records] since 2005 exists. [The claimant] worked for many years despite the anxiety and polysubstance abuse. [The claimant] has long [history] of [alcohol] dependence and drug addiction, she continues to drink to excess daily.”

The report noted that drugs and alcohol could be contributing to her condition: “Many of the limitations noted by the Clmt and 3rd party could be related to the [alcohol] effects and/or some depression.” Whether drugs and alcohol was a primary cause of the woman’s disability remained a pertinent, but unsettled, question: “[T]he claimant admits to daily heavy [alcohol] use but we do not have evidence to support establishing DAA as material....There is no evidence to indicate she functions well or better sober.”

On February 2, 2009, mental health clinic records state that the claimant had “been on Xanax for 2 years. She reports being prescribed to take it 3 per day in 2000 to 2003, and was taking her husband’s prescription recently before his death in 8/09. She ran out of medication about 2 weeks ago, and has resorted to alcohol to curtail her anxiety.” The doctor also noted: “She has some awareness that her Xanax use is abusive,” and “She is dependent on her Xanax.” The clinic records also indicate alcohol was a problem: “She was arrested in the 80s for a DUI. In 2004 she moved out of her husband’s house and got a DUI.”

In the course of the 2009 evaluation, according to the psychologist, the claimant said: “I have and have had anxiety for 10 years. I was taking my husband’s Xanax, but he died and now I don’t have any. I need to get out of the house and go to work.” The psychologist concluded that her behavior may be manipulative and drug-seeking: “[S]he is dependent, and will use others to get her needs met, she is addicted to Xanax.”

Judge O’Bryan Opinion. DDS denied the claimant’s initial application and request for reconsideration. On appeal, Judge O’Bryan found the claimant’s disability began on August 12, 2008, the day her husband died. He later amended the disability onset date to February 12, 2008, six months prior, though the change was not explained.

His fully favorable decision, rendered “on-the-record” and without a hearing, failed to adequately acknowledge the evidence of past work and drug and alcohol abuse. With respect to

the latter issue, the decision simply said, without further explanation: “The claimant’s substance use disorder(s) is not a contributing factor material to the determination of disability.”

Judge O’Bryan found the claimant disabled under medical listing 12.04 for affective disorders. Later in his opinion, he explained the listing was met because, “The paragraph A criteria are satisfied because the claimant has 12.04, 12.06, 12.09, etc.” This explanation is difficult to understand, but may amount to a circular argument in which “12.04 was met because the claimant has 12.04.” The 12.04 listing requires an individual to have several specific symptoms, such as an inability to sleep, appetite disturbance characterized by weight loss, feelings of guilt or worthlessness, or hallucinations, with resulting factors that limit the claimant’s abilities. Within his opinion, Judge O’Bryan not only did not discuss whether the claimant had any of the required symptoms, he inserted images from a consultative exam on December 31, 2008 that found the claimant did *not* meet the requirements of listing 12.04.

The remainder of the opinion failed to identify any symptoms experienced by the claimant or to discuss the medical evidence. Rather, it consisted only of reproductions of portions of the claimant’s application, which appear to have been copied and pasted into the document, primarily a several-page October 2008 consultative exam record (referenced above). This record, however, had also been submitted to the DDS examiner who referenced it specifically and rejected it as unreliable evidence, concluding: “Medical evidence does not show any other impairments which keep you from working.” The DDS examiner then denied the request for benefits. The O’Bryan opinion simply does not explain why he reached the opposite conclusion.

Oklahoma Case 146. In 2010, Judge O’Bryan awarded a 43 year-old woman SSDI and SSI benefits effective June 1, 2007, based on depression and diabetes. The evidence of record, however, documented consistent noncompliance with her prescribed medical treatment, which can disqualify someone from receiving benefits, as well as evidence that the claimant had worked after her alleged disability onset date.

The claimant applied for benefits on February 26, 2009, disclosing in her application that she was experiencing financial and marital difficulties: “My husband and I are talking about possibly reconciling. I may be moving in with my mother because I can’t afford to keep my apartment.” In addition to alleging depression and diabetes, she claimed to suffer from Bell’s palsy and repeated MRSA infections.

Her application was denied by DDS on June 3, 2009, and again under reconsideration on October 20, 2009. DDS explained in its denial that since she was still working and earning more than was allowed, her medical condition did not qualify her for disability. The agency provided the following explanation for denying her reconsideration request:

The medical evidence shows the following: While you are treated for Bell’s palsy, medical records indicate this is not a disabling condition. Your MRSA has responded to treatment and will not keep you from doing all types of work. While your depression and anxiety keep you from doing stressful and complex types of work, you can do simple, routine work.

Although you are experiencing pain in your back, shoulders, knees, and your legs from neuropathy, you are able to sit, stand, bend and walk well enough to work. Your diabetes could be controlled by medicine and diet if you would follow prescribed treatment. Medical evidence does not show any other impairments which keep you from working. On further review of the evidence and your description of the job you did as a clerical worker for some time, evaluation reveals that you are able to return to this job.

On March 10, 2010, ALJ O'Bryan reversed the previous denials, ruling fully favorably for the claimant. His opinion failed to take into account the woman's long history of noncompliance with her prescribed treatments for diabetes as well as evidence the claimant worked a full-time job for a three-month period following her application for benefits. Like many of his other decisions, this one contained little original analysis. Rather, in its place he cut and pasted unexplained computer screen shots into the decision from the claimant's records.

Noncompliance with Prescribed Treatment. Over a period of several years, a number of doctors prescribed various treatments for the claimant's conditions, but she often failed to comply with them. SSA rules require a person to follow their doctor's prescribed treatments, stating: "If you do not follow the prescribed treatment without a good reason, we will not find you disabled or, if you are already receiving benefits, we will stop paying you benefits."⁷⁷ Her medical records showed not only that the claimant was non-compliant, but possibly willfully so.

On November 25, 2006, a physician made the following stark assessment of her condition:

Diabetes mellitus type 2, uncontrolled, due to patient noncompliance. She refuses a diabetic diet. Cover with Humalog and start metformin but I seriously doubt this will be of benefit to her. She constantly drinks Coke whenever she can. She has no insight to her disease process or is not willing to have insight to it She is uncontrolled today and is unwilling to assess her needs for insulin control or management.

Three months later, on March 11, 2007, the same physician stated in medical notes that the claimant's Type II diabetes remained uncontrolled:

Patient very noncompliant with treatment. When told I had a magic wonder drug that would help her, she said I don't want drugs, I want food. She is not willing to comply with diet nor to assist with her therapy. I will add Jenova but I doubt this is going to have a significant effect if she doesn't comply with diet. ... She has no retinopathy, nephropathy. She is grossly obese.

A medical note dated August 14, 2008 stated: "[Claimant] admits to dietary noncompliance." On September 15, 2008, the claimant's treating physician recorded her weight at 284 pounds and

⁷⁷ 20 C.F.R. §404.1530. Need to follow prescribed treatment, http://www.ssa.gov/OP_Home/cfr20/404/404-1530.htm.

diagnosed her with “uncontrolled and noncompliant with diabetes and hypertension,” adding she “admits to noncompliance with sweets, Cokes, and foods.” He further explained:

We discussed the importance of compliance with micro and macrovascular complications. Recommended a healthy diet, which she is very resistant to and actually leaves tearful today because of that...She needs to monitor her sugars.

The same pattern continued. A year later, on August 11, 2009 the claimant’s physician’s noted the claimant was “quite noncompliant with diet-she does take [medications] as directed. Poor control of DM 2 [Type 2 Diabetes]. Discussed need to make good food choices or [number]s will not improve.”

Despite this extensive evidence in the claimant’s file, Judge O’Bryan failed in his opinion to acknowledge or address the claimant’s noncompliance with dietary restrictions, failure to control her blood sugar, and failure to take her medication after 2007.

Evidence of Work. A second set of issues involved evidence that the claimant was working at the time she requested the ALJ hearing, contrary to her claim that she was disabled.

On May 26, 2009, a doctor performing a consultative examination wrote: “She reported that she is currently working a full-time job, so she goes to work, and when she is home she cleans or runs errands.” On July 23, 2009, she disclosed to the SSA: “I did work for 3 months as a Cashier at [a] store since filing for disability. It was very difficult to be on my feet for 7-8 hours a day and to perform the multitude of tasks expected of me. I didn't get along well with management because they cared more about profits and percentages than about people. They did not care about my health.”

Such work and activities are inconsistent with the claimant’s allegations of disability and should have been addressed by the ALJ through questioning at a hearing, but Judge O’Bryan instead decided the case by examining her case file and without holding a hearing.

In his opinion, Judge O’Bryan found the claimant to be disabled because of: “Primary: AFFECTIVE MOOD DISORDERS (2960), etc., etc., etc., Secondary: DIABETES MELLITUS (2500), etc., etc., etc.” To support his decision, he included several screenshots of medical records, one of which said: “Claimant can adapt to a work situation.” Then he wrote: “Various physicians, treating and non-treating, have written that the claimant suffered from various medical problems and that the claimant has significant work restrictions.” This portion of the decision never named the physicians, the medical problems, or the work restrictions.

V. PROBLEMS WITH MEDICAL-VOCATIONAL RULES THAT ALLOW FOR “GRIDDING”

When claimants apply for Social Security disability benefits, they can receive an award in one of two ways. The first, which has already been discussed, is to meet the criteria for a “medical listing.” If a claimant meets the medical listing criteria, the disability application process ends at Step Three with an award of benefits. The second way for claimants to receive an award of benefits occurs at Step Five of the process if they meet the requirements of the “Medical-Vocational Rules.”

The Medical-Vocational Rules apply to claimants who do not meet the criteria for a medical listing, but still have a severe enough impairment that they may not be able to work. To help DDS examiners and appellate personnel determine in these circumstances when someone is disabled, promote consistent decision-making across the agency and the country, conserve resources, and increase efficiency, SSA has developed a grid incorporating a number of variables providing guidance on how to handle disability claims that reach Step Five.⁷⁸ When a person is analyzed under the Medical-Vocational Rules to determine whether they are disabled, it is commonly referred to as “gridding.”

More than 80 grid options apply to claimants, with variables that include a person’s age, level of education, past work history, ability to speak English and his or her “residual functional capacity” – known as an RFC. An RFC reflects an individual’s capacity for engaging in “substantial gainful activity,” or SGA. Persons who engage in SGA cannot be considered disabled. RFCs can range from a person’s being able to engage in “heavy” work on the high end to “sedentary” and “less than sedentary” work on the low end.

In the cases examined in the investigation, a large number of claimants were awarded disability benefits via “gridding.” While some of these cases appear to have correctly applied the gridding rules, others raised questions about whether they were used as intended. This finding was confirmed by the OAO, which found that hearing offices decided cases at Step Five versus Step Three at about a 4 to 1 ratio.⁷⁹

One key issue involves how the grid rules treat older workers. Under the grid rules, SSA assumes a person becomes significantly less able to work once they reach the age of 50, and even less capable once they reach 55 or 60. As persons reach those specified ages, the grid rules are

⁷⁸ From the introduction to the Medical-Vocation Rules: “The following rules reflect the major functional and vocational patterns which are encountered in cases which cannot be evaluated on medical considerations alone, where an individual with a severe medically determinable physical or mental impairment(s) is not engaging in substantial gainful activity and the individual’s impairment(s) prevents the performance of his or her vocationally relevant past work. They also reflect the analysis of the various vocational factors (*i.e.*, age, education, and work experience) in combination with the individual’s residual functional capacity (used to determine his or her maximum sustained work capability for sedentary, light, medium, heavy, or very heavy work) in evaluating the individual’s ability to engage in substantial gainful activity in other than his or her vocationally relevant past work.”

http://www.ssa.gov/OP_Home/cfr20/404/404-app-p02.htm

⁷⁹ Office of Appellate Operations, Executive Director’s Broadcast, Vol. 3, Special Edition – Quality Review, January 13, 2012.

progressively less likely to find them able to work and more likely to be disabled. For example, under the grids, a 49 year-old that can perform sedentary work, has less than a high school education, and whose past work is considered unskilled is found “not disabled.” See 201.18. In contrast, a 50 year-old that can perform sedentary work with the same education and past work experience is “disabled.” See 201.09. Because of the way the rules are designed, it is possible to find someone “not disabled” on the day before their 50th birthday, but “disabled” on the next day with nothing changed but their age.

In a large number of cases reviewed by the Subcommittee, claimants alleged their disabilities began before the ages of 50, 55 or 60, but had RFCs suggesting they could work. In some cases, ALJs adjusted the onset date of their disabilities to the date on which they turned one of the ages specified under the grid rules and found them to be disabled. This practice is known as “amending the onset date.” In fact, this practice is encouraged by the agency in its rules and regulations. In a section entitled, “Your age as a vocational factor,” the agency says:

We will not apply the age categories mechanically in a borderline situation. If you are within a few days to a few months of reaching an older age category, and using the older age category would result in a determination or decision that you are disabled, we will consider whether to use the older age category after evaluating the overall impact of all the factors of your case.⁸⁰

The intent of these rules is to give claimants the benefit of the doubt in “borderline” situations.

Oklahoma Case 170. DDS awarded SSDI benefits to a 60-year old woman alleging arthritis in her hip, PTSD, and incontinence. While her medical records reveal some evidence of mental or physical impairments, she received treatment for both and was physically active. She was nevertheless approved for benefits under the “gridding” rules based upon her age and work experience. The claimant was 59 years old when she applied, and her application was denied. Within days of her denial she turned 60 years old and was then approved for benefits several months later under program rules. The decision to award her benefits did not address the contradictory medical evidence in the case file.

Application Denied at DDS and Approved upon Reconsideration. The claimant applied for benefits on September 3, 2008, alleging a disability beginning on October 20, 2006. For several years after her alleged onset date, however, the claimant’s records showed her to be physically active and even working three days a week at a health club as a receptionist. On September 30, 2008, DDS denied this claim, making the following determination:

We have determined that your condition is not severe enough to keep you from working. ... The medical evidence shows the following: While you have been treated for arthritis and incontinence, this condition has not seriously affected your ability to work. Although you are experiencing pain in your right hip, you are able to sit, stand, bend and walk well enough to work. Although you

⁸⁰ 20 C.F.R. §404.1563. Your age as a vocational factor, http://www.ssa.gov/OP_Home/cfr20/404/404-1563.htm

sometimes experience PTSD, there are no sign of a severe mental illness which keeps you from working. Most of the time you can think clearly and carry out normal activities. Medical evidence does not show any other impairments which keep you from working. Based on your description of the work you performed as a cashier for several months, evidence indicates you are capable of doing this type of work as it is generally performed.

When the claimant applied for reconsideration on November 7, 2008, she had just recently turned 60 years old. DDS reviewed the case file once more than then reversed itself on February 18, 2009, finding her disabled as of October 20, 2006. The explanation accompanying the reversal said the claimant now met the rules for disability based on vocational factors, specifically Grid Rule 202.06. This rule states an individual is disabled if they have a residual functional capacity for no more than light work, are of advanced age (60 years or older), and are a high school graduate with no skilled work or transferable skills. DDS found, "The claimant can not return to [prior work]. The claimant's age and mental limitations limit the claimant's ability to transfer skills. The claimant's vocational profile matches vocational rule 202.06 which directs a decision of disabled."

Evidence of Increasing Health and Work Activity The DDS award of benefits did not take into account the records in her case file demonstrating the claimant's physical activity, lack of incontinence, and mental health. Over a period of several years, the claimant had complained of chronic hip pain as well as depression, but received treatment for both. On August 1, 2006, the claimant was seen by a physician at a Department of Veterans Affairs (VA) medical center as a new patient. Physician progress notes from that date state: "Here for first time visit. Interested in getting care and help with medications." The claimant's past medical history noted problems with hypertension, high cholesterol and an acne-like rash on her face. The medical notes from this visit also stated that she "feels depressed, tired, stressed, lack motivation, does not want to be around people." There is no mention of PTSD. Reports from all other body systems were determined to be normal. The gynecology section noted the date of her last mammogram and pelvic examinations and noted she had never received a bone density scan, but did not mention any complaints of incontinence. Her social history noted that she was retired.

Her doctor recommended a treatment plan that consisted of four items: (1) a change in her blood pressure medication; (2) a referral to a dermatology clinic for her rash; (3) a referral to the gynecology clinic for a bone density test and mammogram; and (4) a discussion of her depression complaints. The notes also state that while they discussed treatment options for depression, including medication and counseling, the claimant indicated that she wanted "to think about it."

Two weeks later on August 15, 2006, the claimant went to her initial gynecology appointment. Progress notes from that appointment state she "presents today as a referral because she 'just got into the VA system.' [Patient] has no [complaints] today." The notes further stated that "[s]he has no [gynecological] complaints."

In November 2006, nearly a month her alleged disability onset date, the claimant told her doctor "that she has been taking Naproxen for right hip pain. States it helps but she does not want to

continue taking it.” The following month in December 2006, she began an exercise regimen. Progress notes state: “[V]eteran began initial program of aerobic exercise including walking on the treadmill and light weight resistance exercises. Veteran will also begin AB/back groups on 12/27/06 to work on strengthening core muscles.” She would continue this exercise regimen for the next several years.

In April 2007, the claimant began attending psycho-educational group sessions in which she was able to discuss events in her life. Progress notes indicate in 2007 she was actively dating, took multiple out-of-town trips, and went out with friends.

Around the middle of 2007, the claimant complained again of chronic hip pain, which she described as “excruciating.” But on June 21, 2007, her progress note stated: “[V]eteran is currently using the bicycle, arc trainer, ab machine, treadmill, and an assortment of free weights and machine weights. She is doing an excellent job of maintaining loss of inches while building overall strength and fitness.” In July 2007, she returned from travelling and “reports she had a great time on her vacation to the Grand Canyon.”

On October 1, 2007, a progress note with her physician contained a section asking: “Does the patient display any of the following: immobility; incontinence; poor nutritional status?” to which the doctor wrote: “No.”

A medical progress note from February 12, 2008, found the claimant was continuing her gym routine, “4 days/wk (treadmill, bike and arc slider), abs class 3xwk, walks her dog 15-20 min most days; had been doing weights,” but her trainer “told her to quit” because “adding muscle would make her gain weight.” In addition, she was eating out on a regular basis and had “gone to Vegas twice lately.”

By April 24, 2008, her psychiatric progress notes found, “[Patient] doing well. Plans on a train trip to LA with fr[ien]d in July. May have to sell dog, [name withheld], b/c she is gone too much. Is exercising at VA gym and attends MAPS. Has found some [] friends through the MAPS group.” The notes made no reference to issues involving PTSD. On June 2008, medical records stated the claimant was “doing very well physically.”

By August 2008, group therapy notes even stated the claimant “was cheerful and had good energy.” While the claimant believed she was “in a personal relationship that was not serving her needs,” physically she appeared to be fit and healthy.

Despite evidence of increasing emotional and physical health, on September 3, 2008, the claimant applied for disability benefits. In her disability application forms, the claimant alleged an inability to bend and stoop due to pain and difficulty walking and standing for long periods of time.

On September 8, 2008, the claimant visited her doctor at the Veterans clinic who advised her, “to continue general aerobic exercises at least twice a week.” Several days later on September 16, her doctor said she was physically well enough to “return to a regular exercise program...this

will include both aerobic and strengthening to help her attain her goals. Arc Trainer, bicycle and cross trainer for aerobics and moderate weight lifting for toning.”

Her application for benefits was denied on September 30, 2008, and she applied for reconsideration on November 7, 2008. On November 17, 2008, her doctor advised her to get more exercise, writing: “Advised to gradually increase until walks briskly (15-20 minute mile) for 1 hour at least 3-4 times weekly. Other forms of exercise may be utilized if desired or needed by the patient.”

According to a psychological evaluation on January 21, 2009, the woman explained that at least one of her recent job losses was unrelated to any disability: “She reports being fired from last work at [name withheld] for being disrespectful to customers and from [name withheld] after three weeks due to she stayed in the bathroom too long.”

During a psychological exam on February 10, 2009, she told her doctor, “she is applying for Social Security Disability benefits, ‘for my hip, it’s been hurting four or five years, I can walk and it goes out, and the pain goes into my back and in the other hip I have numbness down my right leg.’” When asked to describe her typical day, she noted she, “had been going to the gym, but the doctor took me off until he finds out about my hip”

She explained again that she was not working, in part, because of factors unrelated to disability: “last worked as a part-time crew member at [name withheld] in December, 2008, a job from which she was terminated after only ten days of employment because, ‘he said I was being disrespectful to customers.’ Prior to that, she had worked as a crew member at [name withheld] part time for three weeks until being terminated because, ‘they said I stayed in the restroom too much,’ and prior to that, she had been a receptionist part time at the [name withheld] for five months until quitting because, ‘I felt unsafe there.’”

The DDS decision to grant the claimant benefits upon reconsideration under the grid rules failed to acknowledge any of the evidence in the file about the claimant’s physical activity, lack of incontinence and PTSD complaints, and ability to work.

Oklahoma Case 177. The Social Security Appeals Council (“SSAC”) overturned ALJ Thomas Bennett’s denial of benefits for a claimant who alleged disability due to due to arthritis, anxiety, and depression. The SSAC did not disagree with his review of the medical records, which found her not to be disabled, but rather that he incorrectly stated her age. In so doing, SSAC found the woman qualified for disability benefits by meeting the grid rules.

The majority of records in evidence involved prison medical records from 2005-07, which documented only routine check-ups. Notes from her last prison health checkup dated February 2007, stated the claimant told the physician she had a history of Hepatitis C, but reported no other issues. The physician prescribed ibuprofen, but failed to document why. An earlier progress note dated April 2005, stated the claimant had arthritis in her back, but no x-rays or other tests corroborated this finding. The state DDS sent the claimant to both physical and psychological consultative examinations.

Physical CE. On September 17, 2007, a doctor performed a “comprehensive internal medicine examination” on the claimant. Her chief complaint was “chronic low back pain and pain in neck shoulders, hand, knees, and feet,” however, the claimant “does not take medication.” The physician wrote:

The patient has normal speech and hearing. She has normal cognitive function. She has good dexterity of her hands and fingers and good grip strength. She has some mild limited rotation of her neck and some mild limited flexion of her back. She ambulates in the hallway at a normal gait and pace and without a limp. She has no chronic pain behaviors or malingering behaviors. She has flat affect and appears to be depressed.

The doctor also noted that the claimant “has adequate muscle strength and tone in the upper and lower extremities” and “can heel, toe and tandem walk without difficulty.” The notes contained no reference to the presence of arthritis.

Psychological CE. On October 11, 2007, the claimant was assessed by a licensed psychologist. Based on his assessment, the psychologist determined the claimant “reported the onset of severe anxiety symptoms in the eighth grade.” He also pointed out “she has a history of substance abuse, most notably prescription medications.” The psychologist determined the claimant had “generalized anxiety disorder” and “avoidant personality disorder.” The claimant had, however, never taken medications for either of these conditions, making it difficult to determine how long they had really existed and whether they had responded or would respond to treatment. The analysis did not contain any information or documentation establishing that the claimant suffered from the disorders prior to 12/31/2006, the latest date on which she was insured.

The psychologist also found:

Cognitively, her memory and concentration were within normal limits. Her vocabulary is average, as is her ability to perform simple math operations. She is able to reason abstractly, and she has a below average fund of General Information. It is estimated that her intelligence lies within the low average range.

The CE made no recommendations regarding particular work limitations, but stated the claimant had a history of substance abuse and could manage her own money.

DDS Explanation of Determination. The DDS denied the claim and explained that the claimant did not have enough evidence to make any finding of a disability.

Insufficient [medical evidence of record] at [date last insured], 12/31/06. Currently, with CE in file, claimant shows no manifestations of osteoarthritis or rheumatoid arthritis in hand or fingers. Joints have normal [range of motion], back has slight decrease in [range of motion], SLR-negative, heel/toe waling normal, normal gait. Physical is nonsevere.

The initial denial was affirmed at reconsideration for the same reason and stated “insufficient evidence to find the claimant disabled prior to 12/31/2006, the date she was last insured to receive benefits.”

ALJ Determination. The claimant appealed the decision and requested a hearing before an ALJ. On February 2, 2009, however, the claimant wrote to the Oklahoma City ODAR and explained that she “will not be able to attend the hearing scheduled ... due to [her] health problems, in particular [her anxiety] of being around people.” Therefore, she requested “the Judge to make a decision on [her] case based on the records without [her] live testimony.”

ALJ Thomas Bennett denied the claim. Based on the medical evidence, Judge Bennett determined “the claimant does not have an impairment or combination of impairments that meets or medically equals” a listed impairment. The Judge’s opinion explained:

In activities of daily living, the claimant has mild restrictions. In social functioning, the claimant has moderate difficulties. With regard to concentration, persistence or pace, the claimant has mild difficulties. As for episodes of decompensation, the claimant has experienced no episodes of decompensation, which have been of extended duration. This is identical to the assessment of the State agency.

With regard to her residual functional capacity, Judge Bennett found that the claimant could perform sedentary work. The judge also found:

The claimant’s medically determinable impairments could reasonably be expected to cause the alleged symptoms; however the claimant’s statements concerning the intensity, persistence and limiting effects of these symptoms are not credible to the extent they are inconsistent with the above residual function capacity assessment.

Therefore, “considering the claimant’s age” – which the ALJ believed to be 44 years old – “education, work experience, and residual functional capacity,” Judge Bennett explained that “there are jobs that exist in significant numbers in the national economy that the claimant can perform.”

On April 28, 2010, the Social Security Appeals Council (SSAC) notified the claimant that the ALJ had incorrectly considered the claimant to be 44 years old. She was actually 49. The SSAC concluded that, due to her age, the claimant would qualify for disability benefits under a grid rule when she turned 50. On June 16, 2010, the SSAC overturned Judge Bennett’s decision and found the claimant disabled by moving her disability onset date to her 50th birthday. The SSAC, however, acknowledged “the claimant’s subjective complaints are not fully credible for the reasons contained in the body of the hearing decision.”

This case demonstrates how a person who appears to be healthy enough to work, based exclusively on the available medical records, was found to be disabled simply because of her age. While the judge mistakenly believed her to be five years younger than she was, this age

difference did not change that the fact that her case file lacked the required evidence for a medically supported finding of disability.

Alabama Case 87. In this case, a 49 year-old man was in a car accident in 2008, and sustained lower leg and collarbone fractures. The individual underwent corrective surgery and while DDS determined his injuries would not last more than 12 months, Judge Samuel Childs decided otherwise and awarded SSDI and SSI benefits based on the grid rules. In this case, the judge applied the rules to the man “non-mechanically” as if he were 50, during a period in which he was actually 49 years old.

Medical Evidence of Record. The claimant underwent corrective surgery shortly after the accident and his post-surgery notes from February 8, 2008 stated: “[O]verall he is doing very well ... excellent alignment of the fracture with good callus formation.” A year later, on March 9, 2009, an SSA consultative examination found the claimant had light work restrictions, but the examiner also noted: “[The claimant’s] allegations are considered partially credible based on the objective information in file.” As of September 2009, the claimant reported “no neck pain now” and stated he “wishes to return to the gym doing activities and wants to go to therapy.” His physician gave “him a prescription for physical therapy.”

In January 2010, the claimant complained of some residual rib pain and breathing difficulty and underwent a rib fixation procedure. Medical records documenting the procedure reported: “[H]e tolerated the procedure well with some improvement in his pain and resolution of his difficulty breathing.... [The claimant] was allowed to ambulate as tolerated.” Further, “all lab work and radiological exams were within acceptable limits.” A post-surgical exam on February 2, 2010 resulted in the doctor reporting: “everything looks good However, he remains frustrated that he was not immediately cured by this operation. If the x-ray shows the plates to be in good position, and I suspect they are, we will give him a period of about ten weeks to heal and then I will follow him up in 2 ½ months” That assessment was echoed in a follow-up appointment two-and-a-half months later on April, 20, 2010, where the doctor reported “the rib fixation appears to be in good position.” The doctor reported the claimant “still has a little bit of popping when he does certain activities, but his pain has almost completely resolved.” The doctor “reviewed his chest x-ray and the plates appear to be in good position.”

While he was healing from surgery, on April 29, 2010, the claimant saw a doctor because he “stuck a piece of 2x4 in his right palm about four or five days ago” and he complained that “it still hurts.” The medical report did not address the reason the claimant was working with a 2x4 piece of wood, and no inquiry was made to determine whether the claimant may have been engaged in paid work.

DDS Review. The claimant filed his claim on October 9, 2008. He stated he “became disabled on 10/4/08 because of acute multisystem trauma secondary to [a] motor vehicle accident, hypertension, dysthymia, sleep apnea, C6-7 fracture, left clavicle fracture.” In response, DDS determined: “the evidence indicates [the claimant’s] condition is severe and keeps [the claimant] from working at the present time.” DDS denied the claim, however, finding the claimant’s injuries were “not expected to remain severe enough for 12 months in a row to keep [the claimant] from working.” DDS explained that “in order to be eligible for disability benefits, a

condition must keep [an individual] from doing any work for twelve (12) months from the onset of your condition.” Therefore, DDS determined “since you should be able to return to some types of work within twelve (12) months, [the claimant did] not meet the requirements for disability benefits.”

ALJ Review. On appeal, despite the fact that the claimant was only 49 when his accident occurred, Judge Childs decided to “non-mechanically apply the grids in this case,” and treat him as if he were 50 when the accident took place. The judge reasoned that since the accident was only two weeks prior to his 50th birthday, the claimant should be considered under the grid rules. Judge Childs then found the claimant met grid rule 201.14 on the basis of his age and inability to perform even sedentary work, even though his limitation was expected to last less than twelve months and no medical evidence indicated he was unable to work. Interestingly, the judge also added the following to his decision, which suggests that even if a claimant were found able to work, they could still be considered disabled under the grid rules.

Even if the claimant had the residual functional capacity for the full range of sedentary work, considering the claimant's age, education, and work experience, a finding of disabled would be directed by Medical-Vocational Rule 201.14.

The ALJ made a fully favorable award of disability benefits. His opinion did not discuss the lack of medical evidence establishing the claimant’s inability to work, or the March 2009 note in which the claimant sought medical attention for a hand injury he sustained while carrying a 2x4 piece of lumber.

Alabama Case 64. In some cases, ALJs found claimants to be disabled even when medical consultants rendered opinions finding they were not. The claimant applied for SSI on November 30, 2006, and alleged her disabling back and leg pain began a week earlier on November 22, 2006 – less than the 12 months required to establish a disability. Despite medical records suggesting that she did not have a disability, Judge Intoccia found her disabled under the grid rules based upon her age and limited work history.

Medical Evidence of Record. The DDS examiner noted the claimant had “not seen a doctor in over 5-6 years,” and sent her to a physician for a DDS consultative exam on January 10, 2007. The claimant reported to the physician that she “last worked in 1996 doing maintenance work in a dance studio. She worked there for five years.” The claimant told the doctor: “I was told there was no more work for me there to do, and they let me go. I didn’t look for any work after that. I could’ve worked but I didn’t.”

With regard to the claimant’s physical health, the doctor noted the claimant “stood up from sitting with ease and moved about with reasonable agility.” While the claimant carried a cane, the doctor “determined [the cane] not to be required indoors and probably not outside, either.” He also found:

The strength of her major muscle groups including those of her shoulders and pelvic girdles, those of the proximal and distal portions of her upper and lower limbs, her hand grip strength and finger dexterity were all rated 5 out of 5. She

could make a fist with each hand; she could oppose the thumb to the fingers of each hand. She could button and unbutton clothes, tie shoelaces, pick up small objects, hold a glass, turn a doorknob, etc.

The doctor also noted: “She sat comfortably in the chair, virtually in the same position, for about one and a half hours; she did not appear to be in any distress.” He then described the claimant as having a tendency “to be very evasive, contradictory, and to exaggerate. She did not appear to be a credible historian.” He concluded:

Based on the medical findings for this examination, I would conclude that she could perform work-related activities such as sitting, standing, walking, lifting, carrying, and handling objects with some minor limitations. There is no problem with hearing or speaking, and she could travel a reasonable distance.

The 2007 consultative exam thus concluded that the claimant could perform a variety of work-related activities with only “some minor limitations.”

DDS Review. The DDS denied the claim and found the “medical evidence in [the] file [was] insufficient to establish a diagnosis.” The only evidence considered by the DDS was the consultative exam. DDS explained its denial:

You state that you are disabled because of having pain in your back and left leg. It has been determined that your medical condition does not significantly affect your ability to carry out most routine activities. Since your ability to work is not significantly affected, you do not meet the requirements for disability benefits.

The claimant appealed the decision.

Additional Medical Evidence. After the January 2007 consultative exam, the claimant began to see a physician. Her physician noted on March 6, 2007, that the claimant complained of a “[history] of headache, last worked in 5 years. Having some low back pain.” He also noted that the claimant was “awaiting disability.” When she saw her physician in August 2007, he noted the claimant had “missed blood pressure med[ication]s past 2 days.” In December, the physician noted her “hypertension [was] uncontrolled.” On January 30, 2008, the doctor reported the claimant was “doing well, no chest pain.” Later that year, on May 7, 2008, the doctor noted that the claimant was “doing better.”

No medical evidence indicated the claimant’s condition had worsened since her consultative exam.

ALJ Hearing. On May 28, 2008, in a 12-minute hearing, Judge Intoccia announced he was making a fully favorable bench decision and awarded disability benefits “as of November 22, 2006 because of gouty arthritis, hypertension, urinary tract infections, and osteoarthritis so severe that you are unable to perform any work existing in significant numbers in the national economy.” Arthritis was not mentioned in any of the medical evidence in the case file; her hypertension was being treated with medication.

During the hearing, the claimant did not speak, and the judge did not ask her a single question. He did, however, add the following:

And based upon review of the available evidence of record it appears that a wholly favorable Bench Decision can be issued in this particular pursuant claim pursuant [to] Grid Rule 201.01. There are no other jobs that exist in the national and/or regional economy in significant numbers based upon her Residual Functional Capacity of a full range of sedentary, as coupled with her vocational profile during the period at issue.

Because the claimant had reached age 62, had “limited education,” and the Judge determined the claimant had the residual functional capacity “to perform less than the full range of sedentary work,” he found her disabled.

The judge’s opinion did not discuss the consultative exam which found that the claimant could perform a number of work-related activities with only “some minor limitations.” Instead, despite the absence of medical evidence supporting a finding of a reduced residual functional capacity, Judge Intoccia used the grid rules to award benefits to the claimant.

Virginia Case 244. ALJ William Russell ruled favorably for a claimant in an on-the-record decision, without holding a hearing, and awarded her SSDI benefits. The claimant alleged disability beginning November 15, 2006 due to osteoarthritis, anxiety and depression. The claimant’s attorney requested the case be processed by a Kentucky Social Security office, despite the claimant’s residing in Virginia. The claimant originally alleged her disability began when she was 53 years old, but ALJ Russell amended the claimant’s onset date (at the request of the claimant) to the date of her 55th birthday and awarded disability benefits under Grid Rule 202.02.

Medical Evidence of Record. While the claimant’s medical records showed her seeking medical care for a variety of ailments, the claimant received successful treatment for each of her complaints. When she twisted her ankle in October 2007, she was told “just to take ibuprofen.” The following month, x-rays of her ankle and cervical spine were normal. The claimant also had high blood pressure, high cholesterol, anxiety and acid reflux, all of which were treated with medication.

Physician progress notes indicated that, with respect to her depression and anxiety, she sought treatment and received counseling and medication in 2006. Physician notes dated December 2007, indicated she was “smiling, alert, and oriented and stated ‘I am doing much better.’”

A consultative examination in October 2008 was even more positive. It described the claimant as an “alert and cooperative, physically healthy-appearing, 55-year-old female who was fully ambulatory, and free of any acute distress and who was not using an assistive device.” The physician noted the claimant “was free of any workplace or any environmental limitations” and “would have minimal manipulative and minimal postural limitations.” With regard to the claimant’s residual functional capacity, the physician determined:

This lady, in her present state of health, could occasionally pick up and carry 20 pounds of weight up to one-third of an 8-hour workday with frequent breaks. She could frequently pick up and carry 10 pounds of weight up to one-half to two-thirds of an 8-hour workday. Sitting, standing, and walking were unaffected.

According to SSA regulations, these restrictions allowed the claimant to perform “light” work.

DDS Review. In October 2008, DDS denied the claim and found, according to the grid rules, the 53-year old claimant was not disabled. DDS determined that the claimant, given her education and past work experience, “retains the capacity to perform such jobs as: ticket-taker (amusement and rec.); folder (laund.); marker (ret.tr.).” DDS also noted the claimant’s “allegations are not fully credible and [claimant had a] non severe impairment.”

The claimant requested the agency reconsider her denial, which was affirmed upon reconsideration because there were “no new allegations or worsening.” As mentioned earlier, “on 10/14/08 [the claimant] was seen for a physical CE and she was alert, cooperative, and healthy-appearing, NAD. She was very well oriented, related well to others and gross mental status was intact. She had normal affect [and] memory.” On July 16, 2009, the claimant changed attorneys, requesting new representation.

ALJ On-the-Record Decision. While DDS denied the claimant, who initially alleged that her disability began when she was 53 years old, she was approved by Judge Russell in August 2009, after moving her onset date to her 55th birthday. Under the grid rules for “advanced age,” 55 and older, the Judge used the DDS finding to award benefits under the grid rules for claimants able to perform light work. His decision shows how the grid rules allow claimants to be categorized as disabled and receive disability payments, despite being found able to perform light work.

Suspect Use of Gridding Rules. The 300 cases reviewed in the investigation provided evidence of some troubling results under the gridding rules. In some cases, ALJs found a claimant disabled and awarded benefits even when medical evidence indicated that the claimant was able to work. In other cases, some ALJs found claimants to be able to perform work at a “less than sedentary” level, even if other agency officials or doctors found them able to work at a higher level. In still other cases, “less than sedentary” seemed to function as a catch-all to find a person disabled if they did not match either the medical listings or the grid rules. Judges would simply total up a claimant’s various medical ailments and explain that even though a plain reading of the Medical-Vocational Rules would find “not disabled,” additional evidence obtained by the judge found the person to be limited to less than sedentary work, and so a finding of disability was most appropriate. Several examples illustrate these concerns.

In *Virginia Case 257*, Judge Peters awarded SSDI and SSI benefits to a claimant. The claimant’s attorney and Judge Peters agreed, in an off the record conversation prior to the hearing, to amend the claimant’s onset date to take advantage of the grid rules.

When the claimant applied, she alleged her disability began on November 6, 2007. The 48 year old female asserted she suffered from “diabetes, heart, hypertension, cholesterol, depression, degenerative disc disease, left elbow pain, limited use of left hand, headaches, dizziness,

numbness in feet, fatigue, shortness of breath, blurred vision.” DDS denied the claim on April 15, 2009, and reasoned:

Records reveal no significant damage to vital organs due to hypertension, diabetes mellitus, or cholesterol levels. There is no significant abnormality related to headaches, dizziness, numbness fatigue, shortness of breath, and blurred visions. She has adequate range of motion and muscle strength throughout.

In assessing the claimant’s credibility, the DDS doctor who reviewed the claimant’s file determined:

Of greatest significance in determining credibility of the claimant’s statements regarding symptoms and their effects on her functioning was her medical history. The description of the symptoms and limitations provided by the claimant throughout the record has been inconsistent and is not persuasive. Based on the evidence of record, the claimant’s statements are found to be partially credible.

On May 1, 2009, the claimant appealed her denial and requested a hearing before an ALJ.

In the meantime, in January of 2010, the claimant was referred to a doctor to be evaluated for gastric bypass surgery. The examining doctor noted the claimant had worked at her job “until she was laid off.” The evaluating physician determined, after the claimant completed a basic personality inventory, that she “presents as an acceptable candidate for gastric bypass surgery.” He also noted that “she displays a willingness to follow medical directions and complicated medication routines.”

ALJ Hearing. On May 19, 2010, Judge Peters held a hearing and went on the record at 11:24 a.m. The hearing transcript is excerpted below:

ALJ: Well, good morning. Judge Peters, I’m the Administrative Law Judge. Counselor, do I need to go over the definition of disability in any preliminary matter?

Atty: You don’t, your honor. I waive reading of those.

ALJ: All right. Now, according to my notes, this lady applied July 11th of 2008. Her date last insured is 12/31/08; so she’s well within her insurance status Any objection admitting the record, sir?

Atty: I do not, your honor.

ALJ: Let me state for the record that just before we went on the record, we had a brief discussion – or I had a brief discussion with about the possibility of amending the onset in this case to this lady’s 49-and-a-half birthday which is how far we can take a grid backwards. You would be 50 as of this year?

Clmt: Yes.

ALJ: So you[re] just 49. Okay, so if you move that six months, September, October, November, December, January – so we're talking about March 19th of this year, that isn't going to give her much of a lump sum.

Atty: Right.

ALJ: But, at least that get us lined up with where the medical record is, I think. And the reason I'm trying to reach an agreement on this ma'am, is that we have a physical assessment [] by a physician. A physician actually reviewed you[r] record April 9th of 2010. He put you at a light exertional level. It seems to me that over time you've actually been getting worse so that – you wouldn't disagree with that. And so it seems to be that some point in time, you along the way, probably have actually reached the sedentary exertional level. And the, the furthestest back I can stretch it and meet the grid rules would be age 49-and-a-half, and that simplifies things for us and allows me to reach a decision more quickly and conclusively using that grid rule. But you are giving up a little bit of – not a little bit – you're giving up your onset date of July '08 – excuse me, your onset date of November '07 and moving it forward to March of '09. Are you satisfied with that result? Do you understand why we're trying to –

Cmt: Yes.

ALJ: -- to settle it that way?

Clmt: Yes.

ALJ: Okay. If you're satisfied with that ma'am, then I will find in your favor that you are at a sedentary exertional level, and that you could not return to your past work at a sedentary exertional level with some other limitations that you might have, and that therefore you would fit that grid rule. Okay? Anything else sir?

Atty: I think that's everything, your honor.

ALJ: All right. Thank you all so much, we appreciate your coming and we'll get a decision out to you as quickly as we can ma'am.

Clmt: Thank you.

ALJ: All right, thank you.

Judge Peters closed the hearing at 11:28 a.m., four minutes later, and awarded the claimant benefits under Medical-Vocation Grid Rule 201.14, finding she could perform sedentary work.

The decision noted “at the hearing, the claimant and her representative amended the alleged onset date of disability from November 6, 2007 to March 19, 2010, which is within 6 months of the claimant’s 50th birthday.” While this decision may have reduced the amount of back-pay by two years by moving the disability onset date from 2007 to 2009, the judge also essentially ignored the evidence questioning whether the claimant was, in fact, disabled.

Oklahoma Case 129. In this case, an SSA senior attorney awarded disability benefits for a rotator cuff injury and “continued chronic pain and limited mobility of the left shoulder.” The claimant, who was “right hand dominant,” was cleared to return to work with some restrictions, but was ultimately found by SSA unable to do any job in the national economy because of the grid rules. After alleging a disability that began in 2006, the claimant’s disability onset date was moved to after her 50th birthday, at which point she was found disabled.

The claimant injured her rotator cuff on the job in 2006, and later received corrective surgery. Following surgery and physical therapy, her physician cleared her to return to work in 2007, with only an over-head lifting restriction and a 39-pound weight lifting restriction. Her physician indicated she could do work with her hands, but should work a shortened day during her recovery period. Evidence suggests the claimant returned to work for a short period of time, but stopped because her former job required her to lift 60-75 pounds.

The claimant filed for SSDI and SSI benefits on March 13, 2009, alleging a disability that began on November 26, 2006 when lifting a heavy object at work. On May 5, 2009, the claimant amended the application to move the date of disability back to May 26, 2006, six months earlier.

Her claim was denied by DDS. The claimant obtained an attorney, and on November 4, 2009, requested an ALJ hearing, explaining, “Based on my age, education and ability I do not believe that I can perform any substantial gainful work activity.”

A review of her medical records, however, showed the claimant could still work, even if not at her prior position. She had shoulder surgery on May 22, 2007, and on September 28, 2007, her treating physician commented, “I think she is doing very well, but I don’t think she is going to be able to go back to all of this overhead work that she has been doing.... I am going to get a functional capacity exam on her to see what she can do.”

The physician’s notes later reported: “The functional capacity exam felt that she could perform medium level work for an 8 hour day. At her regular job she has to lift [objects] that weigh 60 pounds. During testing, she could only lift 39 pounds safely. She could only push 48 pounds safely. They felt that she could lift the lightest [objects], which fell within the safety requirement, and I agree with this.”

Notes from her rehabilitation clinic found on October 23, 2007, five months after her disability onset date: “[W]e recommend a work reintegration program in which she would begin working a shortened day and only lift the lightest [objects]. She can then be advanced as tolerated.”

By March 2009, she continued to complain of shoulder pain, but a physical examination documented “she has good passive [range of motion].” The examiner even questioned whether

the claimant was providing a credible description of her abilities. He wrote: “I am not sure whether she is fighting me or not on the exam. Her exam is too random to make any objective findings.” While also stating that she was under a “reasonable” permanent restriction for light duty, continuously lifting 25 pounds and occasionally 50 pounds, he also called them “somewhat generous.” He said she could return to work on March 9, 2009.

Shortly after, on May 4, 2009, the claimant’s application for benefits was denied by DDS, which explained: “Your condition is not severe enough to keep you from working....Based on your description of the work you performed as a [job title] for several months, evidence indicates you are capable of doing this type of work.” The claimant appealed this decision.

On October 14, 2009, DDS denied the claim again under reconsideration, explaining: “Although you cannot move your left shoulder as well as you used to, you can still perform some types of work. Medical evidence does not show any other impairments which keep you from working. Your condition prevents you from doing your past work, but it does not prevent you from doing other work which is less demanding.”

While the claimant appealed to have her case heard before an administrative law judge, her attorney wrote a letter to an SSA staff attorney of the Oklahoma City office on January 14, 2010. The letter said he was, “asking you to consider an amended onset date of May 22, 2007, in this matter. It is my understanding that the amendment of the claimant’s onset date to May 22, 2007, will allow for the issuance of a fully favorable decision in this case.”

A little more than a week later, his request was granted. On January 25, 2010, an SSA senior attorney awarded benefits by deciding the case in the manner requested by the attorney. The senior attorney adjusted the disability onset date and also found the claimant capable of only sedentary work. Such a finding is counter to SSA regulations, which state the ability to lift 39 pounds is “light work,” a level higher than “sedentary.” The senior attorney amended the claimant’s onset date from 2006 (the date of her original injury) to May 22, 2007, the date of her surgery. By doing so, the claimant’s onset date was then after the claimant’s fiftieth birthday, at which point the SSA Medical-Vocational Rules offer a grid, which makes it easier to find the claimant is disabled.

VI. CASES AWARDED WITH INSUFFICIENT, LATE AND CONTRADICTORY EVIDENCE

An award of disability benefits must be supported by medical records establishing how the claimant is disabled. The 300 cases reviewed in the investigation, however, found case files that contained no medical evidence at all as well as case files where the medical evidence contradicted or disputed a claim of disability, but was not addressed by the agency. Other cases contained medical evidence indicating the claimant was suffering only a non-severe condition or one that would not last more than one year, as statutorily required. In still other cases, the medical evidence consisted of only the claimant's subjective complaints, with no objective tests such as x-rays, doctor notes, or laboratory findings, to support the claim. In addition, in some case files, the medical evidence was submitted at the last minute, giving medical experts insufficient time to evaluate the new evidence or to weigh it against other information in the file.

A. Use of Late-Breaking Evidence

On the Social Security Administration website, the agency encourages claimants requesting a hearing with an administrative law judge to submit any new evidence as soon as possible.⁸¹ While the rules in most SSA regions allow new evidence to be introduced at or even after the hearing, doing so is discouraged because it gives too little time for proper review. In a document titled, "Best Practices for Claimant's Representative," the agency strongly suggests getting all evidence submitted "more than 10 working days before" a hearing.

Early submission (more than 10 working days before hearing) allows hearing office personnel to exhibit the evidence and ensures that the claimant's copy of the file includes a copy of all the evidence that has been received. It also gives the ALJ time to review all the evidence, and helps to ensure that all relevant evidence is timely provided to experts scheduled to appear at [the] hearing.⁸²

In Region One, which includes six Northeastern states, it is not merely a suggestion, but a requirement that all evidence be submitted "no later than 5 business days before the scheduled [ALJ] hearing. Failure to comply with this request may result in the ALJ declining to consider the evidence."⁸³

While a mandatory deadline is in place only in this one region, the agency's Chief ALJ, Debra Bice, told the Subcommittee that she strongly discourages late evidence in all regions, because it

⁸¹ Social Security Administration, Hearings and Appeals, Best Practices for Claimants' Representatives, http://www.ssa.gov/appeals/best_practices.html

⁸² Social Security Administration, Office of Disability Adjudication and Review, Office of the Chief Administrative Law Judge, "Best Practices for Claimant's Representatives," January 2011, http://www.ssa.gov/appeals/documents/BestPractices_508.pdf.

⁸³ The five-day submission requirement applies to claims filed in: Maine, New Hampshire, Vermont, Massachusetts, Rhode Island, and Connecticut. Website of the Social Security Administration, page for "Request for Hearing By Administrative Law Judge – Form HA-501," accessed August 30, 2012.

leaves too little time for proper review.⁸⁴ When asked how ALJs should handle late-arriving evidence, she said: “My policy is if evidence comes in at the last minute, you can do a hearing, but you may need a supplemental hearing” to allow sufficient time for review.

In several cases reviewed in the investigation, late evidence was introduced into the hearing record and given controlling weight, leading to a claimant being found disabled. In some of these cases, the evidence arrived only hours before the hearing began, while in others the evidence came in the final days or weeks before the hearing even though that hearing took place one or two years after the DDS denial of benefits. In several of those cases, the claimant’s attorney submitted the new evidence, often in the form of a questionnaire from the claimant’s treating physician showing a total disability. Judge Howard O’Bryan called such reports “dead man’s reports,” and told the Subcommittee they were often disregarded.⁸⁵

For example, in **Alabama Case 69**, mentioned in a prior section, a hearing held on the morning of January 7th featured evidence created and submitted the day before, on January 6th. Not only was the evidence late-breaking, it consisted of a one-page questionnaire in the form of a “pain assessment” created by the claimant’s attorney. The options it provided and asked the doctor to circle were vague and difficult to understand and assess with specificity. The ALJ nevertheless afforded it controlling weight and used it to determine the claimant was disabled. Several other examples follow.

Alabama Case 67. Administrative Law Judge Tracy Guice awarded disability benefits in a bench decision to a 39 year-old female “as of January 23, 2007 because of partial complex seizure disorder; sleep apnea disorder; lumbar disc disease; bursitis; right shoulder; headaches; depression; asthma; and morbid obesity so severe that you cannot perform your past relevant work or other work existing in significant numbers in the national economy.” The evidence in the claimant’s case file did not sufficiently support a finding of disability, but evidence submitted less than 24 hours prior to the hearing was used by the judge to issue a bench decision – typically reserved only for those cases with the most obvious disabilities.

Medical Evidence of Record. Most records in the claimant’s file pertained to the claimant’s hernia repair in 2006-2007. Following a 2006 hernia surgery, she experienced an infection that required a second surgery in January 2007. When discharged on January 28, 2007, her physician noted “she had significant improvement in her preoperative pain status.”

She underwent outpatient surgery later that year to remove a benign uterine fibroid. Neither the hernia, nor the fibroid surgery was expected to cause disabling loss in function lasting over 12 months. The remaining evidence in the record consisted of brief progress notes from her treating physician that documented routine visits for complaints including a urinary tract infection, headaches, indigestion, anemia, hypertension, and insomnia, all of which were treated by her physician. None of the treating physician’s notes mention the issue of disability until July 2009, when the claimant told her physician “she is going to apply for disability.”

⁸⁴ Subcommittee interview of Chief ALJ Debra Bice (8/3/2012).

⁸⁵ Subcommittee interview of ALJ Howard O’Bryan (8/31/2012).

Evidence of Work. The case file also contained evidence suggesting that the claimant may have been working during the timeframe the claimant asserted she was unemployed and disabled. A medical note dated February 6, 2007, after the claimant's alleged disability onset date, stated that the claimant was "having some lower abdominal pain;" and her physician noted the claimant "[d]oes a lot of lifting at work." The physician found the claimant's "abdomen benign," but noted "the patient [was] post-excision of infected hernia mesh."

Morbid Obesity. A number of notes in the claimant's file also described the claimant as a "morbidly obese female," which resulted in related health issues. For example, her physician prescribed the use of a continuous positive airway ("CPAP") machine to address the claimant's sleep apnea. She was also routinely advised to lose weight. However, her weight increased rapidly from 215 pounds in January 2007 to 288 pounds in 2009, though only five feet tall. A doctor's note from August 2008 said the claimant "was 140 lbs. in high school" and that her weight had doubled since then.

Her physician noted on October 8, 2007, that he was "concerned about [the claimant's] weight gain [and] encourage[d] exercises." Just over a year later, on October 22, 2008, the claimant's physician again noted she was a "morbidly obese female." At the same time, her doctor stated she was in "no acute distress." Her doctor also noted her "vital signs [were] stable, "lungs are clear, "cardiovascular system [was] normal, and "extremities [were] stable." In January 2009, the claimant stated "she desire[d] obesity surgery." But her doctor noted, "she has not lost any weight since starting" and noted his "referral to obesity clinic."

DDS Review. Alabama DDS reviewed the claim and determined the claimant was not disabled. The DDS examiner determined the claimant could perform other jobs that existed in the national economy, based on a review of the Dictionary of Occupational Titles, and cited specific examples: (1) hander; (2) lens inserter; or (3) cuff folder.

New Evidence Prior to ALJ Hearing. On April 8, 2010, at 2:00 p.m. the day before the claimant's ALJ hearing, the claimant's attorney sent documents from the claimant's treating physician dated April 6, 2010 and April 7, 2010. Included in the documents was a one-page letter from the doctor to SSA stating, "Unfortunately, this pleasant young lady is 100 [percent] disabled" with a short explanation of her medical history. The ALJ heavily relied on this letter to award benefits, despite contradictory medical evidence and evidence suggesting the claimant was able to work.

During the 15-minute ALJ hearing, Judge Guice asked the medical expert present if the claimant could perform work that "involved complex instructions." He responded: "There is not information in here that indicates that she would not be able to perform complex tasks." When pressed by the ALJ, however, the doctor testified it "would probably be difficult, yes." The basis for his view, however, was not requested and is unclear from the evidence in the file. Judge Guice then asked the vocational expert whether the claimant could perform past work or any other work, to which he responded: "No to both questions." The judge then announced that based on the record and the "testimony of the experts, I'm going to issue a fully favorable bench decision."

Virginia Case 240. ALJ David Daugherty of the Huntington, West Virginia ODAR office ruled favorably in an on-the-record decision, finding a 28 year old claimant disabled due to sciatica, traumatic arthritis, and chronic pain.

Medical Evidence of Record. The claimant alleged his disability began on March 30, 2009, the same day he was laid off from his job as a truck driver. On May 27, 2009, the claimant was evaluated for depression at a care center. Physician notes documented the claimant worked at the same job for eight years; the physician noted the “[p]atient report[ed] he lost his job on March 30.” The physician noted the claimant’s “job was his life,” and that he complained “now he has too much time on his hands.” The physician stated the claimant “has been trying to find a job, but with the economy it’s very hard.” The physician also reported the claimant experienced “financial problems, kid’s birthday coming up [that created] a lot of stress on him trying to provide for his family.” The record mentioned the claimant “has back pain” and his “medications include methadone.” The claimant was prescribed Celexa for his depression.

The latest medical record in the file dated September 1, 2009, regarding the patient’s depression, noted the claimant’s “interest ok,” “sleep ok,” but that he “report[ed] feeling bored/restless being out of work.” He reported “being worried about finding a job.”

DDS Review. Based on the evidence, the DDS denied the claim and explained after reconsideration:

The evidence shows that you are suffering from pain in your back and left leg. Despite this pain, you are still able to sit, stand, walk and move about within an adequate range without assistance. Blood levels of cholesterol do not affect a person’s ability to perform work. Sleeping problems can be controlled with medication. Your feelings of fatigue may be bothersome, but it does not prevent you from work. You have had problems with depression, anxiety, and substance abuse in the past, but you still retain the capacity to interact appropriately with others as well as to understand and follow work related instructions with normal supervision.

As such, the DDS found that “based on the description of the job you performed as a heavy equipment operator in the past for 10 years, we have concluded that you have the ability to do this job.”

Attorney-Procured Medical Assessment. In the decision awarding benefits, Judge Daugherty relied solely on the attorney-procured medical opinion that arrived two-and-a-half weeks before the decision was issued. The physician evaluated the claimant on February 11, 2010. On March 1, 2010, Judge Daugherty found “[h]aving considered all the evidence, [he] was satisfied that the information provided by [the doctor] most accurately reflects the claimant’s impairments and limitations.” The physician’s opinion, labeled “Social Security Disability Medical Assessment,” opined the claimant had been “injured in a very serious accident” and “had extensive degenerative arthritis, high blood pressure, high cholesterol, and previous fractures involving his collarbone.” No other medical records in the file supported or even mentioned

these findings. The physician also referred to an MRI performed at a local hospital that was “positive.” The medical file, however, contained no MRI.

Judge Daugherty’s opinion acknowledged that the evidence would suggest a finding of “not disabled,” but that he was ruling in favor of the claimant anyway.

If the claimant had the residual functional capacity to perform the full range of sedentary work, considering the claimant’s age, education, and work experience, a finding of “not disabled” would be directed by Medical-Vocational Rule 201.27. However, the additional limitations so narrow the range of work the claimant might otherwise perform that a finding of disabled is appropriate under the framework of this rule.

Judge Daugherty’s approved the claim based on the attorney-procured medical opinion, despite the fact the opinion was inconsistent with the other medical records in the case file.

Alabama Case 54. ALJ Vincent Intoccia ruled fully favorable for a claimant who was not only working after his alleged disability, but reported earnings significantly higher than “substantial gainful activity” or SGA. Under SSA rules, even if a person alleges a serious injury or illness, earning above SGA means that person is considered “not disabled.” In this case, the judge used late-arriving evidence to make a questionable determination that the claimant was working in a “sheltered workshop.” By doing so, he ruled that none of the claimant’s earnings would count against him, and found him disabled.

A “sheltered workshop” under SSA rules is an organization that provides a non-competitive work environment for people with impairments. These organizations train individuals in how to return to the workforce free from work pressures, and are often funded with government money.

A sheltered workshop is a private non-profit, state, or local government institution that provides employment opportunities for individuals who are developmentally, physically, or mentally impaired, to prepare for gainful work in the general economy. These services may include physical rehabilitation, training in basic work and life skills (e.g., how to apply for a job, attendance, personal grooming, and handling money), training on specific job skills, and providing work experience in the workshop.⁸⁶

In contrast to that description, the claimant’s employer was a for-profit manufacturing company.

The claimant alleged problems with his right leg and knee, chronic obstructive pulmonary disease, colon issues, and diabetes, which he said made him unable to work beginning on January 1, 2009.

⁸⁶ RS 02101.270 Services for Sheltered Workshops, <https://secure.ssa.gov/poms.NSF/lrx/0302101270>.

After this date, however, the claimant reported income above the program's allowable amounts in both 2009 and 2010. Yet, when asked in paperwork for SSA, "[d]id you work at any time after the date your illness, injuries or conditions first interfered with your ability to work?" he answered "No" and that he stopped working on December 31, 2008. The reason for the contradictory information was explained during the ALJ hearing in which the claimant explained that his employer let him keep working with a reduced workload after he could no longer do his old job.

On December 10, 2010, the employer wrote a short, two-paragraph letter to the claimant's attorney "at the request of [the claimant]." It said the claimant had become "physically unable to perform his duties" and "should be considered a candidate for disability." The letter ended with the employer's human resources specialist saying she would "be more than happy" to do what was needed to help with his disability claim.

At the hearing on February 1, 2011, which lasted 15-minutes, the judge confirmed with the claimant that he had "continued to work at the same place" he had prior to his alleged disability. The judge also asked the claimant, "are you still working a 40-hour week?" to which he answered, "Yes." During the remainder of the hearing, ALJ Intoccia queried the claimant about the employer's accommodations, such as allowing for an increase in breaks and a higher than usual number of days off per month. He asked the claimant whether it, "would be fair to say that part of the reason that they are letting you get away with all of this, missing days at work is because of the past relationship that you've had with this employment," and the claimant said, "Yes."

The claimant informed the ALJ, however, that only a week-and-a-half prior to the hearing, on January 20, 2011, his employer issued him a second letter from the same human resources specialist, this time threatening potential disciplinary action if he did not correct his "attendance problem." The letter said: "[W]e are having to inform you that we would take the necessary step to correct that problem...if you are having any personal problems that are contributing to the absences on your record, we urge you to utilize the [Employee] Assistance Program." He said he forgot to bring the letter from home, but the judge told his attorney, "It might not hurt to fax it in to the e-file after the hearing."

In addition to the letter arriving late into the case file, it contradicted the claimant's explanation that he had received special accommodations from the employer. If the employer had approved and arranged for a special work schedule, it was not clear why the claimant was being threatened with disciplinary action for doing what had been approved. Second, it appeared that the letter was created to assist his disability claim by showing that the work arrangement might soon come to an end.

The prevalence of issues related to the claimant's apparent ongoing work overshadowed questions related to his medical impairments. At the hearing, his attorney offered to explain his client's medical records, but the judge declined, saying he was only concerned about "the issue of the employment" and to get the letter sent in as soon as possible.

ATTY: Your Honor, I did not go into the medical evidence when, when I still was examining my client. I thought you wanted me to just go onto the issue of the employment.

ALJ: That's all that I'm concerned about. Oh, unless –

ATTY: I had gotten all those hospital records in. I, I was prepared –

ALJ: Right.

ATTY: -- to go over them with you.

ALJ: Uh-huh.

ATTY: But that's fine.

ALJ: Yeah, they're in here. Then we'll go ahead and close the hearing, and, and get a decision out as soon as possible, and do you think in the next five, six days you could fax that letter into the e-file?

ATTY: Yes

In his fully favorable decision, Judge Intoccia found the claimant disabled from January 1, 2009, based primarily on the late evidence regarding the claimant's work conditions. The judge found that "the claimant has not engaged in substantial gainful activity since January 1, 2009." In 2009, agency rules determined "substantial gainful activity" was \$11,760 and in 2010 it was \$12,000. During that same period, however, the claimant's records show he earned \$22,671.19 in 2009 and \$43,219 in 2010 – several times the amount allowed. The judge explained his ruling by saying:

according to the credible testimony of the claimant these earnings were because the claimant was provided special accommodations beginning January 1, 2009 by his long time employer of 18 years so [he] could keep his health insurance. These special accommodations included, but were not limited to, performing only 50% of his assigned duties and allowing him to take a 30-minute break every hour in an eight hour work day, which in essence constitutes a less than sedentary type of accommodated/sheltered environment. In addition, he is permitted to be absent for five workdays per month, although the policy only allows for no more than two absences. Despite the claimant performing his work at a level substantially less than what is permitted in a competitive work environment versus what other employees are allow[ed] to do he was still paid by his employer.

The judge went on to explain that SSA regulations allow certain types of income that exceed SGA not to be counted against a claimant, including income from sheltered workshops, which as explained above, are rehabilitation centers dedicated to putting individuals back in the workforce. SSA guidance does not allow for a person's place of employment to be considered a

sheltered workshop simply because an employer allows a person to remain working for insurance purposes. Moreover, the explained purpose of the arrangement was not to get him *into* the workforce, but to await a time when he would *leave* the workforce. Seemingly in recognition of these limitations, the judge concluded the claimant worked in a “sheltered workshop type of environment.”

Oklahoma Case 200. Judge Ralph Wampler awarded benefits to a woman for diabetic neuropathy, a condition causing stomach pain. Benefits were awarded even though the claimant explained that she could perform the type of activities ordinarily performed by people who can do “light” work. The judge determined instead she could only perform work that was “less than sedentary,” relying heavily in his opinion on a letter provided by the claimant’s attorney that arrived six days after her hearing.

On July 9, 2008, the woman underwent a physical exam to determine her “residual functional capacity.” The doctor concluded she was not disabled, but rather able to do many things.

Claimant lives with her family. She is able to take care of her personal needs with no problems. She does prepare meals multiple times a week. Some of the chores she does around the house include: light cleaning, laundry, most weeding and watering and sometimes she does the mowing. She is able to drive. She does the grocery shopping. She enjoys reading, watching television, knitting, photography and gardening. She attends Church, bible study groups, she goes for walks with friends, and she visits family.

She continued, however, to complain of stomach pain and underwent exploratory surgery. The doctors concluded that there was no identifiable source of her pain, and she suffered from diabetic neuropathy.

At the claimant’s hearing on September 9, 2009, the judge said he was unfamiliar with diabetic neuropathy and would need more information from the attorney before making a decision.

ALJ: I think I have a good idea about this case.

ATTY: All right, Judge.

ALJ: But I’ll tell you what I need from you. I’m not that familiar with this abdominal neuropathy. I need a one-page brief from you within ten days. That give you enough time?

ATTY: Yes, Judge.

ALJ: Okay. At this time, I’ll take the matter under advisement.

Six days after the hearing, on September 15, 2009, the claimant's representative sent a one-page letter to the judge that contained a single paragraph about diabetic neuropathy, copied word-for-word from an online journal article, though the source was not attributed.⁸⁷ The letter also referenced a "Physical Capacity Evaluation" dated January 2009 and filled out by the claimant's doctor, which the attorney asked to be given "controlling weight" in the final opinion. It was a two-page questionnaire in which the doctor checked a box that said the claimant had: "No ability to work. Severe limitation of functional capacity, incapable of minimal activity."

In his November 4, 2009, fully favorable decision, Judge Wampler relied heavily on the September 15 letter from the attorney. He concluded the claimant qualified under the grid rules, because she could not perform "even a limited range of sedentary work." This description stood in contrast, however, to the claimant's own explanation of her daily activities, which were inconsistent with a "less than sedentary" RFC. As controlling evidence, he referenced the January 2009 "Physical Pain Evaluation" and concluded "the claimant's chronic abdominal pain has persisted and appears to result from diabetic neuropathy."

B. Insufficient Evidence Cited to Support Case

When an individual applies for disability benefits, but does not have sufficient medical records for the agency to make a decision, SSA has a number of options. For applicants whose medical records are available, but were simply not submitted, the agency can go to each of the claimant's medical providers and ask for all of the records, for which the agency bears the expense. For claimants that do not have medical records, the agency can send the claimant to a physician for an evaluation paid for by SSA, which is called a consultative exam (or "CE"). According to agency regulations, these consultative exams should be done by a doctor from the medical field in which the claimant is alleging a disability.⁸⁸

If after these attempts are made, and a person is found to be disabled, he or she will be awarded benefits. If the available records show the person not disabled, they will be denied. In a number of cases examined in the investigation, however, claimants who did not have sufficient medical evidence to support the claim were approved anyway.

In these cases, the kinds of problems found by the investigation included cases that lacked any records mentioning the disabling condition at all or mentioned other non-disabling conditions. In others, doctors from the wrong medical field provided the key diagnosis. Some cases did not contain any evidence of objective medical tests, but only the claimant's subjective complaints. A last set of cases referenced the alleged disability, but said that it was "non-severe," "well-controlled," or "in remission."

⁸⁷ Bernstein, Gerald, M.D., "The Diabetic Stomach: Management Strategies for Clinicians and Patients," *Diabetes Spectrum*, Volume 13, Number 2000, <http://journal.diabetes.org/diabetesspectrum/00v13n1/pg11.htm>.

⁸⁸ See 20 C.F.R. §404.1519g, "Who we will select to perform a consultative examination" (explaining that a "qualified" medical source must "have the training and experience to perform the type of examination or test [the agency] will request").

Alabama Case 95. In this case, the claimant applied for disability benefits alleging disabling pain, high blood pressure, and diabetes. The DDS examiner awarded benefits, relying on a medical opinion provided by an obstetrician-gynecologist to diagnose medical conditions outside of his area of expertise involving degenerative disc disease and hypertension, diagnoses which conflicted with medical records obtained from the claimant's doctors in the correct field.

The available medical records in the case file noted that the claimant's diabetes and blood pressure were controlled through medication. Related to her back pain, the results of magnetic resonance imaging ("MRIs") on every section of her spine showed only mild findings. Nerve conduction studies were normal with only mild inflammation in the lumbar spine and the T-6.

On August 7, 2009, DDS sent a letter asking if the claimant's treating physician would perform an examination of the claimant for purposes of her disability claim, but he replied "No." DDS then requested that another physician review her medical records and render a medical opinion on the claimant's condition, which he did on October 24, 2009. The consultative examiner hired by the agency was not an orthopedic specialist, who would be familiar with the claimant's alleged health problems, but an obstetrician-gynecologist (Ob-Gyn). It appears from the case file the DDS examiner requested the Ob-Gyn specialist to analyze these issues involving back pain, hypertension, and diabetes.

The Ob-Gyn reviewed the MRIs already in the case file and inaccurately concluded they demonstrated the claimant had a ruptured disc even though she did not. The claimant's own physician, who had ordered the MRIs and reviewed them, noted in September 2008, that the "alignment [of her spine] is anatomic. Vertebral body height and marrow signal are normal. The discs demonstrate normal morphology." The same report went on to state each specific level of the claimant's spine was "normal." There was no evidence whatsoever of a ruptured disc. The MRI reports noted mild degeneration, but specifically noted "no nerve herniation." Despite these findings, the Ob-Gyn specialist diagnosed the claimant with "degenerative disk [sic] disease of the cervical spine" and for the "lumbar spine."

The Ob-Gyn specialist also diagnosed the claimant with "hypertension," though the claimant had only two medical records mentioning it, one from 2006 and one from 2008. In the 2006 record, the doctor noted test results that did not lead to a diagnosis of hypertension, but only what "could be a possible cause of potential hypertension." The 2008 record was from a pain clinic, and made a passing reference to the claimant having a history of hypertension.

DDS found the claimant capable only of "sedentary" work, which in combination with the claimant's vocational factors, allowed her to be found disabled under the "gridding" rules under Vocational Rule 201.06. DDS based its analysis primarily on an analysis by a specialist from an unrelated field of medicine.

Oklahoma Case 156. DDS approved benefits for a 42-year-old man alleging depression, anxiety, "nerves," lower back problems, and asthma. His case file contained virtually no medical evidence prior to 2008, when SSA paid for several examinations, yet he was awarded benefits under medical listing 12.05(C) for mental retardation and depression. This listing requires

establishing the mental impairment before the age of 22, which in this case was more than twenty years prior.

The claimant applied for both SSDI and SSI benefits shortly after being fired from his work as a mason. SSA awarded benefits by finding the claimant met medical listing 12.05(C) for mental retardation, which requires the claimant to demonstrate a valid IQ score between 60 through 70 along with a physical or other mental impairment imposing an additional and significant work-related limitation of function. A claimant under this listing must also show the mental impairment to have begun prior to age 22.

While the medical evidence documented the claimant's IQ scores met the requirements of 12.05(C) (VIQ of 61; PIQ of 68; FSIQ of 61), no other objective medical evidence in the file established "an additional and significant work-related limitation of function." The only available evidence submitted with the application consisted of the claimant's subjective allegations of pain in his application for benefits. In response, the agency paid for the claimant to receive both a psychological and physical consultative exam to assess his allegations.

The "Work History" filled out by the claimant for SSA indicated that he worked from 2000 until November 2007, as a mason. He alleged, however, that his disability began more than a year before he stopped working, in July 2006.

In January 2008, the claimant attended the consultative examination to evaluate his physical condition. The examining physician found:

The patient has normal speech and hearing. He has normal cognitive function. He has good dexterity of his hands and fingers and good grip strength. His hands are callused. He has some mild limited rotation of his neck and some mild limited flexion of his back. He ambulates in the hallway at a normal gait and pace without a limp. He has no chronic pain behaviors or malingering behaviors.

While the claimant "state[d to the physician] he has had chronic back pain for years," the physician documented the claimant "has not had an MRI scan," "has never had back surgery," and "has no chronic pain behaviors." The case file, thus, not only lacked objective evidence of the claimant's physical limitation, but also a physician's opinion that he observed no limitations during the exam.

A month later, in February 2008, DDS sent the claimant to a psychologist for a consultative exam for an evaluation of his mental state. In that exam, the physician noted the above cited IQ scores and "the presence of depression was also noted." The examining physician reported the claimant told her "he had experienced depression 'for years'" and "reported a suicide attempt occurred in the 1980s." As a result, the physician determined the claimant was depressed. No objective evidence supported the claimant's claim of depression "for years," nor did the evidence support the fact the depression constituted a "significant work-related limitation of function" since it did not prevent the claimant from working from 2000 to 2006.

The claimant also told the examiner that he had attended special education classes in school, but that he dropped out in fifth grade because of a drugs and alcohol problem. No evidentiary proof, however, was provided that the claimant attended special education or any other document that supported the onset of a mental impairment prior to the age of 22. Nor did it provide evidence of an additional significant work-related limitation, especially in light of the claimant's long work history.

The claimant also reported to the psychological examiner that he had hepatitis B and C, but never sought treatment.

The claimant previously received SSDI from 1991 through 1997; his payments were then suspended due to an incarceration for almost five years. The claimant reapplied for SSDI in 2001, but was denied benefits. Based on his most recent application, DDS found the claimant met the medical listing for disability for both a developmental disorder (based on recent testing results) and affective mood disorder and awarded benefits beginning in 2006. The case file simply did not contain sufficient medical evidence supporting an award dating back to 2006.

Virginia Case 229. This 59 year-old claimant sustained a crush injury to his foot at work in January 2006, underwent a partial foot amputation, and received a prosthesis that should enable him to walk. The medical record documented that his wounds were healing well when the agency awarded benefits at the reconsideration level. By law, disability benefits may only be awarded to individuals with an impairment "which has lasted or can be expected to last for a continuous period of at least 12 months." In this case, an award was made on October 26, 2006 – only ten months after the injury. Nothing in the record suggested that the claimant would suffer from permanent restrictions.

On January 19, 2006, the claimant was admitted to a hospital due to "trauma, right foot and right lower leg, with pain." The medical records indicated a truck bed fell on the claimant's right foot.

On January 23, 2006, the claimant underwent a "mid foot amputation from the right foot," after which "there were no immediate post procedure complications." When the claimant saw his physician on February 27, 2006, he reported "his pain [was] significantly better." On March 10, 2006, the claimant returned for the physician to check his foot. The physician noted "his wound continues to granulate well" and the claimant "reports no problems."

He applied for disability benefits but was denied by DDS on May 23, 2006 because, "We have determined that your condition is not expected to remain severe enough for 12 months in a row to keep you from working."

Medical evidence indicated that by August 8, 2006, he was making progress in his healing.

All of [the claimant's] incisions are well healed. He has excellent motion to his knee with full extension and flexion to 130 degrees, which is painless. He has significant quad atrophy and does have some pain with patellofemoral loading. His extensor mechanism is intact. The soft tissue injury around the midfoot appears to be healing well. ... X-rays taken today show excellent alignment to

his tibia fracture. He appears to have completely healed both portions of his segmental fracture.

With regard to the claimant's use of his prosthesis, the doctor noted: "Once the knee pain has improved and he is able to tolerate full weightbearing on the right lower extremity, we can modify the prosthesis as needed." The physician also stated that "on physical exam, his wound is healed except for that small punctuate area that is over the distal tip. There is an eschar over it. This is not debrided."

Since the claimant was unable to bear weight due to continued pain around his knee, his physician stated:

[I have] given a slip for physical therapy for quad strengthening and range of motion as I think at least some portion of his pain is patellofemoral in nature secondary to his quad atrophy. I will see him back in six weeks time. We will repeat x-rays to the right tibia then.

Review by DDS. On his application forms, "the claimant [] described [daily] activities that are significantly limited." When DDS reviewed the claimant's initial application, it found that "based on the evidence of record, the claimant's statements are found to be partially credible."

When DDS reconsidered the claimant's application, a different DDS examiner found the same statements "to be fully credible" and the "assessment supports a fully favorable allowance determination." The DDS award of benefits was in October 2006, just ten months after his injury, when medical evidence indicated the claimant was healing well. No evidence in the record supported a finding that the claimant's condition would prevent him from working for a full year or that the claimant would be unable to walk using his prosthesis. Further, the claimant's physician clearly stated that the knee pain was likely due to muscle atrophy from lack of use. Insufficient medical evidence existed to award this claimant benefits. Further, no evidence indicated the claimant's listed resources decreased below allowable amounts at reconsideration.

Alabama Case 65. In this case, ALJ Charles Thigpen awarded benefits to a 35 year-old woman based on cervical spondylosis, tension headaches, migraines, a history of anxiety and depression, and fibromyalgia. The ALJ ignored evidence the claimant failed to comply with prescribed medications, which was in part the reason the claim was denied by the DDS examiner.

DDS Review of Claim. Specifically, DDS noted that while the claimant's physician prescribed various medications to prevent migraine headaches, the medical evidence documented the claimant had not filled any prescriptions. On December 8, 2008, an examining doctor wrote: "35 [year old] woman alleges intractable migraine...there is no indication in the pharmacy print out of [the claimant] ever obtaining the Keppra. These drugs are intended as preventative therapy and body of evidence in [the medical records] indicates very poor compliance in treatment." In fact, the claimant filled only narcotic pain medications, sleeping medications, abortive pain medications, and anxiety pills. The agency's denial also noted that the claimant's alleged impairments did not prevent her from working.

You state that you are disabled because of migraines and depression. It has been determined that your medical condition does not significantly affect your ability to carry out most routine activities. Since your ability to work is not significantly affected, you do not meet the requirements for disability benefits.

The ALJ failed to address the issue that the claimant was able to work despite her mental impairments and was failing to take medication intended to alleviate her symptoms. The judge rendered an on-the-record decision.

The ALJ also failed to address the lack of sufficient medical evidence in this case to substantiate the claimant's allegations of anxiety and depression. In fact, on December 9, 2008, a psychiatric consultative examiner determined the woman's depression and anxiety symptoms were "not severe." The examiner also noted that despite receiving Xanax, an anxiety medication, from her treating physician, there was "no professional [mental health history]." The examiner went on to say the "complaints are overwhelmingly of a physical nature; therefore, there is no need for further [mental health] development. Her mental health [history] doesn't appear to affect her current functioning." While the file shows the claimant took medication for anxiety as needed, no treatment records or other evidence existed that documented her mental condition had any impact on her ability to function.

Oklahoma Case 178. DDS awarded SSDI and SSI benefits under reconsideration for a man who met Medical Listing 12.05(B) for mental retardation. Under this listing, a claimant qualifies for benefits if they have "a valid verbal, performance, or full scale IQ of 59 or less" and provide proof of the impairment prior to the age of 22. While the claimant stated he attended special education classes in school, no proof was provided the claimant's mental impairment began before age 22.

The claimant, who was married and had seven children from his current and prior marriages, initially applied for benefits alleging diabetes and blurred vision, making no mention of any mental impairment. In fact, the records show the opposite. On November 2, 2005, the claimant visited the hospital, but denied, "any nervousness, tension, mood changes, depression, changes in memory, suicidal ideation or homicidal ideation." The application was denied for lack of evidence, with DDS making the following finding:

31 y/o male alleges diabetes and blurred vision. The medical evidence in file is insufficient to show an impairment. Additional evidence was not available. In addition, the claimant failed to return Work History and Function Report forms that were sent to him on 11/08/06, 12/19/06, and 05/29/07. The case is denied due to insufficient evidence.

In October 2007, the claimant obtained an attorney and filed for reconsideration by the DDS in Oklahoma City. DDS sent the claimant for a consultative evaluation. The DDS examiner diagnosed the claimant with mild mental retardation and impulse control disorder after an IQ exam found scores of 56, 58 and 62. The examiner also noted: "He has a 12th grade education, but was in special education throughout school." Rather than require the claimant's attorney to

obtain objective records to substantiate his education history, however, the examiner wrote: “He alleged problems with reading and writing at Initial level.”

An eye exam, also done at the request of DDS on September 27, 2007, resulted in the doctor reporting that tests “failed to reveal any diabetic retinopathy or hypertensive retinopathy.” Moreover:

[b]ased on the examination findings, the patient should not be limited in work-related activities such as sitting, standing, walking lifting, carrying, handling objects, hearing, speaking, traveling, and/or mental activities such as understanding and memory, sustained concentration and persistence, social interaction and adaptation.

Despite this medical evidence and the lack of any other evidence of a significant work-related limitation, the DDS office awarded disability benefits to this individual based upon the findings of mental retardation and affective mood disorders.

C. Benefits Awarded in Cases With Contradictory Evidence

Cases containing contradictory evidence present a particular problem for agency officials, especially if the differing opinions come from two sources of seemingly equal weight. In these borderline cases, it is not unusual for the agency to choose the outcome most favorable to the claimant. In addition, in a number of cases examined in the investigation, when the contradictory evidence came from two seemingly unequal sources, DDS and ALJ decision-makers still tended to cite the most favorable evidence to find claimants disabled.

Contradictory evidence came in a number of forms. In some cases, it involved conflicting medical records between two doctors. In such cases, the disability decision-maker is required to explain why it chooses to give more weight to one than another, though often that did not happen. In other cases, evidence of a person working after their alleged disability onset date provides contradictory evidence regarding the claimant’s ability to work.

As part of the disability application, a claimant is required to state the date on which they believe their disability began. This date is known as the “disability onset date.” When benefits are awarded, the evidence must support a finding that the alleged disability began on the specified disability onset date. Evidence of work after the disability onset date raises questions about an award of benefits, even if the work results in earnings below the SGA rate which is currently about \$12,000 per year, since the claimant must be found unable to perform any job in the national economy.

When evidence of work activity existed, ALJs generally assumed it provided earnings below the SGA rate or relied on statements by the claimant that they were incapable of working at SGA, without any further questioning. ALJs rarely addressed a claimant’s current work activity other than eliciting perfunctory statements that the claimant was not earning SGA. There were many instances when medical records suggested that a claimant was or might be working, at which point an ALJ should have asked whether the claimant was, in fact, employed. Additional

appropriate questions might be whether the claimant was intentionally working under SGA in order to qualify for disability benefits, receiving unreported wages, or was capable of working longer hours equal to SGA. Some claimants also admitted engaging in such activities as cooking, cleaning, driving, and sitting for extended periods of time that belied the functional limitations described to them in an application form or related document. This contradictory information should also be acknowledged and examined, but rarely was.

Oklahoma Case 181. In this case, ALJ Lance Hiltbrand awarded SSI benefits to a child without properly addressing conflicting medical evidence about his impairment. Three doctors determined that the child did not have marked limitations in any of six “domains of functioning” required to qualify for benefits, though program rules required two marked limitations. Despite this medical evidence, Judge Hiltbrand concluded the child had marked limitations in three domains, and awarded benefits, without fully explaining why he differed from the doctors.

The child was in the custody of his grandparents, who applied for disability benefits on August 7, 2007, while the child was still in preschool. They alleged attention deficit and hyperactivity disorder (“ADHD”) and oppositional/defiant disorder.

The initial application for benefits was denied by DDS on January 3, 2008, and again under reconsideration on March 25, 2008. The reconsideration denial explained: “The medical evidence shows the Attention Deficit Hyperactivity Disorder and behavior problems appear to respond to treatment. There is no evidence of a disabling condition due to a learning disability.”

Medical evidence dated 2007 through 2009 demonstrated the child’s symptoms were well-controlled by treatment and medication. In fact, one of his kindergarten teachers remarked on an October 22, 2007, evaluation “his amazing progress in my classroom gave us both the awareness he is exceptional – and shy – just trying to cover it up. ... Of all my students, I am most thrilled with [the child]. A student like [name withheld] is the reason I am a teacher.”

His kindergarten teacher made several written comments on a November 2007 evaluation including:

This is [claimant’s] second year in kindergarten. He is currently on medication for ADD& ADHD. I have seen remarkable improvement in [claimant] this year as compared to last year. [Claimant] is currently working on grade level in all areas. [Claimant] is currently taking Adderal for ADD & ADHD. ... Last year, [claimant] had problems in all areas. I am seeing considerable improvement in behavior and academics this year. ... Since [claimant] has started taking medication, I have no problem w/ [claimant’s] behavior. ... Since [claimant] started medication for ADD & ADHD, I have seen positive things. He can sit and complete his work. He cooperates with others. He participates in circle activities and centers. He is a completely different child than he was last year.

Despite the treatment leading to improvements, some behavioral challenges remained, causing stress on the grandfather. The child’s physician commented on November 21, 2007, at a

pediatric visit, “Grandfather reports things are better but then launches into a litany of problem behaviors, many of which sound like normal kid behavior.”

On January 3, 2008, a DDS consultative examiner found the child with a “less than marked” limitation in acquiring and using information as well as for health and well being. All other domains were found to have “No limitation.”

Several days later on January 8, 2008, the grandfather took both the claimant and his older sister for a consultation at a child study center, but the physician noted the grandfather, “has a very negative attitude and very unrealistic expectations of his 7 & 6 y.o. grandchildren...By teacher report does not quite make criteria for ADD but by report of [grand]father teacher is the one who recommended evaluation for ADD.”

The child was seen by a different consultative examining doctor on March 24, 2008, to evaluate his “domain limitations,” and found the child’s limitations were “less than marked” for acquiring and using information, but he had “no limitation” for the five other domains. A pediatric evaluation in April 2008 when the child was six years old noted, “He has problems with noncompliant behavior, but does not appear to have oppositional defiant disorder at this time.”

In February 2009, his first grade teacher wrote, “[Claimant] is a strong student with great potential. He is currently on medication to help him focus. His grandparents, guardians are very good about seeing that he takes his medication before he comes to school.” The teacher described a number of behavior problems, which she attributed to abuse by his father who had recently been released from prison. She described how his behavior improved significantly when the grandparents regularly gave him his prescribed medications.

On May 26, 2009, notes from a pediatric visit showed that the father’s recent return from prison had negatively impacted the boy’s behavior and he, “had real problems, sounds like aggression as well as not staying in seat & not getting work done. About to be suspended for rest of year....[but] Grandfather started giving [medication], behavior at school much better.” The notes contained an assessment of the ADHD, saying it was, “improved with meds though some residual [symptoms]. Hard to sep[arate] from other behaviors.”

On June 2, 2009, a counselor providing services to the child wrote that he, “is being seen for issues related to depression, anger, self-esteem and social relationships. In the past, [claimant] has had difficulties paying attention in class, following directions, and getting along with his peers. His teacher has reported classroom behaviors including difficulties with school work, paying attention, fighting, stealing, and lying. These behaviors have resulted in [claimant’s] diagnosis of Depressive Disorder 311, and ADHD 314.09. Continuation of counseling services with [claimant] is anticipated with expected prognosis fair-good.”

On August 13, 2009, the day prior to the ALJ hearing, the child’s grandfather submitted two signed statements explaining his financial difficulties, and how additional funds would help with the care for both the child and his sister, though almost none of the expenses were medical:

As I stated when this claim was started 2 years ago, there is a loan for my grandson's household expenses. I have spent a fortune on him and it has been very difficult financially for me and my wife. We have a balance of over \$14500 in credit cards for things we had to buy or repair because of him. Because he was crank baby he has violent outbursts and damages the home. I have also had to spend so much money on clothes, furniture, counseling, medications, toys and school supplies, etc. The household expenses average \$477 a month. This amount multiplied by 25 months is \$11,925.00. This is the amount I need reimbursed.

...

I hereby certify that we are in a difficult financial situation. We could really use the 08/2009 check to help with back to school expenses. I also would like to request an advance of the backpayment for the loan. This would be to help pay off the credit card that has expenses incurred for [the child's] care. Not having this credit card debt would ease our monthly expenditures so we can better care for [the child] and [his sister].

At the June 30, 2009, hearing, the judge obtained the opinion of a medical expert by telephone, and explained to the claimant's attorney, "I've used him – well, I've had him testify a lot," but that he was very "competent." During the hearing, the medical expert testified that the child had "less than marked" limitations in all six domains of functioning. Moreover, "with the introduction of Adderall and particularly adding a second dose in the afternoon, his problems disappeared for [a certain] period with medical improvement both in school and somewhat at home." The doctor concluded that the child did not have either oppositional defiant disorder or post-traumatic stress disorder, but was possibly at risk for these in coming years.

Before closing out the hearing, Judge Hiltbrand suggested to the grandfather that he might be more lenient than usual in this case: "[W]e don't want to penalize a good parent ... and a good family environment. You've done a wonderful job. You did all the right things. I know it's hard when you have to sometimes turn against a loved one, your son and others, but I think you had – you saved an individual. So you should be very proud."

Judge Hiltbrand overturned the DDS determination in a fully favorable ALJ decision from August 14, 2009, awarding SSI benefits. Despite none of the doctors finding a marked limitation in more than one domain, the judge found the child had marked limitations in three domains including: acquiring and using information; attending and completing tasks; and interacting and relating to others. He determined the child was disabled since August 7, 2007, the day his grandparents filed an application for benefits and while the child was still in pre-school.

In his opinion, he wrote: "Although [the medical expert] indicated the claimant's limitations were less than marked in the six areas, the Administrative Law gave some weight to the testimony of the grandfather at the hearing and the opinion of [a counselor], and finds the claimant is more limited than determined." Judge Hiltbrand added that the "State agency medical opinions are given little weight." He reasoned the child would "likely need to remain on medication," but failed to acknowledge the substantial improvement made since he had started medication, as noted by both his teacher and doctor.

Alabama Case 62. In 2009, ALJ Charles Thigpen awarded SSI and SSDI benefits to a claimant disabled for major depressive disorder, panic disorder and hypertension as of October 2006, but whose records document nearly uninterrupted work activity through May 2009. In addition to containing conflicting information about the claimant's ability to work, the case file also contained conflicting information about the claimant's wages. Judge Thigpen calculated his wages to be nearly one-third less than the records showed was the case.

Following initial application, the claimant was sent at the request of DDS for two consultative examinations, one mental and the other physical. The first, a mental evaluation on February 23, 2007, led the doctor to conclude: "Attention and concentration adequate for two-hour periods across an eight-hour day...No significant limitations." On March 8, 2007, she underwent a physical exam, at which the doctor found: "Based on the information in the file the severity of her impairments is not consistent with the severity of the medical in the file. Claimant symptoms are partially credible."

On March 9, 2007, the day after her physical exam, DDS denied the application, giving the following reasons:

You state you are disabled because of cholesterol, high blood pressure and nervous problems. Considering the restrictions of your conditions, individually and combined, you cannot do the jobs you have done in the past. However, the evidence shows you are able to carry out most activities. Therefore, based on your age, education and past work experience, you are capable of performing certain types of work and do not meet the requirements for disability benefits.

Five days later, the claimant hired an attorney and requested a hearing at the ALJ level, citing as the reason for appealing the DDS decision: "I am disabled because of cholesterol, high blood pressure and nerve problems." When asked on Form SSA-3441, filled out by claimants wishing to appeal to an ALJ, whether her condition had worsened since she first applied, she answered, "no."

Throughout the application process, the claimant continued working, providing significant evidence that she might not have met the statutory definition of disability. According to May 2007 treatment notes from her mental health clinic, the claimant said she had a long history of work prior to applying for disability: "Worked from 1967-2006 first in factories then in home health. Due to multiple medical problems including hypertension, high cholesterol and what appears to be congestive heart failure she was unable to work and has now filed for disability."

During the early part of 2007, the claimant was put on bed rest stemming from a stressful divorce, but she returned to work on May 29, 2007. A treatment note from her mental health clinic showed she was, "working 14 hours per week on a PRN [as-needed] type basis." Notes from the same clinic on the next day state the claimant "report[s] situational stresses daily and her largest concern is financial. Not being able to pay her bills."

On June 27, 2007, her therapist noted, "she is doing much better with the increase in Xanax and starting the Lexapro meds. Sleep has improved, eating less has lost a few pounds, not as irritable

or anxious. Also feel[s] better about herself since working a few hours a week and is maintaining her home.” Two months later in August, her therapist wrote: “Client need[s] to be financially stable to help minimize her stresses.” Notes from August, though, also show she was still employed, “working about 17 hours a week...doing light duty.”

On October 29, 2007, the therapist commented that the claimant, “report[ed] changes in mood d[ue] to lack of financial support,” and urged her, “to contact lawyer concerning disability claim.” A January 2008 note from the mental health clinic said the claimant, “Works 17 hours a week, part time, light duty spread over five days....Has not heard from social security yet.” By September 25, 2008, notes from the same clinic show the claimant had significantly increased her workload, and “went back to working 35 hours a week and said she is doing okay.” Records from her employer show that she continued at her job through May 2009.

ALJ Decision. In his February 2009 decision, ALJ Thigpen ruled favorably for the claimant, determining her disability began on the day she filed her application, October 16, 2006. His ruling failed to address why evidence of the claimant’s current and past work history was not relevant to her disability claim. He even appeared to have made a basic factual error in determining the claimant’s earnings – finding them too low – and increasing her odds of acceptance into the program. He wrote: “At the hearing, the claimant testified that she is working part-time as a home health aide for the elderly. She stated she works about thirty-five hours per week and earns \$300 every two weeks,” averaging \$4.29 per hour or less than minimum wage. As such, the judge found “these earnings are too low to be considered substantial gainful activity.”

The error appears to have stemmed from the ALJ misinterpreting the claimant’s hearing testimony in January 2009. At the hearing, the claimant told the judge, “I’m just working part time,” but that “it’s just minimum wage, you know. I bring home less than probably about three-something every two weeks.”

Two pay stubs in the file, one from September 2008 and another from December 2008, show the claimant earned \$6.55 an hour, the minimum wage at that time. Yet they also show that the claimant earned \$412.65 and \$458.50 respectively in each of the two-week pay periods, or more than fifty percent higher than the amount of \$300 per week determined by the ALJ. The judge erroneously reported her total income as the amount she kept after taxes, rather than reporting her actual income as reported on the pay stubs in the file. Additionally, a record of monthly earnings from her employer showed that in July 2008, she earned \$1,158.85, which when divided by her hourly wage amounted to an average of 39.7 hours worked per week that month.

Further evidence of the claimant’s ability to work was delivered at the hearing by the vocational expert present. Under questioning by Judge Thigpen about whether the claimant could, “do her past work or other work?” the vocational expert answered, “Yes, sir.” The judge then asked several more rounds of questions, each time increasing the claimant’s hypothetical limitations. Each time the vocational expert affirmed such a person could work, concluding, “I didn’t see anything that would preclude work on her testimony.”

Despite the available evidence, Judge Thigpen ruled that the claimant was not capable of returning even to her current job, finding: “The claimant has the residual functional capacity to perform less than a full range of sedentary work....The claimant is unable to sustain a full eight-hour workday or forty-hour workweek at a regular and consistent basis.” Records from her employer show, however, that despite the judge’s findings the claimant did, in fact, return to her old job, which she retained as of May 2009, the last records available.

The judge found her reported wages were under SGA, and apparently relied on that fact in support of his determination that the claimant was incapable of working. In fact, the records show the claimant worked just under the limit permissible under SSA regulations to qualify for disability benefits, earning around \$1,000 per month. In July 2008, she earned \$1,100, indicating she was capable of working a full 40-hour workweek. In awarding benefits, however, the ALJ failed to question the claimant at the hearing about whether she was capable of working more than 35 hours and failed to address in his opinion the conflicting evidence regarding her ability to work.

Alabama Case 66. ALJ Vincent Intoccia awarded SSDI and SSI benefits to a claimant in a bench decision for glaucoma, severe bilateral spinal stenosis, and a back impairment. The case contained a number of pieces of conflicting medical evidence, raising questions about why it was approved. In particular, it contained two medical reports within a month of each other with vastly different conclusions about the claimant’s RFC. During the hearing, the judge referenced only the more severe RFC, leaving out reference to the one suggesting the claimant could work.

Further, the claimant made clear to his physician that his unemployment payments were running out and he hoped to be awarded disability benefits. Since unemployment insurance (UI) is reserved for those who *can work*, but cannot find it, receiving UI conflicts with a claim of disability. Rather than properly resolving these conflicts with a thorough hearing, Judge Intoccia held only a brief session at which the claimant did not speak, nor was asked any questions.

Medical Evidence of Record. In February 2007, the claimant saw a physician for a glaucoma evaluation. The doctor concluded that the claimant’s “visual field is consistent with his optic nerve exam showing marked constriction of the visual field to probably less than 5 to 10 degrees in the right eye. The left visual field appeared more normal although was slightly depressed superior nasally.” The physician concluded the claimant “has severe advanced primary open angle glaucoma with his right eye worse than the left eye.” The physician went on to state that “we will have to work together to accomplish successful treatment of [the claimant’s] glaucoma condition.” Later that year, on September 11, 2007, the claimant’s physician stated he did “not rec[ommend a] job working [at] night due to depth perception.” He did not state the claimant could not work.

Despite his alleged vision problems, the claimant listed that his physical activities included “take my daughter to school. No problem driving in daytime....I have to be very careful driving at night. I don’t unless I have to.” While the claimant stated he had “a severe blind spot on [the] right side,” he had no problem standing, walking, or sitting. The claimant also claimed that he was “laid off due to my vision problems” from his job as an equipment operator, which he had

held for nearly 12 years, from 1995 to February 2007, presumably because his vision had worsened over time.

Other Income. The claimant reported that he received unemployment insurance from March 2008 through May 2009 in monthly amounts ranging from \$844 to \$1,055. The claimant also received a pension payment each month under the retirement plan of his former employer of \$521.50.

DDS Review. In August 2008, DDS denied the claim based on the claimant was a “younger individual” under the age of 49 and had a high school education, he could perform “medium work range.” This included a conclusion that the claimant was under no restrictions for lifting, sitting, standing, pushing or pulling. Even though “the claimant has not acquired transferable skills,” “the overall vocational profile remains favorable for work adjustment to other jobs. Examples of jobs this claimant can perform include: (1) scrap sorter; (2) plugger; and (3) battery stacker.” All of these jobs qualified as work under the “medium work range.”

DDS denied the claim for disability benefits and explained:

We have determined that your condition is not severe enough to keep you from working. We considered the medical and other information, your age, education, training, and work experience in determining how your condition affects your ability to work.

You state you are disabled because of glaucoma. The evidence shows you have some restrictions and are not able to perform work that you have done in the past. However, based on your age, education and past work experience, you are still able to perform certain types of work.

Post-DDS Medical Evidence. On September 9, 2008 – only a month after the DDS decision – the claimant retained an attorney. Little more than a week later, on September 18, the claimant visited a doctor, but the results of the exam were far different than the DDS determination in August. During this exam, the doctor found the claimant had such a severe back impairment he could barely walk, sit, stand, climb or lift. The doctor limited the claimant to lifting no more than 5 pounds along with sitting and standing restrictions to no more than 1-3 hours per day.

The next month, the claimant saw an orthopedist on October 28, 2008 for an evaluation of his back. The physician noted “it is my understanding that he is trying to obtain some unemployment benefits for his back problem.” At the same time, he told the doctor his “unemployment benefits ran out.” The examining physician noted that a prior doctor “ordered an MRI scan ... which showed significant grade II spondylolisthesis at L5-S1 level with severe bilateral foraminal stenosis.” The claimant “complain[ed] of right hip and lower leg pain,” but the physician noted the claimant “has not had any treatment per se for his back problem” even though he claimed “intermittent problems for the last 15 years.”

The physician recommended treatment with medication and a back brace. The physician noted the claimant “may eventually need evaluation to see if he is a surgical candidate for stabilization

of his lower back which would give him the best chance for him to do any type of work in the future.”

ALJ Hearing. Judge Intoccia made a fully favorable decision under the grid rules, which he made with a “bench decision” – typically reserved for only claimants with obvious disabilities. At the outset of the hearing, the claimant agreed to amend his onset date to October 10, 2008, just before his back exam on October 28, 2008.

The brief hearing included one question to the vocational expert based on the most severe assessment provided on September 18. Based on this, the VE found the claimant could perform no jobs that existed in the national economy. The judge did not mention the DDS determination or the October assessment of the claimant’s back pain. No questions were asked of the claimant. The ALJ noted that the claimant “has a good work history ... [that] goes to his credibility ... generally individuals with work histories such as this don’t pretend to be disabled unless they really are.” His bench decision, by nature, failed to explain how various doctors could come to such different conclusions within a month of one another. Moreover, his decision did not reconcile why the claimant was collecting unemployment insurance, which is statutorily limited to individuals that are able and available to work, while claiming at the same time to be disabled.

Judge Intoccia determined the claimant “is entitled to a Step Five finding within the framework of Grid Rule 201.28.” While Grid Rule 201.28 mandates a finding of “not disabled,” Judge Intoccia determined the claimant was further limited due to his “inability to complete a scheduled workday, which precludes all competitive employment and, as such, there are no other jobs available that [the claimant] could perform.” Therefore, while the grid rules, which considered the claimant’s age, education, and previous work experience, directed a finding of “not disabled,” the ALJ further limited the claimant’s alleged capabilities to find him disabled.

VII. PROPERLY DECIDED CASES SHOW CONTRAST WITH QUESTIONABLE CASES

Despite the problems revealed in this report, the investigation found no apparent problems with a third of the case files. Those properly decided cases were found at all levels of review, from the initial application stage to the ALJ level through the Appeals Council. They properly weighed the medical evidence and made reasonable conclusions based on the entirety of the record. The ALJ decisions were written carefully to show that the conclusions were documented by the relevant exhibits and did not rely on poor or incomplete arguments. These cases demonstrate not only the best practices at the agency, but also help illuminate the problems that need to be tackled by providing an informative contrast.

Alabama Case 50. In 2009, DDS awarded SSI benefits after finding a 17-year old boy met Medical Listing 112.05(C) due to a full scale IQ score of 59. The case file contained extensive information about the claimant's activities and abilities.

Reports by the Claimant's Parent. When DDS contacted the claimant on April 7, 2009, DDS reported the following additional information:

Heart murmur/hole in heart – no treatment in 3 years. Is supposed to get [follow up] every two years but Medicaid ran out. His mother said he has no symptoms. [Learning disabled] – has been in special [education] all through school until this year when he was mainstreamed into regular [education] classes. His mom says he gets “easier work.” She says he is not as mature as other kids his age and has problems learning.

The contact form also reported “no new information identified.” When questioned regarding the claimant's social activities, the claimant's mother responded on agency forms the claimant “does not play sports but he is in the band at school.” She also stated “sometimes he won't ask for help if he needs it” and “only finishes his homework because I stay on him to get it done.”

Medical Evidence of Record. On September 22, 2003, the claimant, who was in the fifth grade at the time, was re-evaluated to determine if he still qualified for special education classes. During that evaluation, the examiner noted:

[The claimant] appears to be small physically for his chronological age. He is presently in the 5th grade. [The claimant] report[ed] that he resided in the home with both parents. He also stated that he enjoys playing games, jumping on the trampoline, bike riding and riding his skate board.

With regard to the examination the psychologist noted:

[The claimant] appeared to be attentive and cooperative during the entire testing session. Rapport was easily established and effectively maintained. [The claimant] was eager to complete the assignment. He appeared confident and comfortable in his interactions with the examiner. Overall he appeared to

understand instructions given. [The claimant] maintained good interest and effort throughout the entire testing session.

Ultimately, in a decision signed by the claimant's parents and his teachers, the claimant remained in special education classes. The claimant's Individualized Education Plan (IEP) for the 2009-10 school year stated:

[The claimant] is a 16 year old eleventh grader [in high school] currently resides with both parents. [The claimant] reported having five sisters and two brothers. He enjoys basketball and would like to play baseball. [The claimant] is part of [the] Middle School marching band and [] drum line. He enjoys mathematics and working out. [The claimant] reported that one day he would like to be a personal trainer. He also stated that he takes medication for occasional headaches.

In May 2009, the claimant received a physical consultative exam, which noted the claimant "has seen his cardiologist 1 [year] ago, was told everything is fine and to [follow up] in 2 [years]." The examiner noted the claimant's general appearance was "normal habitus, well developed, and [], well groomed, appears mildly less than state[d] age, no acute distress, color good." The physician continued to review the claimant and noted no issues. The examiner stated the claimant's ventricular septal defect was "stable and without any symptoms."

The agency referred the claimant to a psychologist for a psychological consultative exam on June 19, 2009. The psychologist that conducted the report found, in part:

Today the patient's chief complaint was "nothing." His mother who came with him reported that his "mental maturity is behind and he has been in special education." She also reported that he had a heart murmur. He has had no nervous trouble or depression of any significance. He has never had a behavior problem. He is being treated by [his physician], a pediatrician [], and takes no medication.

His mental retardation was obvious. He was a pleasant, soft-spoken young man. His thoughts and conversation were logical. Associations were intact. His affect was normal. No confusion was noted. He denied anxiety and was not restless. His mood was normal and he rarely cries. His sleep has been good and his appetite fair. His weight has been stable while his energy level is normal. No psychomotor retardation or agitation was noted. His was not suicidal or homicidal. There was no evidence of any hallucinations, delusions or persecutory type fears. No phobias or obsessive compulsive traits or any significance were noted. He was alert.

The CE went on to report the claimant "plays drums in the school band and practices a good deal at home making his mother miserable." The examiner also pointed out the claimant "attends church where his behavior is good." Like at church, his behavior was good at school. The examiner noted his "teachers have had no complaints about his behavior in school and his conduct grades have been good."

The CE also included intelligence testing. The CE documented the claimant received a full scale IQ score of 59 on the Wechsler Adult Intelligence Scale IV, which the examiner concluded placed the claimant “in the mild range of mental retardation at the time of testing.”

DDS Determination. DDS determined the claimant met medical listing 112.05(C). A claimant meets this listing with “a valid verbal, performance, or full scale IQ of 59 or less.” As stated, in the most recent CE, the child received a full scale IG score of 59. Therefore, DDS relied on proper evidentiary proof to award benefits.

Oklahoma Case 173. This case file is an example of one in which sufficient medical evidence existed and was cited to support a favorable decision by DDS. The claimant alleged disability beginning March 2003, due to a congenital hip defect, hip dysplasia, and degenerative disease in her knees. She submitted detailed subjective documentation providing thorough descriptions of her daily activities, her pain, her treatment, and her medical condition. The claimant also submitted evidence regarding how her alleged impairments affected her daily life and prevented her from being able to work. Each of the claimant’s subjective allegations was also substantiated by objective medical documentation in the case file.

The claimant worked as a legal secretary until March 2003, at which time she had already undergone several hip surgeries and revisions. Specifically, she underwent a left hip arthroplasty in 2000, and several revisions (in 2001, 2002, 2003 and 2005) due to frequent hip dislocations. She underwent a right hip replacement in 2004, and a left hip replacement in 2005. She also fractured her knee in 2005, which required her to make temporary use of an electric scooter. In June 2006, she had spasticity and internal rotation. Her physician prescribed she use a cane and walker prior to her surgeries, as of 2006, she was still using a cane, walking with a limp, and complaining of hip and knee pain. She was taking oxycontin, a powerful pain medication.

In a letter dated December 31, 2003, her treating physician listed her diagnoses, symptoms, treatments, and described in detail her functional abilities, activity limitations, and pain. Her physician’s treatment notes consistently stated the claimant was disabled. Even in 2006, when the claimant expressed a desire to return to work, her physician opposed the idea and stated:

[W]e spent quite a bit of time discussing the pros and cons of her returning to work. I am not at all sure that she will be able to tolerate a fulltime position. I am, in fact, very concerned that she is setting herself up for failure. ... I would like to see her start in a much reduced work load fashion.

DDS properly applied the treating physician’s recommendations, and came to an appropriate determination that the claimant was disabled effective March 2003, the date she stopped working. The case file contained sufficient medical evidence, which substantiated each of the treating physician’s statements regarding her disability and the claimant’s numerous subjective allegations.

Virginia Case 264. This case file presents an instance in which the ALJ properly evaluated the evidence. Here, the ALJ addressed the lack of medical evidence in the record to support the claimant’s alleged disability onset date by amending the onset date as supported by the record.

The ALJ also properly explained the weight given to the treating physician's opinion. In addition, the ALJ addressed portions of the treating physician's opinion that were inconsistent with the record and provided a sufficient explanation of the weight he was according each opinion in the file. The ALJ's opinion also addressed the claimant's obesity and its effect on her alleged impairments.

The claimant separately applied for SSI and SSDI in April and May 2008, respectively, alleging disability beginning in January 2002, due to lower back and hip pain. After the claim was denied by DDS, the claimant retained an attorney and added an allegation of anxiety. She submitted new evidence in the form of treatment notes from a psychiatrist who began treating her for anxiety in 2009.

Amended Onset Date. The records documented that the claimant sustained a back injury at work in January 2002; she was diagnosed with a bulging disc. Her physician treated the injury with epidural injections in May and June 2002. She returned to light duty work in February 2003, and received a worker's compensation settlement a few months later. There are very few medical records in the file after this date until 2009, following the claimant's SSDI and SSI applications.

Accordingly, ALJ De Monbreum correctly explained during the hearing that the file lacked medical records that supported a claim for disability back to 2002, for either an ongoing back injury or a work impairment due to anxiety. During the hearing, ALJ De Monbreum explained that no medical records substantiated the claimant's allegation of a mental condition prior to April 2009, the date her treatment began. He suggested that she amend her onset date to April 2009. While the progress notes in the claimant's file showed less than disabling levels of this mental impairment, the claimant did proffer a medical source statement from her psychiatrist that opined that the claimant was markedly limited in numerous areas of functioning required to perform work activity.

In his decision, ALJ De Monbreum discussed the claimant's medical progress notes, and specifically cited her treating physician's medical opinion, which found that the claimant had marked limitations in numerous work-related functions. The ALJ discussed the weight he accorded the physician's opinion and addressed weaknesses in the physician's opinion, which opined the claimant was limited in all areas of functioning. The ALJ noted the claimant stayed home and cared for a son and handicapped brother. He pointed out that if she was limited as the doctor suggested, she would not be capable of caring for her son and brother or even attending the ALJ hearing.

The ALJ noted that no other medical opinions existed in the file, and he gave substantial weight to the treating physician after reviewing her treatment notes. While another decision-maker may have reached a different conclusion, ALJ De Monbreum sufficiently addressed all relevant factors in this file, and clearly and thoroughly explained his rationale for finding the claimant disabled at a later onset date.

Analysis of Claimant's Obesity. The ALJ also sufficiently explained why he believed the claimant could claim an impairment due to obesity, although she had not alleged that factor. This diagnosis appeared on several medical notes, and the ALJ analyzed this diagnosis as

required by SSR 02-1p, which requires ALJs to consider obesity in determining whether claimants have medically determinable impairments that are severe, in determining whether those impairments meet or equal a listing, and in determining a claimant's residual functional capacity. In this case, the ALJ noted the claimant's BMI of 32.0 which rendered her obese by National Institute of Health guidelines. The ALJ's thorough explanation of how obesity is factored into the residual functional capacity indicated that he properly made such a consideration. The Subcommittee investigation found such a thorough analysis of the obesity guidelines absent in most decisions in which obesity was an obvious factor.

Alabama Case 68. The ALJ properly analyzed whether a claimant met one of SSA's Listing of Impairments. Here, the claimant was a 26 year-old man diagnosed with sickle cell disease. Claimants with documented sickle cell disease meet the criteria of Listing 7.05, if they have one of the following: (1) documented painful thrombotic crises at least three times within the past five months prior to adjudication; (2) required extended hospitalization at least three times within the past 12 months prior to adjudication; (3) chronic severe anemia with persistent hematocrit of less than 26 percent; or (4) the disease has caused an impairment to another body system that meets another listed impairment.

In this case, the claimant's treating physician completed a medical statement in support of the claimant's disability application. The statement indicated the claimant's condition met the criteria of Listing 7.05 by asserting the claimant had painful thrombotic crises at least three times within the past five months, had chronic anemia with hematocrit below 26 percent, and required the patient be hospitalized three times within the past year. If the ALJ accepted this statement on its face without verifying whether it was consistent with the medical evidence in the record, the ALJ might have awarded benefits finding that the claimant met the criteria of Listing 7.05.

ALJ David Horton correctly did not apply Listing 7.05, however, because the medical evidence in the record was inconsistent with the statements made by the treating physician. Despite the treating physician's statement, the medical records only showed two hospitalizations within a five month period of time – on November 22, 2008 and December 10, 2008 – not the three required to meet the listing. Also, the physician's statement regarding hematocrit levels was inconsistent with the medical evidence.

Judge Horton correctly found the claimant did not meet the criteria of the listing and instead analyzed the claim at step five of the sequential evaluation process, related to vocational factors.

Oklahoma Case 150. This case provides an example of an ALJ opinion which properly explained how the medical evidence in the case file supported the ALJ's decision that the claimant's impairments met the criteria of Listing 2.07A and B, Disturbance of Labyrinthine-Vestibular Function. This listing is met if the claimant has frequent attacks of balance disturbance, tinnitus, and progressive loss of hearing with documented hearing loss established by audiometry, and disturbed function of vestibular labyrinth demonstrated by caloric or other vestibular tests.

In her fully favorable decision, ALJ Kim Parrish explained:

The medical record describes a several year history of progressive hearing loss, episodic dizziness, loss of balance, headaches and tinnitus. Audiogram showed bilateral low frequency hearing loss. Electronystagmography and bithermal caloric testing showed strong unilateral weakness on the left and right benign paroxysmal positional vertigo. There is objective medical evidence that the claimant is unable to heel, toe or tandem walk due to difficulty with balance, and he has to hold on to the wall during ambulation. Based on careful evaluation of the evidence of record, the Administrative Law Judge finds that there is evidence of a history of frequent attacks of balance disturbance, tinnitus, and progressive loss of hearing as well as disturbed function of vestibular labyrinth demonstrated by caloric or other vestibular tests and hearing loss established by audiometry. The undersigned concludes that the claimant has impairments that meet the criteria of Listing 2.07A and B.

Alabama Case 65. This case provides an example of proper analysis of claimant noncompliance with prescribed treatment. Failure to comply with a physician's treatment orders was rarely addressed by DDS or ALJs in their decision-making rationale. Discussed earlier as an example of an ALJ ignoring clear evidence of noncompliance, this case also serves as an example of how examiners at the DDS level properly analyzed a claimant's lack of compliance with prescribed treatment and denied benefits.

In her initial application, the claimant alleged disabling migraine headaches. The treating physician's notes referred to numerous medications the physician prescribed, which the claimant reported did not work. The DDS examiner reviewed the pharmacy print-out showing the drugs filled by the claimant for a 10-month period of time. DDS determined the claimant had never filled the prescriptions for the drugs prescribed to prevent her headaches. DDS concluded the claimant had failed to comply with her prescribed medication regimen.

The DDS examiner also reviewed other medical records and concluded the claimant failed to comply with her scheduled follow-up appointments. The ALJ, however, failed to address this issue, overturned the DDS decision, and awarded benefits.

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