Empire Justice Center

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DISABILITY LAW NEWS

Bank Freeze Problems Attract Attention

Despite the protections afforded to recipients of Social Security and Supplemental Security Income (SSI) benefits by 42 U.S.C. §407 exempting benefits from creditors, advocates hear countless stories from clients whose bank accounts have been seized or frozen. The plight of these clients and the dubious actions taken by their creditors and banks are finally receiving some well-deserved scrutiny.

Recent reports in both the *Christian Science Monitor* and the *Wall Street Journal* have highlighted the problems that arise when creditors seek to enforce judgments against Social Security and SSI recipients. The March 21, 2007 article in the *Christian Science Monitor* - entitled "Direct deposit of Social Security checks: safe, fast - and disastrous" and available at http://tinyurl.com/ytosax - relates the story of a client of Johnson Tyler from South Brooklyn Legal Services. At the encouragement of Social Security, she arranged for her disability checks to be directly deposited into her account, only to have her account frozen. The story chronicles the nightmare the client faced as a result.

The article also summarizes attempts by the advocacy community to address this problem. Johnson Tyler's litigation challenging the New York law upon which banks rely to freeze accounts is cited, as is litigation in North Carolina. [See the September 2005 *Disability Law News* for a summary of *Mayer, et al v. New York Community Bankcorp, et al.*] Virginia attempted to alleviate the problems caused by seizures of exempt funds by amending restraining notices to prohibit banks from freezing accounts that contained only exempt funds. The Virginia Bankers Association (VBA) met with court officials to argue that the change violated Virginia law. Virginia, however, has since reinstated the old forms.

As the *Christian Science Monitor* points out, the banks argue that they should not be put in the position of determining which funds should not be frozen. But advocates note that the banks have a financial interest in restraining accounts, as the fees charged by the banking institutions are significant. Some banks, however, such as New York Community Bank (NYCB) have implemented systems to protect Social Security funds from improper garnishment. NYCB checks to be sure an account does not contain exempt funds before freezing it. According to John Fennell, NYCB vice president, the policy "has been effective in protecting depositors" and has not been a burden to the bank.

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Statewide DAP Conference Planned

The Empire Justice Center is pleased to announce the presentation of a Statewide Disability Advocacy Program (DAP) Conference on June 11 and 12, 2007 at Sage College of Albany in Albany, New York. The conference will run from 12:00 pm on Monday, June 11 to 1:30 pm on Tuesday, June 12. Conference sessions include substantive information for new and experienced advocates, a medical presentation, ethics discussion and sample cross examination of a vocational expert. Conference registration materials are attached to this newsletter and are also available at Empire Justice Center's website, www.empirejustice.org.

Bank Freeze Problems—continued

(Continued from page 1)

[*Note: other banks have also agreed not to seize accounts containing only exempt funds. Johnson Tyler informs us that Banco Popular will not restrain a bank account containing only direct deposit Social Security/SSI provided there has been no other deposit activity in the account during the last 90 days. Additionally, Chase and Astoria Federal will not honor restraining notices when the account contains only direct deposit SSI/SSD.*]

The front page article in the *Wall Street Journal* on April 28, 2007, entitled "The Debt Collector vs. The Widow," similarly highlights the problems faced by several disabled social security beneficiaries whose supposedly exempt accounts were frozen. The article, available as DAP #453**,** points out that Pennsylvania's Supreme Court recently issued a rule that barred banks from freezing accounts that contain only direct deposits of Social Security. [To read the new rules, see www.aopc.org/OpPosting/Supreme/out/471civ.5attach.pdf.]

The good news on the local front is that New York is considering new legislation modeled on a Connecticut statute that offers more protection to debtors with exempt funds. Thanks to the hard work of members of New Yorkers for Responsible Lending (NYRL) and others, a new bill will be introduced by Assemblywoman Helene Weinstein. Copies of the bill, along with the Connecticut statute and a comprehensive memo on other state laws, are available as DAP #454. We'll keep readers posted on the progress of the legislation.

Federal Court Remands on the Rise

Between 1995 and 2005, the number of Social Security disability claims remanded - rather than affirmed - by federal district courts increased by 36 percent. On average, during that time period, the courts upheld SSA's decisions to deny benefits in 44 percent of the cases and reversed in six percent. Fifty percent of the claims were remanded back to the agency for further review. According to a recent study by the Government Accountability Office (GAO), 66 percent of those claimants whose cases were remanded back to SSA were ultimately awarded benefits.

The GAO undertook its study at the request of Congress to examine 1) the trends in the past decade in the number of appeals reviewed by the district courts and their decisions; 2) the reasons for court remands and factors that may contribute to the incidence of those remands; and 3) SSA's progress for responding to appellate court decisions that conflict with agency policy and the agency's response in recent years. The GAO reviewed data, interviewed SSA officials, ALJs and representatives. It ultimately concluded that SSA needs to do more to ensure the reliability of data on remands, coordinate agency data collection on remands, and ascertain how best to use this information to reduce the proportion of cases remanded by the federal courts. It criticized SSA's inability to identify trends in the reasons for remand and take corrective actions to reduce the number of remands

In analyzing the data, the GAO in particular reviewed information from 2005, which is the only year for which district court data was available broken down by circuits. The good news for New York advocates is that the district courts in the Second Circuit affirmed 19 percent and remanded 74 percent of cases. Contrast this with the Sixth Circuit, where 61 percent of SSA's denials were affirmed and only 35 percent remanded. District courts in the Second Circuit also reversed the agency seven percent of the time in 2005, tying with the eighth circuit, and topped only by the Ninth Circuit, with a ten percent reversal rate. The First Circuit only reversed in one percent of the cases!

According to the GAO, stakeholders in the process suggested that the high rates of remand were the result of heavy workloads. Per the GAO, however, SSA data that would confirm such speculation are incomplete and not well-managed. The spike in the numbers of cases being remanded, which occurred in 1998, was attributed at least in part to the publication of the so-called Process Unification Rulings (1996 Social Security Rulings). Arguably, the 1996 SSRs led to federal courts using more remands to ensure that the guidelines were followed.

The study also reviewed the process that SSA has in place for addressing appellate court decisions that conflict with agency interpretations of law or regulations. Here the GAO was referring to SSA's acquiescence regulations, promulgated as a result of the *Stieberger* litigation. [For more on *Stieberger*, see the Class Action Section of this newsletter.] The GAO noted that since establishing the regulations in 1990, SSA has issued 45 acquiescence rulings (ARs), although there have been fewer rulings in recent years, and a number of the earlier ones have been rescinded. SSA once again attributes that shift to the 1996 process unification rulings, "clarifying" SSA policy and filling in gaps previously open for the courts to fill.

The GAO did take note of SSA's introduction of new decision-writing templates for ALJs that will ensure more legally sufficient decisions, as well as the new DSI (Disability Improvement Process) initiatives, including the shift from the Appeals to the Decision Review Board (DRB). SSA agreed with the GAO's recommendations, noting that a planned update to the Case Processing Management System will make reasons for remands a mandatory data input field. Of interest is that Commissioner Astrue, while noting SSA's agreement with the GAO's recommendations, added a handwritten note indicating that SSA is "in the process of reevaluating DSI and looking at more direct ways to reduce backlogs" - adding fuel to the rumors that the replacement of the Appeals Council with the DRB has been tabled.

GAO-07-331 (April 2007), *Disability Programs: SSA Has Taken Steps to Address Conflicting Court Decision, But Needs to manage Data Better on the Increasing Number of Remands,* is available at www.gao.gov.

REGULATIONS

Medical Facility Benefits Amendments Proposed

SSA announced at 72 Fed. Reg. 14053 (March 26, 2007), a revision of 20 C.F.R. §416.212 ("Continuation of full benefits in certain cases of medical confinement") plus several regulatory sections revising the definition of "medical facility." Comments deadline is May 25, 2007.

SSA provides this background information--"Residents of public institutions generally are ineligible to receive SSI payments. However, there are some exceptions to this general rule. One exception in 42 USC §1382(e)(1)(B) provides that residents of medical treatment facilities (which we are proposing to define as a facility licensed or otherwise approved by a Federal, State, or local government to provide inpatient medical care and services) may be eligible for SSI if Medicaid pays a substantial part (more than 50 percent) of the cost of the beneficiary's care. In such cases, SSI payments to the resident of the medical treatment facility are limited to a maximum of $30 a month."

"Another exception in section 42 USC §1382(e)(1)(G) allows payment of full SSI benefits for up to 3 full months after entering a public facility if a physician certifies that the recipient's stay in the facility is likely not to exceed 3 months and we determine the recipient needs to continue to maintain and provide for the expenses of the home to which he or she may return. These benefits are referred to as 'temporary institutionalization benefits.' "

The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Public Law 104-193), enacted August 22, 1996, amended section 1611(e)(1)(B) of the Act to allow children under age 18 who are in medical treatment facilities and who have private health insurance to receive the reduced SSI payment ($30). However, Public Law 104-193 did not amend the statutory provision on temporary institutionalization to extend such benefits to children with private health insurance. Consequently, children who were temporarily in private medical facilities could not be eligible for 3 months of full benefits if private health insurance, or a combination of Medicaid and private health insurance, paid more than 50 percent of the cost of their care. Payments to these children were limited to the reduced benefit amount of no more than $30 a month beginning with their first full month of institutionalization.

Section 5522(c) of Public Law 105-33 revised section 1611(e)(1)(G) of the Act to correct this omission. Those children in private medical facilities for whom private health insurance or a combination of Medicaid and private health insurance was paying more than 50 percent of the cost of care, now can be eligible for continuation of their full SSI benefits for up to 3 months.

For example, when a child who is receiving SSI while living at home goes into a medical treatment facility, and private insurance through the parent's employment pays for more than 50 percent of the cost of care, the child can continue to receive SSI benefits during a temporary institutionalization of up to 3 months. Providing SSI benefits during a temporary period of institutionalization is a provision designed to enable SSI beneficiaries (adult or child) to provide for the expenses of the home where they live and to reduce the risk of losing their place of residence due to a sudden loss of SSI benefits during a temporary period of institutionalization.

The current definition of a medical facility at 20 C.F.R. §416.414(b) ("medical care facility") would be amended to "an institution or that part of an institution that is licensed or otherwise approved by a Federal, State, or local government to provide inpatient medical care and services." Related revisions will replace "medical care facility" and "medical facility" references with "medical treatment facility."

Presumptive Disability Correction

The Social Security Administration (SSA) announced in the March 19, 2007 Federal Register [72 Fed. Reg. 12730] a correction to 20 C.F.R. §416.933, "How we make a finding of presumptive disability or presumptive blindness":

"We may make a finding of presumptive disability or presumptive blindness if the evidence available at the time we make the presumptive disability or presumptive blindness finding reflects a high degree of probability that you are disabled or blind. In the case of readily observable impairments (e.g., total blindness), we will find that you are disabled or blind for purposes of this section without medical or other evidence. *For other impairments, a finding of disability or blindness must be based on medical evidence or other information that, though not sufficient for a formal determination of disability or blindness, is sufficient for us to find that there is a high degree of probability that you are disabled or blind.* For example, for claims involving the human immunodeficiency virus (HIV), the Social Security Field Office may make a finding of presumptive disability if your medical source provides us with information that confirms that your disease manifestations meet the severity of listing-level criteria for HIV. Of course, regardless of the specific HIV manifestations, the State agency may make a finding of presumptive disability if the medical evidence or other information reflects a high degree of probability that you are disabled." (Added sentence in italics).

SSA Requires Special Authorization Form

Just when you thought that the federal government might be serious about paperwork reduction, here comes another SSA directive:

> In some situations, an authorized representative delegates some duties to another individual in the firm. The assistant contacts SSA to obtain information on behalf of the authorized representative. In such situations, the assistant must present a signed Form SSA-3288 (Social Security Administration Consent for Release of Information), which designates either the firm or the assistant him/herself before SSA can release the requested records. (GN 03305.015.)

The form is available at http://www.ssa.gov/online/ssa-3288.pdf

COURT DECISIONS

Second Circuit Decides Fee Case

How far does one need to go to protect a $1200 fee awarded under Section 406 in a Social Security case? For the law firm of Binder & Binder, try two trips to the Court of Appeals, with a side trip to Bankruptcy Court in New Jersey. In the case of *Binder & Binder, P.C. v. Barnhart,* 481 F.3d 141 (2d Cir. 2007), Binder & Binder sought to protect an award that had already been authorized and paid to it by SSA. SSA sought to recover the fee after the claimant had filed for bankruptcy protection and received a discharge of what she had characterized as a disputed, unsecured claim. SSA, claiming that the fee had been paid in error, relied on Program Circular OCO 98-050, entitled "Bankruptcy and Attorneys Fees," which provides that where a bankruptcy court discharges all of a claimant's debts, including the representative's fee, no fee may be authorized or paid by SSA.

After SSA demanded the payment back from Binder & Binder, Binder filed an action for a declaratory judgment in District Court. The court denied the parties' cross-motions for summary judgment, pending a determination by the Bankruptcy Court as to whether the claimant's discharge extinguished Binder's claim for fees. After the Bankruptcy Court's order closed the adversary proceeding, which the Court interpreted as requiring Binder to establish a charging lien in state court, the District Court denied Binder's motion for summary judgment, granted SSA's motion and dismissed the Complaint. It relied on 42 U.S.C. §407, finding that social security funds are not subject to attachment by creditors.

On Binder's first trip to the Court of Appeals, the Court remanded the claim to determine in the first instance if there were subject matter jurisdiction over the claims. *Binder & Binder, PC v. Barnhart,* 399 F.3d 128 (2d Cir. 2005). It also encouraged the District Court to revisit its earlier ruling in light of *Washington State Department of State & Health Services v. Guardianship of Keffeler,* 537 U.S. 371, 382-83 (2003), which interpreted the "other legal process" language of section 407(a) in regard to the alienation of Social Security benefits. On remand, the District Court held that Binder's charging lien was not "other legal process" in terms of §407, and ruled that Binder did not have subject matter jurisdiction.

On the second trip to Circuit, the Court expounded on a variety of topics that may be of interest - and future use - to advocates beyond the fee issue. In finding that Binder had federal question jurisdiction under 28 U.S.C. §1331, the Court reviewed the basics of the three possible jurisdictional bases: 42 U.S.C. 405g (not applicable because Binder was not a party), 28 U.S.C. §1331, and mandamus. In discussing SSA's duty and authority to pay attorneys' fees, it also discussed the extent to which SSA's internal promulgations have force of law. It specifically held that the Program Circular upon which SSA had relied does not have force of law. The decision also includes interesting language on the value of POMS as well.

Ultimately, the Court concluded that in the absence of anything authorizing SSA to interpret or apply bankruptcy law, or to enforce an order of a Bankruptcy Court, SSA's unambiguous and limited duty was to certify Binder's fee. It deferred to the Bankruptcy Court for a determination of whether Binder is obligated to return the fee to the claimant.

If the claimant pursues her claim for the return of the $1200 in Bankruptcy Court, the battle royal over the $1200 fee may continue. In the meantime, the Court of Appeal's decision may well play a role in other realms.

Court Remands for Equivalency Determination

Sometimes claims involving limited intellectual ability fall just short of meeting Listing 12.05C on all fours. Advocates will recall that 12.05 requires an IQ score between 60 and 70, and another impairment that imposes significant work-related restriction although it need not be disabling in and of itself. Louise Tarantino of the Albany office of the Empire Justice Center recently convinced a federal court magistrate that some borderline cases should still be given full consideration under 12.05C.

Louise's client had IQ scores of 74 verbal, 73 performance, and 71 full scale. She also suffered from a panic disorder and chronic difficulties with her knees. The ALJ ignored the IQ scores and applied the Medical-Vocational Guidelines (the "Grid") to find her not disabled. Louise argued, however, that the ALJ should have considered whether the claimant's condition was medically *equivalent* to Listing 12.05C.

Magistrate George Lowe of the Northern District agreed. He held that "if Plaintiff's symptoms 'appear to match' those described in Listing 12.05C but nevertheless the ALJ finds the Plaintiff's impairments do not medically equal that Listing, the ALJ must provide a reason." The Magistrate relied on POMS § DI 14515.056(D)(C), which states that "slightly higher IQs (e.g. 70-75) in the presence of other physical or mental disorders that impose additional and significant work-related limitation of function may support an equivalence determination." Because the ALJ did not consider equivalency, the court found that his decision was not supported by substantial evidence.

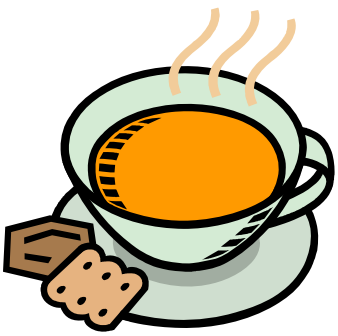
Magistrate Lowe also criticized the ALJ for failing to take into account the opinions of the treating sources at step three of the Sequential Evaluation. He also faulted the ALJ for relying on the Grid. On remand, if the ALJ does not find an equivalency to Listing 12.05C, he must consider the impact of the claimant's nonexertional impairments and determine whether a vocational expert is necessary.

The Magistrate also commented on the standard to be used in determining the second requirement of Listing 12.05C, noting that district courts in the Second Circuit have applied the severity test.

Louise's memorandum and Magistrate Low's decision in *Small v. Commissioner of Social Security* are available as DAP #455. Although not discussed by the Magistrate, of note is that this case originally involved a continuing disability review on a childhood SSI claim, but languished in the administrative process for so long, that the child turned 18, and filed an adult claim, which was consolidated with the CDR. More power to Louise for simplifying this complicated case!

Deciphering SSA's Alphabet Soup

Can you tell a TWP from a UWA? Much less ISM from PWV? Thanks to Dorothy Hanmer from Queens Legal Services for pointing out a POMS section on SSA's acronyms: GN 04440.001 List of Acronyms, available at www.ssa.gov.



Magistrate Orders Remand in CFS Case

Fiscal year 2006 statistics from the Social Security Administration (SSA) tell us that 44% of Federal Court dispositions are remands back to the agency. We see those remands as another opportunity for success for our clients because they are always older, sometimes much older given the delays in decision making, and they are usually sicker and more infirm. So, we are happy to report that Magistrate David Peebles from the Northern District of New York recently granted a remand in a case handled by the Empire Justice Center.

The client claimed disability based on chronic fatigue syndrome (CFS), depression, anxiety, and numerous physical conditions. Despite the existence of serious nonexertional impairments, the Administrative Law Judge (ALJ) applied the Grid rules to deny the claim. In Federal Court, Rob Cisneros of Empire Justice Center's White Plains office and Louise Tarantino of the Albany office argued that the ALJ erred in three major respects: subjective allegations were improperly found to be not credible; the finding of a residual functional capacity (RFC) for light work was not supported by substantial evidence; and it was wrong to apply the Grid rules when nonexertional impairments affected the ability to perform basic work activities.

In a lengthy and comprehensive decision, Magistrate Peebles found that each of the claimant's arguments was meritorious. He also reiterated that the ALJ had the duty to develop the record if evidence was lacking, here treatment notes from a chiropractor who the claimant testified to seeing shortly before the hearing. He also noted that before relying on the infrequency of treatment for a condition as evidence that the condition was not severe, the ALJ should have inquired into possible reasons for sporadic treatment, including inability to pay for treatment, lack of access to free or low-cost medical services, lack of transportation to medical appointments, and inability or reluctance to drive. The Magistrate also quoted extensively from Social Security Ruling (SSR) 99-2p which addresses evaluating cases involving CFS.

The Magistrate issued a recommended decision which was adopted by District Court Judge David Hurd. The Magistrate's decision in *Peart v. Commissioner of Social Security* is available as DAP #456.

Listing Met in HIV Case

District Court Judge Michael Telesca of the Western District issued a decision ordering the immediate calculation of benefits in a case in which he found that the claimant met not one, but two HIV listings. His decision echoed almost verbatim many of arguments put forth by L.J. Fisher, of the Rochester office of the Empire Justice Center.

L.J.'s client, a 36 year old former assembly line worker, had been diagnosed with AIDS in 1995, when her CD4 count was 196. Throughout the years, her condition, as is fairly typical, waxed and waned, and at times was described as asymptomatic. As L.J. aptly pointed out, however, she continued to suffer manifestations of her HIV disease. The ALJ nonetheless applied the Medical-Vocational Guidelines (the "grid") to deny her claim.

The District Court overruled the ALJ, finding that the claimant's condition met both Listings 14.08D2a and 14.08N. Based on L.J.'s marshalling of the evidence, it was clear to the Court that the claimant's manifestations of recurrent HSV (herpes simplex virus) met the requirement of 14.08D2a of proof of HIV infection as well as HSV causing mucotaneous infections lasting one month or longer. The Court was also persuaded by L.J.'s argument that the claimant met Listing 14.08N in that her recurrent HSV infections were associated with leg pain. There was also evidence of night sweats, sleepiness as a side effect of her medications, and fat redistribution.

Judge Telesca criticized the ALJ for dismissing claimant's leg pain by characterizing it as related to the use of medication and not her HIV status. The Court found that to be error, "since even if plaintiff's leg pain was a side effect of the medication, Listing 14.08N clearly requires that the side effects of medication be considered." This was particularly significant in this case, since the claimant had been relegated to a "rescue regimen." A rescue regimen, as L.J. explained to the Court, is an HIV treatment designed for patients who have used many HIV drugs in the past, have failed to respond to a least two regimens and have extensive drug resistance. As the Court noted, the claimant did not have the "luxury of altering her HIV medication regimen." Additionally, the claimant's treating physician had attributed the leg pain to both medication and the HSV.

The Court also agreed that, as required by Listing 14.08N, the claimant had marked limitations in activities of daily living. The Court relied on the claimant's testimony, as well as a residual functional capacity assessment from the treating physician that had been submitted to the Appeals Council. The Court further criticized the ALJ for failing to accord proper weight to the opinions of the treating physician, and for applying a grid rule to deny the claim.

Judge Telesca's decision in *Gonzalez v. Barnhart*, as well as L.J.'s memorandum, is available as DAP #457.

Injunction Denied in Fleeing Felon Case

In the January 2007 edition of the *Disability Law News*, available at www.empirejustice.org, we reported on a class action case that had been filed in the Southern District of New York. *Clark v. Barnhart* challenged SSA's practice of suspending benefits of any recipient who has an outstanding warrant alleging a violation of probation or parole without a finding that the person is actually violating probation or parole.

The district court has denied plaintiff's motion for a preliminary injunction. *See Clark v. Astrue*, 2007 WL 737489 (S.D.N.Y. March 8, 2007). The court refused the relief requested under the "likelihood of success on the merits" preliminary injunction standard. The court found the plaintiffs' proposed statutory argument construction unpersuasive "in light of express statutory language reflecting that Congress contemplated and intended for the SSA to suspend benefits based on the warrant alone." 2007 WL 737489 *5.

The district court distinguished the Second Circuit's decision in *Fowlkes v. Adamec*, 432 F.3d 90 (2d Cir. 2005), which struck down the SSA's practice of assuming that anyone with an outstanding warrant is fleeing prosecution and held that the SSA must first determine whether the person intended to flee prosecution before suspending benefits. It found that "to the contrary, the SSA has shown that it suspends benefits pursuant to 42 U.S.C. §§1382(e)(4)(A)(ii) based only on warrants that specifically address violations of probation or parole, as opposed to general arrest warrants." 2007 WL 737489 *6.

The court did find a basis to waive the exhaustion requirement for the plaintiffs, finding it would be futile for the plaintiffs to challenge SSA's policy in the administrative process. Plaintiffs are forging ahead with the case, and are currently engaged in discovery. They are represented by the Urban Justice Center, along with the National Senior Citizens Law Center and the law firm Proskauer Rose LLP.

SSI Refugee Case Survives Dismissal Motion

Almost every recent edition of this newsletter has reported on the dilemmas faced by refugees who arrived in the United States after August 22, 1996, and whose SSI benefits are being terminated under SSI's seven-year time limit. *See, e.g.*, the January 2007 editions of the *Disability Law News*, available at http://www.empirejustice.org/content.asp?contentid=2074, where we reported on a nationwide class action that has been filed against officials of the Department of Homeland Security (formerly the Immigration and Naturalization Services) and the Social Security Administration.

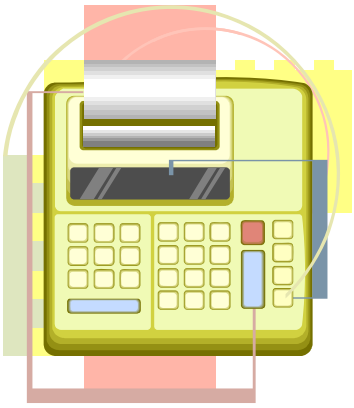
The class, representing refugees, asylees and other humanitarian immigrants who face loss of their SSI benefits, challenges the lack of timely processing of their applications for naturalization. The suit seeks more timely processing and continuation of SSI benefits beyond the current seven-year time limit until the claimants have a reasonable opportunity to complete the naturalization process. Plaintiffs alleged a denial of due process and equal protection, as well as a violation of the Administrative Procedure Act.

The District Court has dismissed the plaintiffs' due process claims, finding that the seven-year time limit is not a procedural device, as contended by the plaintiffs, but instead a substantive element of the plaintiffs' eligibility for benefits. *See Kaplan v. Chertoff*, 2007 WL 966510 (E.D. Pa., March 29, 2007). The court held that plaintiffs do not have a property interest in receipt of benefits after seven years.

The court denied, however, the government's motion to dismiss one of plaintiffs' equal protection claims. It found that the plaintiffs' claim that the government decision to expedite naturalization proceedings in some offices but not others constitutes a denial of equal protection since it is intentional discrimination without a rational basis. The court also allowed the plaintiffs' Administrative Procedure Act (APA) claim on the failure to adjudicate applications for naturalization and adjustment of status within a reasonable time limit to proceed. The plaintiffs are now moving for class certification. They are represented by Community Legal Services in Philadelphia and a private firm in Philadelphia.

ADMINISTRATIVE DECISIONS

Appeals Council Orders Calculation of Benefits



It is not often that an advocate receives a fully favorable decision from the Appeals Council, but that is exactly what E. Cynthia Richard of the Legal Aid Society of Mid-New York in Binghamton recently obtained. Cynthia's client was diagnosed with Major Depression, Disorder, Recurrent, Panic Disorder with Agorophobia and Avoidant Personality Disorder.

Despite ample evidence from the claimant's treating psychiatrist and even the consultative examiner (CE) of his marked limitations of functioning, the ALJ found that he retained the ability on a sustained basis to remember simple instructions; respond appropriately to supervision, coworkers and usual work situations; and to deal with changes in routine work settings. The ALJ apparently relied heavily on evidence of the claimant's limited "work" for his landlord for her conclusion that the claimant was able to work competitively.

At the time of the hearing, the claimant - on his own initiative - was working approximately eight hours every weekend doing janitorial work. The employer provided numerous accommodations: the claimant could set his own hours, and when he had a panic attack, he could simply retreat to his room. Cynthia not only reiterated that argument to the Appeals Council; she bolstered it with new and material evidence she secured from the claimant's treating sources. At Cynthia's request, his psychiatrist and therapist confirmed that the claimant often had to flee his cleaning post and retreat to his room. They opined that while the work activity was in some ways therapeutic for the claimant, he was unable to function in competitive employment in any effective manner.

The Appeals Council specifically relied on the new evidence that Cynthia had obtained, demonstrating how important it can be to address at the Appeals Council level any outstanding factual issues raised by the ALJ. The Appeals Council also gave appropriate weight to the opinions of the claimant's treating sources. Although finding that his condition did not meet the "B" criteria of Listings 12.04 or 12.08, it went on to consider the effects of the claimant's mental impairments on his functional abilities.

Relying on the assessments of the treating sources and CE, the Appeals Council concluded that the claimant's mental residual functional capacity was significantly limited such that he was unable to interact appropriately with the public and co-workers; respond appropriately to work pressures in a usual work setting; or respond appropriately to changes in a routine work setting to meet acceptable levels in a competitive work environment. As such, his mental limitations significantly eroded the occupational base to the point that jobs do not exist in significant numbers in the national economy that the claimant can perform.

Congratulations to Cynthia for her work in this case. We know how challenging it can be simply to get assessments from treating sources. Cynthia's ability to persuade the treating sources to write a specific response to the Appeals Council regarding the claimant's "work attempt" made all the difference in the successful outcome of this claim.

Advocate's Arguments Adopted

On the topic of the mysteries of the Appeals Council, how many times are advocates' compelling arguments seemingly ignored while the Appeals Council remands - or even reverses - on totally different grounds? Not so for Jody Davis, Senior Paralegal at the Legal Assistance of Finger Lakes office of LAWNY in Geneva. The Appeals Council adopted her arguments practically verbatim when it remanded her client's case for a new hearing.

Jody's client suffers from joint disease to the extent that his treating physician had repeatedly opined that he was totally disabled. The ALJ ignored these opinions, as well as an updated opinion that Jody submitted after the hearing confirming that the claimant was progressing very slowly from back surgery and was at least temporarily totally disabled. Although the ALJ stated in the beginning of her decision that she would address the additional evidence later, it was not further discussed. Nor, as noted by the Appeals Council, was it included in the List of Exhibits. (Jody had cited the HALLEX I-2-1-20 requirement of a complete exhibit list.) The Appeals Council also criticized the ALJ for failing to evaluate this opinion evidence in accordance with Social Security Rulings (SSR) 96-2p and 96-5p.

Additionally, the Appeals Council responded to Jody's argument that the ALJ failed to provide an explanation for the conflict between the vocational expert's (VE) testimony and the Dictionary of Occupational Titles (DOT), as required by SSR 00-4p. The ALJ had relied on the VE's testimony about a hypothetical individual who could perform sedentary work with a sit /stand option. Under Jody's cross-examination, the VE acknowledged that the DOT does not consider the sit/stand option with the jobs she had identified. Although the VE attempted to resolve the conflict by testifying about her experience with the jobs she named, the ALJ failed to address that testimony in her decision.

The case was remanded for the ALJ to update the medical records from the treating sources, and to give further consideration to their opinions pursuant to 20 C.F.R. §§416.927 and SSRs 96-2p and 96-5p. It also ordered the ALJ to obtain additional evidence from the VE, based on hypothetical questions reflecting the limitations established by the record as a whole. Further, it ordered the ALJ to identify and resolve any conflicts with the evidence provided by the VE and the DOT.

Jody's astute and well-reasoned arguments obviously caught the attention of the Appeals Council. Great job, Jody!

Detailed Remand Order Follows District Court Case

While, as reported elsewhere in this newsletter, we may still have it to kick around for awhile, will we ever understand the mysterious workings of the Appeals Council? Seemingly good cases are given short shrift with perfunctory refusals to review. Similarly, perfunctory orders are often issued ordering remand of cases sent back from District Courts. On the other hand, in some cases the Appeals Council issues detailed orders following court remands, embellishing or reinterpreting a judicial order or stipulation.

Following a voluntary remand from District Court in the Western District, the Appeals Council issued what appears to be a whole new decision, highly critical of the ALJ, and very specific about what she should do on remand. It is ironic that senior paralegal Doris Cortes of the Rochester office of the Empire Justice Center had raised many of the same points in her memo to the Appeals Council, which resulted in a *pro forma* refusal to review.

Doris's client suffers from lumbar disc disease; arthritis of the neck, back and knees bilaterally; hepatitis C; a depressive disorder; drug and alcohol abuse; and chronic obstructive pulmonary disease. Despite these impairments, the ALJ, based on vocational testimony, found that the claimant could perform work in the national economy and was thus not disabled. The Appeals Council criticized the ALJ for giving the opinion of the consultative examiner (CE) "considerable weight" in reaching her findings. It noted that the CE's opinion that the claimant could push, pull and lift objects of a "moderate degree on an intermittent basis is vague - in that it did not quantify in terms of weight or duration the amount he could push, pull and lift - and did not address the amount he could carry."

The Appeals Council was also critical of the ALJ for not obtaining treatment records from a source mentioned by the claimant. It admonished the ALJ for rejecting the opinion of a treating source without first establishing whether he was a physician or nurse practitioner, and for failing to recontact him to clarify his opinion limiting the claimant to less than a full range of sedentary work. Furthermore, the ALJ failed to note that the opinion of a State Agency analyst, rather than physician, had no probative value.

The ALJ's reliance on a GAF score of 54 as proof that the claimant's condition was improving was also found to be erroneous. That score had been reported in July 2003, while the ALJ failed to note that a GAF of 45 was assigned in August 2003. Finally, the ALJ failed to distinguish between limitations secondary to the claimant's drug and alcohol abuse and his other mental impairments.

On remand, the ALJ has been ordered to recontact both the CE and treating sources, clarify the GAF scores, obtain an additional CE to establish the severity of the mental impairments, and determine whether or not the claimant's substance abuse is material to his claim. Bottom line? When the Appeals Council gets it, it really seems to get it, but these cases seem to be few and far between. Good luck to Doris as she goes on to vindicate this claim!

Overpayment Advocacy Successful

To prevail on a request for a waiver of an overpayment, a beneficiary must show that he was both without fault in causing the overpayment and unable to afford to pay it back. E. Cynthia Richard of the Legal Aid Society of Mid-New York in Binghamton found a creative way to argue that her client was without fault for an alleged overpayment of $12,833.00 caused by excess resources.

Cynthia's client has a serious obsessive compulsive disorder that manifests itself in behaviors of compulsive frugality and "hypersaving." Although the client had earned a Master's Degree in English Literature, he has never been unable to work due to his obsessions. He had previously incurred an SSI overpayment when, thanks to his savings, his resources - generally kept as cash in paper bags - went over the SSI resource limit of $2000. When - not surprisingly - this occurred again, the beneficiary went to SSI and voluntarily refunded the cash he had at the time, totaling $4,410, which was the amount he had accumulated from his SSI checks between March 2002 and May 2004. SSI, however, refused to waive the rest of the overpayment, which was calculated by multiplying the number of months he was "over-resource" by the amount of his monthly SSI check.

On appeal, the ALJ found that Cynthia's client was not without fault in causing the overpayment. He "magnanimously" recognized, however, that he should not be required to pay back more than $40 per month! Cynthia went to the Appeals Council, where she argued that the overpayment was not caused by her client so much as by the inaction of SSA. As she pointed out, agency staff, based on the prior overpayment, was well aware of her client's problems and the extent to which he could not stop himself from compulsively saving. She provided information from his treating psychiatrist explaining his particular disorder. She faulted SSA for failing to follow its own regulations, requiring the appointment of a representative payee for mentally ill claimants who have proven that they are unable to handle their own money.

The Appeals Council, while not responding directly to Cynthia's argument, was nonetheless swayed. Although it agreed with the ALJ that the beneficiary was not without fault in causing and accepting the overpayment, it agreed with Cynthia that his degree of fault did not rise to the standard of knowingly and willfully failing to report excess resources. Consequently, it was able to rely on POMS §§ SI 02260.025C&D to find the beneficiary liable only for the difference of the maximum amount that the resources exceeded the resource limit in any one month. The overpayment was recalculated as $3,927.31 (cash of $4,410.00 and bank account of $1,417.31, minus the applicable resource limit of $2,000). Since Cynthia's client had already refunded more than that amount, the Appeals Council was willing to call it a day!

Cynthia has been working with the client and SSA to ensure against repeated overpayments in the future. Once again, Cynthia's dedication to her clients - especially those with mental impairments - has paid off.

Appeals Council Reopens Subsequent Application Conundrum

The Appeals Council has added yet another permutation to the various scenarios that can arise when a claimant is approved on a subsequent application while an appeal of a prior application is pending at the Appeals Council. Advocates will recall that the Appeals Council had "clarified" this issue back in December 30, 1999, when SSA issued an Emergency Message (EM-99147) changing SSA policy with regard to claim filing while an appeal was pending. Prior to December 30, 1999, SSA policy was that a claimant could receive a protective filing date on a subsequent claim, but that the claim would not be developed or adjudicated until the pending review request was decided. Although a few subsequent claims did slip through this policy, as a general matter a claimant could not have a subsequent claim adjudicated while an appeal was pending. On December 30, 1999, SSA changed this policy to permit development and adjudication of subsequent claims. *See* POMS DI 12045.027 and HALLEX I-5-317.

HALLEX I-5-317(B)(2) provides that if the Appeals Council agrees with the allowance of the subsequent claim, but is remanding the prior claim for further ALJ action, it will "adopt the subsequent allowance determination because the remand would be to further consider only that period prior to the date disability found." Since an ALJ cannot take any action inconsistent with an Appeals Council remand order (20 C.F.R. 404.977(b)), an ALJ reopening of a subsequent allowance when the Appeals Council has agreed with the subsequent allowance should be easily reversed.

It is more problematic if the Appeals Council order does not specifically adopt the subsequent allowance, either because the Appeals Council is unaware of the subsequent allowance due to a failure by SSA to follow the subsequent application procedure, or because the Appeals Council fails to follow its own procedures. On May 21, 2003, then Acting Chief Administrative Law Judge Jesse H. Butler issued a Memorandum in response to reports of "confusion" in Hearing Offices on how to handle these cases. The Memorandum, entitled "Handling Appeals Council Remand Cases Where the Remand Does Not Address a Subsequent Allowance Determination- ACTION," is available as DAP #384. According to ALJ Butler, if the Appeals Council agrees with the subsequent allowance, the Appeals Council will affirm the allowance and limit the issues on remand to the period prior to the onset established in the subsequent claim. The ALJ is then precluded from reviewing the subsequent allowance.

What if the Appeals Council does not agree with the subsequent allowance? It must consider whether there is a basis for reopening the allowance under the reopening regulations found at 20 C.F.R. §§404.987-989 & 416.1487-1489. The Appeals Council will generally propose consolidating both claims, and the ALJ will issue a decision covering both periods based on both the prior and subsequent applications. If, however, the Appeals Council does not address the subsequent allowance, the ALJ must determine if the subsequent allowance can/should be reopened before s/he can take any action on the subsequent allowance. ALJ Butler specifically referred to the reopening regulations and to HALLEX TI I-5-3-17 Section III,B.2. in support of this.

But then what if the Appeals Council does not agree with the subsequent allowance, but the conditions for reopening are not met? According to a January 8, 2007 memorandum from William C. Taylor, Executive Director of the Office of Appellate Operations, the Appeals Council may not "wish to foreclose the possibility of reopening if additional development before the Administrative Law Judge establishes a basis for reopening and the period for reopening has not expired." The Taylor memorandum is accompanied by new standard language for notices, warning the claimant that although the Appeals Council did not reopen the subsequent allowance, it also did not affirm it. This means it could be subject to reopening in the course of the remand proceedings. The memorandum and the sample notice language are available at DAP #458.

Appeals Council Vacates Its Own Decision

And more on the mysterious vagaries of the Appeals Council...Alecia Elston of Segar & Sciortino in Rochester reports that following a *pro forma* denial of a request for review by the Appeals Council, she wrote asking the Council to reopen its prior action. Her client suffers from fibrolyalgia. In her second plea to the Appeals Council, Alecia cited *Green-Younger v. Barnhart*, 335 F.3d 99 (2d Cir. 2003), the Second Circuit's seminal case on fibromyalgia. As a result, the Appeals Council - without citing *Green-Younger* - vacated it earlier decision and remanded the claim for further proceedings!

In so doing, the Appeals Council noted that the ALJ had failed to address adequately the treating source's opinions of total disability and functional limitations, as required by 20 C.F.R. §404.1527 and SSR 96-2p. The ALJ had given little weight to the treating physician's opinions, citing a lack of clinical findings. The Appeals Council noted, however, that the doctor - a leading expert on fibromyalgia - had conducted and reported on a full physical examination. Although his subsequent treatment notes consisted of patient questionnaires and interpretive letters, the ALJ had made no attempts to clarify his opinion or give him the opportunity to supply supporting documentation.

On remand, the ALJ was ordered to clarify the opinion of the treating physician, to evaluate further the claimant's subjective complaints and give consideration to her maximum mental and physical residual capacity, as well as obtain supplemental evidence from a vocational expert regarding the effects of her nonexertional impairments. Of note, the ALJ had already conducted two hearings, having ordered a supplemental hearing that was limited to consideration of the claimant's mental impairments; the first hearing had had a vocational expert who considered her physical limitations.

Kudos to Alecia for her success at convincing the Appeals Council to take a second look.

Write Your Own ALJ Decision

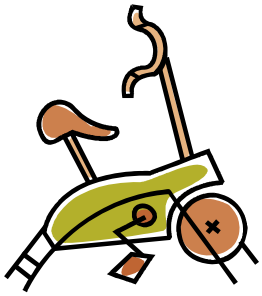
Have you noticed how ALJ decisions are more uniform these days, and even go so far as to track the Sequential Evaluation? That is thanks to FIT- or the "Findings Integrated Template" that SSA has been using for the past two years. According to SSA:

> Findings Integrated Templates (FIT) is a Commissioner initiative designed to improve the quality and consistency of Office of Disability Adjudication and Review (ODAR) decisions. The FIT approach integrates the findings of fact into the body of the decision.

FIT is now available online, at www.ssa/gov/appeals/fit:

> In conjunction with the new electronic disability process, representatives now have access to FIT and may take advantage of this new and innovative tool in order to better serve their clients. Representatives wishing to submit proposed decisions for consideration should do so using the FIT format.

Keep us informed as to your success with getting FIT.



ALJ Allows Trial Work Period

What if your client worked - and earned SGA (substantial gainful activity) - for a number of months after the date of her application for benefits? All is not lost - if, that is, you are able to convince the ALJ that the work consisted of several unsuccessful work attempts and trial work period months, combined with the Extended Period of Eligibility. Greg Phillips of Segar & Sciortino in Rochester did just that.

Greg's client had suffered a cerebral vascular accident (CVA) in 2002 at a relatively young age. Although she improved somewhat from a neurological stand point, she developed cognitive deficits and was diagnosed with depression and anxiety to the point where she became unable to perform competitive work. In 2003, however, she attempted to return to work at a job that she was only able to sustain for a four month period. The ALJ considering the claim agreed that although she earned more than SGA each month, that job, as well as another job she held for four months between December 2004 and March 2005, constituted unsuccessful work attempts (UWA). [See 20 C.F.R. §§404.1574(c), 1576(d) & 416.974(c), 416.976(d); POMS § DI 11010.210 Discontinuance or Reduction of Work: Unsuccessful Work Attempts.]

The claimant returned to work again between June 2005 and January 2006, which she was unable to sustain. Although this was too long to be considered another unsuccessful work attempt, the ALJ determined that these months could count towards a trial work period (TWP). [20 C.F.R. §§404.1592; POMS DI 130010.035 *et seq.*] The claimant was able to take advantage of this provision of SSA's incentive earnings programs prior to the hearing decision because she did not engage in work activity for more than twelve months after her onset date in July 2002. Otherwise, she would have been barred by the Supreme Court's decision in *Barnhart v. Walton,* 122 S.Ct. 1265 (2002), which affirmed SSA's policy of denying disability to claimants who return to work and engage in SGA prior to adjudication of disability within twelve months of onset of disability. For more on the ramifications of *Walton* and work incentives, *see* http://www.nls.org/pdf/winter-2002.pdf.

Finally, even though Greg's client actually worked beyond her trial work period prior to the hearing decision, Greg convinced the ALJ that she should only lose benefits for one month, and then be automatically reinstated the following month - when she ceased earning SGA - under the Extended Period of Eligibility (EPE). [20 C.F.R. §404.1592a; POMS DI 13010.210 *et seq.*]

Greg's succinct letter memorandum to the ALJ, complete with an easy to read chart outlining the claimant's earning and Greg's designation of those earnings, as well as the ALJ's decision outlining the various work incentive provisions, are available as DAP #459. If you want to learn more about this alphabet soup of incentive earnings programs, consider ordering the new 2007 Benefits Management for Working People with Disabilities: An Advocates Manual. For a description of the manual and ordering information *see* http://www.empirejustice.org/content.asp?contentid=2493.

CLASS ACTIONS

Stieberger, et al. v. Sullivan, 84 Civ. 1302 (S.D.N.Y.)
("the non-acquiescence case")

Description - Certified class of New York residents challenges SSA policy of non-acquiescence in Second Circuit precedents. The district court initially granted plaintiff's motion for a preliminary injunction. The Circuit vacated the injunction in light of parallel proceedings in *Schisler*. On remand, the district court granted, in part, plaintiffs' motion for summary judgment. The court declared SSA's non-acquiescence policy unlawful. The court denied SSA's motion to dismiss. The court found that SSA non-acquiesced in the following four circuit holdings: (1) treating physician rule, (2) cross examination of authors of post hearing reports, (3) ALJ observations of pain, and (4) credibility of claimants with good work histories. The court left open for trial the question of whether SSA non-acquiesced with respect to three other Second Circuit holdings (1) findings of incredibility must be set forth with specificity, (2) weight must be given to decisions of other agencies, (3) conclusory opinion of treating physician cannot be rejected without notice of need for more detailed statement.

Relief - Re-openings available for almost 200,000 disability claims denied or terminated: (a) between 10/1/81 and 10/17/85 at any administrative level of review, or (b) between 10/18/85 and 7/2/92 at the hearing or Appeals Council level of review. Also, denials at any administrative level between 10/1/81 and 7/2/92 will not be given *res judicata* effect and thus will not bar subsequent claims for Title II disability benefits regardless of "date last insured."

Citation - *Stieberger v. Heckler*, 615 F. Supp. 1315 (S.D.N.Y. 1985), prel. inj. vacated, *Stieberger v. Bowen*, 801 F.2d. 29 (2d Cir. 1986), on remand, *Stieberger v. Sullivan*, 738 F. Supp. 716 (S.D.N.Y. 1990).

Information - Ken Stephens (kstephens@legal-aid.org), Legal Aid Society (ask for "Stieberger Hotline" 888-284-2772 or 212-440-4354), Christopher Bowes, CeDar (212-979-0505); Ann Biddle, Legal Services for the Elderly (646-442-3302).

Martinez v. Secretary, No. 82-4816, (E.D.N.Y.)
("the Title II delay case")

Description - Certified class challenged delays in the hearing process in claims for Title II disability benefits.

Relief - SSA is required to send notice to Title II claimants with the acknowledgment of the request for hearing stating that claimants have a right to a decision in a reasonable time. Claimants are entitled to bring separate federal mandamus actions where delay is unreasonable.

Citation - Unpublished order dated April 24, 1986.

Information - Toby Golick, Bet Tzedek Legal Services, Cardozo School of Law (212-790-0240).

Sharpe v. Sullivan, No. 79-1977 (E.D.N.Y.)
("the SSI delay case")

Description - Certified plaintiff class challenged delays in holding administrative hearings, issuance of hearing decisions, and issuance of payments, on SSI claims. In 1980 Judge Haight entered order placing time limits on each step, and requiring SSA to pay interim benefits when time limits were exceeded. In 1985 Judge Haight vacated these time limits in light of *Heckler v. Day*, U.S. 104 (1984), and in 1990 entered a new order, below.

Relief - 1990 orders require (1) SSI disability cases: (a) OHA must issue notices explaining delay and right to sue after 120 days from hearing request, and (b) SSA must pay interim benefits if regular benefits have not been paid within 60 days of favorable hearing decision (with certain exceptions, e.g. non-cooperation); (2) SSI nondisability cases: SSA must pay interim benefits within 60 days of favorable hearing decision, or within 60 days of favorable hearing decision, or within 90 days from hearing request.

Citations - *Sharpe v. Secretary*, No. 79-19777 (S.D.N.Y. July 10, 1980) (unpublished order), aff'd 621 F.2d 530 (2d Cir. 1980), vacated No. 79-1977 (S.D.N.Y. 1985) (unpublished), revised, No. 79-1977 (S.D.N.Y. March 6, 1990) (unpublished).

Information - Johnson Tyler, South Brooklyn Legal Services (718-237-5500).

WEB NEWS

Visit Veteran's Advocacy Group

Some of our disability clients may be veterans eligible for some benefits from the Veterans' Administration. The NY State Division of Veterans' Affairs provides advocacy for these veterans and has a website that provides useful information for advocates and veterans alike. The mission of this office is to provide benefits counseling and advocacy for New York's military veterans and members of the active duty armed forces and their families.

http://www.veterans.state.ny.us/

DOL Website Updated

New York State Department of Labor (DOL) has reconfigured its web page, including its information of the employment base for certain occupational groupings (not individual jobs). Data for the entire state and specific regions are available. This information is helpful in preparing for cross examination of vocational expert testimony in disability hearings. The link is:

http://www.labor.state.ny.us/workforceindustrydata/apps.asp?reg=nys&app=projections

Also, for those with LEXIS, there is an interesting source available through its Labor Law data base: "Occupational Crosswalk: Dictionary of Occupational Titles, Selected Characteristics, and Other Government Sources." Its searchable format provides detailed information on the requirements of individual jobs. Here's the Lexis link:

https://www.lexis.com/research/retrieve/frames?_m=8e67e7f290a68f5c83faea32a9d35458&_fmtstr=TOC&wchp=dGLbVzW-zSkAb&_md5=dd8862d0726feef1e66a6a55ce2ba095&USER_AGENT=Mozilla/4.0%20(compatible;%20MSIE%207.0;%20Windows%20NT%205.1)&js=1&du=0

Did You Claim the Telephone Excise Tax Refund?

Maybe you've heard that the feds over-taxed everyone who paid for long distance service (including cell phones), and the solution is to give a $30-$60 tax refund. So, in order to get the money you have to had long distance service between February 28, 2003 and July 31, 2006, and file a tax return claiming the credit. Claiming this credit requires no documents or proof, and it's pretty much on the honor system. This particular refund system works fine for people who normally file a tax return, but not for people who generally don't have any taxable income and don't file a tax return, e.g., people who receive SSI and/or SSD. There hasn't been much attention or publicity about this glitch, so it might be worthwhile to ask SSD and SSI recipients if they had a long distance telephone service. If so, encourage them to go to the local VITA site (a volunteer tax program; locate the VITA nearest you by calling 1-800-829-1040) or go to

http://www.irs.gov/individuals/article/0,,id=107626,00.html

About the only thing they will need to bring is their social security card. They will need to know the monthly amount of social security, they receive and a few vital facts like address and date of birth.

For more information on the Telephone Excise Tax Refund see http://www.irs.gov/newsroom/article/0,,id=164032,00.html

BULLETIN BOARD

This "Bulletin Board" contains information about recent disability decisions from the United States Supreme Court and the United States Court of Appeals for the Second Circuit.

We will continue to write more detailed articles about significant decisions as they are issued by these and other Courts, but we hope that this list will help advocates gain an overview of the body of recent judicial decisions that are important in our judicial circuit.

SUPREME COURT DECISIONS

Barnhart v. Thomas, 124 S. Ct. 376 (2003)

The Supreme Court upheld SSA's determination that it can find a claimant not disabled at Step Four of the sequential evaluation without investigation whether her past relevant work actually exists in significant numbers in the national economy. A unanimous Court deferred to the Commissioner's interpretation that an ability to return to past relevant work can be the basis for a denial, even if the job is now obsolete and the claimant could otherwise prevail at Step Five (the "grids"). Adopted by SSA as AR 05-1c.

Barnhart v. Walton, 122 S. Ct. 1265 (2002)

The Supreme Court affirmed SSA's policy of denying SSD and SSI benefits to claimants who return to work and engage in substantial gainful activity (SGA) prior to adjudication of disability within 12 months of onset of disability. The unanimous decision held that the 12-month durational requirement applies to the inability to engage in SGA as well as the underlying impairment itself.

Sims v. Apfel, 120 S. Ct. 2080 (2000)

The Supreme Court held that a Social Security or SSI claimant need not raise an issue before the Appeals Council in order to assert the issue in District Court. The Supreme Court explicitly limited its holding to failure to "exhaust" an issue with the Appeals Council and left open the possiblity that one might be precluded from raising an issue.

Forney v. Apfel, 118 S. Ct. 1984 (1998)

The Supreme Court finally held that individual disability claimants, like the government, can appeal from District Court remand orders. In *Sullivan v. Finkelstein*, the Supreme Court held that remand orders under 42 U.S.C. 405(g) can constitute final judgments which are appealable to circuit courts. In that case the government was appealing the remand order.

Lawrence v. Chater, 116 S. Ct. 604 (1996)

The Court remanded a case after SSA changed its litigation position on appeal. SSA had actually prevailed in the Fourth Circuit having persuaded that court that the constitutionality of state intestacy law need not be determined before SSA applies such law to decide "paternity" and survivor's benefits claims. Based on SSA's new interpretation of the Social Security Act with respect to the establishment of paternity under state law, the Supreme Court granted certiorari, vacatur and remand.

Shalala v. Schaefer, 113 S. Ct. 2625 (1993)

The Court unanimously held that a final judgment for purposes of an EAJA petition in a Social Security case involving a remand is a judgment "entered by a Court of law and does not encompass decisions rendered by an administrative agency." The Court, however, further complicated the issue by distinguishing between 42 USC §405(g) sentence four remands and sentence six remands.

SECOND CIRCUIT DECISIONS

Torres* v. *Barnhart, 417 F.3d 276 (2d Cir. 2005)

In a decision clarifying the grounds for equitable tolling, the Second Circuit found that the District Court's failure to hold an evidentiary hearing on whether a plaintiff's situation constituted "extraordinary circumstances" warranting equitable tolling was an abuse of discretion. The Court found that the plaintiff, a *pro se* litigant, was indeed diligent in pursuing his appeal but mistakenly believed that counsel who would file the appropriate federal court papers represented him. This decision continues the Second Circuit's fairly liberal approach to equitable tolling.

Pollard v. Halter, 377 F.3d 183 (2d Cir. 2004)

In a children's SSI case, the Court held that a final decision of the Commissioner is rendered when the Appeals Council issues a decision, not when the ALJ issues a decision. In this case, since the Appeals Council decision was after the effective date of the "final" childhood disability regulation, the final rules should have governed the case. The Court also held that new and material evidence submitted to the district court should be considered even though it was generated after the ALJ decision. The Court reasoned that the evidence was material because it directly supported many of the earlier contentions regarding the child's impairments.

Green-Younger v. Barnhart, 335 F.3d 99 (2d Cir. 2003)

In a fibromyalgia case, the Second Circuit ruled that "objective" findings are not required in order to make a finding of disability and that the ALJ erred as a matter of law by requiring the plaintiff to produce objective medical evidence to support her claim. Furthermore, the Court found that the treating physician's opinion should have been accorded controlling weight and that the fact that the opinion relied on the plaintiff's subjective complaints did not undermine the value of the doctor's opinion.

Encarnacion v. Barnhart, 331 F.3d 79 (2d Cir. 2003)

In a class action, plaintiffs challenged the policy of the Commissioner of Social Security of assigning no weight, in children's disability cases, to impairments which impose "less than marked" functional limitations. The district court had upheld the policy, ruling that it did not violate the requirement of 42 U.S.C. §1382c(a)(3)(G) that the Commissioner consider the combined effects of all of an individual's impairments, no matter how minor, "throughout the disability determination process." Although the Second Circuit upheld SSA's interpretation, affirming the decision of the district court, it did so on grounds that contradicted the lower court's reasoning and indicated that the policy may, in fact, violate the statute.

Byam v. Barnhart, 324 F.3d 110 (2d Cir. 2003)

The Court ruled that federal courts might review the Commissioner's decision not to reopen a disability application in two circumstances: where the Commissioner has constructively reopened the case and where the claimant has been denied due process. Although the Court found no constructive reopening in this case, it did establish that "de facto" reopening is available in an appropriate case. The Court did, however, find that the plaintiff was denied due process because her mental impairment prevented her form understanding and acting on her right to appeal the denials in her earlier applications. The Circuit discussed SSR 91-5p and its *Stieberger* decision as support for its finding that mental illness prevented the plaintiff from receiving meaningful notice of her appeal rights.

Veino v. Barnhart, 312 F.3d 578 (2d Cir. 2002)

In a continuing disability review (CDR) case, the Second Circuit ruled that the medical evidence from the original finding of disability, the comparison point, must be included in the record. In the absence of the early medical records, the record lacks the foundation for a reasoned assessment of whether there is substantial evidence to support a finding of medical improvement. The Court held that a summary of the medical evidence contained in the disability hearing officer's (DHO) decision was not evidence.

Draegert v. Barnhart, 311 F.3d 468 (2d Cir. 2002)

The Second Circuit addressed the issue of what constitutes "aptitudes" as opposed to "skills" in determining whether a claimant has transferable skills under the Grid rules. The Court found that there was an inherent difference between vocational skills and general traits, aptitudes and abilities. Using ordinary dictionary meanings, the Court found that aptitudes are innate abilities and skills are learned abilities. The Circuit noted that for the agency to sustain its burden at step 5 of the sequential evaluation that a worker had transferable skills, the agency would have to identify specific learned qualities and link them to the particular tasks involved in specific jobs that the agency says the claimant can still perform.

Does Voc Rehab Increase Earnings?

According to a recent study by the Government Accountability Office (GAO), earnings increased for many SSA beneficiaries after completing vocational rehabilitation (VR) services, but few earned enough to leave SSA's disability rolls. The purpose of the study was to examine long-term outcomes for SSA beneficiaries who participate in VR, on (1) the extent to which SSA disability beneficiaries who exit VR programs engage in work at the substantial gainful activity (SGA) level and ultimately reduce or replace their benefits with earned income, (2) whether there are certain disability beneficiary characteristics associated with positive employment outcomes, and (3) whether some VR agencies have particular policies and approaches that can be associated with positive employment outcomes

The GAO acknowledged that although it had inadequate data to answer the questions completely, the study provided information about long-term earnings outcomes for disability beneficiaries one or more years after exiting VR. After completing VR in 2002-2003, a number of disability beneficiaries achieved positive earnings outcomes, and a few left the disability rolls for a period of time. While only a small number of the beneficiaries in the study left the disability rolls, SSA benefit reductions were realized as a result of increased beneficiaries' earnings and subsequent reductions in their benefits.

Earnings outcomes were mixed in the year following VR and also over time. Approximately 40 percent of the over 303,500 SSA disability beneficiaries in the study increased their earnings compared to the year prior to VR services, while 32 percent did not have any earnings and another 28 percent had fewer earnings. In comparison to Title II and concurrent beneficiaries, more SSI beneficiaries - 42 percent versus 36 and 39 percent - increased their earnings in the year following VR. Of the disability beneficiaries who exited VR in fiscal year 2000, 33 percent sustained some level of earnings through 2004, although their median earnings decreased by 12 percent over this period.

Most beneficiaries' annual earnings, however, remained below SGA in the year following VR. Specifically, 88 percent of all disability beneficiaries in the study had annual earnings below SGA in the year following VR. The GAO acknowledged that it could not determine how many of those beneficiaries were "parking" - or deliberately keeping their earnings just below the SGA level in order to retain benefits.

GAO-07-332 (March 2007) is available at www.gao.gov.

You Be the Judge

Social Security has announced that it plans to hire 150 Administrative Law Judges from a new list to be compiled by the Office of Personnel Management. It has reopened the Administrative Law Judge hiring process for the first time in a number of years - but only for a very brief period. It closes on May 18, 2007 - OR when 1,250 applications are received - whichever comes first.

Complete information concerning the job requirements and the application process, and the application itself, is available online. Go to http://jobsearch.usajobs.opm.gov. At the field for keyword search, enter Administrative Law Judge.

This announcement follows criticism of late for delays in the hearing process. See the lead article in the March 2007 edition of the *Disability Law News.* In fact, SSA waiting times were the subject of a recent article in the *New York Times* describing the plight of homeless man trying to weather the long wait for a hearing as well as an editorial calling on Congress to increase funding to SSA. The articles appeared on April 1 and May 1, 2007.

Although much has been made of delays at the hearing level, cases still linger at the Appeals Council as well. According to a public information line (703 - 605-8000) at the Appeals Council, the average processing time is eight months, although 50% of more recent requests have taken 120 days or less. It is not unusual, however, for cases to take 30 months or more. If a case takes more than 30 months it will be considered for expedited review. Advocates have reported success at getting the Appeal Council's attention with requests for expedited processing accompanied by a showing of dire need.

END NOTE

Mother Knows Best

Just in time for Mothers Day, the *Wall Street Journal* reports in an article published on May 8, 2007, that mothers are the unsung heroes of the health care system. According to a 2003 report from the Kaiser Family Foundation, 80% of mothers take the lead in choosing doctors, scheduling appointments and following through with visits. Why?

Not surprisingly, the reasons that mothers shoulder more of these responsibilities are complex. According to the article, women tend to manage households, and are bigger users of health care than men. But there is also a question of whether mothers have an instinctive advantage. A November 1999 study reported in *Nature* speculates that motherhood may permanently alter the brain's memory and learning centers. Rats who were mothers did a better job of finding food in mazes than those who had not given birth. The hormones of pregnancy - and the experience of childbirth itself - may enhance cognitive abilities relating to the caring for the young. Even "foster" rat mothers who cared for babies from birth experienced some of these benefits.

Alan Greene, a pediatrician from Danville, California, speculates that "human mothers' uncanny ability to juggle and problem-solve" may not be coincidental. And Harvard physician and author Jerome Groopman relates a personal experience to demonstrate mothers' instincts. Despite assurances from the pediatrician that their nine-month old baby just had a virus, Groopman's wife was convinced that something more was wrong based on the smell of the baby's diaper. Indeed, several hours later, the baby was diagnosed with an intestinal obstruction, requiring emergency surgery.

Groopman, the author of *How Doctor Think*, also told of another mother who spent months insisting that her six-year old child's headaches were not related to tension. A brain scan finally revealed a tumor. While Groopman admits that not all mothers' medical instincts are legitimate, he found that the "the really good pediatricians I've met, they take the mothers very seriously."

So remember your mother's advice this Mothers Day!

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