Social Security Rulings Update

November 18, 2020

12:30 p.m. – 2:30 p.m.

CT Bar Association

Webinar

CT Bar Institute, Inc.

CT:2.0 CLE Credits (General)
NY: 2.0 CLE Credits (AOP)

Table of Contents

Lawyers' Principles of Professionalism 3
Agenda 6
Faculty Biographies 7
Social Security Rulings – A Disability Advocate's Resource for Hearings and Appeals 8

LAWYERS' PRINCIPLES OF PROFESSIONALISM

As a lawyer, I have dedicated myself to making our system of justice work fairly and efficiently for all. I am an officer of this Court and recognize the obligation I have to advance the rule of law and preserve and foster the integrity of the legal system. To this end, I commit myself not only to observe the Connecticut Rules of Professional Conduct, but also conduct myself in accordance with the following Principles of Professionalism when dealing with my clients, opposing parties, fellow counsel, self-represented parties, the Courts, and the general public.

Civility:

Civility and courtesy are the hallmarks of professionalism. As such,

- I will be courteous, polite, respectful, and civil, both in oral and in written communications;
- I will refrain from using litigation or any other legal procedure to harass an opposing party;
- I will not impute improper motives to my adversary unless clearly justified by the facts and essential to resolution of the issue;
- I will treat the representation of a client as the client's transaction or dispute and not as a dispute with my adversary;
- I will respond to all communications timely and respectfully and allow my adversary a reasonable time to respond;
- I will avoid making groundless objections in the discovery process and work cooperatively to resolve those that are asserted with merit;
- I will agree to reasonable requests for extensions of time and for waiver of procedural formalities when the legitimate interests of my client will not be adversely affected;
- I will try to consult with my adversary before scheduling depositions, meetings, or hearings, and I will cooperate with her when schedule changes are requested;
- When scheduled meetings, hearings, or depositions have to be canceled, I will notify my adversary and, if appropriate, the Court (or other tribunal) as early as possible and enlist their involvement in rescheduling; and
- I will not serve motions and pleadings at such time or in such manner as will unfairly limit the other party's opportunity to respond.

Honesty:

Honesty and truthfulness are critical to the integrity of the legal profession – they are core values that must be observed at all times and they go hand in hand with my fiduciary duty. As such,

- I will not knowingly make untrue statements of fact or of law to my client, adversary or the Court;
- I will honor my word;
- I will not maintain or assist in maintaining any cause of action or advancing any position that is false or unlawful;

- I will withdraw voluntarily claims, defenses, or arguments when it becomes apparent that they do not have merit or are superfluous;
- I will not file frivolous motions or advance frivolous positions;
- When engaged in a transaction, I will make sure all involved are aware of changes I make to documents and not conceal changes.

Competency:

Having the necessary ability, knowledge, and skill to effectively advise and advocate for a client's interests is critical to the lawyer's function in their community. As such,

- I will keep myself current in the areas in which I practice, and, will associate with, or refer my client to, counsel knowledgeable in another field of practice when necessary;
- I will maintain proficiency in those technological advances that are necessary for me to competently represent my clients.
- I will seek mentoring and guidance throughout my career in order to ensure that I act with diligence and competency.

Responsibility:

I recognize that my client's interests and the administration of justice in general are best served when I work responsibly, effectively, and cooperatively with those with whom I interact. As such,

- Before dates for hearings or trials are set, or if that is not feasible, immediately after such dates have been set, I will attempt to verify the availability of key participants and witnesses so that I can promptly notify the Court (or other tribunal) and my adversary of any likely problem;
- I will make every effort to agree with my adversary, as early as possible, on a voluntary exchange of information and on a plan for discovery;
- I will attempt to resolve, by agreement, my objections to matters contained in my opponent's pleadings and discovery requests;
- I will be punctual in attending Court hearings, conferences, meetings, and depositions;
- I will refrain from excessive and abusive discovery, and I will comply with all reasonable discovery requests;
- In civil matters, I will stipulate to facts as to which there is no genuine dispute;
- I will refrain from causing unreasonable delays;
- Where consistent with my client's interests, I will communicate with my adversary in an effort to avoid needless controversial litigation and to resolve litigation that has actually commenced;
- While I must consider my client's decision concerning the objectives of the representation, I nevertheless will counsel my client that a willingness to initiate or engage in settlement discussions is consistent with zealous and effective representation.

Mentoring:

I owe a duty to the legal profession to counsel less experienced lawyers on the practice of the law and these Principles, and to seek mentoring myself. As such:

- I will exemplify through my behavior and teach through my words the importance of collegiality and ethical and civil behavior;
- I will emphasize the importance of providing clients with a high standard of representation through competency and the exercise of sound judgment;
- I will stress the role of our profession as a public service, to building and fostering the rule of law;
- I will welcome requests for guidance and advice.

Honor:

I recognize the honor of the legal profession and will always act in a manner consistent with the respect, courtesy, and weight that it deserves. As such,

- I will be guided by what is best for my client and the interests of justice, not what advances my own financial interests;
- I will be a vigorous and zealous advocate on behalf of my client, but I recognize that, as an officer of the Court, excessive zeal may be detrimental to the interests of a properly functioning system of justice;
- I will remember that, in addition to commitment to my client's cause, my responsibilities as a lawyer include a devotion to the public good;
- I will, as a member of a self-regulating profession, report violations of the Rules of Professional Conduct as required by those rules;
- I will protect the image of the legal profession in my daily activities and in the ways I communicate with the public;
- I will be mindful that the law is a learned profession and that among its desirable goals are devotion to public service, improvement of administration of justice, and the contribution of uncompensated time and civic influence on behalf of those persons who cannot afford adequate legal assistance; and
- I will support and advocate for fair and equal treatment under the law for all persons, regardless of race, color, ancestry, sex, pregnancy, religion, national origin, ethnicity, disability, status as a veteran, age, gender identity, gender expression or marital status, sexual orientation, or creed and will always conduct myself in such a way as to promote equality and justice for all.

Nothing in these Principles shall supersede, supplement, or in any way amend the Rules of Professional Conduct, alter existing standards of conduct against which a lawyer's conduct might be judged, or become a basis for the imposition of any civil, criminal, or professional liability.

Social Security Rulings Update (EDL201118)

November 18, 2020
12:30 p.m. to 2:30 p.m.

Speakers

John P. Spilka, Connecticut Legal Services, New Britain
Russell D. Zimberlin, Zimberlin Law LLC, Manchester

Agenda

I. Rescinded or Superseded Rulings
II. Rulings Related to Specific Impairments
III. Rulings Related to Past Relevant Work and Other Work
IV. Rulings Related to Residual Functional Capacity
V. Rulings Related to the Sequential Evaluation
VI. Miscellaneous Rulings
VII. Rulings Related to Procedural Issues in Disability Claims
VIII. Children's Disability Rulings

Faculty Biographies

John P. Spilka has been a legal aid attorney since 1974 and practices out of the New Britain office of Connecticut Legal Services, Inc. He is employed as the Managing Attorney of the Disability Unit where he oversees the Social Security and SSI disability work for his program. His practice primarily focuses on representing disability claimants at administrative hearings and handling appeals at the Appeals Council and in Federal District Court. He has prepared resource materials and provided training on Social Security and SSI disability law for numerous CBA seminars. He is a graduate of Fairfield University and the University of Detroit, School of Law. He currently serves on the Executive Committee of the Disability Section of the CBA.

Russell Zimberlin is an attorney with Zimberlin Law LLC where he represents claimants in Veterans Disability, Connecticut State Employee Disability Retirement, Social Security Disability/SSI, and ERISA/Non-ERISA based Long-Term Disability Insurance plans. Mr. Zimberlin is admitted to practice in Connecticut and before United States District court for the District of Connecticut and the United States Court of Appeals for Veterans Claims.

He also practices before the Department of Veterans Affairs and the Social Security Administration. Mr. Zimberlin is a member of the Hartford County Bar Association, Connecticut Bar Association, Manchester Bar Association, and Tolland County Bar Association. He earned his B.S. degree from Temple University and his J.D. degree from New England Law. He currently serves as Chair for the Disability Section of the CBA.

CBA Training – November 18, 2020

SOCIAL SECURITY RULINGS – A DISABILITY ADVOCATE'S RESOURCE FOR HEARINGS AND APPEALS

Presented by: John P. Spilka, Esq., Connecticut Legal Services, Inc.
Russell Zimberlin, Esq., Zimberlin Law, LLC

With the precipitous decline in the favorable decision rate at the ALJ hearing level in recent years and the need to appeal more claims to the Appeals Council and District Court, it is important that SSI/SSDI advocates are familiar with the Commissioner's Social Security Rulings. These Rulings can help with the preparation of the legal strategy for a hearing. They can also provide the basis for legal arguments raised on appeal. The Social Security Administration at all levels of adjudication is bound to follow these Rulings.

"We publish Social Security Rulings in the Federal Register under the authority of the Social Security Commissioner. They are binding on all components of the Social Security Administration. These rulings represent precedent final opinions and orders and statements of policy and interpretations that we have adopted." 20 CFR 402.35(b) (1).

This seminar will include a discussion of some of the Rulings that can assist disability advocates in their representation of SSI/SSDI claimants. Court decisions specifically referencing the Rulings or addressing a topic in the Rulings are cited in this material. Some of the court decisions relate to a superseded Ruling but these decisions may have some value in analyzing the new Ruling. In addition, there are some practice tips included.

Please note that all of the Rulings referenced herein are not fully reproduced. You are encouraged to read the full Ruling to have the best understanding of the Commissioner's statements of policy and interpretations. The Commissioner has been very active rescinding or superseding Rulings in recent years. It would not be surprising if additional Rulings are rescinded or superseded.

TABLE OF CONTENTS

	Page
Rescinded or Superseded Rulings	3
Rulings Related to Specific Impairments	4, 6
Rulings Related to Past Relevant Work and Other Work	4, 36
Rulings Related to Residual Functional Capacity	5, 49
Rulings Related to the Sequential Evaluation	5, 55
Miscellaneous Rulings	5, 61
Rulings Related to Procedural Issues in Disability Claims	6, 87
Children's Disability Rulings	6, 90

Rescinded or Superseded Rulings

SSR 82-59 – Titles II and XVI: Failure to Follow Prescribed Treatment

This Ruling has been replaced by SSR 18-3p.

SSR 83-20 – Titles II and XVI: Onset of Disability

This Ruling has been replaced by SSR 18-1p.

SSR 87-6 – The Role of Prescribed Treatment in the Evaluation of Epilepsy

This Ruling was rescinded by Federal Register Notice Vol. 82, No. 41, page 12485, effective March 3, 2017. See the epilepsy Listings that were revised on September 29, 2016.

SSR 93-2p – Evaluation of Human Immunodeficiency Virus Syndrome

See: Listings 14.08, 114.08 in place of this Ruling.

SSR 96-2p – Giving Controlling Weight to Treating Source Medical Opinions

See: Fed. Reg. Vol. 82, p. 5845; see also 20 CFR 404.1527, 416.927 re law to be applied to applications filed prior to March 27, 2017 and 20 CFR 404.1520c, 416.920c re law to be applied to applications filed on or after March 27, 2017.

SSR 96-3p – Considering Allegations of Pain and Other Symptoms in Determining Whether a Medically Determinable Impairment Is Severe

This Ruling was rescinded effective June 14, 2018.

SSR 96-4p – Symptoms, Medically Determinable Physical and Mental Impairments, and Exertional and Nonexertional Limitations

This Ruling was rescinded effective June 14, 2018.

SSR 96-5p – Medical Source Opinions on Issues Reserved to the Commissioner

See: Fed. Reg. Vol. 82, p. 5845; 20 CFR 404.1520c, 416.920c and 20 CFR 404.1527, 416.927. This Ruling was rescinded effective March 27, 2017.

SSR 96-6p – Consideration Of Administrative Findings Of Fact By State Agency Medical And Psychological Consultants And Other Program Physician And Psychologists At The Administrative Law Judge And Appeals Council Levels Of Administrative Review; Medical Equivalence

See: Fed. Reg. Vol. 82, p. 5845; 20 CFR 404.1520c, 416.920c and 20 CFR 404.1527 416.927; see SSR 17-2p re medical equivalence. This Ruling was rescinded effective March 17, 2017.

SSR 96-7p – Evaluation of Symptoms in a Disability Claim: Assessing the Credibility of an Individual's Statements

This Ruling has been replaced by SSR 16-3p.

SSR 01-2p Obesity

This Ruling has been replaced by SSR 19-2p

SSR 06-3p – Considering Opinions and Other Evidence from Sources Who Are Not "Acceptable Medical Sources"; Considering Decisions On Disability By Other Governmental and Nongovernmental Agencies

This Ruling was rescinded effective March 27, 2017. See: 20 CFR 404.1527(f), 416.927(f) for disability applications filed prior to March 27, 2017.

Rulings Related To Specific Impairments **Page**

SSR 82-57 – Loss of Speech 6
SSR 03-1p – Post Polio Syndrome 6
SSR 03-2p – Reflex Sympathetic Dystrophy 6
SSR 06-1p – Tremolite Asbestos-Related Impairments 7
SSR 12-2p – Fibromyalgia 7
SSR 13-2p – Alcoholism and Drug Addiction 9
SSR 14-1p – Chronic Fatigue Syndrome 13
SSR 14-2p – Diabetes Mellitus 15
SSR 14-3p – Endocrine Disorders Other Than Diabetes 18
SSR 15-1p – Interstitial Cystitis 18
SSR 17-3p – Sickle Cell Anemia 19
SSR 19-2p – Obesity 25
SSR 19-4p – Primary Headache Disorders (Including Migraines) 29

Rulings Related To Past Relevant Work And Other Work

SSR 82-40 – Past Relevant Work in a Foreign Country 36
SSR 82-41 – Work Skills and Their Transferability 37
SSR 82-61 – Past Relevant Work as Actually or Generally Performed 38
SSR 82-62 – Capacity to Do Past Relevant Work 38
SSR 82-63 – Medical-Vocational Profiles Showing an Inability to Make Adjustment to Other Work 38
SSR 83-10 – Determining Capability to Do Other Work 39
SSR 83-11 – Capability to Do Other Work – The Exertionally Based Medical-Vocational Rules Met 42

Page

SSR 83-12 – Capability to Do Other Work – The Medical-Vocational Rules as a Framework for Evaluating Exertional Limitations within a Range of Work or Between Ranges of Work 42
SSR 83-14 – Capability to Do Other Work – The Medical-Vocational Rules as a Framework for Evaluating a Combination of Exertional and Nonexertional Impairments 43
SSR 85-15 – Capability to Do Other Work – The Medical-Vocational Rules as a Framework for Evaluating Solely Nonexertional Impairments 45
SSR 96-9p – RFC For Less Than Sedentary Work - See below under RFC 47
SSR 00-4p – Use of Vocational Expert and Vocational Specialist Evidence and Other Reliable Occupational Information in Disability Decisions 47
SSR 05-1c – Whether Past Relevant Work Must Exist in Substantial Numbers in the National Economy 48

Rulings Related To Residual Functional Capacity

SSR 85-15 – Capability to Do Other Work – The Medical-Vocational Rules as a Framework for Evaluating Solely Nonexertional Impairments 49
SSR 85-16 – Residual Functional Capacity for Mental Impairments 49
SSR 96-8p – Assessing Residual Functional Capacity 50
SSR 96-9p – Determining Capability to Do Other Work – Implications of a Residual Functional Capacity for Less Than a Full Range Of Sedentary Work 52

Rulings Related To The Sequential Evaluation

SSR 85-28 – Medical Impairments That Are Not Severe 55
SSR 16-3p – Evaluation of Symptoms in Disability Claims 55
SSR 17-2p – Evidence Needed by Adjudicators at the Hearings and Appeals Council Levels of the Administrative Review Process to Make Findings about Medical Equivalence 60

Miscellaneous Rulings

SSR 94-1c – Illegal Activity as Substantial Gainful Activity 61
SSR 11-2p – Documenting and Evaluating Disability in Young Adults 61
SSR 17-4p – Responsibility for Developing Written Evidence 64
SSR 18-1p – Determining Established Onset Date in Disability Claims 69
SSR 18-3p – Failure to Follow Prescribed Treatment 75
SSR 20-1p – How We Determine an Individual's Education Category 84

Rulings Related Procedural Issues In Disability Claims **Page**

SSR 91-5p – Mental Incapacity and Good Cause for Missing the Deadline to Request Review 87
SSR 11-1p – Procedures for Handling Requests to File Subsequent Applications for Disability Benefits 87
SSR 13-1p – Allegations of Unfairness, Prejudice, Partiality, Bias, Misconduct or Discrimination 88
SSR 13-3p – Appeal of an Initial Medical Disability Cessation Determination or Decision 89
SSR 17-1p – Reopening Based on Error on The Face of the Evidence 89
SSR 19-1p – Titles II and XVI: Effect of the Decision in Lucia v. Securities and Exchange Commission (SEC) on Cases Pending at the Appeals Council 89

Children's Disability Rulings

SSR 98-1p – Determining Medical Equivalence in Childhood Disability Claims When a Child Has Marked Limitations in Cognition and Speech 90
SSR 09-1p – Determining Childhood Disability under the Functional Equivalence Rule – The "Whole Child" Approach 90
SSR 09-2p – Documenting a Child's Impairment Related Limitations 91
SSR 09-3p – Acquiring and Using Information 92
SSR 09-4p – Attending and Completing Tasks 92
SSR 09-5p – Interacting and Relating with Others 93
SSR 09-6p – Moving About and Manipulating Objects 93
SSR 09-7p – Caring for Yourself 93
SSR 09-8p – Health and Physical Well-Being 94

Rulings Related To Specific Impairments

SSR 82-57 – Loss of Speech

Ordinarily, when an individual's impairment prevents effective speech, the loss of function is sufficiently severe so that an allowance under Listing 2.09 is justified on the basis of medical considerations alone, unless such a finding is rebutted by work activity. To speak effectively, an individual must be able to produce speech that can be heard, understood, and sustained well enough to permit useful communication in social and vocational settings. These criteria are applicable to the production of speech whether by natural function of the voice mechanism or by the use of a prosthetic device.

SSR 03-1p – Post Polio Syndrome

Comment: This ruling will not have much application with the passage of time because fewer people contracted polio after the 1950s.

SSR 03-2p – Reflex Sympathetic Dystrophy/Complex Regional Pain Syndrome

RSDS/CRPS are terms used to describe a constellation of symptoms and signs that may occur following an injury to bone or soft tissue. The precipitating injury may be so minor that the individual does not even recall sustaining an injury. Other potential precipitants suggested by the medical literature include, but are not limited to, surgical procedures, drug exposure, stroke with hemiplegia, and cervical spondylosis.

RSDS/CRPS is a chronic pain syndrome most often resulting from trauma to a single extremity. It can also result from diseases, surgery, or injury affecting other parts of the body. Even a minor injury can trigger RSDS/CRPS. The most common acute clinical manifestations include complaints of intense pain and findings indicative of autonomic dysfunction at the site of the precipitating trauma. Later, spontaneously occurring pain may be associated with abnormalities in the affected region involving the skin, subcutaneous tissue, and bone. It is characteristic of this syndrome that the degree of pain reported is out of proportion to the severity of the injury sustained by the individual. When left untreated, the signs and symptoms of the disorder may worsen over time.

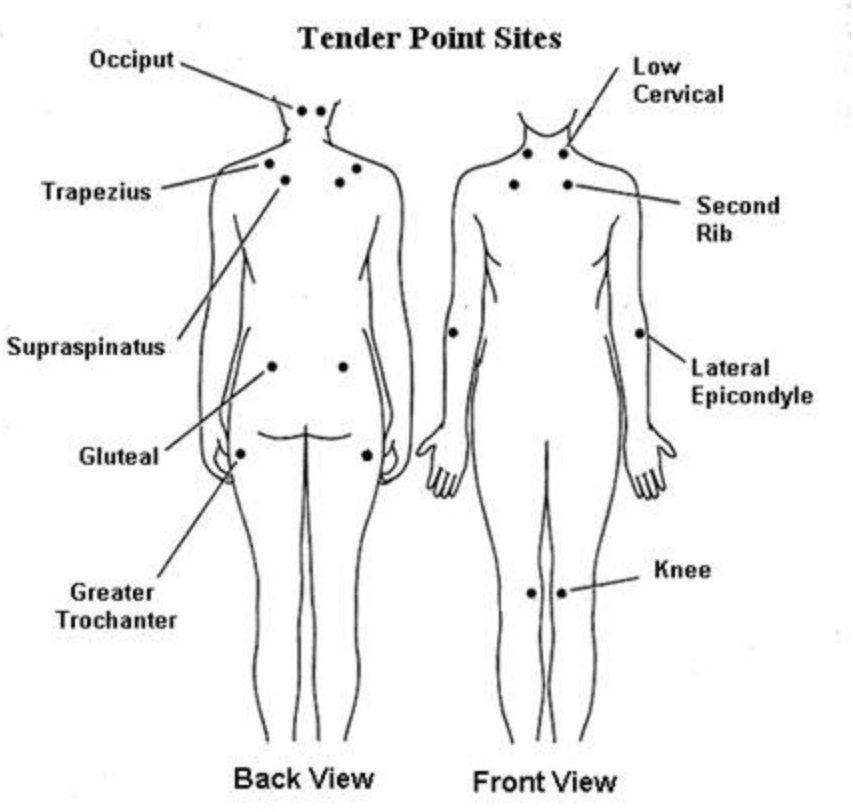
Blodgett v. Comm'r of SSA, 3:16-cv-2110, (D. Conn. Jan. 24, 2018) (JAM) (unreported decision).This case was remanded because, *inter alia*, the ALJ failed to consider SSR 03-2p in light of the claimant's pain.

Pensiero v. Saul, 2019 WL 6271265 (D.Conn. Nov. 25, 2019) (WIG). The court remanded this case because the ALJ failed to evaluate the claimant's pain under SSR 03-2p.

SSR 06-1p – Tremolite Asbestos-Related Impairments

This Ruling explains how tremolite asbestos-related impairments are evaluated under the sequential evaluation process.

SSR 12-2p – Fibromyalgia



Generally, a person can establish that he or she has an MDI of FM by providing evidence from an acceptable medical source.[3] A licensed physician (a medical or osteopathic doctor) is the only acceptable medical source who can provide such evidence. We cannot rely upon the physician's diagnosis alone. The evidence must document that the physician reviewed the person's medical history and conducted a physical exam. We will review the physician's treatment notes to see if they are consistent with the diagnosis of FM, determine whether the person's symptoms have improved, worsened, or remained stable over time, and establish the physician's assessment over time of the person's physical strength and functional abilities.

Two ways in which to document fibromyalgia include:

The 1990 ACR Criteria for the Classification of Fibromyalgia. Based on these criteria, we may find that a person has an MDI of FM if he or she has all three of the following:

1. A history of widespread pain—that is, pain in all quadrants of the body (the right and left sides of the body, both above and below the waist) and axial skeletal pain (the cervical spine, anterior chest, thoracic spine, or low back)—that has persisted (or that persisted) for at least 3 months. The pain may fluctuate in intensity and may not always be present.
2. At least 11 positive tender points on physical examination (see diagram below). The positive tender points must be found bilaterally (on the left and right sides of the body) and both above and below the waist.

a. The 18 tender point sites are located on each side of the body at the:

- Occiput (base of the skull);
- Low cervical spine (back and side of the neck); Trapezius muscle (shoulder);
- Supraspinatus muscle (near the shoulder blade); Second rib (top of the rib cage near the sternum or breast bone);
- Lateral epicondyle (outer aspect of the elbow);
- Gluteal (top of the buttock);
- Greater trochanter (below the hip); and
- Inner aspect of the knee.

b. In testing the tender-point sites,[6] the physician should perform digital palpation with an approximate force of 9 pounds (approximately the amount of pressure needed to blanch the thumbnail of the examiner). The physician considers a tender point to be positive if the person experiences any pain when applying this amount of pressure to the site.

3. Evidence that other disorders that could cause the symptoms or signs were excluded. Other physical and mental disorders may have symptoms or signs that are the same or similar to those resulting from FM.[7] Therefore, it is common in cases involving FM to find evidence of examinations and testing that rule out other disorders that could account for the person's symptoms and signs. Laboratory testing may include imaging and other laboratory tests (for example, complete blood counts, erythrocyte sedimentation rate, anti-nuclear antibody, thyroid function, and rheumatoid factor).

The 2010 ACR Preliminary Diagnostic Criteria. Based on these criteria, we may find that a person has an MDI of FM if he or she has all three of the following criteria[8]:

1. A history of widespread pain (see section II.A.1.);
2. Repeated manifestations of six or more FM symptoms, signs,[9] or co-occurring conditions,[10] especially manifestations of fatigue, cognitive or memory problems (“fibro fog”), waking unrefreshed,[11] depression, anxiety disorder, or irritable bowel syndrome; and
3. Evidence that other disorders that could cause these repeated manifestations of symptoms, signs, or co-occurring conditions were excluded (see section II.A.3.).

Footnote 9: Symptoms and signs that may be considered include the "(s)omatic symptoms" referred to in Table No. 4, "Fibromyalgia diagnostic criteria," in the 2010 ACR Preliminary Diagnostic Criteria. We consider some of the "somatic symptoms" listed in Table No. 4 to be "signs" under 20 C.F.R. 404.1528(b) and 416.928(b). These "somatic symptoms" include muscle pain, irritable bowel syndrome, fatigue or tiredness, thinking or remembering problems, muscle weakness, headache, pain or cramps in the abdomen, numbness or tingling, dizziness, insomnia, depression, constipation, pain in the upper abdomen, nausea, nervousness, chest pain, blurred vision, fever, diarrhea, dry mouth, itching, wheezing, Raynaud's phenomenon, hives or welts, ringing in the ears, vomiting, heartburn, oral ulcers, loss of taste, change in taste, seizures, dry eyes, shortness of breath, loss of appetite, rash, sun sensitivity, hearing difficulties, easy bruising, hair loss, frequent urination, or bladder spasms.

Footnote 10: Some co-occurring conditions that may be considered are referred to in Table No. 4, "Fibromyalgia diagnostic criteria," in the 2010 ACR Preliminary Diagnostic Criteria as "somatic symptoms," such as irritable bowel syndrome or depression. Other co-occurring conditions, which are not listed in Table No. 4, may also be considered, such as anxiety disorder, chronic fatigue syndrome, irritable bladder syndrome, interstitial cystitis, temporomandibular joint disorder, gastroesophageal reflux disorder, migraine, or restless leg syndrome.

Green-Younger v. Barnhart, 335 F.3d 99 (2d Cir. 2003). The seminal fibromyalgia case in the Circuit.

Crossman v. Astrue, 783 F. Supp. 2d 300 (D.Conn. 2010) (MRK). This case relies upon Green-Younger v. Barnhart, 335 F.3d 99 (2d Cir. 2003) to reject the ALJ's analysis of the claimant's fibromyalgia.

D'Auria v. Saul, 3:19-cv-108 (D.Conn. Jan. 23, 2020) (SALM) (unreported). The ALJ erred in failing to recognize the waxing and waning nature of FMS as set forth in SSR 12-2p.

Daniel E., Jr. v. Saul, (D.Md. Apr. 6, 2020), 2020 WL 1675960.

Sherteeke'o B. V. Saul, (D.Md. Mar. 26, 2020), 2020 WL 1491350.

DeCepeda v. Berryhill, (D.Mass. Aug. 6, 2018), 2018 WL 3748170. The court noted that there are two sets of criteria for making a fibromyalgia diagnoses under SSR 12-2p.

Practice Tip: Since a characteristic of FMS is that the symptoms can wax and wane, it is important to ask the claimant if they have good days and bad days, the frequency of these days, and how a good and bad day is described with regard to symptoms and functional activity.

SSR 13-2p – Alcoholism and Drug Addiction

Selected excerpts from the ruling:

- Sections 223(d)(2)(C) and 1614(a)(3)(J) of the Social Security Act (Act) provide that a claimant "shall not be considered to be disabled * * * if alcoholism or drug addiction would * * * be a contributing factor material to the Commissioner's determination that the individual is disabled."

- All adjudicators must provide sufficient information in their determination or decision that explains the rationale supporting their determination of the materiality of DAA so that a subsequent reviewer considering all of the evidence in the case record is able to understand the basis for the materiality finding and the determination of whether the claimant is disabled.

- Although the terms "drug addiction" and "alcoholism" are medically outdated, we continue to use the terms because they are used in the Act.

- With one exception—nicotine use disorders—we define the term *DAA* as *Substance Use Disorders*; that is, *Substance Dependence* or *Substance Abuse* as defined in the latest edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) published by the American Psychiatric Association.

- *Substance Use Disorders* are diagnosed in part by the presence of maladaptive use of alcohol, illegal drugs, prescription medications, and toxic substances (such as inhalants).

- The key factor we will examine in determining whether drug addiction or alcoholism is a contributing factor material to the determination of disability is whether we would still find a claimant disabled if he or she stopped using drugs or alcohol.

a. *DAA* is not *material* to the determination that the claimant is under a disability if the claimant *would still meet our definition of disability*[7] if he or she were not using drugs or alcohol. If *DAA* is not *material*, we find that the claimant is disabled.[8]

b. *DAA* is *material* to the determination of disability if the claimant *would not meet our definition of disability* if he or she were not using drugs or alcohol. If *DAA* is *material*, we find that the claimant is not disabled.

- *Burden of Proof*. The claimant has the burden of proving disability throughout the sequential evaluation process. Our only burden is limited to producing evidence that work the claimant can do exists in the national economy at step 5 of the sequential evaluation process.

- DAA Evaluation Process:

1. Does the claimant have *DAA*?	a. No–No *DAA* materiality determination necessary. b. Yes–Go to step 2.
2. Is the claimant disabled considering all impairments, including *DAA*?	a. No–Do not determine *DAA* materiality. (Denial.) b. Yes–Go to step 3.
3. Is *DAA* the only impairment?	a. Yes–*DAA* material. (Denial.) b. No–Go to step 4.
4. Is the other impairment(s) disabling by itself while the claimant is dependent upon or abusing drugs or alcohol?	a. No–*DAA* material. (Denial.) b. Yes–Go to step 5.
5. Does the *DAA* cause or affect the claimant's medically determinable impairment(s)?	a. No–*DAA* not material. (Allowance.) b. Yes, but the other impairment(s) is irreversible or could not improve to the point of nondisability–*DAA* not material. (Allowance.) c. Yes, and *DAA* could be material–Go to step 6.
	a. Yes–*DAA* material. (Denial.) b. No–*DAA* not material (Allowance.)

- If the claimant has another physical or mental impairment(s) that results in disability[16] and *DAA* is not causing or does not affect the other impairment(s) to the point where the other impairment(s) could be found nondisabling in the absence of *DAA*, *DAA* is not material to the determination of disability. The claim should be allowed. There are three basic scenarios:

- The claimant has a disabling impairment independent of DAA; for example, a degenerative neurological disease, a hereditary kidney disease that requires chronic dialysis, or intellectual disability (mental retardation) since birth. See 20 CFR 404.1535(b)(2)(ii) and 416.935(b)(2)(ii).
- The claimant *acquired a separate disabling impairment(s) while using* a substance(s). One example is the claimant has quadriplegia because of an accident while driving under the influence of alcohol. A second

example is the claimant acquired listing-level human immunodeficiency virus (HIV) infection from sharing a needle for intravenous drug use. In each example, the claimant acquired the impairment because of an activity related to substance use, but the *Substance Use Disorder* did not medically cause or exacerbate the impairment.

- The claimant's *DAA medically caused* the other disabling impairment(s) *but the other impairment(s) is irreversible or could not improve to the point of nondisability* in the absence of *DAA*. Examples of such impairments could include peripheral neuropathy, permanent encephalopathy, cirrhosis of the liver, Substance-Induced Persisting Dementia, and Substance-Induced Persisting Amnestic Disorder that result from long-term alcohol or drug use.

- As in any determination regarding materiality, adjudicators must apply the sequential evaluation process twice even when the other impairment(s) is irreversible or could not improve to the point of nondisability.

- *DAA* is material if the claimant's other impairment(s) would improve to the point that the claimant would not be disabled in the absence of *DAA*. On these findings, we deny the claim. However, if the claimant's other impairment(s) would not improve to the point that the claimant would not be disabled in the absence of *DAA*, we allow the claim. In this instance, the DAA is not material to the determination of disability.

- Usually, evidence from a period of abstinence[17] is the best evidence for determining whether a physical impairment(s) would improve to the point of nondisability. The period of abstinence should be relevant to the period we are considering in connection with the disability claim.[18] This evidence need not always come from an acceptable medical source. If we are evaluating whether a claimant's work-related functioning would improve, we may rely on evidence from “other” medical sources, such as nurse practitioners, and other sources, such as family members, who are familiar with how the claimant has functioned during a period of abstinence.

- Some claimants who have been diagnosed with a Substance Use Disorder do not have a period of abstinence. If a claimant does not have a period of abstinence, an acceptable medical source can provide a medical opinion regarding whether the claimant's impairments would be severely limiting even if the claimant stopped abusing drugs or alcohol. We consider the opinion of an acceptable medical source sufficient evidence regarding materiality as long as the acceptable medical source provides support for their opinion. The determination or decision must include information supporting the finding.

- We will not continue to develop evidence of *DAA* if the claimant is disabled by another impairment(s) and *DAA could not be material* to the determination of disability. For example, if the claimant has a disabling impairment(s) that is unrelated to, and not exacerbated by *DAA*, or that is irreversible, we would find that *DAA* is not material to the determination of disability even if we completed the development.

- Many claimants with *Substance Use Disorders* receive care from “other” non-medical and medical sources that are not acceptable medical sources. Evidence from these sources can be helpful to the adjudicator in determining the severity of DAA and whether DAA is material to the finding of disability.[23] Examples of “other” nonmedical sources include, but are not limited to: Non-clinical social workers, caseworkers, vocational rehabilitation specialists, family members, school personnel, clergy, friends, licensed chemical dependency practitioners, and the claimant. Examples of “other” medical sources include but are not limited to: nurse practitioners, physicians' assistants and therapists.

How do we consider periods of abstinence?

a. Each substance of abuse, including alcohol, has different intoxication and long-term physiologic effects. In addition, there is a wide variation in the duration and intensity of substance use among claimants with *DAA*, and there are wide variations in the interactions of *DAA* with different types of physical and mental disorders. For these reasons, we are unable to provide exact guidance on the length and number of periods of abstinence to demonstrate

whether *DAA* is material in every case. In some cases, the acute and toxic effects of substance use or abuse may subside in a matter of weeks, while in others it may take months or even longer to subside. For some claimants, we will be able to make a judgment about *materiality* based on evidence from a single, continuous period of abstinence, while in others we may need to consider more than one period.[26]

b. In all cases in which we must consider periods of abstinence, the claimant should be abstinent long enough to allow the acute effects of drug or alcohol use to abate. Especially in cases involving co-occurring mental disorders, the documentation of a period of abstinence should provide information about what, if any, medical findings and impairment-related limitations remained after the acute effects of drug and alcohol use abated. Adjudicators may draw inferences from such information based on the length of the period(s), how recently the period(s) occurred, and whether the severity of the co-occurring impairment(s) increased after the period(s) of abstinence ended. To find that *DAA* is *material*, we must have evidence in the case record demonstrating that any remaining limitations were not disabling during the period.[27]

In the sections that follow, we provide more detail about these general principles.

c. In addition to the length of the period, we must consider when the period of abstinence occurred.

d. We may also consider the circumstances under which a period(s) of abstinence takes place, especially in the case of a claimant with a co-occurring mental disorder(s).

i. Improvement in a co-occurring mental disorder in a highly structured treatment setting, such as a hospital or substance abuse rehabilitation center, may be due at least in part to treatment for the co-occurring mental disorder, not (or not entirely) the cessation of substance use. We may find that *DAA* is not material depending on the extent to which the treatment for the co-occurring mental disorder improves the claimant's signs and symptoms. If the evidence in the case record does not demonstrate the separate effects of the treatment for *DAA* and for the co-occurring mental disorder(s), we will find that *DAA* is not material, as we explain in Question 7.[28]

ii. A co-occurring mental disorder may appear to improve because of the structure and support provided in a highly structured treatment setting. As for any mental disorder, we may find that a claimant's co-occurring mental disorder(s) is still disabling even if increased support or a highly structured setting reduce the overt symptoms and signs of the disorder.[29]

iii. Given the foregoing principles, a single hospitalization or other inpatient intervention is not sufficient to establish that *DAA* is material when there is evidence that a claimant has a disabling co-occurring mental disorder(s). We need evidence from outside of such highly structured treatment settings demonstrating that the claimant's co- his DAA case remanded hospitalizations, emergency department visits, or other treatment for the co-occurring mental disorder—with or without treatment for *DAA*—is an indication that *DAA* may not be material even if the claimant is discharged in improved condition after each intervention.

Ostrowski v. Barnhart, 2003 WL 22439585, *3 (D.Conn. Oct. 10, 2003) (TPS). The court stated the mere fact that claimant chose to treat one of two ailments first (substance abuse) did not imply the other (major depressive disorder, etc.) was less severe.

LaVallee v. Astrue, 759 F. Supp. 2d 238 (D.Conn. 2011) (TPS). “Alcoholism is not a character defect, nor is it a persuasive indicium of incredibility. For many poor people, like the plaintiff, who is homeless and afflicted with multiple severe and painful impairments, alcohol is the only available analgesic that is cheap and easily accessible. This is not good, but it is sometimes the only way the down-and-out can cope.”

Cage v. Commissioner, 692 F.3d 118 (2d Cir. 2012). The court ruled the claimant has the burden of proving immateriality of her drug and alcohol addiction.

Wehrhahn v. Colvin, 111 F.Supp.3d (D.Conn. 2015). The court deferred to the Cage decision rather than remand under SSR 13-2p.

Watson v. Saul, 2020 WL 5700454 (D.Conn. Sept. 24, 2020) (RMS). The court remanded because the ALJ erred in making serious misstatements of the record and in not properly applying the treating physician ruling in assessing whether DAA was a contributing factor to the disability.

Polanco v. Berryhill, 2019 WL 2183121 (D.Conn. May 21, 2019) (JAM). The court stated that, even though the DSM says that the criteria for the diagnosis of schizophrenia requires that it not be due to the direct psychological effects of a substance, it ruled, "[T]here is no merit to or support for Polanco's argument that the Social Security Act precludes the consideration of drug and alcohol use for claimants who suffer from schizophrenia."

Comment: The impact of substance abuse on a disability claim varies with the ALJ.

SSR 14-1p – Chronic Fatigue Syndrome

CFS is a systemic disorder consisting of a complex of symptoms that may vary in frequency, duration, and severity.

The CDC and other medical experts characterize CFS, in part, as a syndrome that causes prolonged fatigue lasting 6 months or more, resulting in a substantial reduction in previous levels of occupational, educational, social, or personal activities.

A. *General*. Under the CDC case definition, the hallmark of CFS is the presence of clinically evaluated, persistent or relapsing chronic fatigue that:
    1. Is of new or definite onset (that is, has not been lifelong);
    2. Cannot be explained by another physical or mental disorder;
    3. Is not the result of ongoing exertion;
    4. Is not substantially alleviated by rest; and
    5. Results in substantial reduction in previous levels of occupational, educational, social, or personal activities.
B. *Additional indications of CFS*. CFS results in additional symptoms, some more common than others.
    1. *Diagnostic Symptoms*. The CDC case definition requires the concurrence of 4 or more specific symptoms that persisted or recurred during 6 or more consecutive months of illness and did not pre-date the fatigue:
        - Postexertional malaise lasting more than 24 hours (which may be the most common secondary symptom);
        - Self-reported impairment(s) in short-term memory or concentration severe enough to cause substantial reduction in previous levels of occupational, educational, social, or personal activities;[14]
        - Sore throat;
        - Tender cervical or axillary lymph nodes;
        - Muscle pain;
        - Multi-joint pain without joint swelling or redness;
        - Headaches of a new type, pattern, or severity; and
        - Waking unrefreshed.[15]
    2. *Other Symptoms*. Within these parameters, the CDC case definition, CCC, and ICC describe a wide range of other symptoms a person with CFS may exhibit:[16]
        - Muscle weakness;
        - Disturbed sleep patterns (for example, insomnia, prolonged sleeping, frequent awakenings, or vivid dreams or nightmares);
        - Visual difficulties (for example, trouble focusing, impaired depth perception, severe photosensitivity, or eye pain);

- Orthostatic intolerance (for example, lightheadedness, fainting, dizziness, or increased fatigue with prolonged standing);
- Respiratory difficulties (for example, labored breathing or sudden breathlessness);
- Cardiovascular abnormalities (for example, palpitations with or without cardiac arrhythmias);
- Gastrointestinal discomfort (for example, nausea, bloating, or abdominal pain); and
- Urinary or bladder problems (for example, urinary frequency, nocturia, dysuria, or pain in the bladder region).

3. *Co-occurring Conditions*. People with CFS may have co-occurring conditions, such as fibromyalgia (FM),[17] myofascial pain syndrome, temporomandibular joint syndrome, irritable bowel syndrome, interstitial cystitis,[18] Raynaud's phenomenon, migraines, chronic lymphocytic thyroiditis, or Sjogren's syndrome. Co-occurring conditions may also include new allergies or sensitivities to foods, odors, chemicals, medications, noise, vibrations, or touch, or the loss of thermostatic stability (for example, chills, night sweats, or intolerance of extreme temperatures).

A. *Medical signs*. For the purposes of Social Security disability evaluation, one or more of the following medical signs clinically documented over a period of at least 6 consecutive months help establish the existence of an MDI of CFS:

- Palpably swollen or tender lymph nodes on physical examination;
- Nonexudative pharyngitis;
- Persistent, reproducible muscle tenderness on repeated examinations, including the presence of positive tender points;[21] or
- Any other medical signs that are consistent with medically accepted clinical practice and are consistent with the other evidence in the case record. For example, the CCC and ICC explain that an acute infectious inflammatory event may precede the onset of CFS, and that other medical signs may be present, including the following:
    - Frequent viral infections with prolonged recovery;
    - Sinusitis;
    - Ataxia;
    - Extreme pallor; and
    - Pronounced weight change.

B. *Laboratory findings*. At this time, we cannot identify specific laboratory findings that are widely accepted as being associated with CFS. However, the absence of a definitive test does not preclude our reliance upon certain laboratory findings to establish the existence of an MDI in people with CFS. While standard laboratory test results in the normal range are characteristic for many people with CFS, and they should not be relied upon to the exclusion of all other clinical evidence in decisions regarding the presence and severity of an MDI, the following laboratory findings establish the existence of an MDI in people with CFS:

- An elevated antibody titer to Epstein-Barr virus (EBV) capsid antigen equal to or greater than 1:5120, or early antigen equal to or greater than 1:640;
- An abnormal magnetic resonance imaging (MRI) brain scan;
- Neurally mediated hypotension as shown by tilt table testing or another clinically accepted form of testing; or
- Any other laboratory findings that are consistent with medically accepted clinical practice and are consistent with the other evidence in the case record (for example, an abnormal exercise stress test or abnormal sleep studies, appropriately evaluated and consistent with the other evidence in the case record).

Mental limitations. Some people with CFS report ongoing problems with short-term memory, information processing, visual-spatial difficulties, comprehension, concentration, speech, word-finding, calculation, and other symptoms suggesting persistent neurocognitive impairment. When ongoing deficits in these areas have been documented by mental status examination or psychological testing, such findings may constitute medical signs or (in the case of psychological testing) laboratory findings that establish the presence of an MDI.[22] When medical signs or laboratory findings suggest a persistent neurological impairment or other mental problems, and these signs or findings are appropriately documented in the medical record, we may find that the person has an MDI.

SSR 14-2p – Diabetes Mellitus

Note: The Listing for diabetes was rescinded in 2011.This ruling references other Listings that may be impacted by an individual's diabetes.

A. *General*

DM is a chronic condition characterized by high blood glucose levels that result from the body's inability to produce or use insulin. Insulin is a hormone that regulates blood glucose. When the body cannot make enough insulin, a person takes it by injection or through the use of an insulin pump. Although DM usually requires lifelong treatment, medical advances in the diagnosis and treatment of DM have resulted in better management of DM in adults and children.

B. *Two Major Types of DM and Their Treatments*

C.

1. *Type 1 DM*. In Type 1 DM, previously known as juvenile-onset DM or insulin-dependent DM, the pancreas does not produce insulin due to an autoimmune destruction of the insulin-producing cells. This results in increased blood glucose levels. The onset of Type 1 DM usually has the following symptoms: polydipsia (increased thirst); polyphagia (increased appetite); polyuria (increased urination); unexplained weight loss; fatigue or drowsiness; and blurred vision.

   Type 1 DM develops most often in children but can occur at any age. People with Type 1 DM must take daily insulin to live. They generally check their blood glucose levels prior to each meal and at bedtime; however, more frequent checking may be necessary as prescribed by a physician (for example, DM management of young school-aged children may require more frequent blood glucose level checks). Many children with Type 1 DM experience significant day-to-day variability in their DM, usually due to variations in activity. Depending on the child's age, this may necessitate daily, or even hourly, decision-making and intervention either by an adult or under the close supervision of an adult.

   For each insulin dose, the decision regarding the amount and type of insulin the person needs is based on: current blood glucose level (high, normal, or low); knowledge of the timing and type(s) of insulin the person had earlier in the day; the amount of food the person expects to consume; and the nature of activities the person planned for the next several hours. The total insulin administered each day may consist of various combinations of rapid-acting, short- acting, intermediate-acting, and long-acting insulin.

2. *Type 2 DM*. In Type 2 DM, previously known as adult-onset DM or non-insulin-dependent DM, the pancreas does not produce enough insulin, or there is failure in the transfer of insulin into the body cells (insulin resistance). People with Type 2 DM have symptoms similar to those of Type 1 DM, but the symptoms are usually not as obvious. Other symptoms include cuts or bruises that are slow to heal, numbness in the hands and feet, or recurrent infections of the skin, gums, or bladder.

   Type 2 DM is more common in people with obesity and those who have a family history of DM. The first line of treatment is management of DM through diet and exercise. Oral medication

or daily insulin is usually required when the weight loss and diet alone fail to manage blood glucose levels.

D. *Hyperglycemia*

Hyperglycemia (high blood glucose) means a person does not have enough insulin in his or her body. It can occur when a person does not take his or her insulin, eats too much, or does not exercise enough. It can also occur when a person is sick or is under stress. Symptoms of hyperglycemia include frequent urination, increased thirst, blurred vision, headaches, difficulty concentrating, abdominal pain or nausea, and "fruity-smelling" breath.

1. *Chronic hyperglycemia* leads to DM complications such as diabetic retinopathy, cardiovascular disease, diabetic nephropathy, and diabetic neuropathy. These complications occur more often in adults than in children because body system and organ changes due to DM develop over time.
2. *Diabetic ketoacidosis (DKA)* is an acute complication of hyperglycemia and is potentially life-threatening. It is not uncommon for people with Type 1 DM to initially present with DKA. DKA occurs when there is a shortage of insulin, resulting in toxicity in the blood. DKA may result in dehydration and an altered metabolic state with potential neurological, renal, respiratory, or cardiac dysfunction(s). When not appropriately treated, DKA may lead to chronic neurocognitive changes, coma, or even death.

E. *Chronic DM Complications*

1. *Diabetic retinopathy*, caused by damage to the small blood vessels in the retina, can result in leakage of blood into the eye and growth of abnormal new blood vessels, leading to vision loss over time. Symptoms may include pain or increased eye pressure. Nonproliferative retinopathy is an early stage of diabetic retinopathy. Although damage to the eyes from diabetic retinopathy may be permanent, some types of treatment, such as laser surgery, may alter the progression of the retinal changes. Diabetic retinopathy is a specific vascular complication of DM that may develop over time. Glaucoma, cataracts, and other disorders of the eye occur earlier and more frequently in people with DM. See 2.00 and 102.00 in the listings for guidance on evaluating vision loss.
2. *Cardiovascular disease (CVD)* affects the heart and blood vessels and is more common in people with DM than in people without DM. CVD is a major cause of morbidity and mortality for individuals with DM. People with DM, especially Type 2, have abnormal blood cholesterol and fat levels, which accelerates the development of CVD such as coronary artery disease or peripheral arterial disease (PAD). Amputation and foot ulceration are common consequences of PAD. See 4.00 and 104.00 in the listings for guidance on evaluating CVD.
3. *Diabetic nephropathy* is damage to the kidneys caused by chronic hyperglycemia. When the kidneys are damaged, protein leaks out of the kidneys into the urine. Damaged kidneys can no longer remove waste and extra fluids from the bloodstream. Diabetic nephropathy is a leading cause of end-stage renal disease. Careful management of blood glucose levels, together with the reduction of a co-morbid condition such as high blood pressure, may slow the damage. See 6.00 and 106.00 in the listings for guidance on evaluating genitourinary impairments.
4. *Diabetic neuropathy* is permanent nerve damage. The most common types of diabetic neuropathy are peripheral and autonomic. It can affect every organ system in the body and produce abnormal function or a loss of sensation in the affected nerve area distribution. See 11.00 and 111.00 in the listings for guidance on evaluating neurological impairments.
    a. *Peripheral neuropathy* (also known as sensorimotor neuropathy), nerve damage that affects the feet, legs, or hands, can cause pain, numbness, and tingling in toes, feet, legs, hands, and arms, which may subsequently cause difficulty walking and holding onto objects. A loss of sensation, combined with poor blood circulation, makes it common for a person with DM and neuropathy to be unaware of an injury to a lower extremity, where cuts or blisters can turn into ulcerations. The ulcerations may become infected and have difficulty healing. Complications of these ulcerations can include ***cellulitis*** (a painful inflammation of the skin and tissues, usually from an infection), ***gangrene*** (decomposing

soft tissue that often results in amputation), and *sepsis* (an infection that spreads through the blood stream, potentially causing shock, widespread organ failure, or death).

b. *Autonomic neuropathy*, nerve damage that affects the heart and blood vessels, digestive system, and urinary tract, can cause dizziness, fainting, nausea, vomiting, and infrequent or frequent urination. It can also cause hypoglycemia unawareness due to nerve dysfunction that affects the body's ability to secrete epinephrine (the hormone adrenaline). Autonomic neuropathy is strongly associated with CVD in people with DM.

F. *Hypoglycemia*

Hypoglycemia (low blood glucose) means that a person has abnormally low levels of blood glucose (also known as "insulin reaction"). It causes acute symptoms and signs, such as weakness, hunger, sweating, trembling, nervousness, palpitations, and difficulty with concentration. In young children, other symptoms may include inattention, fainting, falling asleep at inappropriate times, unexplained behavior, and temper tantrums. Hypoglycemia can occur when a person takes too much insulin (or a drug that increases insulin resistance), misses a meal, or exercises more than usual. It can also occur when a person takes medications for other health conditions. Episodes of hypoglycemia occur commonly in people with Type 1 DM and occur in some people with Type 2 DM. Episodes of hypoglycemia can occur during sleep or while a person is awake. During sleep, a person is unaware of hypoglycemia, but on awaking may be confused, disoriented, or may complain of a headache or extreme fatigue. Family members or observers may note that the person during sleep is restless, sweating, or even having seizure-like movements. The only sure way to assess for hypoglycemia is to check blood glucose levels while the person is sleeping. This checking does not prevent hypoglycemia; rather, it identifies the acute need to increase blood glucose levels by consuming something like orange juice.

If not treated promptly, hypoglycemia can become severe, causing an inadequate supply of glucose to brain cells, which can lead to complications including seizures or loss of consciousness, altered mental status, cognitive deficits, permanent brain damage, or death. Complications of hypoglycemia occur more frequently in young children because they are not able to recognize and respond to symptoms of hypoglycemia, and they depend on an adult to check their blood glucose levels. Because children's bodies are growing and developing, they are more sensitive to fluctuations in blood glucose levels brought on by eating, physical activity, and illness.

Daily insulin doses are based on a person's anticipated food intake and physical activity. Proper dosing of insulin requires complex decisionmaking 24 hours a day. For children, it may be difficult to predict daily insulin doses. If an adult administers insulin to a child based on the expectation that the child will consume a certain amount of food and engage in certain activities, but the child does not eat or exercise as expected, the amount of administered insulin may exceed the child's needs and lead to hypoglycemia. Additionally, during episodes of illness, a child's need for insulin will most likely change from his or her customary need.

Hypoglycemia unawareness means a person with DM either cannot recognize or does not experience the symptoms of hypoglycemia. It generally occurs in people who have had DM for a long time and experienced many episodes of hypoglycemia. Hypoglycemia unawareness interferes with a person's ability to control blood glucose levels and puts a person at risk for severe hypoglycemia-related complications. It can result in prolonged hypoglycemia if not treated immediately, resulting in seizure, loss of consciousness, or brain damage.

G. *DM and Obesity*

Obesity is a complex, chronic disease characterized by excessive accumulation of body fat. It may increase the severity of coexisting or related impairments to the extent that the combination of impairments meets or medically equals the criteria of a listing. Therefore, a person with DM and obesity may have more severe complications than the effects of each of the impairments considered separately.[4] For example, in adults, neurovascular complications of DM may result in an amputation of a lower extremity. The neurovascular impairment, along with obesity, may make successful rehabilitation with prosthesis more

difficult. Although neurovascular complications are rare in children, obesity increases the likelihood of developing these complications.

RFC and diabetes: "The combined effects of DM and another impairment(s) can be greater than the effects of each of the impairments considered separately. We consider all work-related physical and mental limitations, whether due to an adult's DM, other impairment(s), or combination of impairments. For example, adults with peripheral sensory neuropathy may have *difficulty walking, operating foot controls, or manipulating objects because they have lost the ability to sense objects with their hands or feet.* Adults with chronic hyperglycemia may experience *fatigue or difficulty with concentration* that interferes with their ability to perform work activity on a sustained basis." (Emphasis added)

Practice Tip: The functional limitations caused by diabetes set forth in the paragraph above can be crucial to significantly reducing a claimant's RFC. See SSR 96-8p.

SSR 14-3p – Endocrine Disorders Other Than Diabetes

Comment: This ruling addresses disorders such as pituitary gland disorders, thyroid gland disorders, parathyroid gland disorders, adrenal gland disorders, pancreatic disorders, and gonadal disorders.

SSR 15-1p – Interstitial Cystitis

IC is a complex genitourinary disorder resulting in recurring pain or discomfort in the bladder and pelvic region. The AUA and other medical experts characterize IC, in part, as an unpleasant sensation (pain, pressure, discomfort) perceived to be related to the urinary bladder, associated with lower urinary tract symptoms of more than six weeks duration, in the absence of infection or other identifiable causes. IC is most common in women and sometimes occurs before age 18.

In accordance with the AUA guidelines, a physician should make a diagnosis of IC only after reviewing the person's medical history and conducting a physical examination. The physician should also conduct laboratory tests to rule out certain medical conditions that may result in the same or similar symptoms.

Treatments for IC are mostly directed at symptom control. They include, but are not limited to: changes in diet; physical therapy and pelvic floor strengthening exercises; stress management; bladder distention; bladder instillation; oral drugs, such as prescription drugs indicated for IC (for example, Elmiron and dimethyl sulfoxide), antidepressants, antihistamines, antacids, anticoagulants, and narcotic analgesics; transcutaneous electrical nerve stimulation; and surgery, such as substitution cystoplasty or urinary diversion with or without cystectomy. Treatment is not effective for everyone because response varies among patients.

Symptoms. IC symptoms may vary in incidence, duration, and severity from person to person, and even in the same person. For example, a woman's symptoms may worsen around the time of menstruation. Symptoms of IC include, but are not limited to:

1. *Pain.* People who have IC report chronic bladder and pelvic pain, pressure, and discomfort. This pain may range from mild discomfort to extreme distress. The intensity of the pain may increase as the bladder fills and decrease as it empties. In addition to bladder and pelvic pain, people with IC may experience vaginal, testicular, penile, low back, or thigh pain.
2. *Urinary urgency and frequency.* People who have IC may report an urgent need to urinate (urgency) or a frequent need to urinate (frequency), or both. *Some people with severe cases of IC may need to void as often as 60 times per day*, including nighttime urinary frequency (nocturia) with associated sleep disruption. (Emphasis added)
3. *Other symptoms.* In addition to chronic pain and urinary urgency or frequency or both, the person may report additional IC symptoms, such as:
    - Suprapubic tenderness on physical examination;

- Sexual dysfunction (including dyspareunia);
- Sleep dysfunction; and
- Chronic fatigue or tiredness.

Medical signs. Medical signs can support a diagnosis of IC and help establish the MDI. These signs include the following, which can be detected during a medical procedure that stretches the bladder with fluid (cystoscopy under anesthesia with bladder distention):

1. Fibrosis (bladder-wall stiffening);
2. Diffuse glomerulations (pinpoint bleeding caused by recurrent irritation) on the bladder wall; and
3. Hunner's ulcers (patches of broken skin) on the bladder wall.

Laboratory findings. Laboratory test findings can also support a diagnosis of IC. We will make every reasonable effort to obtain the results of appropriate laboratory testing. However, we will not purchase complex, costly, or invasive tests. Some laboratory tests and findings are more widely used and accepted than others. The following laboratory findings can help establish an MDI of IC:

1. Repeated sterile urine cultures while IC symptoms continue;
2. Positive potassium sensitivity test (Parson's test); and
3. Antiproliferative factor (APF) accumulation in the urine.

Mental conditions. People who have IC may report ongoing mental conditions directly associated with their IC. For example, a person may report having anxiety or depression associated with IC symptoms of chronic bladder and pelvic pain, and urinary urgency, frequency, or both. When these mental conditions are documented by mental status examination(s) or psychological testing, they may constitute medical signs or (in the case of psychological testing) laboratory findings that help establish an MDI of IC.

Comment: The frequent need to use the bathroom during work hours could interfere with the ability to perform substantial gainful activity to the extent the individual should be found disabled. See e.g., Pierce v. Apfel, 21 F. Supp. 2d 1274 (D.Kan. 1998); see also, Rivera v. Astrue, Civ. No. 3:11-cv-100 (D.Conn. May 3, 2012) (SRU) (WIG) (unreported).

SSR 17-3p: Titles II and XVI: Evaluating Cases Involving Sickle Cell Disease (SCD)

Purpose: This Social Security Ruling (SSR) provides background information on SCD and how we evaluate SCD during our adjudication process. We provide this guidance to help adjudicators consistently apply our policies in disability claims involving SCD.

Citations: Sections 216(i), 223(d), 223(f), 1614(a)(3) and 1614(a)(4) of the Social Security Act, as amended; Regulations No. 4, subpart P, sections 404.1502, 404.1505, 404.1509, 404.1512, 404.1513, 404.1520, 404.1520a, 404.1520b, 404.1521, 404.1522, 404.1523, 404.1525, 404.1526, , 404.1529, 404.1545, 404.1560-404.1569a, 404.1593, 404.1594, appendices 1 and 2; and Regulations No. 16, subpart I, sections 416.902, 416.905, 416.906, 416.909, 416.911, 416.912, 416.913, 416.920, 416.920a, 416.920b, 416.921, 416.922, 416.923, 416.924, 416.924a, 416.925, 416.926, 416.926a, , 416.929, 416.945, 416.960-416.969a, 416.987, 416.993, 416.994, and 416.994a.

Introduction

SCD is the most common inherited blood disease in the United States, affecting an estimated 100,000 Americans.[1] SCD is not always easy to evaluate due to its varying nature and complications. In this SSR, we provide basic information about SCD and its variants and clarify that sickle cell trait is not a variant of SCD. We also provide guidance for assessing SCD under the hematological disorder listings and determining how this impairment may affect the residual functional capacity finding for adults and the functional equivalence finding for children.

Policy Interpretation

We consider all medical evidence when we evaluate a claim for disability benefits. The following information is in a question and answer format that provides guidance about SCD and how to consider evidence regarding this impairment. Questions 1 and 2 provide basic background information about SCD and its variants. Question 3

clarifies that sickle cell trait is not a variant of SCD. Question 4 discusses the complications and symptoms of SCD. Questions 5 through 7 explain how adjudicators should evaluate SCD at various points of the adjudication process, including the adult and child hematological listings we consider.

List of Questions

1. What is SCD?
2. What are the different variants of SCD?
3. Is sickle cell trait a variant of SCD?
4. What are the common complications and symptoms of SCD?
5. How do we evaluate the complications of SCD under the hematological disorder listings?
6. How do we evaluate the complications of SCD when assessing residual functional capacity (RFC) for adults?
7. How do we evaluate the complications of SCD under functional equivalence for children?

Answers

1. *What is SCD?*

   SCD is a type of hemolytic anemia and an inherited hematological disorder that affects the hemoglobin within a person's red blood cells (RBC). Hemoglobin is the protein within RBC that carries oxygen. The abnormal hemoglobin makes the RBC more prone to distortion ("sickling"), which results in blocked blood vessels and a shortened RBC lifespan. Hemolytic anemia results when the abnormal RBC are destroyed faster than the body can produce them.

   When hemoglobin is normal, a person's RBC are round and easily travel through blood vessels, bringing oxygen to the body's organs and tissues. SCD causes sickle-shaped RBC that are not flexible and can stick to vessel walls, causing blockages (vaso-occlusion) that slow or stop the flow of blood and oxygen. This blockage may in turn cause pain. Persons with SCD are predisposed to pain, infection, and other complications. Because people inherit SCD, the disease is present at birth, but the age when children display symptoms varies.[2]

2. *What are the different variants of SCD?*

   The different variants of SCD may indicate the severity of complications and the resulting functional limitations caused by SCD. Laboratory blood tests such as hemoglobin electrophoresis establish the existence and the variants of SCD. The following are the most common variants of SCD:[3]

   - *Hemoglobin (Hb) SS (HbSS)* — a person with this form of SCD inherits one sickle cell gene from each parent. HbSS is the most common and usually most severe form of SCD.
   - *HbSC* — a person inherits one sickle cell gene from one parent, and another gene for an abnormal hemoglobin called "C" from the other parent. HbSC is usually a milder type of SCD.
   - *Hb S-beta (Sβ) thalassemia* — a person inherits one sickle cell gene from one parent, and a gene for beta thalassemia from the other parent. There are two forms of beta thalassemia, sickle beta zero thalassemia (Hb Sβ0 thalassemia) and sickle beta plus thalassemia (Hb Sβ+ thalassemia). Sickle beta zero thalassemia is usually a more severe form of SCD. People with sickle beta plus thalassemia tend to have a milder form of SCD.
   - *HbSD, HbSE, and HbSO*— people with these variants of SCD have one sickle cell gene plus another abnormal hemoglobin gene, "D," "E," or "O." These are rarer types of SCD with varying severity.

3. *Is sickle cell trait a variant of SCD?*

No. Sickle cell trait is not a variant of SCD. Sickle cell trait occurs when a person inherits one sickle hemoglobin gene from one parent and a normal gene from the other parent. People with sickle cell trait rarely have signs and symptoms associated with SCD and usually do not need treatment. However, in rare cases and under extreme conditions such as intense exercise, people with sickle cell trait have a higher risk of severe breakdown of muscle tissue (exertional rhabdomyolysis) that can lead to serious complications.[4] In spite of this higher risk, recent evidence indicates that sickle cell trait is not associated with an increased probability of death.[5]

Sickle cell trait alone is not an impairment. As defined by the Social Security Act, an impairment must result from anatomical, physiological, or psychological abnormalities that can be shown by medically acceptable clinical and laboratory diagnostic techniques. To establish an impairment in this context, we require objective medical evidence (medical signs and laboratory findings) from an acceptable medical source of complications from sickle cell trait. In addition, a person's complications from sickle cell trait must meet the statutory duration requirement, i.e., be expected to result in death or last or be expected to last for a continuous period of not less than 12 months. Therefore, we cannot find a person disabled due to sickle cell trait if there are no medical signs or laboratory findings of complications from sickle cell trait and the complications from sickle cell trait do not meet the duration requirement.

4. *What are the common complications and symptoms of SCD?*

Complications of SCD may include, but are not limited to pain crises, anemia, osteomyelitis, leg ulcers, pulmonary infections or infarctions, acute chest syndrome, pulmonary hypertension, chronic heart failure, gallbladder disease, liver failure, kidney failure, nephritic syndrome, aplastic crisis, stroke, and mental impairments such as depression. Examples of symptoms that may stem from these complications include pain, fatigue, malaise, shortness of breath, and difficulty feeding in infants. The symptoms of SCD vary from person to person and can change over time.

A. *Pain (vaso-occlusive) crisis* is a common complication of SCD. Pain crises are either acute or chronic. Acute pain crises occur suddenly when sickled RBC stop blood flow and reduce oxygen delivery. This pain can be intense, stabbing, or throbbing. Pain can strike almost anywhere in the body and in more than one spot at a time. The pain often occurs in the lower back, legs, arms, abdomen, and chest.[6] Chronic pain in SCD is more than a continuation of acute pain crisis. It usually occurs when lack of oxygen to the bone due to vaso-occlusion results in the death of bone tissue (avascular necrosis) at various joints such as the hips, shoulders and ankles.[7]

B. *Anemia* is another complication of SCD. It occurs when sickled RBC die prematurely, which reduces the amount of oxygen-carrying hemoglobin in the blood. Symptoms from anemia can include fatigue, weakness, shortness of breath, and dizziness. Chronic deprivation of oxygen-rich blood can damage nerves and organs in the body, including the spleen, brain, eyes, joints, bones, lungs, liver, heart, kidneys, and other organs.

C. *Pulmonary complications* such as acute chest syndrome (ACS) and pulmonary hypertension are the leading cause of death for SCD patients.[8] ACS is a vaso-occlusion of the pulmonary vessels. Symptoms of ACS include but are not limited to chest pain, fever, tachypnea (abnormally rapid breathing), wheezing, or coughing. Pulmonary hypertension can occur when sickled RBC cause pulmonary arteries to become narrow and blocked. The result of this damage to the pulmonary arteries is high blood pressure in the lungs. Symptoms of pulmonary hypertension include shortness of breath, fatigue, and chest pain.[9]

D. *Strokes and silent strokes* affect people with SCD at a higher rate because sickled RBC clump along the walls of larger arteries going to the brain. Strokes can result in full or partial paralysis on one side of the body, problems with balance, or difficulty speaking or understanding. Silent strokes can occur without outward symptoms and are only detectable by brain imaging. However, silent strokes can impair intellectual ability, attention, visual-spatial skills, language, and long-term memory.[10]

E. *Bacterial infections* are often severe complications in people with SCD. Anemia from SCD and vaso-occlusions can damage the spleen, which ultimately increases risk of infection and damages other organs. Infection frequently leads to hospitalization and is the primary cause of death in young children with SCD.[11]

F. *Mental disorders* in people with SCD are often secondary to the impact of treatment, pain, and other symptoms. For example, depression from reoccurring pain is especially common in people with SCD.[12] Other mental disorders that may occur include, but are not limited to, anxiety and cognitive disorders from stroke.[13]

5. *How do we evaluate the complications of SCD under the hematological disorder listings?*

We may evaluate SCD under the following hematological disorder listings:

- Listing 7.05 and 107.05, Hemolytic anemias; or
- Listing 7.17 and 107.17, Hematological disorders treated by bone marrow or stem cell transplantation; or
- Listing 7.18, Repeated complications of hematological disorders.

Under listing 7.05 and 107.05, we assess hemolytic anemias, including sickle cell disease, thalassemia, and their variants. We evaluate pain crises caused by SCD under listings 7.05A and 107.05A. We assess complications of SCD requiring hospitalizations under listings 7.05B and 107.05B. Listings 7.05C and 107.05C describes the criteria we use to evaluate SCD that results in anemia with low hemoglobin levels.

Under listings 7.17 and 107.17, we consider people who receive bone marrow or stem cell transplantation to treat their SCD, to be disabled for at least 12 months after the date of transplant.

We evaluate adults who have repeated complications from SCD, but do not have the requisite findings for listing 7.05 or 7.17, under listing 7.18.[14] To meet listing 7.18, SCD must cause repeated complications, resulting in significant, documented symptoms or signs and a "marked" level of limitation in one of the general areas of functioning: activities of daily living, social functioning, or completing tasks because of deficiencies in concentration, persistence, or pace. We use listing 7.18 to evaluate only hematological disorders.[15]

If a person's SCD does not meet a hematological listing, we will compare the specific findings in each case to any appropriate hematological listings to determine whether medical equivalence may exist. We may also find medical equivalence if the person has multiple impairments, including SCD, none of which meet or medically equal the requirements of a listing alone, but the combination of impairments is medically equivalent in severity to a listed impairment.

If the person's SCD does not meet or equal the criteria in a listing, we will consider whether he or she has an impairment that satisfies the criteria in a listing in another body system. For example, we may evaluate the effects of intracranial bleeding or stroke under 11.00 or 12.00.

6. *How do we evaluate the complications of SCD when assessing residual functional capacity (RFC) for adults?*

For adults, we assess RFC when the effects of a person's SCD, either alone or in combination with another impairment(s), do not meet or medically equal a listing. We base the RFC assessment on all the relevant evidence in the record, including the effects of treatment.[16] In assessing RFC, we must consider all of a person's work-related limitations, whether due to SCD, other impairment(s), or a combination of impairments. For example, adults with SCD may have pain, fatigue, and shortness of breath that may affect their ability to stand and walk. In addition, a person experiencing repeated acute pain crises may have difficulty maintaining concentration to complete tasks and have frequent absences from work.

7. *How do we evaluate the complications of SCD under functional equivalence?*[17]

Children with SCD that does not meet or medically equal a listing may nevertheless have an impairment(s) that functionally equals the listings under our rules for evaluating disability in children.[18] When we determine whether a child's impairment(s) functionally equal the listings, we use the six domains of functioning.

When we evaluate a child's functioning in these six domains, we consider how the child functions compared to children the same age who do not have impairments. We must explain any limitation in a child's ability to function appropriately for his or her age based on a medically determinable impairment(s).[19] It is important to remember that the cumulative physical effects of SCD and its treatment can vary in kind and intensity, affecting each child differently. The six domains of functioning are:

Acquiring and using information. Some children with SCD may have limitations in acquiring and using information due to stroke, including silent stroke.[20] A stroke can cause brain injury that impairs a child's ability to learn, concentrate, speak, and remember.

Attending and completing tasks. Frequent pain crises can result in limitations in attending and completing tasks at school and at home.[21] If a child does not feel well due to pain, it may be difficult for him or her to stay focused on activities long enough to complete them in an age-appropriate manner. A child with SCD who is experiencing pain may also have difficulty paying attention to details and may make mistakes on schoolwork due to an inability to concentrate.

Interacting and relating with others. SCD can also cause limitations interacting and relating with others.[22] The unpredictable nature of pain in SCD may cause anxiety and difficulty maintaining relationships. Children suffering from complications of SCD may become withdrawn, uncooperative, or unresponsive.

Moving about and manipulating objects. If SCD limits a child's ability to move and manipulate objects, we evaluate those effects in the domain of "Moving about and manipulating objects."[23] For example, sickling in the hip bones, knees, and ankles due to SCD may cause joint pain and problems with walking, running, and climbing up and down stairs.

Caring for yourself. Caring for yourself involves a child's basic understanding of his or her body's normal functioning and the adequate emotional health for carrying out self-care tasks.[24] A child with SCD may avoid taking medication or ignore complications of the disease out of frustration with the limitations of SCD.

Health and physical well-being. The ongoing effects of SCD and its treatment may affect a child's health and physical well-being.[25] In this domain, we evaluate the effects of periodic exacerbations of pain crises due to sickle cell anemia. We consider the frequency and duration of the exacerbations as well as the extent to which they affect a child's ability to function physically.

This SSR is applicable on September 15, 2017.[26]

Cross References: SSR 86-8: Titles II and XVI: The Sequential Evaluation Process; SSR 96-3p: Titles II and XVI: Considering Allegations of Pain and Other Symptoms in Determining Whether a Medically Determinable Impairment is Severe; SSR 96-8p: Titles II and XVI: Assessing Residual Functional Capacity in Initial Claims; SSR 09-1p: Title XVI: Determining Childhood Disability Under the Functional Equivalence Rule – The "Whole Child" Approach; SSR 09-2p: Title XVI: Determining Childhood Disability – Documenting a Child's Impairment-Related Limitations; SSR 09-3p: Title XVI: Determining Childhood Disability – The Functional Equivalence Domain of "Acquiring and Using Information"; SSR 09-4p: Title XVI: Determining Childhood Disability – The Functional Equivalence Domain of "Attending and Completing Tasks"; SSR 09-5p: Title XVI: Determining Childhood Disability – The Functional Equivalence Domain of "Interacting and Relating with Others"; SSR 09-6p: Title XVI: Determining Childhood Disability – The Functional Equivalence Domain of "Moving About and Manipulating Objects"; SSR 09-7p: Title XVI: Determining Childhood Disability – The Functional Equivalence Domain of "Caring for Yourself"; SSR 09-8p: Title XVI: Determining Childhood Disability – The Functional Equivalence Domain of "Health and Physical Well-Being"; SSR 16-3p: Titles II and XVI: Evaluation of Symptoms in Disability Claims; and Program Operations Manual System (POMS) DI 22001.001, DI 22505.001, DI 22505.003, DI 24501.021, DI 24510.005, DI 25201.005, DI 25220.010, DI 25505.025, and DI 25505.030.

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[1] See Centers for Disease Control and Prevention, "Sickle Cell Disease." (https://www.cdc.gov/ncbddd/sicklecell/data.html.)

[2] See National Heart, Lung, and Blood Institute, "What Are the Signs and Symptoms of Sickle Cell Disease?" (https://www.nhlbi.nih.gov/health/health-topics/topics/sca). Health problems usually do not appear until an infant is around 5 to 6 months of age.

[3] See Centers for Disease Control and Prevention, "Sickle Cell Disease." (https://www.cdc.gov/ncbddd/sicklecell/facts.html).

[4] Other conditions that could be harmful for people with sickle cell trait include high altitudes, dehydration, low oxygen levels in the air, and increased pressure in the atmosphere. We evaluate impairments that result from sickle cell trait under the affected body system.

[5] See Nelson D.A., et al. Sickle Cell Trait, Rhabdomyolysis, and Mortality among U.S. Army Soldiers. New England Journal of Medicine, Aug; 375(17), 1695-6 (2016).

[6] See National Heart, Lung, and Blood Institute, "What Are the Signs and Symptoms of Sickle Cell Disease?" (http://www.nhlbi.nih.gov/health/health-topics/topics/sca/signs).

[7] See Okpala I, Tawil A. Management of Pain in Sickle-Cell Disease. Journal of the Royal Society of Medicine, Sep; 95(9), 456-458, 2002 (available at: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1279994/).

[8] See Gladwin MT, Miller, A. Pulmonary Complications of Sickle Cell Disease. American Journal of Respiratory and Critical Care Medicine, Jun; 185(11), 1154-1165, 2012 (available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3373067/).

[9] See National Institutes of Health. MedlinePlus. "Pulmonary Hypertension." (https://medlineplus.gov/pulmonaryhypertension.html).

[10] See, The Internet Stroke Center, "Stroke as a Complication of Sickle Cell Disease." (http://www.strokecenter.org/patients/about-stroke/pediatric-stroke/stroke-as-a-complication-of-sickle-cell-disease/).

[11] See Booth, C., et al. Infection in Sickle Cell Disease: A Review. International Journal of Infectious Diseases, Jan; 14(1), e2-e12, 2010 (available at: http://www.sciencedirect.com/science/article/pii/S1201971209001453).

[12] See Jonassaint CR, Jones VL, Leong S, Frierson GM. A Systematic Review of the Association between Depression and Health Care Utilization in Children and Adults with Sickle Cell Disease. British Journal of Hematology, Jul; 174(1), 136-47, 2016.

[13] Becker M, Axelrod DJ. Hematologic Problems in Psychosomatic Medicine. Psychiatric Clinics of North America, Dec; 30(4), 739-759, 2007 (available at: http://www.sciencedirect.com/science/article/pii/S0193953X07000767).

[14] We evaluate a child's functioning under the rules for functional equivalence. See 20 CFR 416.926a.

[15] We use listing 7.18 to evaluate hematological disorders and complications caused by hematological disorders. We can only evaluate anemia under 7.18 if it results from an underlying hematological disorder. If the person's anemia results from a condition that is not a hematological disorder, we would evaluate the anemia under the listing for that impairment.

[16] See 20 CFR 404.1545 and 416.945, and SSR 96-8p.

[17] Functional equivalence applies only to claims for children under title XVI. All claims for title II, even if the claimant is under age 18, are decided under the adult rules.

[18] See 20 CFR 416.926a, SSR 09-1p, 74 FR 7527 (2009) also available at https://www.ssa.gov/OP_Home/rulings/ssi/02/SSR2009-01-ssi-02.html , and SSR 09-2p, 74 FR 7525 (2009) also available at https://www.ssa.gov/OP_Home/rulings/ssi/02/SSR2009-02-ssi-02.html. For the complete titles of all SSRs cited in this footnote and those following, see the *CROSS-REFERENCES* section at the end of this SSR.

[19] See 20 CFR 416.924a(b) and 416.926a.

[20] See 20 CFR 416.926a(g) and SSR 09-3p.

[21] See 20 CFR 416.926a(h) and SSR 09-4p.

[22] See 20 CFR 416.926a(i) and SSR 09-5p.

[23] See 20 CFR 416.926a(j) and SSR 09-6p.

[24] See 20 CFR 416.926a(k) and SSR 09-7p.

[25] See 20 CFR 416.926a(l) and SSR 09-8p.

[26] We will use this SSR beginning on its applicable date. We will apply this SSR to new applications filed on or after the applicable date of the SSR and to claims that are pending on and after the applicable date. This means that we will use this ruling on and after its applicable date in any case in which we make a determination or decision. We expect that Federal courts will review our final decisions using the rules that were in effect at the time we issued the decisions. If a court reverses our final decision and remands a case for

further administrative proceedings after the applicable date of this SSR, we will apply this SSR to the entire period at issue in the decision we make after the court's remand.

SSR 19-2p – Titles II and XVI: Evaluating Cases Involving Obesity

Effective Date: May 20, 2019

This Social Security Ruling (SSR) rescinds and replaces SSR 02-1p; Titles II and XVI: Evaluation of Obesity.

Purpose: This SSR provides guidance on how we establish that a person has a medically determinable impairment (MDI) of obesity and how we evaluate obesity in disability claims under Titles II and XVI of the Social Security Act (Act). [1]

Citations (Authority): Sections 216(i), 223(d), 223(f), 1614(a), and 1614(c) of the Act, as amended; Regulations No. 4, subpart P, sections 404.1502, 404.1509, 404.1512, 404.1513, 404.1520, 404.1521-404.1523, 404.1525, 404.1526, 404.1529, 404.1545, 404.1546, 404.1560-404.1569a, 404.1594 and appendices 1 and 2; Regulations No. 16, subpart I, sections 416.902, 416.909, 416.912, 416.913, 416.920, 416.921-416.923, 416.924, 416.924a, 416.925, 416.926, 416.926a, 416.929, 416.945, 416.946, 416.960-416.969a, 416.987, 416.994, and 416.994a.

Introduction

Obesity, when established by objective medical evidence (signs, laboratory findings, or both) from an acceptable medical source (AMS), is an MDI. We provide guidance in this SSR on how we establish that a person has an MDI of obesity, and how we evaluate obesity in disability claims. People with obesity have a higher risk for other impairments, and the effects of obesity combined with other impairments can be greater than the effects of each of the impairments considered separately. Obesity is not a listed impairment; however, the functional limitations caused by the MDI of obesity, either alone or in combination with another impairment(s), may medically equal a listing.[2] Obesity in combination with another impairment(s) may or may not increase the severity or functional limitations of the other impairment(s). We evaluate each case based on the information in the case record.

On September 12, 2002, we published SSR 02-1p (67 FR 57859) to provide guidance on the evaluation of obesity in disability claims. Since then, we published several final rules that revise some of the criteria we use to evaluate disability claims under Titles II and XVI of the Act. We are issuing this SSR to reflect the changes to the rules we have published, and advances in medical knowledge, since publication of SSR 02-1p.

Policy Interpretation

The following information is in a question and answer format that provides guidance on how we establish that a person has an MDI of obesity and how we evaluate obesity in disability claims. Questions 1 and 2 provide basic background information about obesity and impairments associated with obesity. Questions 3 and 4 discuss how we establish obesity as an MDI and how we determine if it is a severe MDI. Questions 5 and 6 specify how we evaluate obesity under the Listing of Impairments (listings), [3] and how we consider obesity when assessing a person’s residual functional capacity (RFC).

List of Questions

1.How does the medical community diagnose obesity?

2.Which impairments are associated with obesity?

3.How do we establish obesity as an MDI?

4.When is obesity a severe impairment?

5.How do we evaluate obesity under the listings?

6.How do we consider obesity in assessing a person's RFC?

1. How does the medical community diagnose obesity?

Obesity is a complex disorder characterized by an excessive amount of body fat, and is generally the result of many factors including environment, family history and genetics, metabolism, and behavior. Health care practitioners diagnose obesity based on a person's medical history, physical examinations, and body mass index (BMI). For adults, BMI is a person's weight in kilograms divided by the square of his or her height in meters (kg/m2). People with obesity weigh more than what is considered the healthy weight for their height. In the medical community, obesity is defined as a BMI of 30.0 or higher. [4] [5] No specific weight or BMI establishes obesity as a severe impairment within the disability program. For how we establish obesity as an MDI, see Question 3. For when we consider obesity to be a severe impairment, see Question 4.

Health care practitioners may take a waist measurement to help diagnose obesity. If a person's BMI is within the normal range, he or she may still have obesity if his or her waist measurement is high. People who store more fat around their waist rather than their hips may have a greater risk of obesity-related complications. The risk increases for a waist size greater than 35 inches for women and greater than 40 inches for men. [6]

2. Which impairments are associated with obesity?

Obesity is often associated with musculoskeletal, respiratory, cardiovascular, and endocrine disorders. Obesity also increases the risk of developing impairments including:

•Type II diabetes mellitus;

•Diseases of the heart and blood vessels (for example, high blood pressure, atherosclerosis, heart attacks, and stroke);

•Respiratory impairments (for example, sleep apnea, asthma, and obesity hypoventilation syndrome);

•Osteoarthritis;

•Mental impairments (for example, depression); and

•Cancers of the esophagus, pancreas, colon, rectum, kidney, endometrium, ovaries, gallbladder, breast, or liver.

The fact that obesity increases the risk for developing other impairments does not mean that people with obesity necessarily have any of these impairments. It means that they are at greater than average risk for developing other impairments.

3. How do we establish obesity as an MDI?

We establish obesity as an MDI by considering objective medical evidence (signs, laboratory findings, or both) from an AMS. We will not use a diagnosis or a statement of symptoms to establish the existence of an MDI. [7] Signs and laboratory findings from an AMS that may establish an MDI of obesity include measured height and weight, measured waist size, and BMI measurements over time.

We calculate BMI based on the medical evidence in the case record, even if the person's medical source(s) has not indicated that the person has obesity. We will not calculate BMI based on a person's self-reported height and weight. In addition, we will not purchase tests to measure body fat. When deciding whether a person has an MDI of obesity, we consider the person's weight over time. We consider the person to have an MDI of obesity as long as his or her weight, measured waist size, or BMI shows a consistent pattern of obesity.

Although there is often a correlation between BMI and excess body fat, this is not always the case. Someone who has a BMI of 30 or above may not have an MDI of obesity if a large percentage of the person's weight is

from muscle. It will usually be evident from the information in the case record whether the person does not have an MDI of obesity, despite a BMI of 30 or above.

4. When is obesity a severe impairment?

When we evaluate the severity of obesity, we consider all evidence from all sources. We consider all symptoms, such as fatigue or pain that could limit functioning. [8] We consider any functional limitations in the person's ability to do basic work activities resulting from obesity and from any other physical or mental impairments. If the person's obesity, alone or in combination with another impairment(s), significantly limits his or her physical or mental ability to do basic work activities, we find that the impairment(s) is severe. [9] We find, however, that the impairment(s) is "not severe" if it does not significantly limit [a person's] physical or mental ability to do basic work activities. [10]

No specific weight or BMI establishes obesity as a "severe" or "not severe" impairment. Similarly, a medical source's descriptive terms for levels of obesity, such as "severe," "extreme," or "morbid," do not establish whether obesity is a severe impairment for disability program purposes. We do an individualized assessment of the effect of obesity on a person's functioning when deciding whether the impairment is severe.

5. How do we evaluate obesity under the listings?

Obesity is not a listed impairment; however, the functional limitations caused by the MDI of obesity, alone or in combination with another impairment(s), may medically equal a listing. [11] For example, obesity may increase the severity of a coexisting or related impairment(s) to the extent that the combination of impairments medically equals a listing. [12]

We will not make general assumptions about the severity or functional effects of obesity combined with another impairment(s). Obesity in combination with another impairment(s) may or may not increase the severity or functional limitations of the other impairment. We evaluate each case based on the information in the case record.

6. How do we consider obesity in assessing a person's RFC?

We must consider the limiting effects of obesity when assessing a person's RFC. [13] RFC is the most an adult can do despite his or her limitation(s). As with any other impairment, we will explain how we reached our conclusion on whether obesity causes any limitations.

A person may have limitations in any of the exertional functions, which are sitting, standing, walking, lifting, carrying, pushing, and pulling. A person may have limitations in the nonexertional functions of climbing, balancing, stooping, kneeling, crouching, and crawling. Obesity increases stress on weight-bearing joints and may contribute to limitation of the range of motion of the skeletal spine and extremities. Obesity may also affect a person's ability to manipulate objects, if there is adipose (fatty) tissue in the hands and fingers, or the ability to tolerate extreme heat, humidity, or hazards.

We assess the RFC to show the effect obesity has upon the person's ability to perform routine movement and necessary physical activity within the work environment. People with an MDI of obesity may have limitations in the ability to sustain a function over time. In cases involving obesity, fatigue may affect the person's physical and mental ability to sustain work activity. This may be particularly true in cases involving obesity and sleep apnea.

The combined effects of obesity with another impairment(s) may be greater than the effects of each of the impairments considered separately. For example, someone who has obesity and arthritis affecting a weight-

bearing joint may have more pain and functional limitations than the person would have due to the arthritis alone. We consider all work-related physical and mental limitations, whether due to a person's obesity, other impairment(s), or combination of impairments.

This SSR is applicable on May 20, 2019. [14]

Cross References: SSR 82-52: Titles II and XVI: Duration of the Impairment; SSR 85-28: Titles II and XVI: Medical Impairments That Are Not Severe; SSR 86-8: Titles II and XVI: The Sequential Evaluation Process; SSR 96-8p: Titles II and XVI: Assessing Residual Functional Capacity in Initial Claims; SSR 16-3p: Titles II and XVI: Evaluation of Symptoms in Disability Claims; SSR 17-2p: Titles II and XVI: Evidence Needed by Adjudicators at the Hearings and Appeals Council Levels of the Administrative Review Process to Make Findings about Medical Equivalence; and Program Operations Manual System (POMS) DI 22505.001, DI 22505.003, DI 24501.020, DI 24501.021, DI 24503.005, DI 24505.001, DI 24505.005, DI 24508.010, DI 24510.005, DI 24515.062, and DI 24515.063.

[1] For simplicity, we refer in this SSR only to initial adult claims for disability benefits under Titles II and XVI of the Act. The policy interpretations in this SSR, however, also apply to claims of children (that is, people who have not attained age 18) who apply for benefits based on disability under Title XVI of the Act, continuing disability reviews of adults and children under sections 223(f) and 1614(a)(4) of the Act, and redeterminations of eligibility for benefits we make in accordance with section 1614(a)(3)(H) of the Act when a child who is receiving Title XVI payments based on disability attains age 18.

[2] See 20 CFR 404.1526 and 416.926.

[3] See 20 CFR Part 404, Subpart P, Appendix 1.

[4] Jensen, M. D., Ryan, D. H, Donato, K. A., Apovian, C. M., Ard, J.D., Comuzzie, A. G., ... Yanoski, S. Z. (2014). Guidelines (2013) for managing overweight and obesity in adults. Obesity, 22(S2), S1-S410. doi:10.1002/oby/20660

[5] For children age 2 and older, weight status is determined using an age- and gender-specific percentile for BMI rather than the BMI categories used for adults. This is because children's body composition varies as they age and varies between boys and girls. Obesity is defined as a BMI-for-age at or above the 95th percentile. See Barlow, S. E. (2007). Expert committee recommendations regarding the prevention, assessment, and treatment of child and adolescent overweight and obesity: Summary report. Pediatrics, 120, S164-S192. doi:10.1542/peds.2007-2329C

[6] Jensen, M. D., Ryan, D. H, Donato, K. A., Apovian, C. M., Ard, J.D., Comuzzie, A. G., ... Yanoski, S. Z. (2014). Guidelines (2013) for managing overweight and obesity in adults. Obesity, 22(S2), S1-S410. doi:10.1002/oby.20660

[7] See 20 CFR 404.1521 and 416.921.

[8] See 20 CFR 404.1529 and 416.929.

[9] For children applying for disability under Title XVI, we find that the impairment(s) is severe when it causes more than minimal functional limitations. See 20 CFR 416.924(c).

[10] See 20 CFR 404.1522 and 416.922.

[11] See 20 CFR 404.1526 and 416.926.

[12] For children applying for disability under Title XVI, we may evaluate the functional consequences of obesity (either alone or in combination with other impairments) to decide if the child's impairment(s) functionally equals the listings. For example, the functional limitations imposed by obesity, by itself or in combination with another impairment(s), may establish extreme limitation of one domain of functioning or marked limitation of two domains. See 20 CFR 416.926a.

[13] See 20 CFR 404.1545 and 416.945.

[14] We will use this SSR beginning on its applicable date. We will apply this SSR to new applications filed on or after the applicable date of the SSR and to claims that are pending on and after the applicable date. This means that we will use this SSR on and after its applicable date in any case in which we make a determination or decision. We expect that Federal courts will review our final decisions using the rules that were in effect at the time we issued the decisions. If a court reverses our final decision and remands a case for further administrative proceedings after the applicable date of this SSR, we will apply this SSR to the entire period at issue in the decision we make after the court's remand.

Crossman v. Astrue, 783 F. Supp.2d 300 (D.Conn. 2010 (MRK). The court directed the Commissioner on remand to consider the effects of obesity on the claimant's fibromyalgia in light of SSR 02-1p (prior obesity Ruling).

SSR 19-4p – Titles II and XVI: Evaluating Cases Involving Primary Headache Disorders

Effective Date: August 26, 2019
Purpose: This SSR provides guidance on how we establish that a person has a medically determinable impairment (MDI) of a primary headache disorder and how we evaluate primary headache disorders in disability claims under titles II and XVI of the Social Security Act (Act).[1]

Citations: Sections 216(i), 223(d), 223(f), 1614(a)(3) and 1614(a)(4) of the Social Security Act, as amended; Regulations No. 4, subpart P, sections 404.1502, 404.1505, 404.1509, 404.1512, 404.1513, 404.1520, 404.1520a, 404.1520b, 404.1521-404.1523, 404.1525, 404.1526, 404.1529, 404.1545, 404.1560, 404.1562-404.1569a, 404.1593, 404.1594, appendices 1 and 2; and Regulations No. 16, subpart I, sections 416.902, 416.905, 416.906, 416.909, 416.912, 416.913, 416.920, 416.920a, 416.920b, 416.921-416.924, 416.924a, 416.925, 416.926, 416.926a, 416.929, 416.945, 416.960, 416.962-416.969a, 416.987, 416.993, 416.994, and 416.994a.

Introduction

Primary headache disorders are among the most common disorders of the nervous system.[2] Examples of these disorders include migraine headaches, tension-type headaches, and cluster headaches. We are issuing this SSR to explain our policy on how we establish that a person has an MDI of a primary headache disorder and how we evaluate primary headache disorders in disability claims. In 2018, the Headache Classification Committee of the International Headache Society published the third edition of the International Classification of Headache Disorders (ICHD-3).[3] The ICHD-3 provides classification of headache disorders and diagnostic criteria for scientific, educational, and clinical use. We referred to the ICHD-3 criteria in developing this SSR.

We consider a person age 18 or older disabled if he or she is unable to engage in any substantial gainful activity due to any medically determinable physical or mental impairment(s) that can be expected to result in death, or that has lasted or can be expected to last for a continuous period of not less than 12 months.[4] In our sequential evaluation process, we determine whether a medically determinable physical or mental impairment is severe at step 2.[5] A severe MDI or combination of MDIs significantly limits a person's physical or mental ability to do basic work activities. We require that the MDI(s) result from anatomical, physiological, or psychological abnormalities that can be shown by medically acceptable clinical and laboratory diagnostic techniques.[6] Our regulations further require that the MDI(s) be established by objective medical evidence[7] from an acceptable medical source (AMS).[8] We will not use a person's statement of symptoms, a diagnosis, or a medical opinion to establish the existence of an MDI(s).[9] We also will not make a finding of disability based on a person's statement of symptoms alone.[10]

Policy Interpretation

In this SSR, we explain how we establish a primary headache disorder as an MDI and how we evaluate claims involving primary headache disorders. The following information is in a question and answer format. Question 1

explains what primary headache disorders are. Question 2 explains how the medical community diagnoses primary headache disorders. Questions 3, 4, 5, and 6 provide the ICHD-3 diagnostic criteria for four common types of primary headache disorders.[11] Question 7 explains how we establish a primary headache disorder as an MDI. Questions 8 and 9 address how we evaluate primary headache disorders in the sequential evaluation process.

List of Questions

1.What are primary headache disorders?

2.How does the medical community diagnose a primary headache disorder?

3.What are the ICHD-3 diagnostic criteria for migraine with aura?

4.What are the ICHD-3 diagnostic criteria for migraine without aura?

5.What are the ICHD-3 diagnostic criteria for chronic tension-type headache?

6.What are the ICHD-3 diagnostic criteria for cluster headache (a type of trigeminal autonomic cephalalgias)?

7.How do we establish a primary headache disorder as an MDI?

8.How do we evaluate an MDI of a primary headache disorder under the Listing of Impairments?

9.How do we consider an MDI of a primary headache disorder in assessing a person's residual functional capacity?

1. What are primary headache disorders?

Headaches are complex neurological disorders involving recurring pain in the head, scalp, or neck. Headaches can occur in adults and children. The National Institute of Neurological Disorders and Stroke (NINDS), the American Academy of Neurology, and other professional organizations classify headaches as either primary or secondary headaches. Primary headaches occur independently and are not caused by another medical condition. Secondary headaches are symptoms of another medical condition such as fever, infection, high blood pressure, stroke, or tumors.

Primary headache disorders are a collection of chronic headache illnesses characterized by repeated exacerbations of overactivity or dysfunction of pain- sensitive structures in the head. Examples of common primary headaches include migraines, tension-type headaches, and trigeminal autonomic cephalalgias. They are typically severe enough to require prescribed medication and sometimes warrant emergency department visits.[12] The purpose of the emergency department care is to determine the correct headache diagnosis, exclude secondary causes of the headache (such as infection, mass-lesion, or hemorrhage), initiate acute therapy in appropriate cases, and provide referral to an appropriate healthcare provider for further care and management of the headaches.[13]

Migraines are vascular headaches involving throbbing and pulsating pain caused by the activation of nerve fibers that reside within the wall of brain blood vessels traveling within the meninges (the three membranes covering the brain and spinal cord). There are two major types of migraine: Migraine with aura and migraine without aura. Migraine with aura is accompanied by visual, sensory, or other central nervous system symptoms. Migraine without aura is accompanied by nausea, vomiting, or photophobia (light sensitivity) and phonophobia (sound sensitivity). Migraine without aura is the most common form of migraine.

Tension-type headaches are characterized by pain or discomfort in the head, scalp, face, jaw, or neck, and are usually associated with muscle tightness in these areas. There are two types of tension-type headaches: episodic and chronic. Episodic tension-type headaches are further divided into infrequent episodic tension-type headaches, which typically do not require medical management, and frequent episodic tension-type headaches, which may require medical management. Chronic tension-type headaches generally evolve from episodic tension-type headaches.

Chronic tension-type headaches and frequent episodic tension-type headaches may be disabling depending on the frequency of the headache attacks, type of accompanying symptoms, response to treatment, and functional limitations.

Trigeminal autonomic cephalalgias are characterized by unilateral (one-sided) pain. There are three types: cluster headache, paroxysmal hemicrania (rare), and short-lasting unilateral neuralgiform headache attacks with conjunctival injection and tearing (SUNCT; very rare). Cluster headaches are characterized by sudden headaches that occur in "clusters," are usually less frequent and shorter than migraine headaches, and may be mistaken for allergies because they often occur seasonally.

2. How does the medical community diagnose a primary headache disorder?

In accordance with the ICHD-3 guidelines, the World Health Organization (WHO) protocols, and the NINDS definition of headache disorders, physicians diagnose a primary headache disorder only after excluding alternative medical and psychiatric causes of a person's symptoms.[14] Physicians diagnose a primary headache disorder after reviewing a person's full medical and headache history and conducting a physical and neurological examination.[15] It is helpful to a physician when a person keeps a "headache journal" to document when the headaches occur, how long they last, what symptoms are associated with the headaches, and other co-occurring environmental factors.

To rule out other medical conditions that may result in the same or similar symptoms, a physician may also conduct laboratory tests or imaging scans.[16] For example, physicians may use magnetic resonance imaging (MRI) to rule out other possible causes of headaches—such as a tumor—meaning that an unremarkable MRI is consistent with a primary headache disorder diagnosis. Other tests used to exclude causes of headache symptoms include computed tomography (CT) scan of the head, CT angiography (CTA), blood chemistry and urinalysis, sinus x-ray, electroencephalogram (EEG), eye examination, and lumbar puncture. A scan may describe an incidental abnormal finding, which does not preclude the diagnosis of a primary headache disorder. While imaging may be useful in ruling out other possible causes of headache symptoms, it is not required for a primary headache disorder diagnosis.

3. What are the ICHD-3 diagnostic criteria for migraine with aura?

The ICHD-3 diagnostic criteria for migraine with aura are headaches not better accounted for by another ICHD-3 diagnosis and at least two headache attacks meeting the following criteria:

•One or more of the following fully reversible aura symptoms:
•Visual,
•Sensory,
•Speech or language,
•Motor,
•Brainstem, or
•Retinal; and

•At least three of the following six characteristics:

•At least one aura symptom spreads gradually over at least 5 minutes;

•Two or more aura symptoms occur in succession;

•Each individual aura symptom lasts 5 to 60 minutes;

•At least one aura symptom is unilateral (aphasia is always regarded as a unilateral symptom; dysarthria may or may not be);

•At least one aura symptom is positive (scintillations and pins and needles are positive symptoms of aura); or

•The aura is accompanied or followed within 60 minutes by headache.

4. What are the ICHD-3 diagnostic criteria for migraine without aura?

The ICHD-3 diagnostic criteria for migraine without aura are headaches not better accounted for by another ICHD-3 diagnosis and at least five headache attacks satisfying the following criteria:

•Lasting 4 to 72 hours (untreated or unsuccessfully treated);[17] [18] and

•At least two of the following four characteristics:

•Unilateral location;
•Pulsating quality;
•Moderate or severe pain intensity; or
•Aggravation by or causing avoidance of routine physical activity (for example, walking or climbing stairs); and
•During headache, at least one of the following:

•Nausea or vomiting, or
•Photophobia and phonophobia.

5. What are the ICHD-3 diagnostic criteria for chronic tension-type headache?

The ICHD-3 diagnostic criteria for chronic tension-type headache are headaches not better accounted for by another ICHD-3 diagnosis, occurring on at least 15 days per month on average for more than 3 months, and satisfying the following criteria:

•Lasting hours to days, or unremitting; and
•At least two of the following four characteristics:
•Bilateral location;
•Pressing or tightening (non-pulsating) quality;
•Mild or moderate intensity; or
•Not aggravated by routine physical activity (such as walking or climbing stairs); and
•No more than one of photophobia, phonophobia, or mild nausea; and
•Neither moderate nor severe[19] nausea nor vomiting.

6. What are the ICHD-3 diagnostic criteria for cluster headache (a type of trigeminal autonomic cephalalgias)?

The ICHD-3 diagnostic criteria for cluster headache are headaches not better accounted for by another ICHD-3 diagnosis and at least five headache attacks satisfying the following criteria:

•Severe or very severe[20] unilateral orbital, supraorbital, or temporal pain lasting 15 to 180 minutes (when untreated);
•One or both of the following:

•A sense of restlessness or agitation or
•At least one of the following symptoms or signs occurring on the same side of the body as the headache:
•Conjunctival injection (red eye);
•Lacrimation (secretion of tears);
•Nasal congestion or rhinorrhea (runny nose);
•Eyelid edema (puffy eyelid);
•Forehead and facial sweating;
•Miosis (excessive constriction of the pupil); or
•Ptosis (drooping of the upper eyelid); and
•Occurring with a frequency between one every other day and eight per day.

7. How do we establish a primary headache disorder as an MDI?

We establish a primary headache disorder as an MDI by considering objective medical evidence (signs, laboratory findings, or both) from an AMS.[21] We may establish only a primary headache disorder as an MDI. We will not establish secondary headaches (for example, headache attributed to trauma or injury to the head or neck or to infection) as MDIs because secondary headaches are symptoms of another underlying medical condition. We evaluate the underlying medical condition as the MDI. Generally, successful treatment of the underlying condition will alleviate the secondary headaches.

We will not establish the existence of an MDI based only on a diagnosis or a statement of symptoms; however, we will consider the following combination of findings reported by an AMS when we establish a primary headache disorder as an MDI:

•A primary headache disorder diagnosis from an AMS. Other disorders have similar symptoms, signs, and laboratory findings. A diagnosis of one of the primary headache disorders by an AMS identifies the specific condition that is causing the person's symptoms. The evidence must document that the AMS who made the diagnosis reviewed the person's medical history, conducted a physical examination, and made the diagnosis of primary headache disorder only after excluding alternative medical and psychiatric causes of the person's symptoms. In addition, the treatment notes must be consistent with the diagnosis of a primary headache disorder.[22]

•An observation of a typical headache event, and a detailed description of the event including all associated phenomena, by an AMS. During a physical examination, an AMS is often able to observe and document signs that co-occur prior to, during, and following the headache event. Examples of co-occurring observable signs include occasional tremors, problems concentrating or remembering, neck stiffness, dizziness, gait instability, skin flushing, nasal congestion or rhinorrhea (runny nose), puffy eyelid, forehead or facial sweating, pallor, constriction of the pupil, drooping of the upper eyelid, red eye, secretion of tears, and the need to be in a quiet or dark room during the examination. In the absence of direct observation of a typical headache event by an AMS, we may consider a third party observation of a typical headache event, and any co-occurring observable signs, when the third party's description of the event is documented by an AMS and consistent with the evidence in the case file.

•Remarkable or unremarkable findings on laboratory tests. We will make every reasonable effort to obtain the results of laboratory tests. We will not routinely purchase tests related to a person's headaches or allegations of headaches. We will not purchase imaging or other diagnostic or laboratory tests that are complex, may involve significant risk, or are invasive.

•Response to treatment. Medications and other medical interventions are generally tailored to a person's unique symptoms, predicted response, and risk of side effects. Examples of medications used to treat primary headache disorders include, but are not limited to, botulinum neurotoxin (Botox®), anticonvulsants, and antidepressants. We will consider whether the person's headache symptoms have improved, worsened, or remained stable despite treatment and consider medical opinions related to the person's physical strength and functional abilities. When evidence in the file from an AMS documents ongoing headaches that persist despite treatment, such findings may constitute medical signs that help to establish the presence of an MDI.[23]

8. How do we evaluate an MDI of a primary headache disorder under the Listing of Impairments?

Primary headache disorder is not a listed impairment in the Listing of Impairments (listings);[24] however, we may find that a primary headache disorder, alone or in combination with another impairment(s), medically equals a listing.[25]

Epilepsy (listing 11.02) is the most closely analogous listed impairment for an MDI of a primary headache disorder. While uncommon, a person with a primary headache disorder may exhibit equivalent signs and limitations to those detailed in listing 11.02 (paragraph B or D for dyscognitive seizures), and we may find that his or her MDI(s) medically equals the listing.

Paragraph B of listing 11.02 requires dyscognitive seizures occurring at least once a week for at least 3 consecutive months despite adherence to prescribed treatment. To evaluate whether a primary headache disorder is equal in severity and duration to the criteria in 11.02B, we consider: a detailed description from an AMS of a typical headache event, including all associated phenomena (for example, premonitory symptoms, aura, duration, intensity, and accompanying symptoms); the frequency of headache events; adherence to prescribed treatment; side effects of treatment (for example, many medications used for treating a primary headache disorder can produce drowsiness, confusion, or inattention); and limitations in functioning that may be associated with the primary headache disorder or effects of its treatment, such as interference with activity during the day (for example, the need for a darkened and quiet room, having to lie down without moving, a sleep disturbance that affects daytime activities, or other related needs and limitations).

Paragraph D of listing 11.02 requires dyscognitive seizures occurring at least once every 2 weeks for at least 3 consecutive months despite adherence to prescribed treatment, and marked limitation in one area of functioning. To evaluate whether a primary headache disorder is equal in severity and duration to the criteria in 11.02D, we consider the same factors we consider for 11.02B and we also consider whether the overall effects of the primary headache disorder on functioning results in marked limitation in: physical functioning; understanding, remembering, or applying information; interacting with others; concentrating, persisting, or maintaining pace; or adapting or managing oneself.

9. How do we consider an MDI of a primary headache disorder in assessing a person's residual functional capacity?

If a person's primary headache disorder, alone or in combination with another impairment(s), does not medically equal a listing at step three of the sequential evaluation process, we assess the person's residual functional capacity (RFC). We must consider and discuss the limiting effects of all impairments and any related symptoms when assessing a person's RFC.[26] The RFC is the most a person can do despite his or her limitation(s).

We consider the extent to which the person's impairment-related symptoms are consistent with the evidence in the record. For example, symptoms of a primary headache disorder, such as photophobia, may cause a person to have difficulty sustaining attention and concentration. Consistency and supportability between reported symptoms and objective medical evidence is key in assessing the RFC.

This SSR is applicable on August 26, 2019.[27]

Cross References: SSR 83-12: Title II and XVI: Capability To Do Other Work—The Medical-Vocational Rules as a Framework for Evaluating Exertional Limitations Within a Range of Work or Between Ranges of Work; SSR 83-14: Titles II and XVI: Capability To Do Other Work—The Medical-Vocational Rules as a Framework for Evaluating a Combination of Exertional and Nonexertional Impairments; SSR 85-15: Titles II and XVI: Capability To Do Other Work—The Medical-Vocational Rules as a Framework for Evaluating Solely Nonexertional Impairments; SSR 86-8: Titles II and XVI: The Sequential Evaluation Process; SSR 96-8p: Titles II and XVI: Assessing Residual Functional Capacity in Initial Claims; SSR 96-9p: 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; SSR 11-2p: Titles II and XVI: Documenting and Evaluating Disability in Young Adults; SSR 16-3p: Titles II and XVI: Evaluation of Symptoms in Disability Claims; SSR 17-2p: Titles II and XVI: Evidence Needed by Adjudicators at the Hearings and Appeals Council Levels of the Administrative Review Process to Make Findings about Medical Equivalence; and Program Operations Manual System (POMS) DI 22001.001, DI 22505.001, DI 22505.003, DI 24501.020, DI 24501.021, DI 24503.005, DI 24503.025, DI 24503.030, DI 24503.035, DI 24505.001, DI 24510.005, DI 24510.057, DI 24515.012, DI 24515.062, DI 24515.063, DI 25025.001, DI 25505.025, and DI 25505.030.

[1] For simplicity, we refer in this SSR only to initial adult claims for disability benefits under titles II and XVI of the Act. The policy interpretations in this SSR, however, also apply to claims of children (that is, people who have not attained age 18) who apply for benefits based on disability under title XVI of the Act, continuing disability reviews of adults and children under sections 223(f) and 1614(a)(4) of the Act, and redeterminations of eligibility

for benefits we make in accordance with section 1614(a)(3)(H) of the Act when a child who is receiving title XVI p
[2] See World Health Organization. (2016). Headache disorders. Retrieved from http://www.who.int/news-room/fact-sheets/detail/headache-disorders.
[3] See International Headache Society (IHS). (2018). The international classification of headache disorders (3rd ed.). Retrieved from https://www.ichd-3.org/wp-content/uploads/2018/01/The-International-Classification-of-Headache-Disorders-3rd-Edition-2018.pdf.
[4] See sections 223(d)(1)(A) and 1614(a)(3)(A) of the Act.
[5] See 20 CFR 404.1520(a)(4)(ii) and (c) and 416.920(a)(4)(ii) and (c).
[6] See sections 223(d)(3) and 1614(a)(3)(D) of the Act, and 20 CFR 404.1521 and 416.921.
[7] Objective medical evidence is defined as signs, laboratory findings, or both. See 20 CFR 404.1502(f).
[8] See 20 CFR 404.1502, 404.1513, 404.1521, 416.902, 416.913, and 416.921.
[9] See 20 CFR 404.1521 and 416.921.
[10] See 20 CFR 404.1529(a) and 416.929(a).
[11] Although this SSR only provides information about four common types of primary headache disorders, diagnostic criteria for other types of primary headache disorders can be found in the ICHD-3.

[12] Clinicians may use terms such as “severe” or “moderate” to characterize a person's medical condition or symptoms and these terms may be seen in medical evidence. These terms will not always have the same meaning in the clinical setting as they do in our program.
[13] Lange, S. E. (2011). Primary headache disorders in the emergency department. Advanced Emergency Nursing Journal, 33(3). doi:10.1097/TME.0b013e3182261105
[14] ICHD-3 provides classification of headache disorders and diagnostic criteria.
[15] Ebell, M. H. (2006). Diagnosis of migraine headache. American Family Physician, 74(12).
[16] Friedman, B. W. & Grosberg, B. M. (2009). Diagnosis and management of the primary headache disorders in the emergency department setting. Emergency Medicine Clinics of North America, 27(1). doi:10.1016/j.emc.2008.09.005
[17] When the person falls asleep during a migraine attack and wakes up without it, duration of the attack is calculated until the time of awakening.
[18] In children (persons under age 18), attacks may last 2-72 hours.
[19] See note 12 above.
[20] Id.
[21] See 20 CFR 404.1502(a) and 416.902(a).
[22] As explained in question 2, a person's “headache journal” may aid a physician in diagnosing a headache disorder after reviewing a person's full medical and headache history. We do not require evidence from a person's “headache journal” in order to establish an MDI of a headache disorder. Our current rules require objective medical evidence, consisting of signs, laboratory finding, or both, from an AMS to establish an MDI. We will, however, consider evidence from a person's “headache journal” when it is part of the record, either as part of the treatment notes or as separate evidence, along with all evidence in the record.
[23] See 20 CFR 404.1502(g) and 416.902(l).
[24] See 20 CFR Part 404, Subpart P, Appendix 1, and 20 CFR 404.1525 and 416.925.
[25] See 20 CFR 404.1526 and 416.926 and SSR 17-2p: Titles II and XVI: Evidence Needed by Adjudicators at the Hearings and Appeals Council Levels of the Administrative Review Process to Make Findings about Medical Equivalence, 82 FR 15263 (2017) (also available at: https://www.ba.ssa.gov/OP_Home/rulings/di/01/SSR2017-02-di-01.html).
[26] See 20 CFR 404.1545 and 416.945.
[27] We will use this SSR beginning on its applicable date. We will apply this SSR to new applications filed on or after the applicable date of the SSR and to claims that are pending on and after the applicable date. This means that we will use this SSR on and after its applicable date in any case in which we make a determination or decision. We expect that Federal courts will review our final decisions using the rules that were in effect at the time we issued the decisions. If a court reverses our final decision and remands a case for further administrative proceedings after the applicable date of this SSR, we will apply this SSR to the entire period at issue in the decision we make after the court’s remand.

See: Listing 11.02 Epilepsy, documented by a detailed description of a typical seizure and characterized by A, B, C, or D:

A. Generalized tonic-clonic seizures (see 11.00H1a), occurring at least once a month for at least 3 consecutive months (see 11.00H4) despite adherence to prescribed treatment (see 11.00C).

OR

B. Dyscognitive seizures (see 11.00H1b), occurring at least once a week for at least 3 consecutive months (see 11.00H4) despite adherence to prescribed treatment (see 11.00C).

OR
C. Generalized tonic-clonic seizures (see 11.00H1a), occurring at least once every 2 months for at least 4 consecutive months (see 11.00H4) despite adherence to prescribed treatment (see 11.00C); and a marked limitation in one of the following:

1. Physical functioning (see 11.00G3a); or
2. Understanding, remembering, or applying information (see 11.00G3b(i)); or
3. Interacting with others (see 11.00G3b(ii)); or
4. Concentrating, persisting, or maintaining pace (see 11.00G3b(iii)); or
5. Adapting or managing oneself (see 11.00G3b(iv)).

OR
D. Dyscognitive seizures (see 11.00H1b), occurring at least once every 2 weeks for at least 3 consecutive months (see 11.00H4) despite adherence to prescribed treatment (see 11.00C); and a marked limitation in one of the following:

1. Physical functioning (see 11.00G3a); or
2. Understanding, remembering, or applying information (see 11.00G3b(i)); or
3. Interacting with others (see 11.00G3b(ii)); or
4. Concentrating, persisting, or maintaining pace (see 11.00G3b(iii)); or
5. Adapting or managing oneself (see 11.00G3b(iv)).

Weatherby v. Berryhill, 2018 WL 4521937 (D.Conn. Sept. 21, 2018) (RMS). In this decision that predates SSR 19-4p, the court issued a remand because the ALJ failed to properly determine if the claimant's migraines equaled a Listing and failed to make a proper RFC assessment.

Practice Tip: Consider having the claimant or a family member keep a record of the migraines and headaches and submit this into the record. The more descriptive of the symptomatology related to the migraines and headaches, the better.

Rulings Related To Past Relevant Work And Other Work

SSR 82-40 – Past Relevant Work in a Foreign Country

A job in a foreign economy need not have a counterpart in the U.S. economy, and the lack of authoritative occupational reference materials for foreign economies is not a barrier to the decision that a claimant can or cannot meet the physical and mental demands of a formerly held foreign job as he or she described it.

Comment: This situation may come up in cases involving claimants from Far Eastern countries. See e.g., Quang Van Han v. Bowen, 882 F.2d 1453 (9th Cir. 1989).

SSR 82-41 – Work Skills and Their Transferability

Comment: This Ruling rarely comes into play with SSI clients because very few have performed skilled work or even semi-skilled work. On the other hand, it is often pertinent in SSDI cases.

A *skill* is knowledge of a work activity which requires the exercise of significant judgment that goes beyond the carrying out of simple job duties and is acquired through performance of an occupation which is above the unskilled level (requires more than 30 days to learn). It is practical and familiar knowledge of the principles and processes of an art, science or trade, combined with the ability to apply them in practice in a proper and approved manner. This includes activities like making precise measurements, reading blueprints, and setting up and operating complex machinery. A skill gives a person a special advantage over unskilled workers in the labor market.

Skills are not gained by doing unskilled jobs, and a person has no special advantage if he or she is skilled or semiskilled but can qualify only for an unskilled job because his or her skills cannot be used to any significant degree in other jobs.

Transferability means applying work skills which a person has demonstrated in vocationally relevant past jobs to meet the requirements of other skilled or semiskilled jobs. Transferability is distinct from the usage of skills recently learned in school which may serve as a basis for direct entry into skilled work (Appendix 2, section 201.00(g)).

Unskilled occupations are the least complex types of work. Jobs are unskilled when persons can usually learn to do them in 30 days or less. The majority of unskilled jobs are identified in the Department of Labor's *Dictionary of Occupational Titles (DOT).*

*Semiskilled occupation*s are more complex than unskilled work and distinctly simpler than the more highly skilled types of jobs. They contain more variables and require more judgment than do unskilled occupations. Even though semiskilled occupations require more than 30 days to learn, the content of work activities in some semiskilled jobs may be little more than unskilled." Examples: transferability of skills probably wouldn't be found in semi-skilled jobs such as a room service waiter and a nurse aide. On the other hand, an office clerk may have some transferable skills to a sedentary occupation.

Where transferability is at issue, it is most probable and meaningful among jobs in which: (1) the same or a lesser degree of skill is required, because people are not expected to do more complex jobs than they have actually performed (i.e, from a skilled to a semiskilled or another skilled job, or from one semiskilled to another semiskilled job); (2) the same or similar tools and machines are used; and (3) the same or similar raw materials, products, processes or services are involved. A complete similarity of all these factors is not necessary. There are degrees of transferability ranging from very close similarities to remote and incidental similarities among jobs.

When a finding is made that a claimant has transferable skills, the acquired work skills must be identified, and specific occupations to which the acquired work skills are transferable must be cited in the State agency's determination or ALJ's decision. Evidence that these specific skilled or semiskilled jobs exist in significant numbers in the national economy should be included (the regulations take administrative notice only of the existence of unskilled sedentary, light, and medium jobs in the national economy).

Note: There are specials rules for transferability for workers over 55 and workers over 60. See 20 CFR Pt. 404, Subpart P, Appendix 2 sections 201.00(e), (f) and 202.00(c), (e), (f).

Stone v. Barnhart, 332 F.Supp.2d 474 (D.Conn. 2004) (CFD) (TPS). This case discusses transferability of skills for individuals over age 55. See 20 CFR Part 404, App. 2, Rule 201.00(f) which says in "order to find transferability of skills to skilled sedentary work for individuals who are of advanced age (55 and over), there must be very little, if any, vocational adjustment required in terms of tools, work processes, work setting, or the industry." In this case, the Court ruled that similarity does not require the work to be identical. "Slight adjustments" will not prevent the transfer of skills.

SSR 82-61 – Past Relevant Work as Actually or Generally Performed

Practice Tip: Clients sometimes describe their job as light when in fact the job as generally performed is medium. This can harm their claim because it makes it easier for the ALJ to deny the claim at step four by finding they have a light RFC and, thus, can perform their past work at the light level of exertion. Be careful in obtaining information from the claimant about their past work.

SSR 82-62 – Capacity to Do Past Relevant Work

- To be considered past relevant work, it must have been *substantial gainful activity*.

- Past relevant work is work performed within the past 15 years of the initial, reconsideration, or ALJ adjudication. Thus, jobs that are relevant at the initial level of adjudication may not be relevant at the ALJ hearing.

- The ALJ should make the following findings of fact: "1. A finding of fact as to the individual's RFC. 2. A finding of fact as to the physical and mental demands of the past job/occupation. 3. A finding of fact that the individual's RFC would permit a return to his or her past job or occupation."

Schaal v. Callahan, 993 F. Supp. 85 (D.Conn. 1997) (RNC). Where the record did not include a description of the job duties and associated mental demands of the job previously performed by a mentally impaired claimant, it was insufficient to enable the court to review the ALJ's determination that the plaintiff could perform past work.

Abbott v. Colvin, 596 Fed.Appx. 21 (2d Cir. 2018). This case was remanded because the ALJ failed to make a "careful appraisal" of the claimant's past relevant work as required by SSR 82-62.

SSR 82-63 – Medical-Vocational Profiles Showing An Inability To Make Adjustment To Other Work

Marginal education (sections 404.1564(b)(2)/416.964(b)(2) of the regulations) indicates that the person may not have attained a level of development in reasoning, arithmetic, and language which would suggest a vocational potential for more than unskilled work. Generally, an individual is considered to have a marginal education if he or she has no more than a sixth grade elementary school education. However, the level of formal education is not conclusive of a person's vocational competence. The responsibilities and tasks of past employment may demonstrate a higher level of competence than that indicated by his or her formal schooling. Conversely, a person may have attended school beyond the sixth grade, but other evidence may establish capability for reasoning, arithmetic, and language which does not, in fact, exceed the "marginal" criterion.

Comment: The actual grade last completed may or may not reflect a reading and/or math ability related to the grade level. See: 20 CFR 404.1564(b), 416.964(b); see also SSR 20-1p.

Special "No Work Experience" Cases

An SSA policy decision of July 7, 1975, provided that, up to the point of advanced age, persons without work experience and those who have performed only unskilled work will be given the same consideration. Recognizing that advanced age (55 or older) is a critical point for a vocational adjustment in that a person would have much difficulty in learning and doing activities not previously performed, SSA decided that a special policy should apply to disability claimants and beneficiaries who are of advanced age and have no recent and relevant work experience.

Generally, individuals are considered as having no recent and relevant work experience when they have either performed no work activity within the 15-year period prior to the point at which the claim is being considered for adjudication, or the work activity performed within this 15-year period does not (on the basis of job content, recency, or duration) enhance present work capability.

All such cases requiring vocational consideration must be decided on the basis of whether the individual's RFC, age, education, and lack of work experience are compatible with an adjustment to competitive remunerative work. Although the absence of relevant work experience represents an adverse vocational consideration, the adjudicative weight to be ascribed to this factor must be viewed in the context of the substantial numbers of unskilled jobs in the national economy which involve only simple job duties that can be learned in a short period of time and require no previous qualifying work experience. Therefore, the absence of work experience can be evaluated only in the context of the range of work the individual can do functionally and of the other vocational factors of age, education and training. The following adjudicative guidelines provide a perspective for evaluating the interaction of the functional and vocational variables in cases involving individuals without work experience:

Generally, the RFC to perform a wide range of light work represents sufficient capacity to engage in substantial work for the individual who is not of advanced age and can communicate, read, and write on a marginal educational level.

Generally, where an individual of advanced age with no relevant work experience has a limited education or less, a finding of an inability to make a vocational adjustment to substantial work will be made, provided his or her impairment(s) is severe, i.e., significantly limits his or her physical or mental capacity to perform basic work-related functions.

In the cases involving individuals of advanced age, the only medical issue is the existence of a severe medically determinable impairment. The only vocational issues are advanced age, limited education or less, and absence of relevant work experience. With affirmative findings of fact, the conclusion would generally follow that the claimant or beneficiary is under a disability. If all the criteria of this medical-vocational profile are not met, the case must be decided on the basis of the principles and definitions in the regulations, giving consideration to the rules for specific case situations in Appendix 2.

Comment: This ruling shows that claimants of advanced age who have somewhat benign though severe impairments can be found disabled.

See: 20 CFR 404.1562(b), 416.962(b).

SSR 83-10 – Determining Capability to Do Other Work

Comment: This ruling contains many of the definitions pertinent to the application of the grid. Selected definitions are presented below.

Levels of Exertion:

1. *Sedentary work*. The regulations define sedentary work as involving lifting no more than 10 pounds at a time and occasionally lifting or carrying articles like docket files, ledgers, and small tools. Although sitting is involved, a certain amount of walking and standing is often necessary in carrying out job duties. Jobs are sedentary if walking and standing are required occasionally and other sedentary criteria are met. By its very nature, work performed primarily in a seated position entails no significant stooping. Most unskilled sedentary jobs require good use of the hands and fingers for repetitive hand-finger actions.

"*Occasionally*" means occurring from very little up to one-third of the time. Since being on one's feet is required "occasionally" at the sedentary level of exertion, periods of standing or walking should generally total no more than about 2 hours of an 8-hour workday, and sitting should generally total approximately 6

hours of an 8-hour workday. Work processes in specific jobs will dictate how often and how long a person will need to be on his or her feet to obtain or return small articles.

2. *Light work.* The regulations define light work as lifting no more than 20 pounds at a time with frequent lifting or carrying of objects weighing up to 10 pounds. Even though the weight lifted in a particular light job may be very little, a job is in this category when it requires a good deal of walking or standing -- the primary difference between sedentary and most light jobs. A job is also in this category when it involves sitting most of the time but with some pushing and pulling of arm-hand or leg-foot controls, which require greater exertion than in sedentary work; e.g., mattress sewing machine operator, motor-grader operator, and road-roller operator (skilled and semiskilled jobs in these particular instances). Relatively few unskilled light jobs are performed in a seated position.

"*Frequent*" means occurring from one-third to two-thirds of the time. Since frequent lifting or carrying requires being on one's feet up to two-thirds of a workday, the full range of light work requires standing or walking, off and on, for a total of approximately 6 hours of an 8-hour workday. Sitting may occur intermittently during the remaining time. The lifting requirement for the majority of light jobs can be accomplished with occasional, rather than frequent, stooping. Many unskilled light jobs are performed primarily in one location, with the ability to stand being more critical than the ability to walk. They require use of arms and hands to grasp and to hold and turn objects, and they generally do not require use of the fingers for fine activities to the extent required in much sedentary work.

3. *Medium work.* The regulations define medium work as lifting no more than 50 pounds at a time with frequent lifting or carrying of objects weighing up to 25 pounds. A full range of medium work requires standing or walking, off and on, for a total of approximately 6 hours in an 8-hour workday in order to meet the requirements of frequent lifting or carrying objects weighing up to 25 pounds. As in light work, sitting may occur intermittently during the remaining time. Use of the arms and hands is necessary to grasp, hold, and turn objects, as opposed to the finer activities in much sedentary work, which require precision use of the fingers as well as use of the hands and arms.

The considerable lifting required for the full range of medium work usually requires frequent bending-stooping. (*Stooping* is a type of bending in which a person bends his or her body downward and forward by bending the spine at the waist.) Flexibility of the knees as well as the torso is important for this activity. (*Crouching* is bending both the legs and spine in order to bend the body downward and forward.) However, there are relatively few occupations in the national economy which require exertion in terms of weights that must be lifted at time (or involve equivalent exertion in pushing and pulling), but are performed primarily in a sitting position, e.g., taxi driver, bus driver, and tank-truck driver (semi-skilled jobs). In most medium jobs, being on one's feet for most of the workday is critical. Being able to do frequent lifting or carrying of objects weighing up to 25 pounds is often more critical than being able to lift up to 50 pounds at a time.

Nonexertional Impairment. Any impairment which does not directly affect the ability to sit, stand, walk, lift, carry, push, or pull. This includes impairments which affect the mind, vision, hearing, speech, and use of the body to climb, balance, stoop, kneel, crouch, crawl, reach, handle, and use of the fingers for fine activities.

Nonexertional Limitation. An impairment-caused limitation of function which directly affects capability to perform work activities other than the primary strength activities.

Nonexertional Restriction (Environmental Restriction). An impairment-caused need to avoid one or more environmental conditions in a workplace.

Levels of Skill:

1. *Unskilled work.* Unskilled work is work which needs little or no judgment to do simple duties that can be learned on the job in a short period of time. The job may or may not require considerable

strength. For example, we consider jobs unskilled if the primary work duties are handling, feeding, and offbearing (that is, placing or removing materials from machines which are automatic or operated by others), or machine tending, and a person can usually learn to do the job in 30 days, and little specific vocational preparation and judgment are needed. A person does not gain work skills by doing unskilled work.

2. *Semiskilled work.* Semiskilled work is work which needs some skills but does not require doing the more complex work duties. Semiskilled jobs may require alertness and close attention to watching machine processes; or inspecting, testing or otherwise looking for irregularities; or tending or guarding equipment, property, material, or persons against loss, damage or injury; or other types of activities which are similarly less complex than skilled work, but more complex than unskilled work. A job may be classified as semiskilled where coordination and dexterity are necessary, as when hands or feet must be moved quickly to do repetitive tasks.

3. *Skilled work.* Skilled work requires qualifications in which a person uses judgment to determine the machine and manual operations to be performed in order to obtain the proper form, quality, or quantity of material to be produced. Skilled work may require laying out work, estimating qualify, determining the suitability and needed quantities, of materials, making precise measurements, reading blueprints or other specifications, or making necessary computations or mechanical adjustments to control or regulate the work. Other skilled jobs may require dealing with people, facts, or figures or abstract ideas at a high level of complexity.

Vocational Factors:

1. *Age*. The regulations provide the older age is an increasingly adverse vocational factor for persons with severe impairments. The chronological ages, 45, 50, 55, and 60 may be critical to a decision. However, the regulations also provide that age categories are not applied mechanically in borderline situations. For example, a rule for an individual of advanced age (55 or older) could be found applicable, in some circumstances, to an individual whose chronological age is 54 years and 11 months (closely approaching advanced age). No fixed guidelines as to when a borderline situation exists are provided since such guidelines would themselves reflect a mechanical approach.
Under Title II, a period of disability cannot begin after a worker's disability insured status has expired. When the person last met the insured status requirement before the date of adjudication, the oldest age to be considered is the person's age at the date last insured. In these situations, the person's age at the time of decision making is immaterial.

2. *Education.* Unless there is evidence to contradict a persons's statement as to the numerical grade level completed in school, the statement will be used to determine the persons's educational abilities. The person's present level of reasoning, communication, and arithmetical ability may be higher or lower than the level of formal education. Evidence of this includes the kinds of responsibilities the person had when working, any acquired work skills, daily activities, and hobbies, as well as the results of testing. Therefore, a person will meet the criteria for the different education levels specified in the regulations, not solely on the basis of his or her statements, but based upon all evidence pertinent to evaluating that person's educational capacities.

The criterion of "high school graduate or more -- provides for direct entry into skilled work" is met when there is little time lapse between the completion of formal education and the date of adjudication, and where the content of the education would enable individuals, with a minimal degree of job orientation, to begin performing the skilled job duties of certain identifiable occupations within their RFC.

3. *Previous Work Experience.* A person's work experience may be none, not vocationally relevant, unskilled, semiskilled, or skilled. To meet the criterion of "skilled or semiskilled -- skills transferable," a person must have performed work which is above the unskilled level of complexity, must have identifiable skills, and must be able to use these skills in specific skilled or semiskilled occupations within his or her RFC.

See: Soules v. Astrue, Civ. No. 3:11-cv-01048 (D.Conn. September 27, 2012) (JCH) (HBF) (unreported). The court stated, "A claimant's formal education is conclusive proof of his educational abilities under the regulations only if no other evidence is presented to contradict it… (there must be 'other evidence' to contradict a claimant's numerical grade level to determine educational abilities)."

SSR 83-11 – Capability to Do Other Work – The Exertionally Based Medical-Vocational Rules Met

This ruling states, "The RFC upon which each table rule is based reflects the absence of any nonexertional limitation."

Hedman-Ouellette v. Social Security Administration, 2009 WL 497605 (D.Conn. Feb. 2, 2009) (JGM). The court ruled that the grid could not be used to direct a finding of not disabled where the claimant had nonexertional limitations that included pain, weakness, fatigue, major depression, poor concentration, memory deficits and word-finding difficulty. The court stated these limitations significantly diminished the claimant's work capacity beyond that caused by her exertional limitations and, thus, vocational expert testimony was needed.

Hilton v. Commissioner Of Social Security, 2002 WL 32152290 (D.Conn. Nov. 11, 2002) (JGM). "In light of the psychological reports suggesting that Hilton is functionally illiterate, reliance on statements that Hilton graduated from high school and evaluating him under a standard that presumes an ability to function commensurate with that educational level may not be warranted. Upon remand, if the ALJ determines that this case is properly resolved by application of the Grid, he is directed to determine whether the grid category applied by ALJ Kanell is warranted in light of the psychological reports."

Practice Tip: POMS DI 25015.006 Borderline Age. This POMS section provides examples of how a claimant might reach a higher age category to be found disabled under the grid.

SSR 83-12 – Capability to Do Other Work – The Medical-Vocational Rules as a Framework for Evaluating Exertional Limitations within a Range of Work or Between Ranges of Work

Where an individual exertional RFC does not coincide with the definitions of any one of the ranges of work as defined in sections 404.1567 and 416.967 of the regulations, the occupational base is affected and may or may not represent a significant number of jobs in terms of the rules directing a conclusion as to disability. The adjudicator will consider the extent of any erosion of the occupational base and access its significance. In some instances, the restriction will be so slight that it would clearly have little effect on the occupational base. In cases of considerably greater restriction(s), the occupational base will obviously be affected. In still other instances, the restrictions of the occupational base will be less obvious.

Where the extent of erosion of the occupational base is not clear, the adjudicator will need to consult a vocational resource.

Comment: ALJs will frequently use the grid as a *framework* to determine whether the individual is or is not disabled.

Alternate Sitting and Standing

In some disability claims, the medical facts lead to an assessment of RFC which compatible with the performance of either sedentary or light work except that the person must alternate periods of sitting and standing. The individual may be able to sit for time, but must then get up and stand or walk for awhile before returning to sitting. Such an individual is not functionally capable of doing either the prolonged

sitting contemplated in the definition of sedentary work (and for the relatively few light jobs which are performed primarily in a seated position) or the prolonged standing or walking contemplated for most light work. (Persons who can adjust to any need to vary sitting and standing by doing so at breaks, lunch periods, etc., would still be able to perform a defined range of work.)

There are some jobs in the national economy -- typically professional and managerial ones -- in which a person can sit or stand with a degree of choice. If an individual had such a job and is still capable of performing it, or is capable of transferring work skills to such jobs, he or she would not be found disabled. However, most jobs have ongoing work processes which demand that a worker be in a certain place or posture for at least a certain length of time to accomplish a certain task. Unskilled types of jobs are particularly structured so that a person cannot ordinarily sit or stand at will. In cases of unusual limitation of ability to sit or stand, a VS should be consulted to clarify the implications for the occupational base.

2. *Loss of Use of an Upper Extremity*

A person who has lost the use of an arm or hand because of amputation, paralysis, etc., obviously cannot perform jobs which require use of both arms or both hands. Loss of major use of an upper extremity is rather definitive in that there is a considerable absence of functional ability. As stated in SSR 82-51, PPS-85, Guidelines for Residual Functional Capacity Assessment in Musculoskeletal and Cardiovascular Impairments*, an amputation above the elbow would limit a person to light work activity with additional limitations because of loss of bimanual manipulation and difficulty or inability to handle bulky objects; effective use of the remaining hand may also be affected.* An amputation below the elbow -- or partial loss of use of the extremity -- will require a more detailed evaluation of functional ability, including the condition of the remaining stump and the person's ability to use a prosthesis -- or the person's remaining ability for fine and gross manipulating.

Experience with persons who have lost the use of an upper extremity has shown that their potential occupational base is between the occupational bases for Table No. 1 (sedentary work) and Table No.2 (light work). While individuals with this impairment have been known to perform selected occupations at nearly all exertional levels, the total number of occupations within their RFC's is less than the number represented by a full or wide range of light work. These individuals would generally not be expected to perform sedentary work because most unskilled sedentary jobs require good use of both hands. Persons who have the least remaining function would have only the lower occupational base, while those who have the most remaining function would have some of the higher occupational base added in terms of numbers of jobs which can be performed with this type of impairment. Given an individual's particular RFC, a VS will be able to determine the size of the remaining occupational base, cite specific jobs within the individual's RFC, and provide a statement of the incidence of those jobs in the region of the individual's residence or in several regions of the country.

Caveat: Despite what the Ruling says, experience shows that vocational experts frequently find unskilled jobs that can be performed with a sit/stand option including sit/stand at will. See SSR 96-9p regarding sit/stand jobs.

SSR 83-14 – Capability to Do Other Work – The Medical-Vocational Rules as a Framework for Evaluating a Combination of Exertional and Nonexertional Impairments

Examples of Evaluation Involving Combinations of Exertional and Nonexertional Limitations

1. *Sedentary exertion combined with a nonexertional impairment.* Example 1 of section 201.00(h) in Appendix 2 illustrates a limitation to unskilled sedentary work with an additional loss of *bilateral manual dexterity* that is significant and, thus, warrants a conclusion of "Disabled." (The bulk of unskilled sedentary

jobs requires bilateral manual dexterity.) An example of nonexertional impairment which ordinarily has an insignificant effect on a person's ability to work is an allergy to ragweed pollen. Many individuals who have this allergy experience no more discomfort during the ragweed season than someone who has a common cold. However, others are more affected by the condition. Assuming that an individual has a severe impairment of the low back which limits that person to sedentary work, and that the assessment of RFC also restricts him or her from workplaces which involve exposure to ragweed pollen, the implications for adjustment to sedentary work are relatively clear. Ragweed grows outdoors and its pollen is carried in the air, but the overwhelming majority of sedentary jobs are performed indoors. Therefore, with the possible exclusion of some outdoor sedentary occupations which would require exposure to ragweed pollen, the unskilled sedentary occupational base is not significantly compromised. The decision maker may need the assistance of a VS in determining the significance of the remaining occupational base of unskilled sedentary work in more difficult cases.

2. *Light exertion combined with a nonexertional impairment.* The major difference between sedentary and light work is that most light jobs -- particularly those at the unskilled level of complexity -- require a person to be standing or walking most of the workday. Another important difference is that the frequent lifting or carrying of objects weighing up to 10 pounds (which is required for the full range of light work) implies that the worker is able to do occasional bending of the stooping type, i.e., for no more than one-third of the workday to bend the body downward and forward by bending the spine at the waist. *Unlike unskilled sedentary work, many unskilled light jobs do not entail fine use of the fingers. Rather, they require gross use of the hands to grasp, hold, and turn objects. Any limitation of these functional abilities must be considered very carefully to determine its impact on the size of the remaining occupational base of a person who is otherwise found functionally capable of light work.*

Where a person has a visual impairment which is not of Listing severity but causes the person to be a hazard to self and others -- usually a constriction of visual fields rather than a loss of acuity -- the manifestations of tripping over boxes while walking, inability to detect approaching persons or objects, difficulty in walking up and down stairs, etc., will indicate to the decision maker that the remaining occupational base is significantly diminished for light work (and medium work as well).
On the other hand, there are nonexertional limitations or restrictions which have very little or no effect on the unskilled light occupational base. Examples are inability to ascend or descend scaffolding, poles, and ropes; inability to crawl on hands and knees; and inability to use the finger tips to sense the temperature or texture of an object. Environmental restrictions, such as the need to avoid exposure to feathers, would also not significantly affect the potential unskilled light occupational base.

Where nonexertional limitations or restrictions within the light work category are between the examples above, a decision maker will often require the assistance of a VS.

3. *Medium exertion combined with a nonexertional impairment.* Most medium jobs, like most light jobs, require the worker to stand or walk most of the time. Also, as in light work, most unskilled medium jobs require gross use of the hands to grasp, hold, and turn objects rather than use of the fingers for fine movements of small objects. Medium work is distinct from the less strenuous levels in the activities needed to accomplish the considerable lifting and carrying involved for the full range of medium work. A maximum of 50 pounds may be lifted at a time, with frequent lifting or carrying of objects weighing up to 25 pounds. (*Frequent* in this context means from one-third to two-thirds of the workday.) Consequently, to perform the full range of medium work as defined, a person must be able to do both frequent stooping and frequent crouching -- bending both the back and the legs -- in order to move objects from one level to another or to move the objects near foot level. While individual occupations classified as medium work vary in exertional demands from just above the light work requirements to the full range of medium work, any limitation of these functional abilities must be considered very carefully to determine its impact on the size of the remaining occupational base of a person who is otherwise found capable of medium work.
In jobs at the medium level of exertion, there is more likelihood than in light work that such factors as the ability to ascend or descend ladders and scaffolding, kneel, and crawl will be a part of the work requirement. However, limitations of these activities would not significantly affect the occupational base.

As in light work, inability to use the finger tips to sense the temperature or texture of an object is an example of a nonexertional limitation which would have very little effect on the potential unskilled medium occupational base. The need to avoid environments which contain objects or substances commonly known not to exist in most workplaces would be an obvious example of a restriction which does not significantly affect the medium occupational base.

Where nonexertional limitations or restrictions within the medium work category are between the examples above, a decision maker will often require the assistance of a VS.

SSR 85-15 – Capability to Do Other Work – The Medical-Vocational Rules as a Framework for Evaluating Solely Nonexertional Impairments

The basic mental demands of competitive, remunerative, unskilled work include the abilities (on a sustained basis) to understand, carry out, and remember simple instructions; to respond appropriately to supervision, coworkers, and usual work situations; and to deal with changes in a routine work setting. A substantial loss of ability to meet any of these basic work-related activities would severely limit the potential occupational base. This, in turn, would justify a finding of disability because even favorable age, education, or work experience will not offset such a severely limited occupational base.

Stress and Mental Illness — Since mental illness is defined and characterized by maladaptive behavior, it is not unusual that the mentally impaired have difficulty accommodating to the demands of work and work-like settings. Determining whether these individuals will be able to adapt to the demands or "stress" of the workplace is often extremely difficult. This section is not intended to set out any presumptive limitations for disorders, but to emphasize the importance of thoroughness in evaluation on an individualized basis.

Individuals with mental disorders often adopt a highly restricted and/or inflexible lifestyle within which they appear to function well. Good mental health services and care may enable chronic patients to function adequately in the community by lowering psychological pressures, by medication, and by support from services such as outpatient facilities, day care programs, social work programs and similar assistance.

The reaction to the demands of work (stress) is highly individualized, and mental illness is characterized by adverse responses to seemingly trivial circumstances. The mentally impaired may cease to function effectively when facing such demands as getting to work regularly, having their performance supervised, and remaining in the workplace for a full day. A person may become panicked and develop palpitations, shortness of breath, or feel faint while riding in an elevator; another may experience terror and begin to hallucinate when approached by a stranger asking a question. Thus, the mentally impaired may have difficulty meeting the requirement of even so-called "low stress" jobs.

Because response to the demands of work is highly individualized, the skill level of a position is not necessarily related to the difficulty an individual will have in meeting the demands of the job. A claimant's condition may make performance of an unskilled job as difficult as an objectively more demanding job, for example, a busboy need only clear dishes from tables. But an individual with a severe mental disorder may find unmanageable the demand of making sure that he removes all the dishes, does not drop them, and gets the table cleared promptly for the waiter or waitress. Similarly, an individual who cannot tolerate being supervised may be not able to work even in the absence of close supervision; the *knowledge* that one's work is being judged and evaluated, even when the supervision is remote or indirect, can be intolerated for some mentally impaired persons. Any impairment-related limitations created by an individual's response to demands of work, however, must be reflected in the RFC assessment.

Postural-Manipulative Impairments

a. Limitations in *climbing and balancing* can have varying effects on the occupational base, depending on the degree of limitation and the type of job. Usual everyday activities, both at home and at work, include

ascending or descending ramps or a few stairs and maintaining body equilibrium while doing so. These activities are required more in some jobs that in others, and they may be critical in some occupations. Where a person has some limitation in climbing and balancing and it is the only limitation, it would not ordinarily have a significant impact on the broad world of work. Certain occupations, however, may be ruled out; e.g., the light occupation of construction painter, which requires climbing ladders and scaffolding, and the very heavy occupation of fire-fighter, which sometimes requires the individual to climb poles and ropes. Where the effects of a person's actual limitations of climbing and balancing on the occupational base are difficult to determine, the services of a VS may be necessary.

b. *Stooping, kneeling, crouching, and crawling* are progressively more strenuous forms of bending parts of the body, with crawling as a form of locomotion involving bending. *Some stooping (bending the body downward and forward by bending the spine at the waist) is required to do almost any kind of work*,, particularly when objects below the waist are involved. *If a person can stoop occasionally (from very little up to one-third of the time) in order to lift objects, the sedentary and light occupational base is virtually intact.* However, because of the lifting require for most medium, heavy, and very heavy jobs, a person must be able to stoop frequently (from one-third to two-thirds of the time); inability to do so would substantially affect the more strenuous portion of the occupational base. This is also true for crouching (bending the body downward and forward by bending both the legs and spine). However, crawling on hands and knees and feet is a relatively rare activity even in arduous work, and limitations on the ability to crawl would be of little significance in the broad world or work. This is also true of kneeling (bending the legs at the knees to come to rest on one or both knees).

c. *Reaching, handling, fingering, and feeling* require progressively finer usage of the upper extremities to perform work-related activities. *Reaching* (extending the hands and arms in any direction) and *handling* (seizing, holding, grasping, turning or otherwise working primarily with the whole hand or hands) are activities required in almost all jobs. Significant limitations of reaching or handling, therefore, may eliminate a large number of occupations a person could otherwise do. Varying degrees of limitations would have different effects, and the assistance of a VS may be needed to determine the effects of the limitations. "*Fingering*" involves picking, pinching, or otherwise working primarily with the fingers. It is needed to perform most unskilled sedentary jobs and to perform certain skilled and semiskilled jobs at all levels of exertion. As a general rule, limitations of fine manual dexterity have greater adjudicative significance — in terms of relative number of jobs in which the function is required — as the person's exertional RFC decreases. *Thus, loss of fine manual dexterity narrows the sedentary and light ranges of work much more than it does the medium, heavy, and very heavy ranges of work.* The varying degrees of loss which can occur may require a decision maker to have the assistance of a VS. However, a VS would not ordinarily be required where a person has a loss of ability to feel the size, shape temperature, or texture of an object by the fingertips, since this is a function required in very few jobs.

This ruling also addresses how hearing impairments, visual impairments, and environmental restrictions impact upon the occupational base.

POMS section DI 25020.010 – Mental Limitations. This POMS section highlights the mental demands of unskilled work and the mental abilities critical for performing unskilled work.

Lancellotta v. Sec'y HHS, 806 F.2d 2d 284 (1 Cir. 1986). A good discussion on how stress should be should be evaluated as it impacts upon a claimant's mental functioning.

Shine v. Barnhart, 2004 WL 834642 (D.Conn.) (HBF). This decision directed the ALJ to reconsider his finding regarding the claimant's ability to perform low stress work in light of SSR 85-15. The court cited Lancellotta v. Secretary of Health and Human Services, 806 F.2d 284 (1st Cir. 1986) in its decision.

Richardson v. Berryhill, 2018 WL 1505575 (D.Conn. Mar. 27, 2018). The court remanded this case because the ALJ failed to address or consider the claimant's ability to handle stress.

SSR 96-9p – Determining Capability to Do Other Work – Implications of a Residual Functional Capacity for Less Than a Full Range Of Sedentary Work

(See below, p. 52)

SSR 00-4p – Use of Vocational Expert and Vocational Specialist Evidence and Other Reliable Occupational Information in Disability Decisions

- This Ruling clarifies our standards for the use of vocational experts (VEs) who provide evidence at hearings before administrative law judges (ALJs), vocational specialists (VSs) who provide evidence to disability determination services (DDS) adjudicators, and other reliable sources of occupational information in the evaluation of disability claims. In particular, this ruling emphasizes that before relying on VE or VS evidence to support a disability determination or decision, our adjudicators must:

- Identify and obtain a reasonable explanation for any conflicts between occupational evidence provided by VEs or VSs and information in the *Dictionary of Occupational Titles* (DOT), including its companion publication, the *Selected Characteristics of Occupations Defined in the Revised Dictionary of Occupational Titles* (SCO), published by the Department of Labor, and

- Explain in the determination or decision how any conflict that has been identified was resolved.

- In making disability determinations, we rely primarily on the DOT (including its companion publication, the SCO) for information about the requirements of work in the national economy. We use these publications at steps 4 and 5 of the sequential evaluation process. We may also use VEs and VSs at these steps to resolve complex vocational issues.[1] We most often use VEs to provide evidence at a hearing before an ALJ. At the initial and reconsideration steps of the administrative review process, adjudicators in the DDSs may rely on VSs for additional guidance. See, for example, SSRs 82-41, 83-12, 83-14, and 85-15.

- Occupational evidence provided by a VE or VS generally should be consistent with the occupational information supplied by the DOT. When there is an apparent unresolved conflict between VE or VS evidence and the DOT, the adjudicator must elicit a reasonable explanation for the conflict before relying on the VE or VS evidence to support a determination or decision about whether the claimant is disabled. At the hearings level, as part of the adjudicator's duty to fully develop the record, the adjudicator will inquire, on the record, as to whether or not there is such consistency.

Neither the DOT nor the VE or VS evidence automatically "trumps" when there is a conflict. The adjudicator must resolve the conflict by determining if the explanation given by the VE or VS is reasonable and provides a basis for relying on the VE or VS testimony rather than on the DOT information.

SSA adjudicators may not rely on evidence provided by a VE, VS, or other reliable source of occupational information if that evidence is based on underlying assumptions or definitions that are inconsistent with our regulatory policies or definitions. For example:

- Exertional Level

  We classify jobs as sedentary, light, medium, heavy and very heavy (20 CFR 404.1567 and 416.967). These terms have the same meaning as they have in the exertional classifications noted in the DOT.

  Although there may be a reason for classifying the exertional demands of an occupation (as generally performed) differently than the DOT (e.g., based on other reliable occupational information), the regulatory definitions of exertional levels are controlling. For example, if all available evidence (including VE testimony) establishes that the exertional demands of an occupation meet the regulatory definition of "medium" work (20 CFR 404.1567 and 416.967), the adjudicator may not rely on VE testimony that the occupation is "light" work.

- Skill Level

A skill is knowledge of a work activity that requires the exercise of significant judgment that goes beyond the carrying out of simple job duties and is acquired through performance of an occupation that is above the unskilled level (requires more than 30 days to learn). (See SSR 82-41.) Skills are acquired in PRW and may also be learned in recent education that provides for direct entry into skilled work.

The DOT lists a specific vocational preparation (SVP) time for each described occupation. Using the skill level definitions in 20 CFR 404.1568 and 416.968, unskilled work corresponds to an SVP of 1-2; semi-skilled work corresponds to an SVP of 3-4; and skilled work corresponds to an SVP of 5-9 in the DOT.

Although there may be a reason for classifying an occupation's skill level differently than in the DOT, the regulatory definitions of skill levels are controlling. For example, VE or VS evidence may not be relied upon to establish that unskilled work involves complex duties that take many months to learn, because that is inconsistent with the regulatory definition of unskilled work. See 20 CFR 404.1568 and 416.968.

- Transferability of Skills

  Evidence from a VE, VS, or other reliable source of occupational information cannot be inconsistent with SSA policy on transferability of skills. For example, an individual does not gain skills that could potentially transfer to other work by performing unskilled work. Likewise, an individual cannot transfer skills to unskilled work or to work involving a greater level of skill than the work from which the individual acquired those skills. See SSR 82-41

- When a VE or VS provides evidence about the requirements of a job or occupation, the adjudicator has an affirmative responsibility to ask about any possible conflict between that VE or VS evidence and information provided in the DOT. In these situations, the adjudicator will:

- Ask the VE or VS if the evidence he or she has provided conflicts with information provided in the DOT; and
- If the VE's or VS's evidence appears to conflict with the DOT, the adjudicator will obtain a reasonable explanation for the apparent conflict.

Smalls v. Astrue, Civ. No. 3:09-cv-1904 (Rec. Ruling, December 2010) (VLB) (TPS) (unreported). In this case, the VE testified the claimant's past work as an assembler was a sedentary job while the DOT indicated it was a light level job. The court stated, "SSR 00-4p holds that an ALJ is responsible for inquiring as to why the VE's testimony deviates from the DOT. The ALJ must develop the record to explain the deviations. This is an 'affirmative duty' of the ALJ."

Lockwood v. Commissioner of the Social Security Administration, 914 F.3d 87 (2d Cir. 2019). The court remanded this claim because there was an unresolved conflict between the DOT and VE testimony. The claimant needed to avoid all overhead reaching and the VE found jobs requiring occasional and frequent reaching. The DOT does not distinguish between overhead reaching and reaching forward.

Haman v. Berryhill, 2019 WL 1383439 (D.Conn. Mar. 27. 2019) (VAB). The ALJ erred because he did not ask the vocational expert about the apparent conflict between the DOT listing for surveillance system monitor (GED reasoning level 3) and the claimant's RFC limitation to "simple, routine, and repetitive" tasks.

SSR 05-1c – Whether Past Relevant Work Must Exist in Substantial Numbers in the National Economy

Barnhart v. Thomas, 124 S.CT. 376 (2003). The Court ruled that past relevant work need not exist in substantial numbers in the national economy for it to be considered at step four in the sequential evaluation process. That case involved a former elevator operator.

Rulings Related To Residual Functional Capacity

SSR 85-15 – Capability to Do Other Work – The Medical-Vocational Rules as a Framework for Evaluating Solely Nonexertional Impairments

(See above, p. 44)

SSR 85-16 – Residual Functional Capacity for Mental Impairments

In analyzing the evidence, it is necessary to draw meaningful inferences and allow reasonable conclusions about the individual's strengths and weaknesses. Consideration should be given to factors such as:

- Quality of daily activities, both in occupational and social spheres (see Listing 12.00, Introduction), as well as of the individual's actions with respect to a medical examination.
- Ability to *sustain* activities, interests, and relate to others *over a period of time*. The *frequency, appropriateness, and independence* of the activities must also be considered (see PPS No. 96, SSR 83-15, Titles II and XVI: Evaluation of Chronic Mental Impairments).
- Level of intellectual functioning.
- Ability to function in a work-like situation.

The evaluation of intellectual functioning by a program physician, psychologist, ALJ, or AC member provides information necessary to determine the individual's ability to understand, to remember instructions, and to carry out instructions. Thus, an individual, in whom the only finding in intellectual testing is an IQ between 60 and 69, is ordinarily expected to be able to understand simple oral instructions and to be able to carry out these instructions under somewhat closer supervision than required of an individual with a higher IQ. Similarly, an individual who has an IQ between 70 and 79 should ordinarily be able to carry out these instructions under somewhat less close supervision.

In addition to medical evidence from medical sources, the ruling says: Other evidence also may play a vital role in the determination of the effects of impairment. To arrive at an overall assessment of the effects of mental impairment, relevant, reliable information, obtained from third party sources such as *social workers*, previous employers, family members, and *staff members of halfway houses*, *mental health centers*, and *community centers,* may be valuable in assessing an individual's level of activities of daily living. Information concerning an individual's performance in any work setting (including sheltered work and volunteer or competitive work), as well as the circumstances surrounding the termination of the work effort, may be pertinent in assessing the individual's ability to function in a competitive work environment.

Reports of *workshop evaluation* may also be of value in assessing the individual's ability to understand, to carry out and remember instructions, and to respond appropriately to supervisors, coworkers, and customary work pressures in a work setting. Consequently, wherever the record shows that a workshop evaluation has been performed, the report should be requested from the source. If no workshop evaluation has been done, but, after complete and comprehensive documentation, genuine doubt remains as to the individual's functional capacity, consideration should be given to obtaining one. Information derived from workshop evaluations must be used in conjunction with the clinical evidence of impairment, but all conflicts between workshop evaluation and evidence and the conclusions based on objective medical findings must be resolved.

Practice Tip: The testimony from social workers and case managers can be invaluable at the hearing. They can explain the claimant’s dependence on others for ADLs and their low level of daily functioning.

Schaal v. Callahan, 993 F. Supp. 85 (D.Conn. 1997) addresses the testimony of a social worker.

Practice Tip: Reports, evaluations, assessments, etc. from the State of Connecticut Bureau of Rehabilitation Services (BRS) can be very helpful in showing the existence of a disabling impairment.

SSR 96-8p – Assessing Residual Functional Capacity

- Ordinarily, RFC is the individual's *maximum* remaining ability to do sustained work activities in an ordinary work setting on a **regular and continuing** basis, and the RFC assessment must include a discussion of the individual's abilities on that basis. A "regular and continuing basis" means 8 hours a day, for 5 days a week, or an equivalent work schedule.

- **It is incorrect to find that an individual has limitations or restrictions beyond those caused by his or her medical impairment(s) including any related symptoms, such as pain, due to factors such as age or height, or whether the individual had ever engaged in certain activities in his or her past relevant work (e.g., lifting heavy weights.)** Age and body habitus (i.e., natural body build, physique, constitution, size, and weight, insofar as they are unrelated to the individual's medically determinable impairment(s) and related symptoms) are not factors in assessing RFC in initial claims.

- The RFC assessment is a function-by-function assessment based upon all of the relevant evidence of an individual's ability to do work-related activities. At step 5 of the sequential evaluation process, RFC must be expressed in terms of, or related to, the exertional categories when the adjudicator determines whether there is other work the individual can do. However, in order for an individual to do a full range of work at a given exertional level, such as sedentary, the individual must be able to perform substantially all of the exertional and nonexertional functions required in work at that level. Therefore, it is necessary to assess the individual s capacity to perform each of these functions in order to decide which exertional level is appropriate and whether the individual is capable of doing the full range of work contemplated by the exertional level.

- The RFC assessment must be based on *all* of the relevant evidence in the case record, such as:

- Medical history,
- Medical signs and laboratory findings,
- The effects of treatment, including limitations or restrictions imposed by the mechanics of treatment (e.g., frequency of treatment, duration, disruption to routine, side effects of medication),
- Reports of daily activities,
- Lay evidence,
- Recorded observations,
- Medical source statements,
- Effects of symptoms, including pain, that are reasonably attributed to a medically determinable impairment,
- Evidence from attempts to work,
- Need for a structured living environment, and
- Work evaluations, if available.

The adjudicator must consider all allegations of physical and mental limitations or restrictions and make every reasonable effort to ensure that the file contains sufficient evidence to assess RFC. Careful consideration must be given to any available information about symptoms because subjective descriptions may indicate more severe limitations or restrictions than can be shown by objective medical evidence alone.

In assessing RFC, the adjudicator must consider limitations and restrictions imposed by all of an individual's impairments, even those that are not "severe." While a "not severe" impairment(s) standing alone may not significantly limit an individual's ability to do basic work activities, it may--when considered with limitations or restrictions due to other impairments--be critical to the outcome of a claim. For example, in combination with limitations imposed by an individual's other impairments, the limitations due to such a "not severe" impairment may prevent an individual from performing past relevant work or may narrow the range of other work that the individual may still be able to do.

- Symptoms. In all cases in which symptoms, such as pain, are alleged, the RFC assessment must:

- Contain a thorough discussion and analysis of the objective medical and other evidence, including the individual's complaints of pain and other symptoms and the adjudicator's personal observations, if appropriate;
- Include a resolution of any inconsistencies in the evidence as a whole; and
- Set forth a logical explanation of the effects of the symptoms, including pain, on the individual's ability to work.

The RFC assessment must include a discussion of why reported symptom-related functional limitations and restrictions can or cannot reasonably be accepted as consistent with the medical and other evidence. In instances in which the adjudicator has observed the individual, he or she is not free to accept or reject that individual's complaints *solely* on the basis of such personal observations.

Practice Tip:

Note there are many mandates in this Ruling including the following:

1. The adjudicator *must* consider all allegations of physical and mental limitations or restrictions and make every reasonable effort to ensure that the file contains sufficient evidence to assess RFC. Careful consideration *must* be given to any available information about symptoms because subjective descriptions may indicate more severe limitations or restrictions than can be shown by objective medical evidence alone.

2. The RFC assessment *must* include a narrative discussion describing how the evidence supports each conclusion.

3. The adjudicator *must* discuss the individual's ability to perform sustained work activities in an ordinary work setting on a regular and continuing basis (8 hours a day, for 5 days a week or an equivalent work schedule).

4. The adjudicator *must* also explain how any material inconsistencies or ambiguities in the evidence in the case record were considered and resolved.

5. The RFC assessment *must* include a discussion of why reported symptom-related functional limitations and restrictions can or cannot reasonably be accepted as consistent with the medical and other evidence.

6. The RFC assessment *must* always consider and address medical source opinions. If the RFC conflicts with the opinion from a medical source the adjudicator *must* explain why the opinion was not adopted.

Cichocki v. Astrue, 729 F.3d 172 (2d Cir. 2013) where the court said, "Adopting a *per se* rule that these functions must be explicitly addressed on pain of remand (no matter how irrelevant or uncontested in the circumstances of a particular case) would thus not necessarily ensure that all relevant functions are considered. Any such rule in this Circuit, moreover, would put us at odds with sister Circuits who have recognized that an ALJ need not expressly discuss a claimant's capacity to perform each work-related function before classifying the claimant's RFC in exertional terms."

Morales v. Berryhill, 2019 WL 762667 (D.Conn. Feb. 21, 2019) (AWT). The court remanded this case because the ALJ failed to provide an adequate narrative discussion of critical evidence in the case. He failed to address the claimant's need for weekly IV infusions for anemia in determining the RFC.

Rivera v. Astrue, Civ. No. 3:11-cv-100 (D.Conn. May 3, 2012) (SRU) (WIG) (unreported). The ALJ erred in assessing the claimant's RFC under SSR 96-8p because he did not fully inquire into the claimant's physical restrictions and limitations. Here, he ignored the claimant's need to self-catheterize four times daily and the impact this would have on her ability to work.

SSR 96-9p – Determining Capability To Do Other Work – Implications Of A Residual Functional Capacity For Less Than A Full Range Of Sedentary Work

- The ability to perform the full range of sedentary work requires the ability to lift no more than 10 pounds at a time and occasionally to lift or carry articles like docket files, ledgers, and small tools. Although a sedentary job is defined as one that involves sitting, a certain amount of walking and standing is often necessary in carrying out job duties. Jobs are sedentary if walking and standing are required occasionally and other sedentary criteria are met. "Occasionally" means occurring from very little up to one- third of the time, and would generally total no more than about 2 hours of an 8-hour workday. Sitting would generally total about 6 hours of an 8-hour workday. Unskilled sedentary work also involves other activities, classified as "nonexertional," such as capacities for seeing, manipulation, and understanding, remembering, and carrying out simple instructions.

- A full range of sedentary work includes all or substantially all of the approximately 200[5] unskilled sedentary occupations administratively noticed in Table No. 1. (Refers to the grid)

- Where any one of the findings of fact does not coincide with the corresponding criterion of a rule in Table No. 1 (except in those cases where the concept of borderline age applies)[6], the rule does not direct a decision. In cases such as the following, the medical-vocational rules must be used as a framework for considering the extent of any erosion of the sedentary occupational base:

- Any one of an individual's exertional capacities is determined to be less than that required to perform a full range of sedentary work; or
- Based on an individual's exertional capacities, a rule in Table No. 1 would direct a decision of "not disabled," but the individual also has a nonexertional limitation(s) that narrows the potential range of sedentary work to which he or she might be able to adjust (i.e., the individual has the exertional capacity to do the full range of sedentary work, but the sedentary occupational base is reduced because of at least one nonexertional limitation).

When there is a reduction in an individual's exertional or nonexertional capacity so that he or she is unable to perform substantially all of the occupations administratively noticed in Table No. 1, the individual will be unable to perform the full range of sedentary work: the occupational base will be "eroded" by the additional limitations or restrictions. However, the mere inability to perform substantially all sedentary unskilled occupations does not equate with a finding of disability. There may be a number of occupations from the approximately 200 occupations administratively noticed, and jobs that exist in significant numbers, that an individual may still be able to perform even with a sedentary occupational base that has been eroded.

- Exertional capacity addresses an individual's limitations and restrictions of physical strength and defines the individual's remaining ability to perform each of seven strength demands: Sitting, standing, walking, lifting, carrying, pushing, and pulling. An exertional limitation is an *impairment-caused* limitation of any one of these activities.

- Nonexertional capacity considers any work-related limitations and restrictions that are not exertional. Therefore, a nonexertional limitation is an *impairment- caused* limitation affecting such capacities as mental

abilities, vision, hearing, speech, climbing, balancing, stooping, kneeling, crouching, crawling, reaching, handling, fingering, and feeling. Environmental restrictions are also considered to be nonexertional.

- if it can be determined that the individual has an ability to lift or carry slightly less than 10 pounds, with no other limitations or restrictions in the ability to perform the requirements of sedentary work, the unskilled sedentary occupational base would not be significantly eroded; however, an inability to lift or carry more than 1 or 2 pounds would erode the unskilled sedentary occupational base significantly.

- If an individual can stand and walk for a total of slightly less than 2 hours per 8-hour workday, this, by itself, would not cause the occupational base to be significantly eroded. Conversely, a limitation to standing and walking for a total of only a few minutes during the workday would erode the unskilled sedentary occupational base significantly. For individuals able to stand and walk in between the slightly less than 2 hours and only a few minutes, it may be appropriate to consult a vocational resource.

- **Sitting:** In order to perform a full range of sedentary work, an individual must be able to remain in a seated position for approximately 6 hours of an 8-hour workday, with a morning break, a lunch period, and an afternoon break at approximately 2-hour intervals. If an individual is unable to sit for a total of 6 hours in an 8-hour work day, the unskilled sedentary occupational base will be eroded. The extent of the limitation should be considered in determining whether the individual has the ability to make an adjustment to other work. See *Alternate sitting and standing* below.

The fact that an individual cannot do the sitting required to perform the full range of sedentary work does not necessarily mean that he or she cannot perform other work at a higher exertional level. In unusual cases, some individuals will be able to stand and walk longer than they are able to sit. If an individual is able to stand and walk for approximately 6 hours in an 8-hour workday (and meets the other requirements for light work), there may be a significant number of light jobs in the national economy that he or she can do even if there are not a significant number of sedentary jobs.

- **Alternate sitting and standing:** An individual may need to alternate the required sitting of sedentary work by standing (and, possibly, walking) periodically. Where this need cannot be accommodated by scheduled breaks and a lunch period, the occupational base for a full range of unskilled sedentary work will be eroded. The extent of the erosion will depend on the facts in the case record, such as the frequency of the need to alternate sitting and standing and the length of time needed to stand. The RFC assessment must be specific as to the frequency of the individual's need to alternate sitting and standing. It may be especially useful in these situations to consult a vocational resource in order to determine whether the individual is able to make an adjustment to other work.

- **Medically required hand-held assistive device:** To find that a hand-held assistive device is medically required, there must be medical documentation establishing the need for a hand-held assistive device to aid in walking or standing, and describing the circumstances for which it is needed (i.e., whether all the time, periodically, or only in certain situations; distance and terrain; and any other relevant information). The adjudicator must always consider the particular facts of a case. For example, if a medically required hand-held assistive device is needed only for prolonged ambulation, walking on uneven terrain, or ascending or descending slopes, the unskilled sedentary occupational base will not ordinarily be significantly eroded.

Since most unskilled sedentary work requires only occasional lifting and carrying of light objects such as ledgers and files and a maximum lifting capacity for only 10 pounds, an individual who uses a medically required hand-held assistive device in one hand may still have the ability to perform the minimal lifting and carrying requirements of many sedentary unskilled occupations with the other hand.[7] For example, an individual who must use a hand-held assistive device to aid in walking or standing because of an impairment that affects one lower extremity (e.g., an unstable knee), or to reduce pain when walking, who is limited to sedentary work because of the impairment affecting the lower extremity, and who has no other functional limitations or restrictions may still have the ability to make an adjustment to sedentary work that exists in significant numbers. On the other hand, the occupational base for an individual who must use such a device for balance because of significant involvement of both lower extremities (e.g., because of a neurological impairment) may be significantly eroded.

In these situations, too, it may be especially useful to consult a vocational resource in order to make a judgment regarding the individual's ability to make an adjustment to other work.

- **Postural limitations:** Postural limitations or restrictions related to such activities as climbing ladders, ropes, or scaffolds, balancing, kneeling, crouching, or crawling would not usually erode the occupational base for a full range of unskilled sedentary work significantly because those activities are not usually required in sedentary work. In the SCO, "balancing" means maintaining body equilibrium to prevent falling when walking, standing, crouching, or running on narrow, slippery, or erratically moving surfaces. If an individual is limited in balancing only on narrow, slippery, or erratically moving surfaces, this would not, by itself, result in a significant erosion of the unskilled sedentary occupational base. However, if an individual is limited in balancing even when standing or walking on level terrain, there may be a significant erosion of the unskilled sedentary occupational base. It is important to state in the RFC assessment what is meant by limited balancing in order to determine the remaining occupational base. Consultation with a vocational resource may be appropriate in some cases.

An ability to stoop occasionally; i.e., from very little up to one-third of the time, is required in most unskilled sedentary occupations. A *complete* inability to stoop would significantly erode the unskilled sedentary occupational base and a finding that the individual is disabled would usually apply, but restriction to occasional stooping should, by itself, only minimally erode the unskilled occupational base of sedentary work. Consultation with a vocational resource may be particularly useful for cases where the individual is limited to less than occasional stooping.

- Manipulative limitations: Most unskilled sedentary jobs require good use of both hands and the fingers; i.e., bilateral manual dexterity. Fine movements of small objects require use of the fingers; e.g., to pick or pinch. Most unskilled sedentary jobs require good use of the hands and fingers for repetitive hand-finger actions.

Any *significant* manipulative limitation of an individual's ability to handle and work with small objects with both hands will result in a significant erosion of the unskilled sedentary occupational base. For example, example 1 in section 201.00(h) of appendix 2, describes an individual who has an impairment that prevents the performance of any sedentary occupations that require bilateral manual dexterity (i.e., "limits the individual to sedentary jobs which do not require bilateral manual dexterity"). When the limitation is less significant, especially if the limitation is in the non-dominant hand, it may be useful to consult a vocational resource.

The ability to feel the size, shape, temperature, or texture of an object by the fingertips is a function required in very few jobs and impairment of this ability would not, by itself, significantly erode the unskilled sedentary occupational base.

- **Mental limitations or restrictions:** A substantial loss of ability to meet any one of several basic work-related activities on a sustained basis (i.e., 8 hours a day, 5 days a week, or an equivalent work schedule), will substantially erode the unskilled sedentary occupational base and would justify a finding of disability. These mental activities are generally required by competitive, remunerative, unskilled work:

- Understanding, remembering, and carrying out simple instructions.
- Making judgments that are commensurate with the functions of unskilled work--i.e., simple work- related decisions.
- Responding appropriately to supervision, co- workers and usual work situations.
- Dealing with changes in a routine work setting.

A less than substantial loss of ability to perform any of the above basic work activities may or may not significantly erode the unskilled sedentary occupational base. The individual's remaining capacities must be assessed and a judgment made as to their effects on the unskilled occupational base considering the other vocational factors of age, education, and work experience. When an individual has been found to have a limited ability in one or more of these basic work activities, it may be useful to consult a vocational resource.

Note: Other limitations mentioned in this Ruling to consider in order to reduce a claimant's functional ability at the sedentary level of exertion include visual limitations or restrictions, communicative limitations, and environmental restrictions.

Robles v. Saul, 2020 WL 5405877 (D.Conn.Sept. 9, 2020) (TOF). The court ordered a remand because, among other things, the record did not contain an assessment of how the claimant's use of a cane would affect his ability to perform sedentary work.

Yulfo-Reyes v. Berryhill, 2018 WL 5840030 (D.Conn. Nov. 8, 2018) (SALM). The court ruled that the ALJ erred in failing to determine whether an assistive device was medically indicated and erred in not determining whether an assistive device should be included in the RFC determination.

Williams v. Saul, 2019 WL 5388098 (D.Conn. Oct. 22, 2019) (SALM). In this case, the ALJ erred because he failed to consider the particular facts of the case regarding the claimant's need to use an assistive device to walk.

Gavazzi v. Berryhill, 687 Fed.Appx. 98 (2d Cir. 2017), 2017 WL 1400456. Pursuant to SSR 96-9p, the court remanded a claim back to the ALJ to issue specific findings as to the need of the claimant to alternate sitting and standing and to explain the consequence of this frequency on the range of work the claimant could perform.

Palmer v. Berryhill, 2018 WL 6304349 (D.Conn. Dec. 3, 2018) (RMS). This case was remanded in light of Gavazzi because the ALJ failed to specify the frequency the claimant needed to change positions from sitting to standing.

Rulings Related To The Sequential Evaluation

SSR 85-28 – Medical Impairments That Are Not Severe

The ruling states: "an impairment can be considered as not severe only if it is a slight abnormality which has such a minimal effect on the individual that it would not be expected to interfere with the individual's ability to work irrespective of age, education, or work experience." As *Baeder* v. *Heckler*, No. 84-5663 (3rd Cir. July 24, 1985), suggested, the severity regulation is to do no "more than allow the Secretary to deny benefits summarily to those applicants with impairments of a minimal nature which could never prevent a person from working."

See: 20 CFR 404.1522, 416.922 (a not severe impairment)

Marshall v. Astrue, Civ. No. 3:11-cv-0648 (Rec. Ruling) (D.Conn. August 15, 2012) (WWE) (HBF) (unreported). "At step two of the sequential framework, the Commissioner may deny an applicant's claim for failure to establish the existence of a 'severe impairment,' but step two should rarely be the stage at which an applicant's claim is rejected." (citing Jakubowski v. Commissioner of Social Security, 131 Fed.Appx. 341, 343 (3rd Cir. 2005))…. "Because step two is to be rarely utilized as basis for the denial of benefits, its invocation is certain to raise a judicial eyebrow. McCrea v. Commissioner of Social Security, 370 F.3d 357, 361 (3rd Cir. 2004)."

SSR 16-3p – Evaluation of Symptoms in Disability Claims

- In determining whether an individual is disabled, we consider all of the individual's symptoms, including pain, and the extent to which the symptoms can reasonably be accepted as consistent with the objective medical and other evidence in the individual's record. We define a symptom as the individual's own description or statement of his or her physical or mental impairment(s).[2] Under our regulations, an individual's statements of symptoms alone are not enough to establish the existence of a physical or mental impairment or disability. However, if an individual alleges impairment-related symptoms, we must evaluate those symptoms using a two-step process set forth in our regulations.[3]

First, we must consider whether there is an underlying medically determinable physical or mental impairment(s) that could reasonably be expected to produce an individual's symptoms, such as pain. Second, once an underlying physical or mental impairment(s) that could reasonably be expected to produce an individual's symptoms is established, we evaluate the intensity and persistence of those symptoms to determine the extent to which the symptoms limit an individual's ability to perform work-related activities for an adult or to function independently, appropriately, and effectively in an age- appropriate manner for a child with a title XVI disability claim.

- This ruling clarifies how we consider:

- The intensity, persistence, and functionally limiting effects of symptoms,
- Objective medical evidence when evaluating symptoms,
- Other evidence when evaluating symptoms,
- The factors set forth in 20 CFR 404.1529(c)(3) and 416.929(c)(3),
- The extent to which an individual's symptoms affect his or her ability to perform work-related activities or function independently, appropriately, and effectively in an age-appropriate manner for a child with a title XVI disability claim, and
- Adjudication standards for evaluating symptoms in the sequential evaluation process.

- Once the existence of a medically determinable impairment that could reasonably be expected to produce pain or other symptoms is established, we recognize that some individuals may experience symptoms differently and may be limited by symptoms to a greater or lesser extent than other individuals with the same medical impairments, the same objective medical evidence, and the same non-medical evidence. In considering the intensity, persistence, and limiting effects of an individual's symptoms, we examine the entire case record, including the objective medical evidence; an individual's statements about the intensity, persistence, and limiting effects of symptoms; statements and other information provided by medical sources and other persons; and any other relevant evidence in the individual's case record.

We will not evaluate an individual's symptoms without making every reasonable effort to obtain a complete medical history[8] unless the evidence supports a finding that the individual is disabled. We will not evaluate an individual's symptoms based solely on objective medical evidence unless that objective medical evidence supports a finding that the individual is disabled. We will evaluate an individual's symptoms based on the evidence in an individual's record as described below; however, not all of the types of evidence described below will be available or relevant in every case.

1. Consideration of Objective Medical Evidence

Symptoms cannot always be measured objectively through clinical or laboratory diagnostic techniques. However, objective medical evidence is a useful indicator to help make reasonable conclusions about the intensity and persistence of symptoms, including the effects those symptoms may have on the ability to perform work-related activities for an adult or to function independently, appropriately, and effectively in an age-appropriate manner for a child with a title XVI claim.[9] We must consider whether an individual's statements about the intensity, persistence, and limiting effects of his or her symptoms are consistent with the medical signs and laboratory findings of record.

The intensity, persistence, and limiting effects of many symptoms can be clinically observed and recorded in the medical evidence. Examples such as reduced joint motion, muscle spasm, sensory deficit, and motor disruption illustrate findings that may result from, or be associated with, the symptom of pain.[10] These findings may be consistent with an individual's statements about symptoms and their functional effects. However, when the results of tests are not consistent with other evidence in the record, they may be less supportive of an individual's statements about pain or other symptoms than test results and statements that are consistent with other evidence in the record.

For example, an individual with reduced muscle strength testing who indicates that for the last year pain has limited his or her standing and walking to no more than a few minutes a day would be expected to have some signs of muscle wasting as a result. If no muscle wasting were present, we might not, depending on the other evidence in the record, find the individual's reduced muscle strength on clinical testing to be consistent with the individual's alleged impairment-related symptoms.

However, we will not disregard an individual's statements about the intensity, persistence, and limiting effects of symptoms solely because the objective medical evidence does not substantiate the degree of impairment-related symptoms alleged by the individual.[11] A report of minimal or negative findings or inconsistencies in the objective medical evidence is one of the many factors we must consider in evaluating the intensity, persistence, and limiting effects of an individual's symptoms.

2. Consideration of Other Evidence

If we cannot make a disability determination or decision that is fully favorable based solely on objective medical evidence, then we carefully consider other evidence in the record in reaching a conclusion about the intensity, persistence, and limiting effects of an individual's symptoms. Other evidence that we will consider includes statements from the individual, medical sources, and any other sources that might have information about the individual's symptoms, including agency personnel, as well as the factors set forth in our regulations.[12] For example, for a child with a title XVI disability claim, we will consider evidence submitted from educational agencies and personnel, statements from parents and other relatives, and evidence submitted by social welfare agencies, therapists, and other practitioners.[13]

a. The Individual

An individual may make statements about the intensity, persistence, and limiting effects of his or her symptoms. If a child with a title XVI disability claim is unable to describe his or her symptoms adequately, we will accept a description of his or her symptoms from the person most familiar with the child, such as a parent, another relative, or a guardian.[14] For an adult whose impairment prevents him or her from describing symptoms adequately, we may also consider a description of his or her symptoms from a person who is familiar with the individual.

An individual may make statements about symptoms directly to medical sources, other sources, or he or she may make them directly to us. An individual may have made statements about symptoms in connection with claims for other types of disability benefits such as workers' compensation, benefits under programs of the Department of Veterans Affairs, or private insurance benefits.

An individual's statements may address the frequency and duration of the symptoms, the location of the symptoms, and the impact of the symptoms on the ability to perform daily living activities. An individual's statements may also include activities that precipitate or aggravate the symptoms, medications and treatments used, and other methods used to alleviate the symptoms. We will consider an individual's statements about the intensity, persistence, and limiting effects of symptoms, and we will evaluate whether the statements are consistent with objective medical evidence and the other evidence.

b. Medical Sources

Medical sources may offer diagnoses, prognoses, and opinions as well as statements and medical reports about an individual's history, treatment, responses to treatment, prior work record, efforts to work, daily activities, and other information concerning the intensity, persistence, and limiting effects of an individual's symptoms.

Important information about symptoms recorded by medical sources and reported in the medical evidence may include, but is not limited to, the following:

- Onset, description of the character and location of the symptoms, precipitating and aggravating factors, frequency and duration, change over a period of time (e.g., whether worsening, improving, or static), and daily activities. Very often, the individual has provided this information to the medical source, and the information may be compared with the individual's other statements in the case record. In addition, the evidence provided by a medical source may contain medical opinions about the individual's symptoms and their effects. Our adjudicators will weigh such opinions by applying the factors in 20 CFR 404.1527 and 416.927.
- A longitudinal record of any treatment and its success or failure, including any side effects of medication.
- Indications of other impairments, such as potential mental impairments, that could account for an individual's allegations.

Medical evidence from medical sources that have not treated or examined the individual is also important in the adjudicator's evaluation of an individual's statements about pain or other symptoms. For example, State agency medical and psychological consultants and other program physicians and psychologists may offer findings about the existence and severity of an individual's symptoms. We will consider these findings in evaluating the intensity, persistence, and limiting effects of the individual's symptoms. Adjudicators at the hearing level or at the Appeals Council level must consider the findings from these medical sources even though they are not bound by them. [15]

c. Non-Medical Sources

Other sources may provide information from which we may draw inferences and conclusions about an individual's statements that would be helpful to us in assessing the intensity, persistence, and limiting effects of symptoms. Examples of such sources include public and private agencies, other practitioners, educational personnel, non-medical sources such as family and friends, and agency personnel. We will consider any statements in the record noted by agency personnel who previously interviewed the individual, whether in person or by telephone. The adjudicator will consider any personal observations of the individual in terms of how consistent those observations are with the individual's statements about his or her symptoms as well as with all of the evidence in the file.

d. Factors to Consider in Evaluating the Intensity, Persistence, and Limiting Effects of an Individual's Symptoms

In addition to using all of the evidence to evaluate the intensity, persistence, and limiting effects of an individual's symptoms, we will also use the factors set forth in 20 CFR 404.1529(c)(3) and 416.929(c)(3). These factors include:

1. Daily activities;
2. The location, duration, frequency, and intensity of pain or other symptoms;
3. Factors that precipitate and aggravate the symptoms;
4. The type, dosage, effectiveness, and side effects of any medication an individual takes or has taken to alleviate pain or other symptoms;
5. Treatment, other than medication, an individual receives or has received for relief of pain or other symptoms;
6. Any measures other than treatment an individual uses or has used to relieve pain or other symptoms (e.g., lying flat on his or her back, standing for 15 to 20 minutes every hour, or sleeping on a board); and
7. Any other factors concerning an individual's functional limitations and restrictions due to pain or other symptoms.

We will consider other evidence to evaluate only the factors that are relevant to assessing the intensity, persistence, and limiting effects of the individual's symptoms. If there is no information in the evidence of record regarding one of the factors, we will not discuss that specific factor in the determination or decision because it is not relevant to the case. We will discuss the factors pertinent to the evidence of record.

How we will determine if an individual's symptoms affect the ability to perform work-related activities for an adult, or age-appropriate activities for a child with a title XVI disability claim

If an individual's statements about the intensity, persistence, and limiting effects of symptoms are consistent with the objective medical evidence and the other evidence of record, we will determine that the individual's symptoms are more likely to reduce his or her capacities to perform work- related activities for an adult or reduce a child's ability to function independently, appropriately, and effectively in an age-appropriate manner for a child with a title XVI disability claim.[16] In contrast, if an individual's statements about the intensity, persistence, and limiting effects of symptoms are inconsistent with the objective medical evidence and the other evidence, we will determine that the individual's symptoms are less likely to reduce his or her capacities to perform work-related activities or abilities to function independently, appropriately, and effectively in an age-appropriate manner.

We may or may not find an individual's symptoms and related limitations consistent with the evidence in his or her record. We will explain which of an individual's symptoms we found consistent or inconsistent with the evidence in his or her record and how our evaluation of the individual's symptoms led to our conclusions. We will evaluate an individual's symptoms considering all the evidence in his or her record.

In determining whether an individual's symptoms will reduce his or her corresponding capacities to perform work-related activities or abilities to function independently, appropriately, and effectively in an age-appropriate manner, we will consider the consistency of the individual's own statements. To do so, we will compare statements an individual makes in connection with the individual's claim for disability benefits with any existing statements the individual made under other circumstances.

We will consider statements an individual made to us at each prior step of the administrative review process, as well as statements the individual made in any subsequent or prior disability claims under titles II and XVI. If an individual's various statements about the intensity, persistence, and limiting effects of symptoms are consistent with one another and consistent with the objective medical evidence and other evidence in the record, we will determine that an individual's symptoms are more likely to reduce his or her capacities for work-related activities or reduce the abilities to function independently, appropriately, and effectively in an age- appropriate manner. However, inconsistencies in an individual's statements made at varying times does not necessarily mean they are inaccurate. Symptoms may vary in their intensity, persistence, and functional effects, or may worsen or improve with time. This may explain why an individual's statements vary when describing the intensity, persistence, or functional effects of symptoms.

We will consider an individual's attempts to seek medical treatment for symptoms and to follow treatment once it is prescribed when evaluating whether symptom intensity and persistence affect the ability to perform work-related activities for an adult or the ability to function independently, appropriately, and effectively in an age- appropriate manner for a child with a title XVI disability claim. Persistent attempts to obtain relief of symptoms, such as increasing dosages and changing medications, trying a variety of treatments, referrals to specialists, or changing treatment sources may be an indication that an individual's symptoms are a source of distress and may show that they are intense and persistent.[17]

In contrast, if the frequency or extent of the treatment sought by an individual is not comparable with the degree of the individual's subjective complaints, or if the individual fails to follow prescribed treatment that might improve symptoms, we may find the alleged intensity and persistence of an individual's symptoms are inconsistent with the overall evidence of record. We will not find an individual's symptoms inconsistent with the evidence in the record on this basis without considering possible reasons he or she may not comply with treatment or seek treatment consistent with the degree of his or her complaints. We may need to contact the individual regarding the lack of treatment or, at an administrative proceeding, ask why he or she has not complied with or sought treatment in a manner consistent with his or her complaints. When we consider the individual's treatment history, we may consider (but are not limited to) one or more of the following:

- An individual may have structured his or her activities to minimize symptoms to a tolerable level by avoiding physical activities or mental stressors that aggravate his or her symptoms.
- An individual may receive periodic treatment or evaluation for refills of medications because his or her symptoms have reached a plateau.

- An individual may not agree to take prescription medications because the side effects are less tolerable than the symptoms.
- An individual may not be able to afford treatment and may not have access to free or low-cost medical services.
- A medical source may have advised the individual that there is no further effective treatment to prescribe or recommend that would benefit the individual.
- An individual's symptoms may not be severe enough to prompt him or her to seek treatment, or the symptoms may be relieved with over the counter medications.
- An individual's religious beliefs may prohibit prescribed treatment.
- Due to various limitations (such as language or mental limitations), an individual may not understand the appropriate treatment for or the need for consistent treatment of his or her impairment.
- Due to a mental impairment (for example, individuals with mental impairments that affect judgment, reality testing, or orientation), an individual may not be aware that he or she has a disorder that requires treatment.
- A child may disregard the level and frequency of treatment needed to maintain or improve functioning because it interferes with his or her participation in activities typical of other children his or her age without impairments.

The above examples illustrate possible reasons an individual may not have pursued treatment. However, we will consider and address reasons for not pursuing treatment that are pertinent to an individual's case. We will review the case record to determine whether there are explanations for inconsistencies in the individual's statements about symptoms and their effects, and whether the evidence of record supports any of the individual's statements at the time he or she made them. We will explain how we considered the individual's reasons in our evaluation of the individual's symptoms.

Dorsey v. Saul, 2020 WL 1307107 (D.Conn. Mar. 19, 2020) (MPS). The court determined the ALJ erred in finding that the claimant's utilization of mental health resources and compliance with treatment should not have been construed as reflecting a greater capacity for work. The court noted that under SSR 16-3p persistent attempts to obtain relief, etc. may be an indication that an individual's symptoms are a source of distress and may show they are intense and persistent.

Greene v. Berryhill, 2018 WL 864666 (D.Conn. Aug. 10, 2018) (JCH). The ALJ committed error because he did not inquire as to the claimant's noncompliance with treatment as required by SSR 16-3p. In addition, the ALJ erred by not confining his review to the impairments that were subject of the claimant's disability claim.

Acosta v. Colvin, 2016 WL 6952338 (S.D.N.Y. Nov. 28, 2016). The court found the ALJ's rejection of the claimant's symptoms pursuant to SSR 16-3p was not based on substantial evidence because he mischaracterized the medical evidence that he found contradicted the claimant's testimony.

SSR 17-2p – Evidence Needed By Adjudicators At The Hearings And Appeals Council Levels Of The Administrative Review Process To Make Findings About Medical Equivalence

- At the hearings level or at the AC level when the AC issues its own decision, the adjudicator is responsible for the finding of medical equivalence. The adjudicator must base his or her decision about whether the individual's impairment(s) medically equals a listing on the preponderance of the evidence in the record. To demonstrate the required support of a finding that an individual is disabled based on medical equivalence at step 3, the record must contain one of the following:

1. A prior administrative medical finding from an MC or PC from the initial or reconsideration adjudication levels supporting the medical equivalence finding, or
2. ME evidence, which may include testimony or written responses to interrogatories, obtained at the hearings level supporting the medical equivalence finding, or

3. A report from the AC's medical support staff supporting the medical equivalence finding.

Miscellaneous Rulings

SSR 94-1c – Illegal Activity As Substantial Gainful Activity

Bell v. Commissioner of Social Sec., 105 F.3d 244 (6th Cir. 1996) – prostitution.

Dotson v. Shalala, 1 F.3d 571 (7th Cir. 1993) – stealing.

SSR 11-2p – Documenting And Evaluating Disability In Young Adults

- We consider people between the ages of 18 to approximately 25 to be young adults.

- Sources of evidence about a young adult's ability to work:

A. Medical sources

B Non-Medical Sources.

Evidence from other sources who are not medical sources, but who know and have contact with the young adult, can also help us evaluate the severity and impact of a young adult's impairment(s). These sources include family members, educational personnel (for example, teachers and counselors), public and private social welfare agency personnel, and others (for example, friends, neighbors, and clergy). Therefore, we consider evidence in the case record from non-medical sources when we determine the severity of the young adult's impairment(s) and how the young adult is able to function.

C. School programs

Evidence from school programs, including secondary and post-secondary schools, can also help us evaluate the severity and impact of a young adult's impairment(s).

1. Many young adults who received special education (including transition services) or related services[19] before they attained age 18 continue to receive these services until they are age 22. Other young adults may participate in postsecondary programs, including college or vocational training.[20]
2. Young adults who receive special education services after age 17 will have an Individualized Education Program (IEP),[21] including an IEP transition plan. The IEP transition plan describes a student's levels of functioning based on reasonable estimates by both the student and the special education team. It also identifies the kinds of vocational and living skills the young adult needs to develop in order to function independently as an adult.
3. The IEP transition goals may range from the development of skills appropriate to supervised and supported work and living settings to those needed in independent work and living situations. For example, an IEP transition goal for an 18-year-old might be, "The student will independently use public transportation," while specific objectives would identify the skills to be developed (for example, reading a bus schedule) and the particular instruction methods to be used to develop the skills (for example, one-to-one tutoring with practice reading a bus schedule).
4. The goals in an IEP may be set at a level that the young adult can readily achieve to foster a sense of accomplishment and may be lower than what would be expected of a young adult without impairments. In this regard:
    - A young adult who *achieves* a goal may or may not have limitations. The young adult may be developing or acquiring skills at a slower rate than young adults without impairments and may have achieved the goal simply because it was set low.

- A young adult who *does not achieve* a goal likely has an impairment-related limitation(s). A young adult's failure to achieve a goal, however, does not, by itself, establish that the impairment(s) is *disabling*.

- The examples in the sections below do not necessarily establish that a young adult is disabled, only that the person may have limitations that affect what work he or she may be able to do.

A. Evidence Regarding Functioning From Educational Programs

As we discussed in section I.C above, we may have evidence about a young adult's functioning from school programs, including IEPs. This evidence may indicate how well a young adult can use his or her physical or mental abilities to perform work activities. The following examples of school-reported difficulties might indicate difficulty with work activities:

- Difficulty in understanding, remembering, and carrying out simple instructions and work procedures during a school-sponsored work experience;
- Difficulty communicating spontaneously and appropriately in the classroom;
- Difficulty with maintaining attention for extended periods in a classroom;
- Difficulty relating to authority figures and responding appropriately to correction or criticism during school or a work-study experience;
- Difficulty using motor skills to move from one classroom to another.

B. Community Experiences, Including Job Placements

1. A young adult may receive services in a community setting(s) through a school or a community agency, such as a mental health center or vocational rehabilitation agency. These services may include:
    - *Community-based instruction (CBI)*, or instruction in a natural, age-appropriate setting (for example, trips to the grocery store to develop math, sequencing, travel, and social skills).
    - *On-the-job training (OJT)*, or placement in various work sites in the community for vocational training and experience, frequently in an "enclave" (small group) of students with a job coach (for example, placement in an enclave in a motel to learn housekeeping tasks such as bed-making and vacuuming).
    - *Work experience*, or supervised part-time or full-time employment to assist a young adult in acquiring job skills and good work attitudes and habits.
2. A young adult may participate in several—or even many—OJT or work experience placements that are unpaid, paid at SGA levels, or paid at less than SGA levels. Some young adults have multiple placements as part of a transition plan that expose them to a variety of work settings. Other young adults have multiple placements because of unsatisfactory performance.

Regardless of whether the work was SGA, information about how well a young adult performed in these placements can help us assess how the young adult functions. For example, a young adult who was unable to sustain OJT placements may have limitations in the ability to understand and remember instructions or to persist at work-related tasks. In contrast, a young adult who performed OJT placements successfully may have a good ability to respond appropriately to supervision. In addition, information about the degree to which a young adult needs special supports in order to work (such as in supported or transitional employment programs) may also help us assess the young adult's functioning.

C. Psychosocial Supports and Highly Structured or Supportive Settings

As for all adults, psychosocial supports and highly structured or supportive settings may reduce the demands on a young adult and help him or her function. However, the young adult's ability to function in settings that are less demanding, more structured, or more supportive than those in which people typically work does not necessarily show how the young adult will be able to function in a work setting. We will consider the kind and extent of support or assistance and the characteristics of any structured setting in

which the young adult spends his or her time when we evaluate the effects of his or her impairment(s) on functioning.

D. Extra Help and Accommodations

Working requires a person to be able to do the tasks of a job independently, appropriately, effectively, and on a sustained basis. In this regard, the analysis for adult disability determination purposes is similar to our "extra help" rules for children.[22] If an adult with an impairment(s) needs or would need greater supervision or assistance, or some other type of accommodation, because of the impairment(s) than an employee who does not have an impairment, the adult has a work-related limitation.

We consider how independently a young adult is able to function, including whether the young adult needs help from other people or special equipment, devices, or medications to perform day-to-day activities. If a young adult can function only if he or she receives more help than would generally be provided to people without medical impairments, we consider how well the young adult would function without the extra help. The more extra help or support of any kind that a young adult receives because of his or her impairment(s), the less independent he or she is in functioning, and the more severe we will find the limitation to be.

Accommodations

a. *Accommodations* are practices and procedures that allow a person to complete the same activity or task as other people. Accommodations can include a change in setting, timing, or scheduling, or an assistive or adaptive device.

b. Some young adults with impairments need accommodations in their educational program in order to participate in the general curriculum or in a transitional program.[23] The fact that a young adult receives or has received accommodations as a part of his or her IEP or Section 504 plan,[24] may be an indication that he or she has a work-related limitation. For example, evidence showing that a student requires an audiotape recording of oral directions for replay at school because he cannot remember more than a one-step instruction might indicate that the student will have the same inability to remember more than a one-step instruction without special assistance in a work setting.

c. Some accommodations may indicate an impairment(s) that meets or medically equals a listing. For example, the need for an augmentative or alternative communication or AAC device (for example, an electronic picture board or an electrolarynx) might indicate a speech impairment that meets listing 2.09 or an impairment that meets one of the neurological listings in section 11.00 of the listings.

d. When we determine whether a person can perform his or her past relevant work, we do not consider potential accommodations unless his or her employer actually made the accommodation. This means that we cannot find that a young adult can do past relevant work with accommodations unless the young adult actually performed that work with those same accommodations and is still able to do so now.

e. When we determine whether a person can do other work that exists in significant numbers in the national economy, we do not consider whether he or she could do so with accommodations, even if an employer would be required to provide reasonable accommodations under the Americans with Disabilities Act of 1990.[25]

1. Effects of treatment, including medications

Treatment, including medications, can have a positive effect on a person's ability to function in a work setting. For example, a young adult who takes an antidepressant medication may be able to interact appropriately with supervisors and co-workers. Treatment, however, may not resolve all of the functional limitations that result from an impairment(s). Medications or other treatment may cause side effects that affect the mental or physical ability to work. For example, an anti-epileptic medication may cause drowsiness that affects the ability to concentrate; daily chest percussion therapy for cystic fibrosis may cause fatigue because of the physical effort involved in the therapy. The frequency of a young adult's treatment may preclude him or her from maintaining a full-time work schedule; that is, 8 hours a day, 5 days a week on a sustained basis.

E. Work-Related Stress

1.Working involves many factors and demands that can be stressful. For example, some people may experience stress related to the demands of getting to work regularly, having work performance supervised, or remaining in the workplace for a full day, 5 days a week on a sustained basis. Moreover, one person's reaction to stress associated with the demands of work may be different from another's, even among people with the same impairments.

2. Sources familiar with the young adult may provide insight about the effect of stress on his or her physical or mental functioning and what, if any, psychosocial supports or structure he or she would need when experiencing work-related stress.[26] We consider impairment-related limitations created by a person's response to the demands of work when we assess RFC.

Coppola v. Berryhill, 2019 WL 1292848 (S.D.N.Y. Mar. 21, 2019). The court ruled the ALJ failed to comply with SSR 11-2p by not examining and discussing the claimant's school records from a highly supportive boarding school for special needs. The court said, "Even in a low stress job with only simple, routine tasks and few workplace changes, without the supports provided by his school environment plaintiff's limitations with respect to punctuality and persistence would likely be more pronounced. Thus, the ALJ's failure to analyze this evidence compromised his RFC determination."

McCarthy v. Berryhill, 2019 WL 125768 (W.D.N.Y. Jan. 8, 2019). The ALJ erred in using the claimant's past work as evidence that his limitations in attention, concentration, social difficulties, etc. were not marked because the claimant received significant accommodations in his job. SSR 11-2p states that when a decision is made regarding the ability to do other work, the adjudicator does not consider whether he or she could do so with accommodations.

SSR 17-4p: Titles II and XVI: Responsibility for Developing Written Evidence

Purpose

This Ruling clarifies our responsibilities and those of the claimant and the claimant's representative to develop evidence and other information in disability and blindness claims under titles II and XVI of the Social Security Act (Act). This Ruling applies at all levels of our administrative review process, as described below.

Citations (Authority)

Sections 206(a), 223(d), and 1614(a) of the Social Security Act, as amended; 20 CFR 404.935, 404.970, 404.1512, 404.1513, 404.1593, 404.1594, 404.1614, 404.1740, 404.1745, 416.912, 416.913, 416.993, 416.994, 416.1014, 416.1435, 416.1470, 416.1540, and 416.1545.

Introduction

We need complete evidentiary records to make accurate, consistent disability determinations and decisions at each level of our administrative review process. Although we take a role in developing the evidentiary record in disability claims, claimants and their appointed representatives have the primary responsibility under the Act to provide evidence in support of their disability or blindness claims. Consequently, we expect claimants and their representatives to make good faith efforts to ensure that we receive complete evidence.

Under the Act, we cannot find that an individual is disabled "unless [he or she] furnishes such medical and other evidence of the existence thereof as the Commissioner of Social Security may require."[1] This statutory provision places primary responsibility for the development of evidence on the claimant. Consistent with the claimant's statutory obligation to provide us with evidence regarding his or her disability or blindness claim, our regulations require a claimant to submit or inform us about all evidence known to him or her that relates to whether or not he or she is disabled or blind.[2] At the hearings level, a claimant generally must submit or inform us about written evidence at least 5 business days before the date of his or her scheduled hearing.[3] We adopted this 5-day requirement in December 2016 and implemented it in May 2017, to address unprecedented workload challenges.[4] As we explained in the preamble to our notice of proposed rulemaking, "[w]e cannot afford to continue postponing hearing proceedings because the record is not complete at the time of the hearing."[5]

A representative's duty to submit evidence is derivative of the claimant's;[6] however, representatives must also follow our rules of conduct and standards of responsibility for representatives.[7] Those rules impose an affirmative duty on a representative to act with reasonable promptness to help obtain the information or evidence that the claimant must submit and forward the information or evidence to us as soon as practicable.[8] A representative also

has an affirmative duty to assist a claimant in complying, as soon as practicable, with our requests for information or evidence.[9]

This Ruling explains the requirement to submit or inform us about evidence and clarifies who has the final responsibility to obtain written evidence.

Policy Interpretation

1. **Statutory Provisions**

In general, an individual has a statutory obligation to provide us with evidence to prove to us that he or she is disabled or blind. The Act also precludes us from finding that an individual is disabled or blind unless he or she submits such evidence to us.[10]

The Act also provides that we "shall consider all evidence available in [an] individual's case record, and shall develop a complete medical history of at least the preceding twelve months for any case in which a determination is made that the individual is not under a disability."[11] In addition, when we make any determination, the Act requires us to "make every reasonable effort to obtain from the individual's treating physician (or other treating health care provider) all medical evidence, including diagnostic tests, necessary in order to properly make such determination, prior to evaluating medical evidence obtained from any other source on a consultative basis."[12]

Thus, although a claimant has the primary responsibility to submit evidence related to his or her disability or blindness claim, the Act also gives us a role in developing evidence. Our statutory responsibilities to ensure that we develop a complete 12-month medical history when we make a determination about whether an individual is under a disability, and to make every reasonable effort to obtain from a claimant's treating source all medical evidence that we need to make a determination before we evaluate medical evidence from a consultative examiner, does not, however, reduce the claimant's responsibilities in any way.

2. **An Individual's Affirmative Duty to Provide Written Evidence**

Our regulations require an individual to submit or inform us about all evidence known to him or her that relates to whether or not he or she is disabled or blind.[13] This duty is ongoing and requires an individual to disclose any additional evidence about which he or she becomes aware. This duty applies at each level of the administrative review process, including the Appeals Council level if the evidence relates to the period on or before the date of the administrative law judge (ALJ) hearing decision.[14]

Generally, individuals must submit or inform us about any written evidence no later than 5 business days prior to the date of the scheduled hearing before an ALJ.[15] The ALJ may decline to consider or obtain any evidence if disclosure takes place after this date, unless certain circumstances outlined in the regulations apply.[16]

We expect individuals to exercise their reasonable good faith judgment about what evidence "relates" to their disability claims.[17] Evidence that may relate to whether or not a claimant is blind or disabled includes objective medical evidence, medical opinion evidence, other medical evidence, and evidence from nonmedical sources.[18]

To satisfy the claimant's obligation under the regulations to "inform" us about written evidence, he or she must provide information specific enough to identify the evidence (source, location, and dates of treatment) and show that the evidence relates to the individual's medical condition, work activity, job history, medical treatment, or other issues relevant to whether or not the individual is disabled or blind. If the individual does not provide us with information specific enough to allow us to identify the written evidence and understand how it relates to whether or not the individual is disabled or blind, the individual has not informed us about evidence within the meaning of 20 CFR 404.935, 404.1512, 416.912 or 416.1435, and we will not request that evidence.

3. **A Representative's Affirmative Duty to Assist in Developing Written Evidence**

Our regulations require appointed representatives to assist claimants in complying fully with their responsibilities under the Act and our regulations. All representatives must faithfully execute their duties as agents and fiduciaries of claimants. In that regard, representatives must assist claimants in satisfying the claimants' duties regarding the submission of evidence and in complying with our requests for information or evidence as outlined in the prior section.[19]

In addition to these responsibilities, a representative has an affirmative duty to provide competent assistance to the claimant, including acting with reasonable promptness to help obtain information or evidence the claimant must submit.[20] To fulfill his or her affirmative duties under our rules, the representative must forward this information or evidence to us and must assist the claimant in complying with our requests for information or evidence as soon as practicable.[21] In addition, under our rules of conduct, the representative is prohibited from, through his or her own actions or omissions, unreasonably delaying or causing to be delayed, without good cause, the processing of a claim at any stage of the administrative decisionmaking process.[22] Representatives are also prohibited from engaging in actions or behavior prejudicial to the fair and orderly conduct of administrative proceedings.[23] A representative's failure to comply with his or her affirmative duties (or his or her engagement in prohibited actions) could result in disciplinary action.

While our regulations state that a claimant must submit or inform us of all written evidence at least 5 business days prior to a hearing, our rules of conduct place additional requirements on representatives. As discussed above, under the rules of conduct, representatives are: 1) required to act with reasonable promptness to help obtain information or evidence the claimant must submit; 2) required to assist the claimant in complying with our requests for information or evidence as soon as practicable; 3) prohibited from unreasonably delaying or causing a delay of the processing of a claim without good cause; and 4) prohibited from actions or behavior prejudicial to the fair and orderly conduct of administrative proceedings. Therefore, we expect representatives to submit or inform us about written evidence as soon as they obtain or become aware of it. Representatives should not wait until 5 business days before the hearing to submit or inform us about written evidence unless they have compelling reasons for the delay (e.g., it was impractical to submit the evidence earlier because it was difficult to obtain or the representative was not aware of the evidence at an earlier date). In addition, it is only acceptable for a representative to inform us about evidence without submitting it if the representative shows that, despite good faith efforts, he or she could not obtain the evidence. Simply informing us of the existence of evidence without providing it or waiting until 5 days before a hearing to inform us about or provide evidence when it was otherwise available, may cause unreasonable delay to the processing of the claim, without good cause, and may be prejudicial to the fair and orderly conduct of our administrative proceedings. As such, this behavior could be found to violate our rules of conduct and could lead to sanction proceedings against the representative.

Pursuant to the Act, we may, after due notice and opportunity for hearing, suspend or prohibit from further practice before the Commissioner a representative who refuses to comply with our rules and regulations or who violates any provision for which a penalty is prescribed.[24]

We will evaluate each circumstance on a case-by-case basis to determine whether to refer a possible violation of our rules to our Office of the General Counsel (OGC). For example, in accordance with the regulatory interpretation discussed above, we may refer a possible violation of rules to OGC when:

- a representative informs us about written evidence but refuses, without good cause, to make good faith efforts to obtain and timely submit the evidence;
- a representative informs us about evidence that relates to a claim instead of acting with reasonable promptness to help obtain and timely submit the evidence to us;
- the representative waits until 5 days before a hearing to provide or inform us of evidence when the evidence was known to the representative or available to provide to us at an earlier date;
- the clients of a particular representative have a pattern of informing us about written evidence instead of making good-faith efforts to obtain and timely submit the evidence; or
- any other occasion when a representative's actions with regard to the submission of evidence may violate our rules for representatives.

When we refer a possible violation to OGC, it does not change our duties with respect to the development of the evidence.[25]

4. **Our Duty to Assist Claimants in Developing Written Evidence**

Before we make a determination that an individual is not disabled, we must develop the individual's complete medical history, generally for at least 12 months preceding the month in which he or she applied for benefits.[26] We will make every reasonable effort to help individuals obtain medical evidence from their own medical sources and entities that maintain medical evidence when the individual gives us permission to request the information.[27] Every reasonable effort means that we will make an initial request for evidence from the medical source or entity that maintains the medical evidence, and, at any time between 10 and 20 calendar days after the initial request, if the evidence has not been received, we will make a follow-up request to obtain the medical evidence necessary to make a determination.[28]

We will assist with developing the record and may request existing evidence directly from a medical source or entity that maintains the evidence if:

- we were informed about the evidence (in the manner explained above) no later than 5 business days before the date of the scheduled hearing; or
- we were not informed about the evidence at least 5 business days before the date of the scheduled hearing, but one of the circumstances listed in 20 CFR 404.935(b) or 416.1535(b) applies.

We will first ask the individual or representative to submit the evidence. However, if the individual or representative shows that he or she is unable to obtain the evidence despite good faith efforts or for reasons beyond his or her control, we may request the evidence directly from the medical source or entity that maintains the evidence.

At the Appeals Council level of review, development of evidence is more limited. The Appeals Council will not obtain or evaluate additional evidence when deciding whether to grant review unless:

- one of the circumstances listed in 20 CFR 404.970(b) or 416.1470(b) applies and the individual or his or her representative shows that the evidence is related to the period on or before the date of the hearing level decision; or
- the claim is a title XVI claim that is not based on an application for benefits (e.g., an age-18 redetermination).

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[1] Sections 223(d)(5)(A) and 1614(a)(3)(H)(i) of the Act, 42 USC 423(d)(5)(A) and 1382c(a)(3)(H)(i).

[2] 20 CFR 404.1512(a) and 416.912(a).

[3] 20 CFR 404.935(a) and 416.1435(a).

[4] 81 FR 90987.

[5] 81 FR 45079, 45080 (2016).

[6] 20 CFR 404.1710(a) and 416.1510(a).

[7] 20 CFR 404.1740 and 416.1540.

[8] 20 CFR 404.1740(b)(1) and 416.1540(b)(1).

[9] 20 CFR 404.1740(b)(2) and 416.1540(b)(2).

[10] See sections 223(d)(5)(A) and 1614(a)(3)(H)(i) of the Act, 42 USC 423(d)(5)(A) and 1382c(a)(3)(H)(i); 20 CFR 404.1512(a)(1) and 416.912(a)(1).

[11] Sections 223(d)(5)(B) and 1614(a)(3)(H)(i) of the Act, 42 USC 423(d)(5)(B) and 1382c(a)(3)(H)(i).

[12] Id.

[13] 20 CFR 404.1512(a)(1) and 416.912(a)(1).

[14] 20 CFR 404.1512(a)(1) and 416.912(a)(1).

[15] 20 CFR 404.935 and 416.1435.

[16] 20 CFR 404.935(b) and 416.1425(b). However, for age-18 redetermination and continuing-disability review cases under title XVI of the Act, the requirement to submit or inform us about evidence no later than 5 business days before a scheduled hearing does not apply if our other rules allow the claimant to submit evidence after the date of an ALJ decision. See 20 CFR 416.1435(c) and 416.1470(b).

[17] 80 FR 14828, 14829 (March 20, 2015).

[18] 20 CFR 404.1513(a) and 416.913(a). However, evidence generally does not include confidential communications between the individual and his or her representative about providing or obtaining legal advice, and it does not include a representative's written analyses of the claim. 20 CFR 404.1513(b) and 416.913(b).

[19] See 20 CFR 404.1740(b)(1), (b)(2) and 416.1540(b)(1), (b)(2).

[20] See 20 CFR 404.1740(b)(3) and 416.1540(b)(3).

[21] 20 CFR 404.1740(b)(1), (b)(2) and 416.1540(b)(1), (b)(2).

[22] 20 CFR 404.1740(c)(4) and 416.1540(c)(4).

[23] 20 CFR 404.1740(c)(7) and 416.1540(c)(7).

[24] 42 USC 406(a)(1). See also 20 CFR 404.1745 and 416.1545 ("When we have evidence that a representative ... has violated the rules governing dealings with us, we may begin proceedings to suspend or disqualify that individual from acting in a representational capacity before us.")

[25] See 20 CFR 404.935 and 416.1435.

[26] Sections 223(d)(5)(B) and 1614(a)(3)(H)(i) of the Act, 42 USC 423(d)(5)(B) and 1382c(a)(3)(H)(i); 20 CFR 404.1512(b) and 416.912(b).

[27] 20 CFR 404.1512(b)(1) and 416.912(b)(1).

[28] 20 CFR 404.1512(b)(1)(i), 404.1593(b), 416.912(b)(1)(i), and 416.993(b).

Practice Tip: Some ALJs require more specificity than others, with regard to what information they want to see in the 5-day rule letter. In addition to noting the records that had not yet been received, consider including the date when the records were requested, follow up efforts to obtain the records, and the period of time for which the records pertain.

The case set forth below do not address SSR 17-4p but they do discuss the importance of the ALJ's duty to develop the record.

Tankisi v. Commissioner of Social Security, 521 Fed.Appx.29 (2nd. Cir. 2013). The court decided the ALJ did not err in failing to seek a treating source opinion regarding RFC. The court felt there was enough evidence in the record to support the ALJ's RFC finding.

See: Connecticut District Court decisions where the court remanded cases back to the Commissioner because the ALJ failed to adequately develop the record.

Berry v. Beryhill, 2020 WL 373076 (D.Conn. Jan. 23, 2020) (RAR)
Fausett v. Saul, 2020 WL 6837767 (D.Conn. Jan. 6, 2020) (MPS)
Demoranville v. Saul, 2019 WL 6712056 (D.Conn. Dec. 10, 2019) (RAR)
Pensiero v. Saul, 2019 WL 6271265 (D.Conn. Nov. 25, 2019) (WIG)
Borelli v. Berryhill, 2019 WL 4233586 (D.Conn. Sept. 6, 2019) (VLB)
Alamo v. Berryhill, 2019 WL 4164759 (D.Conn. Sept. 3, 2019) (JAH)
Johnson v. Berryhill, 2019 WL 1430242 (D.Conn. Mar. 29, 2019) (VAB)

SSR 18-1p – Titles II and XVI: Determining the Established Onset Date (EOD) in Disability Claims

Effective Date: October 2, 2018

We are providing notice of SSR 18-01p, which rescinds and replaces SSR 83-20, "Titles II and XVI: Onset of Disability," except as noted here. Concurrently, we published a separate SSR, SSR 18-02p, "Titles II and XVI: Determining the Established Onset Date (EOD) in Blindness Claims," to discuss how we determine the EOD in statutory blindness claims. SSR 18-02p rescinds and replaces two parts of SSR 83-20. Specifically, SSR 18-02p rescinds and replaces the subsection, "Title II: Blindness Cases," under the section, "Technical Requirements and Onset of Disability"; and the subsection, "Title XVI—Specific Onset is Necessary," which is also under the section "Technical Requirements and Onset of Disability," as it applies to statutory blindness claims. Therefore, as of October 2, 2018, the date this SSR was published in the Federal Register, SSR 83-20 is completely rescinded and replaced by SSR 18-01p and SSR 18-02p.

Purpose: This SSR explains what we mean by EOD and clarifies how we determine the EOD in disability claims under titles II and XVI of the Act. Specifically, it addresses how we determine the EOD in claims that involve traumatic, non-traumatic, and exacerbating and remitting impairments. This ruling also addresses special considerations related to the EOD, such as work activity and previously adjudicated periods. Additionally, this SSR clarifies that an administrative law judge (ALJ) may, but is not required to, call upon the services of a medical expert (ME), to assist with inferring the date that the claimant first met the statutory definition of disability.

Citations: Sections 223 and 1614 of the Act, as amended; 20 CFR 404.130, 404.303, 404.315-.316, 404.320-.321, 404.335-.336, 404.350-.351, 404.988-.989, 404.1505, 404.1510, 404.1512-.1513, 404.1520, 404.1574, 416.202, 416.325, 416.905-.906, 416.910, 416.912-.913, 416.920, 416.924, 416.974, and 416.1488-.1489; 20 CFR part 404, subpart P, appendices 1 and 2.

Policy Interpretation

To be entitled to disability benefits under title II of the Act or to be eligible for Supplemental Security Income (SSI) payments based on disability under title XVI of the Act, a claimant must file an application, meet the statutory definition of disability,[1] and satisfy the applicable non-medical requirements. If we find that a claimant meets the statutory definition of disability and meets the applicable non-medical requirements during the period covered by his or her application, we then determine the claimant's EOD. Generally, the EOD is the earliest date that the claimant meets both the definition of disability and the non-medical requirements for entitlement to benefits under title II of the Act or eligibility for SSI payments under title XVI of the Act during the period covered by his or her application. Because entitlement and eligibility depend on non-medical requirements, the EOD may be later than the date the claimant first met the definition of disability, and some claimants who meet the definition of disability may not be entitled to benefits under title II or eligible for disability payments under title XVI.[2]

Outline

I.How do we determine the EOD?

A.What are the non-medical requirements for entitlement and eligibility under the Act?

B.How do we determine whether a claimant meets the statutory definition of disability and, if so, when the claimant first met that definition?

1.How do we determine when a claimant with a traumatic impairment first met the statutory definition of disability?

2.How do we determine when a claimant with a non-traumatic or exacerbating and remitting impairment first met the statutory definition of disability?

3.How do we determine when a claimant with more than one type of impairment first met the statutory definition of disability?

II.What are some special considerations related to the EOD?

A.How does work activity affect our determination of the EOD?

B.May we determine the EOD to be in a previously adjudicated period?

III.When is this SSR applicable?

Discussion

I. How do we determine the EOD?

When we need to determine a claimant's EOD, we start by considering whether we can establish the EOD as of the claimant's potential onset date (POD) of disability. The POD is the first date when the claimant met the non-medical requirements during the period covered by his or her application. The POD is the earliest date that we consider for the EOD because it affords the claimant the maximum possible benefits for the period covered by his or her application. The POD may be the same as, earlier than, or later than the claimant's alleged onset date, which is the date that the claimant alleges he or she first met the statutory definition of disability.

The period covered by an application refers to the period when a claimant may be entitled to benefits under title II or eligible for SSI payments under title XVI of the Act based on a particular application. The period covered by an application depends on the type of claim. For example, the Act and our regulations explain that if a claimant applies for disability insurance benefits under title II of the Act after the first month that he or she could have been entitled to them, he or she may receive benefits for up to 12 months immediately before the month in which the application was filed.[3] If a claimant applies for SSI payments based on disability under title XVI of the Act after the first month that he or she meets the other eligibility requirements, we cannot make SSI payments based on disability for the month in which the application was filed or any months before that month.[4] That is, we cannot make retroactive payments based on disability under title XVI of the Act.

If the claimant meets the statutory definition of disability on his or her POD, we use the POD as the EOD because it would be the earliest date at which the claimant meets both the statutory definition of disability and the non-medical requirements for entitlement to benefits under title II or eligibility for SSI payments under title XVI during the period covered by his or her application. In contrast, if the claimant first meets the statutory definition of disability after his or her POD, we use the first date that the claimant meets both the statutory definition of disability and the applicable non-medical requirements as his or her EOD.

A. What are the non-medical requirements for entitlement and eligibility under the Act?

The non-medical requirements vary based on the type(s) of claim(s) the claimant filed. To illustrate, we identify below the most common types of disability claims and some of the regulations that explain the non-medical requirements for that type of claim.

Disability insurance benefits: 20 CFR 404.315, 404.316, 404.320, and 404.321;

Disabled widow(er)'s benefits: 20 CFR 404.335 and 404.336;

Childhood disability benefits: 20 CFR 404.350 and 404.351; and

Supplemental Security Income: 20 CFR 416.202 and 416.305.

B. How do we determine whether a claimant meets the statutory definition of disability and, if so, when the claimant first met that definition?

We need specific medical evidence to determine whether a claimant meets the statutory definition of disability. In general, an individual has a statutory obligation to provide us with the evidence to prove to us that he or she is disabled.[5] This obligation includes providing us with evidence to prove to us when he or she first met the statutory definition of disability. The Act also precludes us from finding that an individual is disabled unless he or she submits such evidence to us.[6] The Act further provides that we:

[S]hall consider all evidence available in [an] individual's case record, and shall develop a complete medical history of at least the preceding twelve months for any case in which a determination is made that the individual is not under a disability.[7]

In addition, when we make any determination, the Act requires us to:

[M]ake every reasonable effort to obtain from the individual's treating physician (or other treating health care provider) all medical evidence, including diagnostic tests, necessary in order to properly make such determination, prior to evaluating medical evidence obtained from any other source on a consultative basis.[8]

"Complete medical history" means the records from the claimant's medical source(s) covering at least the 12-month period preceding the month in which the claimant applied for disability benefits or SSI payments.[9] If the claimant says his or her disability began less than 12 months before he or she applied for benefits, we will develop the claimant's complete medical history beginning with the month he or she says his or her disability began, unless we have reason to believe the claimant's disability began earlier.[10] If applicable, we will develop the claimant's complete medical history for the 12-month period prior to the month he or she was last insured for disability insurance benefits,[11] the month ending the 7-year period when the claimant must establish his or her disability if he or she applied for widow's or widower's benefits based on disability,[12] or the month the claimant attained age 22 if he or she applied for child's benefits under title II[13] based on disability.[14]

We consider all of the evidence of record when we determine whether a claimant meets the statutory definition of disability.[15] The period we consider depends on the type of claim and the facts of the case. For example, a claimant who has applied for disability insurance benefits under title II of the Act must show that:

•He or she met the statutory definition of disability before his or her insured status expired, and
•He or she currently meets the statutory definition of disability,[16] or his or her disability ended within the 12-month period before the month that he or she applied for benefits.[17]

As another example, a claimant who has applied for child's benefits under title II must show that:

•He or she met the statutory definition of disability before he or she attained age 22, and

• He or she currently meets the statutory definition of disability,[18] or his or her disability ended within the 12-month period before the month that he or she applied for benefits.[19]

As a final example—because we cannot make SSI payments based on disability for the month in which the application was filed or any months before that month—a claimant who has applied for SSI payments under title XVI must show that he or she currently meets the statutory definition of disability.[20] during the period under consideration, then we will determine when the claimant first met that definition. However, we will not consider whether the claimant first met the statutory definition of disability on a date that is beyond the period under consideration.

1. How do we determine when a claimant with a traumatic impairment first met the statutory definition of disability?

For impairments that result from a traumatic injury or other traumatic event, we begin with the date of the traumatic event, even if the claimant worked on that date. An example of a traumatic event that could result in a traumatic injury is an automobile accident. If the evidence of record supports a finding that the claimant met the statutory definition of disability on the date of the traumatic event or traumatic injury, we will use that date as the date that the claimant first met the statutory definition of disability.

2. How do we determine when a claimant with a non-traumatic or exacerbating and remitting impairment first met the statutory definition of disability?

Non-traumatic impairments may be static impairments that we do not expect to change in severity over an extended period, such as intellectual disability; impairments that we expect to improve over time, such as pathologic bone fractures caused by osteoporosis; or progressive impairments that we expect to gradually worsen over time, such as muscular dystrophy. Exacerbating and remitting impairments are impairments that diminish and intensify in severity over time, such as multiple sclerosis. When a claimant has a non-traumatic or exacerbating and remitting impairment(s), and we determine the evidence of record supports a finding that the claimant met the statutory definition of disability, we will determine the first date that the claimant met that definition. The date that the claimant first met the statutory definition of disability must be supported by the medical and other evidence[21] and be consistent with the nature of the impairment(s).

We consider whether we can find that the claimant first met the statutory definition of disability at the earliest date within the period under consideration, taking into account the date the claimant alleged that his or her disability began. We review the relevant evidence and consider, for example, the nature of the claimant's impairment; the severity of the signs, symptoms, and laboratory findings; the longitudinal history and treatment course (or lack thereof); the length of the impairment's exacerbations and remissions, if applicable; and any statement by the claimant about new or worsening signs, symptoms, and laboratory findings. The date we find that the claimant first met the statutory definition of disability may predate the claimant's earliest recorded medical examination or the date of the claimant's earliest medical records, but we will not consider whether the claimant first met the statutory definition of disability on a date that is beyond the period under consideration.

If there is information in the claim(s) file that suggests that additional medical evidence relevant to the period at issue is available, we will assist with developing the record and may request existing evidence directly from a medical source or entity that maintains the evidence. We may consider evidence from other non-medical sources such as the claimant's family, friends, or former employers, if we cannot obtain additional medical evidence or it does not exist (e.g., the evidence was never created or was destroyed), and we cannot reasonably infer the date that the claimant first met the statutory definition of disability based on the medical evidence in the file.

At the hearing level of our administrative review process, if the ALJ needs to infer the date that the claimant first met the statutory definition of disability, he or she may call on the services of an ME by soliciting testimony or requesting responses to written interrogatories (i.e., written questions to be answered under oath or penalty of perjury). The decision to call on the services of an ME is always at the ALJ's discretion. Neither the claimant nor his or her representative can require an ALJ to call on the services of an ME to assist in inferring the date that the claimant first met the statutory definition of disability.

The Appeals Council may review the ALJ's finding regarding when the claimant first met the statutory definition of disability, or any other finding of the ALJ, by granting a claimant's request for review or on its own motion authority.[22] The Appeals Council may also exercise its removal authority and assume responsibility of the request for hearing. The Appeals Council will review a case if there is an error of law; the actions, findings, or conclusions of the ALJ are not supported by substantial evidence; there appears to be an abuse of discretion by the ALJ; or there is a broad policy or procedural issue that may affect the general public interest.[23] The Appeals Council will also review a case if it receives additional evidence that meets certain requirements.[24] If the Appeals Council grants review, it will issue its own decision or return the case to the ALJ for further proceedings, which may include obtaining evidence regarding when the claimant first met the statutory definition of disability. If the Appeals Council issues a decision, it will consider the totality of the evidence (subject to the limitations on Appeals Council consideration of additional evidence in 20 CFR 404.970 and 416.1470) and establish the date that the claimant first met the statutory definition of disability, which is both supported by the evidence and consistent with the nature of the impairment(s).

3. How do we determine when a claimant with more than one type of impairment first met the statutory definition of disability?

If a claimant has a traumatic impairment and a non-traumatic or exacerbating and remitting impairment, we will consider all of the impairments in combination when determining when the claimant first met the statutory definition of disability. We will consider the date of the traumatic event as well as the evidence pertaining to the non-traumatic or exacerbating and remitting impairment and will determine the date on which the combined impairments first caused the claimant to meet the statutory definition of disability.

II. What are some special considerations related to the EOD?

A. How does work activity affect our determination of the EOD?
We consider the date the claimant stopped performing substantial gainful activity (SGA) when we establish the EOD. SGA is work that involves doing significant and productive physical or mental duties and is done (or intended) for pay or profit.[25] If medical and other evidence indicates the claimant's disability began on the last day he or she performed SGA, we can establish an EOD on that date, even if the claimant worked a full day. Generally, we may not determine a claimant's EOD to be before the last day that he or she performed SGA.

We may, however, determine a claimant's EOD to be before or during a period that we determine to be an unsuccessful work attempt (UWA). A UWA is an effort to do work that discontinues or reduces to the non-SGA level after a short time (no more than six months) because of the impairment or the removal of special conditions related to the impairment that are essential for the further performance of work.[26]

B. May we determine the EOD to be in a previously adjudicated period?

Yes, if our rules for reopening are met[27] and the claimant meets the statutory definition of disability and the applicable non-medical requirements during the previously adjudicated period.[28] Reopening, however, is at the discretion of the adjudicator.[29]

III. When is this SSR applicable?

This SSR is applicable on October 2, 2018. We will use this SSR beginning on its applicable date. We will apply this SSR to new applications filed on or after the applicable date of the SSR and to claims that are pending on and after the applicable date. This means that we will use this SSR on and after its applicable date, in any case in which we make a determination or decision. We expect that Federal courts will review our final decisions using the rules that were in effect at the time we issued the decisions. If a court reverses our final decision and remands a case for further administrative proceedings after the applicable date of this SSR, we will apply this SSR to the entire period at issue in appropriate cases when we make a decision after the court's remand.

[1] See 42 U.S.C. 423(d)(1)(A), 1382c(a)(3)(A); 20 CFR 404.1505(a), 416.905(a) (defining disability for adults); 42 U.S.C. 1382c(a)(3)(C); 20 CFR 416.906 (defining disability for children); see also 20 CFR 404.1520(a)(4), 416.920(a)(4) (setting forth the five-step sequential evaluation we use to determine disability for adults); 20 CFR 416.924 (setting forth the three-step sequential evaluation we use to determine disability for children).

[2] Under title II of the Act, a claimant may be entitled to a period of disability even though he or she does not qualify for monthly cash benefits. 20 CFR 404.320(a).

[3] 42 U.S.C. 423(b); 20 CFR 404.621(a).

[4] 42 U.S.C. 1382(c)(7); 20 CFR 416.335.

[5] To meet the statutory definition of disability, the claimant must show that he or she is unable to engage in any substantial gainful activity by reason of a medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months. 42 U.S.C. 423(d)(1)(A), 1382c(a)(3)(A); 20 CFR 404.1505(a), 416.905(a).

[6] 42 U.S.C. 423(d)(5)(A), 1382c(a)(3)(H)(i); 20 CFR 404.1512(a), 416.912(a).

[7] 42 U.S.C. 423(d)(5)(B), 1382c(a)(3)(H)(i).

[8] Id.

[9] 20 CFR 404.1512(b)(1)(ii), 416.912(b)(1)(ii).

[10] Id.

[11] See 20 CFR 404.130.

[12] See 20 CFR 404.335(c)(1).

[13] See 20 CFR 404.350.

[14] 20 CFR 404.1512(b)(1)(ii).

[15] See 20 CFR 404.1513, 416.913 (describing the categories of evidence we consider).

[16] For a disability insurance benefits claim under title II, an adjudicator may also determine that the claimant had a closed period of disability when the claimant was disabled for at least 12 continuous months and his or her disability ceased after the month of filing, but prior to the date of adjudication.

[17] See 42 U.S.C. 416(i), 423(a)(1); 20 CFR 404.315(a), 404.320. For title II claims, if we find that the claimant did not meet the statutory definition of disability before his or her insured status expired, we will not determine whether the claimant is currently disabled or was disabled within the 12-month period before the month that he or she applied for benefits. If, however, the claimant also filed a different type of claim—for example, a claim for SSI disability payments—we may have to consider whether the claimant is currently disabled to adjudicate the SSI claim.

[18] For a child's benefits claim under title II, an adjudicator may also determine that the claimant had a closed period of disability when the claimant was disabled for at least 12 continuous months and his or her disability ceased after the month of filing, but prior to the date of adjudication.

[19] See 42 U.S.C. 402(d)(1)(B), 416(i); 20 CFR 404.320, 404.350(a)(5). For a child's benefits claim under title II, if we find that the claimant did not meet the statutory definition of disability before he or she attained age 22, we will not determine whether the claimant is currently disabled or was disabled within the 12-month period before the

month that he or she applied for benefits. If, however, the claimant also filed a different type of claim—for example, a claim for SSI disability payments—we may have to consider whether the claimant is currently disabled to adjudicate the SSI claim.

[20] 42 U.S.C. 1382(c)(7); 20 CFR 416.335. For a title XVI claim, an adjudicator may also determine that the claimant had a closed period of disability when the claimant was disabled for at least 12 continuous months and his or her disability ceased after the month of filing, but prior to the date of adjudication.

[21] See 20 CFR 404.1513, 416.913 (describing the categories of evidence we consider).

[22] 20 CFR 404.969, 416.1469.

[23] 20 CFR 404.970, 416.1470.

[24] 20 CFR 404.970(a)(5), (b) and 416.1470(a)(5), (b).

[25] 20 CFR 404.1510, 416.910.

[26] 20 CFR 404.1574(a)(1), (c) and 416.974(a)(1), (c).

[27] 20 CFR 404.988, 404.989, 416.1488, 416.1489.

[28] See also Program Operations Manual System (POMS) DI 25501.250.A.5 (explaining when a period of disability may begin during a previously adjudicated period).

[29] 20 CFR 404.988, 416.1488 (stating that "[a] determination, revised determination, decision, or revised decision may be reopened . . .") (emphasis added).

These cases below address retrospective opinions and the onset date of disability. They were decided when the treating physician rule existed.

Dousewicz v. Harris, 646 F.2d 771, 774 (2nd Cir. 1981)
Wagner v. Secretary, 906 F.2d 856, 861-862 (2nd Cir. 1990)
Rivera v. Sullivan, 923 F.2d 964, 968-969 (2nd Cir. 1991)
Donahue v. Shalala, 851 F.Supp. 27, 31-34 (D.Conn. 1994)
Bentley v. Apfel, 106 F.Supp.2d 371 (D.Conn. 2000)

Practice Tip: Pay attention to the alleged onset date in the disability Application and the Disability Report. The alleged date can often be very inconsistent with the medical evidence. In such instances, it is a good idea to amend the alleged onset date at the beginning of the hearing or in the pre-hearing memo.

SSR 18-3p – Failure to Follow Prescribed Treatment

Effective Date: October 29, 2018

This Social Security Ruling (SSR) rescinds and replaces SSR 82-59: "Titles II and XVI: Failure to Follow Prescribed Treatment."

Purpose: To provide guidance on how we apply our failure to follow prescribed treatment policy in disability and blindness claims under titles II and XVI of the Social Security Act (Act).

Citations (Authority): Sections 216(i), 223(d) and (f), and 1614(a) of the Act, as amended; 20 CFR 404.1530 and 416.930.
Dates: We will apply this notice on October 29, 2018.[1]

Overview

A.Background
B.When we decide whether the failure to follow prescribed treatment policy may apply in an initial claim

Condition 1: The individual is otherwise entitled to disability or statutory blindness benefits under titles II or XVI of the Act

Condition 2: There is evidence that an individual's own medical source(s) prescribed treatment for the medically determinable impairment(s) upon which the disability finding is based

Condition 3: There is evidence that the individual did not follow the prescribed treatment

C.How we will make a failure to follow prescribed treatment determination

Assessment 1: We assess whether the prescribed treatment, if followed, would be expected to restore the individual's ability to engage in substantial gainful activity (SGA)

Assessment 2: We assess whether the individual has good cause for not following the prescribed treatment

D.Development procedures

E.Required written statement of failure to follow prescribed treatment determination

F.When we make a failure to follow prescribed treatment determination within the sequential evaluation process

Adult claims that meet or equal a listing at step 3

Title XVI child claims that meet, medically equal, or functionally equal the listings at step 3

Adult claims finding disability at step 5

G.Reopening a determination or decision

H.Continuing Disability Reviews (CDR)

I.Duration in disability and Title II blindness claims

J.Duration in Title XVI blindness claims

K.Claims involving both drug addiction and alcoholism (DAA) and failure to follow prescribed treatment

A. Background

Under the Act, an individual who meets the requirements to receive disability or blindness benefits will not be entitled to these benefits if the individual fails, without good cause, to follow prescribed treatment that we expect would restore his or her ability to engage in substantial gainful activity (SGA).[1]

We apply the failure to follow prescribed treatment policy at all levels of our administrative review process when we decide an initial claim for benefits based on disability or blindness. We also apply the policy when we reopen a prior determination or decision involving a claim for benefits based on disability or blindness, when we conduct an age-18 redetermination, and when we conduct a continuing disability review (CDR) under titles II or XVI of the Act.

This SSR explains the policy and procedures we follow when we decide whether an individual has failed to follow prescribed treatment as required by the Act and our regulations.[2]

B. When we decide whether the failure to follow prescribed treatment policy may apply in an initial claim

We will determine whether an individual has failed to follow prescribed treatment only if all three of the following conditions exist:

1.The individual would otherwise be entitled to benefits based on disability or eligible for blindness benefits under titles II or XVI of the Act;

2.We have evidence that an individual's own medical source(s) prescribed[3]treatment for the medically determinable impairment(s) upon which the disability finding is based; and

3.We have evidence that the individual did not follow the prescribed treatment.

If all three conditions exist, we will determine whether the individual failed to follow prescribed treatment, as explained below.[4]

Condition 1: The individual is otherwise entitled to disability or statutory blindness benefits under Titles II or XVI of the Act

We only perform the failure to follow prescribed treatment analysis discussed in this SSR after we find that an individual is entitled to disability or eligible for statutory blindness benefits under titles II or XVI of the Act, regardless of whether the individual followed the prescribed treatment. We will not determine whether an individual failed to follow prescribed treatment if we find the individual is not disabled, not blind, or otherwise not entitled to or eligible for benefits under titles II or XVI of the Act.

Condition 2: There is evidence that an individual's own medical source(s) prescribed treatment for the medically determinable impairment(s) upon which the disability finding is based

If we find that the individual is otherwise entitled to disability or eligible for statutory blindness benefits under titles II or XVI of the Act, we will only determine if the individual has failed to follow prescribed treatment for the medically determinable impairment(s) upon which the disability finding is based if the individual's own medical source(s) prescribed the treatment.[5] We will not determine whether the individual failed to follow prescribed treatment if the treatment was prescribed only by a consultative examiner (CE), medical consultant (MC), psychological consultant (PC), medical expert (ME), or by a medical source during an evaluation conducted solely to determine eligibility to any State or Federal benefit.

Prescribed treatment means any medication, surgery, therapy, use of durable medical equipment, or use of assistive devices. Prescribed treatment does not include lifestyle modifications, such as dieting, exercise, or smoking cessation. We will consider any evidence of prescribed treatment, whether it appears on prescription forms or is otherwise indicated within a medical source's records.

We will consider treatment a medical source prescribed in the past if that treatment is still relevant to the individual's medically determinable impairments that are present during the potential period of entitlement or eligibility and upon which the disability finding was based. We will evaluate whether the individual failed to follow

the prescribed treatment, and whether there is good cause for this failure, only for the period(s) during which the individual may be entitled to benefits under the Act.

For example: On January 2, 2017, an individual filed for disability benefits based on an impairment related to a lower-extremity amputation. The individual is no longer wearing a prosthesis that her medical source prescribed in 2015. We determine that the individual meets all of the other criteria for disability. In this scenario, we will evaluate whether the individual is failing to follow the prescribed treatment to wear the prosthesis during the potential entitlement period and whether the individual has good cause for not following the prescribed treatment during this period. However, we will not consider whether the individual failed to follow prescribed treatment prior to the first possible date of entitlement.

Condition 3: There is evidence that the individual did not follow the prescribed treatment

If we have any evidence that the individual is not following the prescribed treatment, this condition is satisfied. For example, a medical source may include in a treatment note that the patient has not been compliant with a prescribed medication regimen.

C. How we will make a failure to follow prescribed treatment determination

If all three conditions exist, we will determine whether the individual has failed to follow prescribed treatment in the claim. To make a failure to follow prescribed treatment determination, we will:

1.Assess whether the prescribed treatment, if followed, would be expected to restore the individual's ability to engage in SGA.

2.Assess whether the individual has good cause for not following the prescribed treatment.

We may make either assessment first. If we first assess that the prescribed treatment, if followed, would not be expected to restore the individual's ability to engage in SGA, then it is unnecessary for us to assess whether the individual had good cause. Similarly, if we first assess that an individual has good cause for not following the prescribed treatment, then it is unnecessary for us to assess whether the prescribed treatment, if followed, would be expected to restore the individual's ability to engage in SGA.

Assessment 1: We assess whether the prescribed treatment, if followed, would be expected to restore the individual's ability to engage in SGA

This assessment focuses on the prescribed treatment. We will determine whether we would expect the prescribed treatment, if followed, to restore the individual's ability to engage in SGA. We are responsible for making this assessment, and we will consider all the relevant evidence in the record. At the initial and reconsideration levels of the administrative review process, an MC or PC will make this assessment. At the hearings and Appeals Council (AC) levels, the adjudicator(s) will make this assessment. Although the conclusion of this assessment ultimately rests with us, we will consider the prescribing medical source's prognosis.

If we first determine that following the prescribed treatment would not be expected to restore the individual's ability to engage in SGA, then it is unnecessary for us to assess whether the individual had good cause for failing to follow the prescribed treatment. If we determine that following the prescribed treatment would restore the individual's

ability to engage in SGA, we will then assess whether the individual has good cause for not following the prescribed treatment.

Assessment 2: We assess whether the individual has good cause for not following the prescribed treatment

This assessment focuses on whether the individual has good cause for not following the prescribed treatment.

In adult claims, the individual has the burden to provide evidence showing that he or she has good cause for failing to follow prescribed treatment.

In child claims, the parent or guardian has the burden to provide evidence showing that the child has good cause for failing to follow prescribed treatment. If the child has a representative payee and the parent, guardian, or child asserts that the child would have followed prescribed treatment but for the actions of the representative payee, we will determine whether to obtain a new representative payee. If we decide to obtain a new representative payee, we will provide additional time for the child to follow the prescribed treatment before we continue considering the claim.

To assess good cause in both adult and child claims, we will develop the claim according to the instructions in the Development procedures section below. The following are examples of acceptable good cause reasons for not following prescribed treatment:

1.Religion: The established teaching and tenets of the individual's religion prohibit him or her from following the prescribed treatment. The individual must identify the religion, provide evidence of the individual's membership in or affiliation to his or her religion, and provide evidence that the religion's teachings do not permit the individual to follow the prescribed treatment.

2.Cost: The individual is unable to afford prescribed treatment, which he or she is willing to follow, but for which affordable or free community resources are unavailable. Some individuals can obtain free or subsidized health insurance plans or healthcare from a clinic or other provider. In these instances, the individual must demonstrate why he or she does not have health insurance that pays for the prescribed treatment or why he or she failed to obtain treatment at the free or subsidized healthcare provider.

3.Incapacity: The individual is unable to understand the consequences of failing to follow prescribed treatment.

4.Medical disagreement: When the individual's own medical sources disagree about whether the individual should follow a prescribed treatment, the individual has good cause to not follow the prescribed treatment. Similarly, when an individual chooses to follow one kind of treatment prescribed by one medical source to the simultaneous exclusion of an alternate treatment prescribed by another medical source, the individual has good cause not to follow the alternate treatment.

5.Intense fear of surgery: The individual's fear of surgery is so intense that it is a contraindication to having the surgery. We require a written statement from an individual's own medical source affirming that the individual's intense fear of surgery is in fact a contraindication to having the surgery. We will not consider an individual's refusal of surgery as good cause for failing to follow prescribed treatment if it is based on the individual's assertion that success is not guaranteed or that the individual knows of someone else for whom the treatment was not successful.

6.Prior history: The individual previously had major surgery for the same impairment with unsuccessful results and the same or similar additional major surgery is now prescribed.

7.High risk of loss of life or limb: The treatment involves a high risk for loss of life or limb. Treatments in this category include:

•Surgeries with a risk of death, such as open-heart surgery or organ transplant.

•Cataract surgery in one eye with a documented, unusually high-risk of serious surgical complications when the individual also has a severe visual impairment of the other eye that cannot be improved through treatment.

•Amputation of an extremity or a major part of an extremity.

8.Risk of addiction to opioid medication: The prescribed treatment is for opioid medication.

9.Other: If the individual offers another reason for failing to follow prescribed treatment, we will determine whether it is reasonably justified on a case-by- case basis.

We will not consider as good cause an individual's allegation that he or she was unaware that his or her own medical source prescribed the treatment, unless the individual shows incapacity as described above. Similarly, mere assertions or allegations about the effectiveness of the treatment are insufficient to meet the individual's burden to show good cause for not following the prescribed treatment.

D. Development procedures

If evidence we already have in a claim is insufficient to make the required assessment(s) in the failure to follow prescribed treatment determination, we may develop the evidence, as appropriate. This development could include contacting the individual's medical source(s) or the individual to ask why he or she did not follow the prescribed treatment. Although it may be helpful to have evidence from a CE or ME, we are not required to purchase a CE or obtain testimony from an ME to help us determine whether we expect a prescribed treatment, if followed, would restore the ability to engage in SGA. We are responsible for resolving any conflicts in the evidence, including inconsistencies between statements made by the individual and information received from his or her medical source(s). We may also evaluate the claim using the procedures for fraud or similar fault, if appropriate.

E. Required written statement of failure to follow prescribed treatment determination

When we make a failure to follow prescribed treatment determination, we will explain the basis for our findings in our determination or decision.

F. When we make a failure to follow prescribed treatment determination within the sequential evaluation process for initial claims

Adult claims that meet or equal a listing at step 3

Generally, if we find that an individual's impairment(s) meets or medically equals a listing at step 3 of the sequential evaluation process, and there is evidence of all three conditions listed in Section B above, we will determine whether the individual failed to follow prescribed treatment. We will determine whether an individual would still meet or medically equal a listing had he or she followed the prescribed treatment. If we determine the individual would no longer meet or medically equal the listing had he or she followed prescribed treatment, we will assess whether there

is good cause for not following the prescribed treatment. We will determine that the individual is disabled if we find that he or she has good cause for not following the prescribed treatment. If we do not find good cause, we will continue to evaluate the claim using the sequential evaluation process by determining the individual's residual functional capacity (RFC).[6]

There are two instances when we will not make a failure to follow prescribed treatment determination at step 3 of the sequential evaluation process, even if there is evidence that an individual did not follow prescribed treatment. First, we will not make a failure to follow prescribed treatment determination when we find the individual disabled based on a listing that requires only the presence of laboratory findings. In these claims, treatment would have no effect on the disability determination or decision. Second, we will not make a failure to follow prescribed treatment determination when we find the individual is disabled based on a listed impairment(s) which requires us to consider whether the individual was following that specific treatment as part of the required listing analysis. If either of these exceptions apply, we will find the individual is disabled without making a failure to follow prescribed treatment determination.

Title XVI child claims that meet, medically equal, or functionally equal the listings at step 3

Generally, if we find that a child's impairment(s) meets, medically equals, or functionally equals the listings at step 3 of the sequential evaluation process, and there is evidence of all three conditions listed in Section B above, we will determine whether there has been a failure to follow prescribed treatment. We will determine whether the child's impairment(s) would still meet, medically equal, or functionally equal the listings had he or she followed the prescribed treatment. If we determine the child's impairment(s) would no longer meet, medically equal, or functionally equal the listings had he or she followed prescribed treatment, we will assess whether there is good cause for not following the prescribed treatment. We will find the child is disabled if we determine that he or she has good cause for not following the prescribed treatment. If we determine that there is not good cause for failing to following the prescribed treatment, we will find the child is not disabled.

There are two instances when we will not make a failure to follow prescribed treatment determination at step 3 of sequential evaluation process even if there is evidence that a child did not follow prescribed treatment. First, we will not make a failure to follow prescribed treatment determination when we find the child is disabled based on a listing that requires only the presence of laboratory findings. In these claims, treatment would have no impact on the disability determination or decision. Second, we will not make a failure to follow prescribed treatment determination when we find the child is disabled based on a listed impairment(s) which requires us to consider whether the child was following that specific treatment as part of the required listing analysis. If either of these exceptions apply, we will find the child is disabled without making a failure to follow prescribed treatment determination.

Adult claims finding disability at step 5

If we find that an individual is disabled at step 5 of the sequential evaluation process and there is evidence the individual is not following treatment prescribed by his or her own medical source(s), before we find the individual is disabled, we will assess whether the individual would still be disabled if he or she were following the prescribed treatment.

We will determine what the individual's residual functional capacity (RFC) would be had he or she followed the prescribed treatment. We will then use that RFC to reevaluate steps 4 and 5 of the sequential evaluation process to determine whether the individual could perform his or her past relevant work at step 4 or adjust to other work at step 5. We will find the individual is disabled if we determine that the individual would remain unable to engage in SGA, even if the individual had followed the prescribed treatment. We will also find the individual is disabled if we find the individual had good cause for not following the prescribed treatment. However, we will find the individual is not disabled if the individual does not have good cause for not following the prescribed treatment and we determine that,

had the individual followed the prescribed treatment, he or she could perform past relevant work or engage in other SGA.

G. Reopening a determination or decision

As permitted by our regulations, we may reopen a favorable determination or decision if we discover we did not apply the failure to follow prescribed treatment policy correctly.[7] We may base our reopening on the evidence we had in the folder at the time we made our determination or decision or based on new evidence we receive. When we reopen a disability or blindness determination or decision and find that an individual does not have good cause for failing to follow prescribed treatment, we will issue a predetermination notice and offer the individual an opportunity to respond before we terminate benefits.

H. Continuing Disability Reviews (CDR)

When we conduct a CDR, we will make a failure to follow prescribed treatment determination when the individual's own medical source(s) prescribed a new treatment for the disabling impairment(s) since the last favorable determination or decision and the individual did not follow the prescribed treatment.

We will also make a failure to follow prescribed treatment determination during a CDR if we find that an individual would continue to be entitled to disability or blindness benefits based upon an impairment first alleged during the CDR and there is evidence that the individual has not followed his or her own medical source's prescribed treatment for that impairment.

If we determine an individual does not have good cause for failing to follow the prescribed treatment that we have determined would restore the individual's ability engage in SGA, we will issue a predetermination notice and, because benefits may be terminated, offer the individual an opportunity to respond before terminating benefits. Individuals are entitled to benefits while we develop evidence to determine whether they failed to follow prescribed treatment. If we determine that an individual failed to follow prescribed treatment without good cause in either situation, we will cease benefits two months after the month of the determination or decision that the individual is no longer disabled or statutorily blind.

I. Duration in disability and Title II blindness claims

If an individual failed to follow the prescribed treatment without good cause within 12 months of onset of disability or blindness, we will find the individual is not disabled because the duration requirement is not met.[8] However, if an individual failed to follow prescribed treatment without good cause more than 12 months after onset of disability or blindness and is otherwise disabled, we will find the individual is disabled with a closed period that ends when the individual failed to follow the prescribed treatment. In this situation, we will continue to pay benefits as usual through the second month after the month disability or blindness ends.

J. Duration in Title XVI blindness claims

Because title XVI blindness entitlement does not have a duration requirement, an individual meeting the title XVI blindness requirements may be entitled to benefits beginning the month after he or she applies for benefits.[9] If we determine an individual failed to follow prescribed treatment without good cause any time before the first day of the month after filing, we will find the individual is not disabled. However, if we determine the individual failed to follow prescribed treatment without good cause any time after the first day of the month after filing, we will find the individual is disabled with a closed period from the date of entitlement until the date we determined the individual

failed to follow the prescribed treatment without good cause. In this situation, we will continue to pay benefits as usual through the second month after the month blindness ends.

If we need further development to determine whether a title XVI blind individual failed to follow prescribed treatment without good cause, the individual is entitled to benefits while we conduct the additional development. At the hearing and Appeals Council levels, we will refer the claim to the effectuating component to develop the evidence necessary to make a failure to follow prescribed treatment determination.

K. Claims involving both drug addiction and alcoholism (DAA) and failure to follow prescribed treatment

In a claim that may involve both DAA and failure to follow a prescribed treatment for an impairment other than DAA, we will first make the DAA determination.[10] If we find that the individual is disabled considering all impairments including the DAA and that DAA is material to our determination of disability, we will deny the claim and not make a failure to follow prescribed treatment determination. If we find that the individual is disabled considering all impairments including the DAA, but the DAA is not material to our determination of disability, we will then make the failure to follow prescribed treatment determination for the impairment(s) other than DAA. Even if the prescribed treatment for the other impairment(s) may also have beneficial effect on the DAA, we do not reevaluate for DAA materiality a second time.

For example, we cannot find that an individual has failed to follow prescribed treatment for liver disease based on a failure to follow treatment prescribed for alcohol dependence. If the cessation of drinking alcohol would be expected to improve the individual's functioning so that he or she is not disabled, we would find that DAA is material to the determination of disability and deny the claim for that reason.

[1] Our adjudicators will apply this ruling when we make determinations and decisions on or after October 29, 2018. When a Federal court reviews our final decision in a claim, we expect the court will review the final decision using the rules that were in effect at the time we issued the decision under review. If a court finds reversible error and remands a case for further administrative proceedings on or after October 29, 2018, the applicable date of this ruling, we will apply this ruling to the entire period at issue in the decision we make after the court's remand. Our regulations on failure to follow prescribed treatment are unchanged.

[2] Sections 223(f) and 1614(a) of the Act. The ability to engage in SGA is the standard in adult disability claims. However, when this policy is applied in title XVI child disability claims, the standard is "the prescribed treatment is expected to eliminate or improve the child's impairment so that it no longer results in marked and severe functional limitations." Similarly, for claims based on statutory blindness, the standard is the prescribed treatment would be expected to "restore vision to the extent that the individual will no longer be blind."

[3] See 20 CFR 404.1530 and 416.930.

[4] There are two exceptions at step 3 of the sequential evaluation process, explained in section F (below), when we will not make a failure to follow prescribed treatment determination even if these three

[5] See 20 CFR 404.1502 and 416.902 for the definition of "medical source."

[6] See 20 CFR 404.1545 and 416.945.

[7] See 20 CFR 404.988, 404.989, 416.1488, and 416.1489.

[8] See 20 CFR 404.1509 and 416.909.

[9] Section 216(i)(1)(B) of the Act.

[10] See SSR 13-2p: Titles II and XVI: Evaluating Cases Involving Drug Addiction and Alcoholism (DAA), 78 FR 11939 (Mar. 22, 2013).

SSR 20-01p: Titles II and XVI: How We Determine an Individual's Education Category

Purpose: This Social Security Ruling (SSR) explains how we determine an individual's education category in adult initial disability decisions, determinations, redeterminations, and continuing disability reviews under titles II and XVI of the Social Security Act.

Citations (Authority): Sections 223(d)(2)(A), 225, 221(i), 1614(a)(3)(B), and 1614(a)(3)(H) of the Social Security Act, as amended and 20 CFR 404.1520, 404.1564, Part 404 Subpart P Appendix 2, 416.920, and 416.964.

Background

We use a five-step sequential evaluation process to determine whether an individual is disabled or blind under titles II and XVI of the Act.[1] If we are unable to make a disability finding at the first four steps, we consider an individual's residual functional capacity (RFC)[2] and the vocational factors of age, education, and work experience to determine whether the individual is able to perform work that exists in significant numbers in the national economy.[3]

Our rules explain how we evaluate the vocational factor of education.[4] Education primarily means formal schooling or other training that contributes to an individual's ability to meet vocational requirements, such as reasoning ability, communication skills, and arithmetical ability.[5] The lack of formal schooling does not necessarily mean that the individual is uneducated or does not have these abilities.[6] Past work experience and the kinds of responsibilities the individual had while working, daily activities, hobbies, or results of testing may show that the individual has significant intellectual ability that can be used to work.[7]

We use the following four education categories to evaluate an individual's education level:[8]

1. *High school education and above.* High school education and above means abilities in reasoning, arithmetic, and language skills acquired through formal schooling at a 12th grade level or above. We generally consider that someone with these educational abilities can do semi-skilled through skilled work.[9]
2. *Limited education.* Limited education means ability in reasoning, arithmetic, and language skills, but not enough to allow a person with these educational qualifications to do most of the more complex job duties needed in semi-skilled or skilled jobs. We generally consider that a 7th grade through the 11th grade level of formal education is a limited education.
3. *Marginal education.* Marginal education means ability in reasoning, arithmetic, and language skills that are needed to do simple, unskilled types of jobs. We generally consider that formal schooling at a 6th grade level or less is a marginal education.
4. *Illiteracy.* Illiteracy means an inability to read or write. We consider someone illiterate if the person cannot read or write a simple message such as instructions or inventory lists even though the person can sign his or her name. Generally, an illiterate person has had little or no formal schooling.

Policy Interpretation

I. Categories of High School Education and Above, Limited Education, and Marginal Education

We generally use the highest numerical grade level of formal education an individual has completed in school regardless of the language used for instruction to determine whether the individual belongs in the education category of high school education and above, limited education, or marginal education. An individual's highest numerical grade level generally reflects the individual's educational abilities, such as reasoning, arithmetic, and communication skills.[10] The highest numerical grade level that the individual completed in school, however, may not represent his or her actual educational abilities.[11] Evidence such as past work experience, the kind of responsibility an individual may have had when working, daily activities, hobbies, results of testing, community projects, or vocational training, may show that an individual's actual educational abilities are higher or lower than his or her formal education level. In such situations, we may assign an individual to a higher or lower education category, as appropriate.

Further, when determining the appropriate education category, we may consider whether an individual received special education. For example, an extensive history of special education may show that the individual's educational abilities are lower than the actual grade he or she completed.

We, however, will not find an individual's education category to be lower than his or her highest level of formal education based solely on an individual's history of having received special education. In all cases, we

determine facts on an individual basis. Therefore, to assign an individual to an education category lower or higher than his or her highest level of formal education, there must be specific evidence supporting the finding in the determination or decision.

When determining the appropriate education category, we will not consider whether an individual attained his or her education in another country or whether the individual lacks English language proficiency. Neither the country in which an individual was educated nor the language an individual speaks informs us about whether the individual's reasoning, arithmetic, and language abilities are commensurate with his or her formal education level.[12]

Generally, when determining the appropriate education category, we will use the information an individual provides. We may request relevant records, such as school or government records, to verify the reported level of formal education and educational abilities.

II. Category of Illiteracy

A. Generally

We consider an individual illiterate if he or she cannot read or write a simple message, such as instructions or inventory lists, even though the individual can sign his or her name.[13] We will assign an individual to the illiteracy category only if the individual is unable to read or write a simple message in any language.

B. Formal education and the ability to read and write a simple message

Generally, an individual's educational level is a reliable indicator of the individual's ability to read and write a simple message. A strong correlation exists between formal education and literacy, which under our rules means an ability to read and write a simple message. Most individuals learn to read and write at least a simple message by the time they complete fourth grade, regardless of whether the schooling occurred in the United States or in another country.[14] We will therefore use an individual's formal education level as the starting point to determine whether the individual is illiterate.

If evidence suggests an individual may be illiterate, we will determine whether the illiteracy category is appropriate as follows:

i. Individuals who completed at least a fourth grade education

Most individuals who have completed at least fourth grade can read and write a simple message. We will generally find that an individual who completed fourth grade or more is able to read and write a simple message and is therefore not illiterate.

We may still find, however, that an individual with at least a fourth grade education is illiterate if the individual provides evidence showing that despite having completed fourth grade or more, he or she cannot, in fact, read or write a simple message in any language. Examples of relevant evidence may include whether an individual:

- has received long-term special education related to difficulty learning to read or write at a basic level;
- lacks work history due to an inability to read or write;
- has valid intelligence test results demonstrating an inability to read or write a simple message;
- has valid reading and writing test results demonstrating an inability to read or write a simple message; and
- has any other evidence demonstrating an inability to read or write a simple message.

We will assign an individual who completed fourth grade education or more to the illiteracy category only if the evidence supports the finding that despite having completed fourth grade education or more, the individual is unable to read or write a simple message in any language. We will not rely on test results alone to determine that illiteracy is the appropriate education category for an individual.

ii. Individuals who completed less than a fourth grade education

Formal education is not the only way individuals learn to read and write; therefore, we do not make any general finding that illiteracy is the appropriate category for individuals who have not completed a fourth grade education. The mere fact that an individual has little or no formal education does not mean that the individual is unable to read or write. Therefore, we will consider all relevant evidence in the claim to determine whether illiteracy is the appropriate education category. Examples of relevant evidence may include whether an individual:

- has worked in the past and the responsibilities he or she had when working;
- can read, write, and understand short and simple statements in everyday life, such as shopping lists, short notes, and simple directions;
- can read newspapers or books;
- can read and write simple emails or text messages;
- had any vocational training or certification requiring reading and writing;
- has or ever had a driver's license that required passing a written test; and
- has any other evidence demonstrating an inability to read or write a simple message.

We will assign an individual to the illiteracy category only if the evidence supports a finding that the individual is unable to read or write a simple message in any language. We will not, however, rely on test results alone to determine that illiteracy is the appropriate education category for an individual.

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[1] See 20 CFR 404.1520 and 416.920.

[2] See 20 CFR 404.1545 and 416.945. RFC is the most an individual can do despite his or her limitations.

[3] See 20 CFR 404.1520(g), 404.1560(c), 416.920(g), and 416.960(c).

[4] See 20 CFR 404.1564 and 416.964.

[5] See 20 CFR 404.1564(a) and 416.964(a).

[6] Id.

[7] Id.

[8] See 20 CFR 404.1564(b)(1)-(4) and 416.964(b)(1)-(4). We no longer have an education category of "inability to communicate in English" as of April 27, 2020. We published a final rule "Removing the Inability to Communicate in English as an Education Category" that removed this education category on February 25, 2020 (85 FR 10586).

[9] We consider a general educational development (GED) certification as equivalent to high school education.

[10] See 20 CFR 404.1564(b) and 416.964(b).

[11] Id.

[12] Specific to language abilities, if there is a question as to whether an individual's actual language abilities are higher or lower than his or her formal education level, we use the language in which the individual most effectively communicates. For most individuals, this language is the language that they use in most situations, including at home, work, school, and in the community.

[13] See 20 CFR 404.1564(b)(1) and 416.964(b)(1).

[14] Typically, fourth grade is when students transition from a focus on learning to read to a focus on reading to learn. See Reading Achievement of U.S. Fourth-Grade Students in an International Context, https://nces.ed.gov/pubs2018/2018017.pdf , p.1. The rate of literacy (defined as an ability to understand, read, and write a short, simple statement on everyday life) increased from 33.4% with one year of primary schooling to 95.3% with four years of primary schooling. How Was Life?: Global Well-being since 1820, OECD Publishing, Juan Luitan van Zanden., et al. (eds.) (2014), p. 91, available at https://read.oecd-ilibrary.org/economics/how-was-life_9789264214262-en#page93. The Common Core reading and writing standards for primary schools demonstrate that an individual who completed fourth grade education should be able to read and write a simple message. http://www.corestandards.org/assets/CCSSI_ELA%20Standards.pdf,

pp.10-33. Finally, the Progress in International Reading Literacy Study, an international assessment of student performance in reading at the fourth grade, shows that the majority of countries that participated in the study were able to educate nearly all their students to a basic level of reading achievement. See http://timssandpirls.bc.edu/pirls2016/international-results/pirls/performance-at-international-benchmarks/ and https://nces.ed.gov/pubs2018/2018017.pdf, pp. 4, 9-10.

Rulings Related to Procedural Issues In Disability Claims

SSR 91-5p – Mental Incapacity and Good Cause For Missing The Deadline To Request Review

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

The claimant will have established mental incapacity for the purpose of establishing good cause when the evidence establishes that he or she lacked the mental capacity to understand the procedures for requesting review.
In determining whether a claimant lacked the mental capacity to understand the procedures for requesting review, the adjudicator must consider the following factors as they existed at the time of the prior administrative action:

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

Comment: From experience, it seems that the SSA office and ALJs (in cases where the claimant is represented by counsel) decide to find good cause, especially when the time to request an appeal to the next level was missed by less than a month.

Canales v. Sullivan, 936 F.2d 755 (2d Cir. 1991) This claim was remanded to determine whether equitable tolling of the 60 day limitations period to seek review should be tolled because of the claimant's mental impairment. This case was decided before the Ruling was published.

SSR 11-1p – Procedures for Handling Requests to File Subsequent Applications for Disability Benefits

- Under the new procedures we are adopting in this Ruling, generally you will no longer be allowed to have two claims for the same type of benefits pending at the same time. If you want to file a new disability claim under the same title and of the same type as a disability claim pending at any level of administrative review, you will have to choose between pursuing your administrative review rights on the pending disability claim or declining to pursue further administrative review and filing a new application.

Note: A claimant can file a new disability application while the prior claim is on appeal if the new claim pertains to a different disabling condition. Also, if the claimant's request for review is denied by the Appeals Council, they can appeal that claim into District Court while filing a new disability application. If the new application is filed within six months of the denial, they can use the day after the prior ALJ unfavorable decision as the onset date.

SSR 13-1p – Allegations of Unfairness, Prejudice, Partiality, Bias, Misconduct or Discrimination

Under our regulations, an ALJ must not conduct a hearing if he or she is prejudiced or partial with respect to any party or has any interest in the matter pending for decision. A claimant or other party to the hearing who objects to the ALJ who will conduct the hearing must notify the ALJ at his or her earliest opportunity. The ALJ will then decide whether to proceed with the hearing or to withdraw. If the ALJ does not withdraw, the claimant or other party to the hearing may, after the hearing, present objections to the Appeals Council as to reasons why the hearing decision should be revised or a new hearing should be held before another ALJ.

If, in conjunction with a request for review, the Appeals Council receives an allegation of ALJ unfairness, prejudice, partiality, or bias, the Appeals Council will review the claimant's allegations and hearing decision under the abuse of discretion standard. We will find an abuse of discretion when an ALJ's action is erroneous and without any rational basis, or is clearly not justified under the particular circumstances of the case, such as where there has been an improper exercise, or a failure to exercise, administrative authority. For example, if the record shows that the ALJ failed to conduct a full and fair hearing by refusing to allow the claimant to testify or cross-examine witnesses, we will find that an abuse of discretion has occurred. An abuse of discretion may also occur where there is a failure to follow procedures required by law. An ALJ also abuses his or her discretion if the evidence in the record shows that the ALJ failed to recuse himself or herself from a case in which he or she was prejudiced or partial with respect to a particular claim or claimant, or had an interest in the matter pending for decision. In this instance, we will remand the case to another ALJ for a new hearing or revise the ALJ's decision pursuant to 20 CFR 404.940 and 416.1440. *In considering allegations of unfairness, prejudice, partiality, or bias by the ALJ, the Appeals Council reviews information in the claimant's administrative record to determine whether to consider the alleged actions an abuse of discretion. The Appeals Council relies solely on information in the administrative record in determining this issue.* The Appeals Council does not otherwise investigate the allegations or consider information or evidence that is not a part of the administrative record. (Emphasis added)

We also may receive allegations and complaints about ALJ conduct directly from claimants and other sources, outside of the scope of Appeals Council review. For example, in addition to receiving complaints from individual claimants, we may also receive complaints from witnesses at a hearing, claimant representatives, agency personnel such as those in our Office of the Inspector General (OIG), Members of Congress, and the Federal courts. Within the Office of Disability Adjudication Review (ODAR), the Division of Quality Service collects, reviews, and if warranted, investigates all allegations and complaints, including allegations referred by the Appeals Council under the process described above. The Division of Quality Service is responsible for receiving, tracking, and monitoring complaints that it receives.

A person who was a party to a hearing may file a discrimination complaint with us alleging discrimination in our hearing process based on race, color, national origin (including English language ability), religion, sex, sexual orientation, age, disability or in retaliation for having previously filed a civil rights complaint.

An individual may file a discrimination complaint alleging discrimination by an ALJ by using Form SSA-437-BK (available at http://www.socialsecurity.gov/online/ssa-437.pdf)

Note: The cases below involve the issue as to whether the denied claim should be remanded to another ALJ because, among other things, the court was concerned with the ALJ's fairness at the initial hearing.

Maggipinto v Astrue, 541 F.Supp.2d 477 (D.Conn. 2007) (RNC) where the court ruled that a remand to another ALJ was appropriate because the factors set forth in United States v. Robin, 553 F.2d 8, 10 (2nd Cir. 1977) were met. These factors include: 1) whether the original judge would reasonably be expected upon remand to have substantial difficulty in putting out of his or her mind previously-expressed views or findings determined to be erroneous or based on evidence that must be rejected; 2) whether reassignment is advisable to preserve the

appearance of justice; and 3) whether reassignment would entail waste and duplication out of proportion to any gain in preserving the appearance of fairness.

Dellacamera v. Astrue, 2009 WL 3766062 (D.Conn. Nov. 5, 2009). This court applied a four prong test to determine if the claimant's case should be remand to another ALJ. These factors are: "(1) a clear indication that the ALJ will not apply the appropriate legal standard on remand; (2) a clearly manifested bias or inappropriate hostility toward any party; (3) a clearly apparent refusal to consider portions of the testimony or evidence favorable to a party, due to apparent hostility to that party; (4) a refusal to weigh or consider evidence with impartiality, due to apparent hostility to any party. *Sutherland v. Barnhart,* 322 F.Supp.2d 282, 292 (S.D.N.Y.2004). *See also Waggener v. Astrue,* No. 08–cv–715(REB), 2009 WL 2601372 (D.Colo. Aug. 21, 2009)(applying same factors when conduct of an ALJ gives rise to serious concerns about the fundamental fairness of the disability review process), *quoting Fortz v. Astrue,* No. C08–5285BHS–JKA, 2009 WL 210713 (E.D.Wash. Jan. 28, 2009)(same). These four factors, while not identical to those in *Robin,* are certainly parallel to them." The court did not order that the claim be remanded to another ALJ but "strongly urged" the Commissioner to reassign the case to another ALJ.

Jordan v. Berryhill, 2019 WL 1429616 (D.Conn. Mar. 29, 2019) (KAD). The court remanded this claim back to another ALJ after applying the four factors set forth in the Dellacamera case. The court said the conduct of the ALJ gave rise to serious concerns about the "fundamental fairness" of the disability review process.

Card v. Astrue, 752 F.Supp.2d 190 (D.Conn. 2010). In this case, the court denied remand to another ALJ.

SSR 13-3p – Appeal of an Initial Medical Disability Cessation Determination or Decision

- This SSR revises our policy to provide that we will use the same timeframe for determinations or decision we make in both title II and title XVI medical disability cessation cases reviewed at the reconsideration and hearings level(s) of our administrative review process. Under the policy we are adopting in this Ruling, the adjudicator reviewing the medical cessation determination or decision will decide whether the beneficiary is under a disability through the date of the adjudicator's determination or decision.

McIntire v. Astrue, 809 F. Supp.2d 13 (D.Conn. 2010). This decision preceded SSR 13-3p. The court discussed the relevant time period in evaluating an SSI disability cessation case. It noted that disability can be established after the date SSA has determined the disability has ceased and that evidence submitted after that alleged cessation date is relevant to determine if a new period of eligibility can be found.

SSR 17-1p – Reopening Based on Error on The Face of the Evidence

- When we have made a determination or decision by applying a Federal or State law that the Supreme Court of the United States later determines to be unconstitutional, the application of that law would not have been correct and reasonable when made. Consequently, we do not interpret the change in legal interpretation criteria in our rules to prevent us from applying our reopening rules in that specific situation.

SSR 19-1p: Titles II and XVI: Effect of the Decision in Lucia v. Securities and Exchange Commission (SEC) on Cases Pending at the Appeals Council

Purpose: This ruling explains how we will adjudicate cases pending at the Appeals Council in which the claimant has raised a timely challenge to the appointment of an administrative law judge (ALJ) under the Appointments Clause of the United States Constitution in light of the Supreme Court's decision in *Lucia v. SEC*, 138 S. Ct. 2044 (2018).

Citations: 20 CFR 404.970, 404.976(b), 416.1470, and 416.1476(b).

The Appeals Council will grant the claimant's request for review in cases where the claimant: (1) timely requests Appeals Council review of an ALJ's decision or dismissal issued before July 16, 2018; and (2) raises before us (either at the Appeals Council level, or previously had raised at the ALJ level) a challenge under the Appointments Clause to the authority of the ALJ who issued the decision or dismissal in the case.

The Appeals Council will either remand the case to a different ALJ; issue a new, independent decision; or, as appropriate, issue an order dismissing the request for a hearing. When the Appeals Council issues a decision, its decision may result in different findings from the ALJ hearing decision that the Appeals Council vacated.[17] When the Appeals Council grants review and issues its own decision, its decision will be based on the preponderance of the evidence.[18]

See Knowles v. Saul, Civil No. 3:19-CV-719 (D.Conn July 22, 2020) RAR (unreported).

Children's Disability Rulings

SSR 98-1p – Determining Medical Equivalence in Childhood Disability Claims When A Child Has Marked Limitations In Cognition And Speech

This ruling defines cognition and speech and explains when impairments in these domains are marked or extreme.

SSR 09-1p – Determining Childhood Disability under the Functional Equivalence Rule – The "Whole Child" Approach

- Any given impairment may have effects in more than one domain.

- The functional equivalence rules require us to begin by considering how the child functions every day and in all settings compared to other children the same age who do not have impairments.

- "Functioning" refers to a child's activities; that is, everything a child does throughout the day at *home*, at *school,* and in the *community*, such as getting dressed for school, cooperating with caregivers, playing with friends, and doing class assignments. We consider:

  - What activities the child is able to perform,
  - What activities the child is not able to perform,
  - Which of the child's activities are limited or restricted,
  - Where the child has difficulty with activities—at home, in childcare, at school, or in the community,
  - Whether the child has difficulty independently initiating, sustaining, or completing activities,
  - The kind of help, and how much help the child needs to do activities, and how often the child needs it, and
  - Whether the child needs a structured or supportive setting, what type of structure or support the child needs, and how often the child needs it.

  20 CFR 416.926a(b)(2).

- A single impairment, as well as a combination of impairments, may result in limitations that require evaluation in more than one domain.

- It is important to determine the extent to which an impairment(s) compromises a child's ability to independently initiate, sustain, and complete activities. To do so, we consider the kinds of help or support the child needs in order to function. *See* 20 CFR 416.924a(b). In general, *if a child needs a person, medication, treatment, device, or structured, supportive setting to make his functioning possible or to improve the functioning, the child will not be as independent as same-age peers who do not have impairments. Such a child will have a limitation, even if he is functioning well with the help or support.*

- The more help or support of any kind that a child receives beyond what would be expected for children the same age without impairments, the less independent the child is in functioning, and the more severe we will find the limitation to be.

- … we may find that a child has a "marked" or "extreme" limitation of a domain *even though the child does not have serious or very serious limitations every day.* As in any case, we must consider the effects of the impairment(s) longitudinally (that is, over time) when we evaluate the severity of the child's limitations.

SSR 09-2p – Documenting a Child's Impairment Related Limitations

- We focus first on the child's activities, and evaluate how appropriately, effectively, and independently the child functions compared to children of the same age who do not have impairments. 20 CFR 416.926a(b) and (c).

- Activities are everything a child does at home, at school, and in the community, 24 hours a day, 7 days a week.

- This SSR explains the evidence we need to document a child's impairment-related limitations, the sources of evidence we commonly see in childhood disability cases, how we consider the evidence we receive from early intervention and school programs (including special education), how we address inconsistencies in the evidence, and other issues related to the development of evidence about functioning.

- A child functions age-appropriately when initiating, sustaining, and completing age-appropriate activities. "Functioning" includes everything a child does throughout a day at home, at school, and in the community. Examples include, getting dressed for school, cooperating with caregivers, playing with friends, and doing class assignments.

- We need evidence that is sufficient to evaluate a child's limitations on a longitudinal basis; that is, over time. This evidence will help us answer the following questions about whether the child's impairment(s) affects day-to-day functioning and whether the child's activities are typical of other children of the same age who do not have impairments. Accordingly, we need evidence to help us determine the following:

- What activities is the child able to perform?
- What activities is the child not able to perform?
- Which of the child's activities are limited or restricted compared to other children of the same age who do not have impairments?
- Where does the child have difficulty with activities--at home, in childcare, at school, or in the community?
- Does the child have difficulty independently initiating, sustaining, or completing activities?
- What kind and how much help does the child need to do activities, and how often does the child need it?
- Does the child need a structured or supportive setting, what type of structure or support does the child need, and how often does the child need it?

- The critical element in evaluating the severity of a child's limitations is how appropriately, effectively, and independently the child performs age-appropriate activities.

- Once we have evidence from an acceptable medical source that establishes the existence of at least one medically determinable impairment, we consider all relevant evidence in the case record to determine whether a child is disabled. This evidence may come from acceptable medical sources and from a wide variety of "other sources."

- Other medical sources can include nurse practitioners, physicians' assistants, naturopaths, chiropractors, audiologists, occupational therapists, physical therapists, and psychiatric social workers. Non-medical sources includes parents, caregivers, educational personnel, teachers, early intervention team members, counselors, development center workers, daycare center workers, social welfare personnel, etc.

- Additional sources of evidence include early intervention and school programs, comprehensive evaluations in early interventions and school programs, individualized family service plans, IEPs, etc.

- The more help or support of any kind that a child receives beyond what would be expected for children the same age without impairments, the less independently the child functions, and the more severe we will find the limitation to be.

- *It is important to remember*, therefore, that the goals in an IFSP or IEP are frequently set at a level that the child can readily achieve to foster a sense of accomplishment. Those goals are frequently lower than what would be expected of a child the same age without impairments. In this regard:

- A child who achieves a goal may still have limitations. The child may have achieved the goal simply because it was set low, and may be developing or acquiring skills at a slower rate than children the same age without impairments.
- On the other hand, the fact that the child does not achieve a goal is likely an indication of the severity of the child's impairment-related limitations. However, the child's failure to achieve a goal does not, by itself, establish that the impairment(s) functionally equals the listings.

- Other factors to consider include the services, settings, and supports provided, the classroom placements, and accommodations.

- A special education teacher's statement the child is *doing well* could mean:

- Compared to that teacher's expectations for the child,
- Compared to other children in the special education class, or
- Compared to children the same age who do not have impairments.

Therefore, the adjudicator will consider both the standards used by the teacher or other source to rate the quality of the child's functioning and the characteristics of the group to whom the child is being compared. 20 CFR 416.924a(b)(3)(ii).

SSR 09-3p – Acquiring and Using Information

This Ruling considers a child's ability to learn information and to think about and use information.

Cruz o/b/o R.F. v. Colvin, 2015 WL 5768384 (D.Conn. Oct. 1, 2015) (SALM). The court remanded this claim back for further proceedings because the ALJ failed to consider a wealth of school records that showed the claimant had serious problems in learning.

SSR 09-4p – Attending and Completing Tasks

This Ruling considers a child's ability to focus and maintain attention, and to begin, carry through, and finish activities or tasks. It is similar to "concentrate, persist, or maintain pace" found in the B section of the adult Listings for Mental Disorders.

SSR 09-5p – Interacting and Relating With Others

This Ruling considers a child's ability to initiate and respond to exchanges with other people, and to form and sustain relationships with family members, friends, and others. It is similar to "interact with others" found in the B section of the adult Listings for Mental Disorders.

SR 09-6p – Moving About and Manipulating Objects

This Ruling considers the physical ability to move one's body from one place to another, and to move and manipulate things. Essentially, it focuses on gross and fine motor skills.

SSR 09-7p – Caring for Yourself

- In the domain of "Caring for yourself," we consider a child's ability to maintain a healthy emotional and physical state. This includes:

- How well children get their emotional and physical wants and needs met in appropriate ways,
- How children cope with stress and changes in the environment, and
- How well children take care of their own health, possessions, and living area.

- … in "Caring for yourself," we focus on how well a child relates to self by maintaining a healthy emotional and physical state in ways that are age-appropriate and in comparison to other same-age children who do not have impairments.

- Children must learn to recognize and respond appropriately to their feelings in ways that meet their emotional wants and needs; for example, seeking comfort when sad, expressing enthusiasm and joy when glad, and showing anger safely when upset. To be successful as they mature, children must also be able to cope with negative feelings and express positive feelings appropriately. In addition, after experiencing any emotion, children must be able to return to a state of emotional equilibrium. The ability to experience, use, and express emotion is often referred to as self-regulation. Children should demonstrate an increased capacity to self-regulate as they develop.

- Footnote 11: *We do not consider a child fully responsible for failing to follow prescribed treatment*. Also, the policy of failure to follow prescribed treatment does not apply unless we first find that the child is disabled. Under this policy, we must also find that treatment was prescribed by the child's "treating source" (as defined in 20 CFR 416.902) and that it is clearly expected that, with the treatment, the child would no longer be disabled. Even then, we must consider whether there is a "good reason" for the failure to follow the prescribed treatment. For example*, if the child's caregiver believes the side effects of treatment are unacceptable, or an adolescent refuses to take medication because of a mental disorder, we would find that there is a good reason for not following the prescribed treatment.* However, if there is not a good reason and all the other requirements are met, a denial based on failure to follow prescribed treatment would be appropriate. See 20 CFR 416.930 and SSR 82-59, Titles II and XVI: Failure To Follow Prescribed Treatment. (Emphasis added).

Norville o/b/o S.P. v. Astrue, 3:11- CV-397 (JBA (JGM)), (D.Conn. 12/12/11) (unreported decision). The Norville case addressed the ALJ's failure to consider the emotional dysfunction of the child under SSR 09-7p.

Benjamin o/b/o E.B. v. Berryhill, 2018 WL 2926276 (D.Conn. 06/08/18) (VAB). The court stated that the ALJ failed to properly assess the claimant's ability to care for herself because he did not address evidence showing

she had meltdowns or temper tantrums once a week and he failed to determine whether the evidence was sufficient to support a finding that the claimant was able to manage the demands of her environment in an age-appropriate level.

SSR 09-8p – Health and Physical Well-Being

- In the domain of "Health and physical well-being," we consider the cumulative physical effects of physical and mental impairments and their associated treatments on a child's health and functioning. Unlike the other five domains of functional equivalence (which address a child's abilities), this domain does not address typical development and functioning.[10] Rather, the "Health and physical well-being" domain addresses how such things as recurrent illness, the side effects of medication, and the need for ongoing treatment affect a child's body; that is, the child's health and sense of physical well-being.

- Some physical effects that we consider in this domain can result directly from a physical or mental impairment(s). For example:

- Feeling weak, dizzy, agitated, short of breath, fatigued, low in energy, short on stamina, or "slowed down" (as with psychomotor retardation),[12] or having local or generalized pain; and
- Allergic reactions, recurrent infections, poor growth, bladder or bowel incontinence, changes in weight or eating habits, stomach discomfort, nausea, seizures or convulsive activity, headaches, or insomnia.

These and other physical effects can also be the consequence of treatment a child receives. For example:

- Medications for physical or mental disorders can cause generalized symptoms, such as fatigue, dizziness, or drowsiness, or more specific problems, such as nausea or weight loss. Certain medications used to treat mental disorders can have indirect physical effects. For example, some medications used to treat attention-deficit/hyperactivity disorder may cause a change in eating habits which may, in turn, limit growth.
- Therapy (for example, chemotherapy, multiple surgeries or procedures, chelation, pulmonary cleansing, or nebulizer treatments) can have physical effects, including generalized symptoms, such as weakness, or more specific problems, such as nausea. In addition, periods of therapy can be frequent or time-consuming, require recovery time, or reduce a child's endurance.

  - A child who otherwise appears to be functioning appropriately may be doing so because of intensive medical or other care needed to maintain health and physical well-being. We evaluate such medical fragility in this domain. Some disorders (for example, cystic fibrosis and asthma) are episodic, with periods of worsening (exacerbation) and improvement (remission). When symptoms and signs fluctuate, we consider the frequency and duration of exacerbations, as well as the extent to which they affect a child's ability to function physically.

Practice Tip: School records are often very crucial to proving a child's disability claim. In addition to requesting a teacher to complete a Teacher Questionnaire (SSA-5665-BK), the school can provide the child's Individual Education Program (IEP), educational and psychological evaluations, grades, attendance and discipline records, behavioral intervention plans, standardized test results, teacher comments about the child's success and deficiencies, Section 504 plans, and nurse's notes.

Prepared by: John P. Spilka, Esq.
Connecticut Legal Services, Inc.
16 Main Street
New Britain, CT 06051
860-357-9321
jspilka@ctlegal.org