Established Procedures in

Although the Social Security Administration was made an independent agency as of 1995, many attorneys and judges with minimal involvement in Social Security disability hearings wonder about this arcane area of law that involves myriads of regularions and unusual courtroom procedures foreign to other trial practice arenas. This article examines general issues and procedures involved in Social Security disability hearings.

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Social Security Disability Cases

Although the Social Security Administration was made an independent agency as of March 31, 1995, pursuant to the Social Security Act, 42 U.S.C. §§ 901–914 (2006), and the federal reporters are filled with cases generated from Social Security disability appeals, many attorneys and judges with minimal involvement in Social Security disability hearings wonder about this arcane area of law that involves myriads of regulations and unusual courtroom procedures foreign to other trial practice arenas. This article examines general issues and procedures involved in Social Security disability hearings before administrative law judges (ALJs) under the purview of the mandatory regulations provided in 20 C.F.R. §§ 404 and 416, et seq. I have also included interpretations of those regulations by the Fifth Circuit Court of Appeals (the appellate court located in my jurisdiction) that are generally consistent with decisions by federal judges throughout the nation.

I will be discussing information relevant to ALJs, the attorney writers who assist ALJs in crafting their opinions, and lawyers and representatives of claimants appearing before ALJs in Social Security disability hearings brought under the auspices of Title II and Title XVI of the Social Security Act, as well as those who entertain appeals from ALJs.

Social Security Disability Hearings Before the Administrative Law Judge: A Brief Overview of the Process

Social Security Administration ALJs determine whether claimants are disabled. ALJs also decide other issues, such as over payments (whether claimants must return funds overpaid them due to their return to work or recovery from disability), the paternity of children claiming benefits based upon a potential parent's disability, and several other issues with which we are not directly concerned here.

ALJs handle appeals of denied claims from the components responsible for initial determinations and reconsiderations of claims, such as the state agency Department of Disability Services (DDS). ALJ decisions are appealed to another Social Security Administration component, the Appeals Council (AC), and from there to the appropriate U.S. district court (often handled by U.S. magistrate judges by agreement of the parties), and from there to the appropriate Circuit Court of Appeals.

ALJs are occasionally asked to handle cases in other offices within their own Office of Disability Adjudication and Review (ODAR) Regions. I am located in Region 4—eight states from North Carolina to Mississippi, inclusive of Tennessee and Kentucky, and my office is located in Jackson, Miss., where I hear disability cases generated from agency components in central, western and southern Mississippi. However, for various reasons such as temporary attrition of judges and the temporary need to help reduce mounting caseloads due to unforeseen circumstances, I have held hearings by video or in person (when claimants refuse to waive in-person hearings) for offices in Covington and Augusta, Ga., Panama City and Melbourne, Fla., Raleigh, N.C., and Lexington and Louisville, Ky.

There exist two major types of cases ordinarily associated with disability hearings: Title II Social Security Benefits and Title XVI Supplemental Security Income Benefits. Actions

under these titles are primarily governed by largely mirror regulations—Title II by 20 C.F.R. Part 404, and Title XVI actions by 20 C.F.R. Part 416.

Claimants eligible for Title II benefits include disabled workers who have not reached full retirement age; retired insured workers aged 62 and over, and their spouses who are aged 62 or over or who are caring for a child either under 16 or over 16 but are disabled, and thus are entitled to benefits on the worker's Social Security record. They also include certain divorced spouses of insured but retired, disabled or deceased workers, and certain minor dependents of insured but retired, disabled or deceased workers, although questions of insured status and quarters of coverage are not the subject of this article. Essentially, Title II covers workers who have sufficient earnings during applicable quarters to qualify for benefits, as noted in 20 C.F.R. §§ 404.110 through 545 (2012).

Those eligible for benefits under Title XVI include those with limited income and resources or those aged 65 or older who are either blind or disabled, including adults and children, as provided in 20 C.F.R. §§ 416.101 through 269 (2012). Essentially, Title XVI covers adults and children who lack insured status or are dependents of those who lack insured status but have very limited income and resources.

Claimants eligible for benefits under Titles II and XVI[1] who have been denied recovery through a DDS determination may appeal to ALJs for a *de novo* consideration of the merits of their claims in disability hearings under the auspices of the ODAR branch of the Social Security Administration.

What are Social Security Disability Hearings?

The ALJ is the decision maker, and the claimant may appear with an attorney or qualified representative, or the claimant may represent him or herself. To be qualified, a nonlawyer representative must have experience in disability hearings and/or understand the basic aspects of the program, including the five-step evaluation. The ALJ determines a representative's competence, and this decision is reviewable.

A hearing monitor (e.g., court reporter in all but name only) is always present during any hearing, and the ALJ may call an expert vocational consultant present where such testimony is deemed essential. The ALJ may also call a medical expert to testify in person or by telephone or video (VTC); the claimant will testify on record and may call fact or expert witnesses in support of a claim. Evidence is ordinarily submitted by claimants or obtained by the ALJ prior to the hearing and is contained in an electronic record available to both the claimant and the ALJ prior to and during the hearing. Subpoenas are available to the ALJ and all parties and counsel or representatives of record.

The hearing is inquisitorial and not adversarial, and the ALJ and claimant's attorney must develop the evidence of record. The ALJ may question the claimant before or after the claimant or his or her representative offers the claimant's direct testimony. Both the ALJ and claimant are allowed to examine experts. Suffice it to say, these hearings can become quite adversarial at times, especially when counsel apply questionable trial techniques of browbeating expert witnesses or arguing with ALJs (knowing the latter lack contempt powers). Both approaches are, needless to say, ill-advised, and will not be long tolerated by ALJs, or, if particularly egregious and/or oft-repeated by counsel, by the agency powers-that-be that may bar counsel from handling Social Security disability cases.

The hearing is not a formal trial, but neither is it so informal that ALJs may dispense with mandated fairness and due process . It is open to the parties and all persons the ALJ deems necessary and proper, but not to the general public. The ALJ will ordinarily render a decision subsequent to the hearing, although ALJs may make an on-the-record favorable decision after the introduction of the evidence and closing argument by counsel. ALJs conduct hearings in person, by phone, or via VTC technology. ALJs in national hearing centers located throughout the country hold hearings only by VTC, allowing them to reach claimants who would not otherwise be able to come to a distant hearing office in their states for a prompt determination of their cases.

After collecting all relevant evidence and eliciting all relevant testimony, the ALJ must perform a five-step sequential evaluation to determine whether the claimant is disabled.

The Sequential Nature of the Disability Evaluation: The Five-Step Process

Social Security Administration regulations define "disability" as the inability to perform any substantial gainful activity by reason of any medically determinable physical or mental impairment 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 twelve months. The mandatory sequential analysis is a specific order of steps each ALJ must follow in evaluating a disability claim. As clarified in 20 C.F.R. §§ 404.1520(a)-(g), and 416.920(a)-(g) (2012), the sequential process is composed of five steps, although the process may cease at any step when a finding of disabled or not disabled can be made.

Step one of the sequential evaluation asks, "Is/was the claimant engaging in substantial gainful activity (SGA)? If the claimant has SGA,[2] then a finding of "not disabled" may be made at step one.

Step two asks, "Does the claimant have any severe medically determinable impairments?" as defined in 20 C.F.R. §§ 404.1520(c)-1523, 416.920(c)-923 (2012). Regulations define a severe impairment as that which causes limitations having more than a minimal

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effect on the claimant's capacity to perform basic work activities.[3] In other words, if an impairment such as degenerative disk disease, limits a claimant's ability to stand, walk, bend, breathe, etc. in more than a minimal way, it is severe and the evaluation must proceed

to step three. The landmark decision of *Stone v Heckler*, 752 F.2d 1099, 1101 (5th Cir. 1985), discusses and defines a severe impairment and must always be cited in an ALJ opinion rendered in Fifth Circuit jurisdiction when an ALJ finds impairments non-severe. The failure to cite S*tone* is grounds for reversal in the Fifth Circuit. Although other Circuits approach this issue in slightly different ways, a discussion of non-severe impairments is generally required by the regulations, including any rationale for making such determinations.

Step three asks, "Does the claimant have any impairment(s) that meets or equals in medical severity a listing impairment(s)?"[4] In other words, if the medical evidence alone documents an impairment or combination of impairments so medically severe as to be presumed disabling (and more often than not, permanent or expected to result in death), the evaluation stops and the claimant is declared disabled without resort to a consideration of vocational factors. A listing of impairments is located at Appendix 1 of 20 C.F.R. Part 404, Subpart P, and these include impairments severe enough to prevent a person from doing any gainful activity and that affect one or more of the various body systems such as the cardiovascular, mental, digestive, and musculoskeletal systems. These regulations describe the severe impairments and extent of limitations caused by them that must exist and the clinical findings and supporting tests required to demonstrate their existence in order to qualify a claimant for disability based on the listings of impairments. Although an ALJ may independently determine that an impairment meets a listing, medical evidence is required for a determination that an impairment equals, or is substantially comparable to, any listing. However, should no listing be met or equaled, the evaluation must proceed to step three-and-a-half.

Relatively few cases are decided at steps one through four, and the vast majority are decided at step five. Major considerations at this final step usually include an analysis of the claimant's residual functional capacity (RFC), vocational considerations pertinent to the RFC, the claimant's credibility, and the weight given to applicable medical evidence. However, there are numerous other considerations that often come into play at this step, such as the effect of obesity, the effect of several impairments together, evidence provided by non-medical sources, and others too numerous to mention here. But several other steps are reached before step five.

Step three-and-a-half is an unofficial step used only by ALJs. Pursuant to this unofficial step but absolutely essential exercise, the ALJ must assess the claimant's residual functional capacity (RFC).[5] RFC is the most that the claimant can do on a sustained basis despite the limitations caused by his or her medically determinable impairment(s). This is not the same as determining if the claimant is disabled, but involves merely determining what types of work activity the claimant can perform despite limitations caused by medically determinable impairments. Work activities to be considered include exertional (i.e., how much the claimant can lift, how long he can sit or stand, and how much he can push and pull), non-exertional (i.e., the claimant's capacity to bend, climb, crouch, concentrate, interact with others, and understand and perform instructions of various degrees of difficulty), and environmental (i.e., the affect of noise, heat, fumes, etc., on the claimant). The above list of activities is far from exhaustive, but sufficient to aid the understanding of the reader. Mental RFC factors include an inquiry into the claimant's ability to understand, remember, and carry out instructions and respond adequately to supervisors, coworkers, the general public, and to adapt to work changes and pressures (stress).[6] The RFC, which may include exertional, non-exertional (including mental), and environmental limitations, as determined by the ALJ in step three-and-a-half, is utilized in steps four and five, known as the vocational steps.

Step four asks, "Does the claimant's medically determinable impairment(s) prevent the performance of past relevant work (PRW)?"[7] PRW is work performed within fifteen years of the adjudication or the date last insured (DLI) for Title II cases when the DLI has expired at a level constituting SGA. A claimant is "insured" through a certain time for Title II purposes if he or she has worked sufficient quarters within a certain period of time close enough to the date of adjudication. If the claimant has an RFC consistent with PRW, then the evaluation ceases and the claimant is declared "not-disabled." If the claimant establishes an impairment that precludes PRW, the ALJ must proceed to the next step in the analysis of disability.

The burden of proof to demonstrate that he or she is disabled rests with the claimant at step four, but once the claimant has met the burden of showing an inability to perform PRW, the burden of proof shifts to the Commissioner, through the adjudicator, to prove that, despite the claimant's impairments and functional limitations, there exist jobs in the national economy that the claimant can perform. After the Commissioner meets this burden, the burden of proof shifts again, back to the claimant to rebut this finding.

Step five asks, "Does the claimant's impairment(s) prevent the performance of other work which exists in significant numbers in the national economy?"[8] In making this determination, the ALJ considers the individual's age, education, and work experience to decide if there are a sufficient number of jobs in the national economy the claimant can perform on a sustained basis. The ALJ may be aided in this step as he/she was in step four by a vocational expert[9] who testifies about the types and numbers of jobs available to the claimant in light of the RFC determined by the ALJ. The ALJ may give several RFC hypotheticals to the expert to determine which jobs are available, if any, in light of several RFCs. The claimant, through legal counsel or qualified representative, may also propose questions about those jobs and/or their own RFC hypotheticals to the vocational expert.

The vocational expert utilizes the Dictionary of Occupational Titles and other materials including the latest vocational studies in reaching his or her conclusions, and the ALJ is aided in his deliberations by referring to a medical vocational guideline, or "the Grids" as ALJs know them, found in Appendix 2 to Subpart P in 20. The Grids consist of tables organized according to exertional levels of work (i.e., Sedentary¾lift no more than ten pounds and stand no more than two hours in an eight-hour day[10]; Light¾lift a maximum of twenty pounds and stand six hours a day; Medium¾lift up to fifty pounds and stand six hours a day; Heavy¾lift no more than a hundred pounds and stand six hours; and Very Heavy¾lift over one hundred pounds and stand six hours in a day).

For example, if the claimant is 55 years old and uneducated, has done only unskilled work, and has degenerative disk disease so severe that he cannot lift more than ten pounds and stand no more than two hours in an eight-hour day, and the vocational expert testifies that the claimant can perform only sedentary jobs, then the ALJ is ordinarily required to find that the claimant is disabled due to the

definitions set out in the grid tables. But, if the expert testifies that the claimant can do medium work, the grids ordinarily require a finding of "not-disabled." There are exceptions to these examples in terms of what an ALJ may decide, but these examples should suffice for clarity's sake.

An ALJ's art, skill, and judgment is largely demonstrated by his or her capacity to accurately determine the claimant's RFC in light of the medical and other evidence in the (usually electronic) court file. Indeed, this very abstract determination, although well-guided by regulations, agency rulings,[11] and federal court decisions, is difficult enough to warrant a significant portion of the reversals of ALJs by the Appeals Council and federal courts.

Defining the "Acceptable Medical Source" for Purposes of Determining Who is a Treating Physician, Psychiatrist, or Psychologist

The Social Security Administration pledges (through its regulations) that before it makes a disability determination, it will develop the claimant's complete medical history for at least twelve months preceding the month the claimant files the application or earlier in some cases, and that it will make every reasonable effort to help the claimant obtain medical reports from his own medical sources, or will take such other steps as become necessary, including holding consultative examinations, to thoroughly develop the medical record.[12] This involves obtaining evidence from various medical sources. Essentially, medical sources include both acceptable medical sources and any other healthcare providers who are not deemed acceptable medical sources in the regulations. These may include nurse practitioners, licensed clinical social workers, chiropractors, therapists, and other similar sources.

Acceptable medical sources include licensed physicians (M.D. or D.O.), licensed or certified psychologists, licensed optometrists, licensed podiatrists, and qualified speech-language pathologists. Only these sources may establish the existence of a medically determinable physical or mental impairment, give medical opinions, and be considered a treating source whose medical opinion may be entitled to controlling weight, consistent with 20 C.F.R. §§ 404.1513(a), 1527(a)(2), 416.913(a)), 927(a) (2012).

An ALJ is required to consider all medical sources in determining whether a claimant is disabled, but may be required to give "controlling weight" to the treating source opinions on the nature and severity of the claimant's impairments, but only if those opinions are not conclusory, are well-supported by medically accepted clinical and laboratory techniques, e.g., mental status or physical exams, x-rays, or MRIs, respectively, and are not inconsistent with the other substantial evidence of record, such as other credible examining physician or state agency physician findings and opinions. In other words, as provided in 20 C.F.R. § 404.1527(d)(2) (2012), the treating source's opinion must be adopted by the ALJ in whole or in part where it is supported by the appropriate findings in the medical record and is not substantially inconsistent with other credible medical opinions.

When an ALJ declines to give a treating physician's opinion controlling weight, his or her other options are (1) to give the treating physician's opinion some weight, or (2) to reject it entirely in favor of another medical opinion. However, these options may not be exercised without undergoing a regulation-mandated analysis.

20 C.F.R. Sections 404.1527(d)2 & 416.927(d)2: Weight Given to Treating Medical Source Opinions

Agency regulations are specific about how an ALJ must analyze the medical evidence in general and medical source opinions specifically. The factors in the analysis address how to weigh treating, examining, and nonexamining physicians' opinions, as well as those of specialists versus non-specialists. After promising to evaluate every medical opinion submitted in the record, the regulations describe how agency adjudicators will weigh such evidence by considering the following factors found at 20 C.F.R. §§ 404.1527(d)(3-6) and 416.927(d)(3-6): (1) the nature and frequency of examinations; (2) the length and substance of the treatment relationship; (3) supportability of the treating doctor's opinion; (4) consistency of the opinion with other medical opinions; (5) specialization of the expert; and (6) other factors.

The courts are generally bound by Social Security Administration regulations and abide by them in their interpretive decisions (although the agency has generated Acquiescence Rulings that explain how SSA applies decisions of the United States Courts of Appeals that are at variance with SSA's national policies in adjudicating claims under Title II and Title XVI of the Social Security Act). For example, in *Newton v. Apfel*, 209 F.3d 448, 456 (5th Cir. 2000), the Fifth Circuit aligned itself with the Second and Tenth Circuits in reaching a rationale that has subsequently been followed by the Third and Fourth Circuits,[13] pertaining to the regulation-mandated factors that must be considered as to the amount of weight given to treating and other physicians--

1. the physician's length of treatment of the claimant,
2. the physician's frequency of examination,
3. the nature and extent of the treatment relationship,
4. the support of the physician's opinion afforded by the medical evidence in the record,
5. the consistency of the opinion with the record as a whole, and
6. the specialization of the treating physician. *Newton v. Apfel*, 209 F.3d at 456

However, the regulations themselves actually include one more factor—"any factors ... which tend to support or contradict the opinion." These "other" factors may include, but are not limited to, the claimant's testimony, statements by nonmedical sources such as family members, statements by employers, evidence of pain or the lack thereof, medical side effects, and the like.

This analysis is essential because the commissioner's (i.e., ALJ's and AC's) denial of social security benefits is reviewed to ascertain whether (1) the final decision is supported by substantial evidence, and (2) whether the Commissioner (ALJ) used the proper legal standards to evaluate the evidence. If the commissioner's (ALJ's) findings are supported by substantial evidence, they must be affirmed. "Substantial evidence" is such relevant evidence as a reasonable mind might accept to support a conclusion. It is more than a mere scintilla and less than a preponderance. The appellate court may not reweigh the evidence of record, retry the case *de novo*, or substitute its judgment for that of the commissioner's (i.e., ALJs or affirming AC's), even if the evidence weighs against the commissioner's decision or the appellate court would have ruled differently.

In *Newton v. Apfel*, the Fifth Circuit declared that,

... absent reliable medical evidence from a treating or examining physician controverting the claimant's treating specialist, an ALJ may reject the opinion of the treating physician *only* if the ALJ performs a detailed analysis of the treating physician's views under the criteria set forth in 20 C.F.R. Section 404.1527(d)(2). 209 F.3d at 453.

The regulations themselves actually include one more factor—"any factors ... which tend to support or contradict the opinion." These "other" factors may include, but are not limited to, the claimant's testimony, statements by non-medical sources such as family members, statements by employers, evidence of pain or the lack thereof, medical side effects, and the like.

The *Newton* court cited only the Title II provision of the regulations because the case at bar was a Title II case. However, the ruling also applies equally to Title XVI cases as per the mirror provision of Title XVI, 20 C.F.R. § 927(d)(2) (2012).

Prior to the 1990s, most federal courts largely engaged in a common sense analysis of the "good cause" necessary to reject a treating medical source's opinion, without specifically requiring the multi-factor analysis mandated by the regulations. For example, in *Scott v. Heckler*, 770 F.2d 482, 485 (5th Cir. 1985), the ALJ was reversed for rejecting the treating doctor's opinion for lack of supporting clinical and laboratory findings, where such evidence did exist, including the doctor's notes of record, without resort to a full blown *Newton*- and regulation- mandated analysis.

Newton and other federal courts would require this analysis in every case where an arguably credible treating medical opinion is rejected. In light of such rulings and applicable Social Security Administration regulations, an analysis of the six regulatory factors when considering rejecting a treating source's conclusions should be foremost on any ALJ's mind when crafting an unfavorable opinion.

Conclusion

"To take from one because it is thought that his own industry and that of his father's has acquired too much, in order to spare to others, who, or whose fathers, have not exercised equal industry and skill, is to violate arbitrarily the first principle of association—the guarantee to every one of a free exercise of his industry and the fruits acquired by it."
—Thomas Jefferson

"The test of our progress is not whether we add more to the abundance of those who have much; it is whether we provide enough for those who have too little."
—Franklin D. Roosevelt

Judicial determinations as to the proper weight given to treating physician opinions are not treated at length in this article, but the subject is broached herein because of its ubiquitous significance in Social Security disability hearings and appeals. Other key issues include a proper determination of the claimant's credibility and a proper determination of the claimant's RFC; issues, which, like the weight given to medical opinions, must be left to another day's considerations.

Nevertheless, the foregoing should provide a comprehensive discussion of the basics of the Social Security disability program vis-à-vis disability hearings before ALJs, with the idea of familiarizing hearing procedures and regulations to those with little previous experience with the disability milieu.

In any event, ALJs are charged with delivering prompt and quality service to the American people. As may be surmised from the above quotes by Presidents Jefferson and Roosevelt, ALJs should make every effort to protect Social Security trust proceeds from unsupported claims and promptly provide disabled applicants with awards to which they are lawfully entitled. To that end, comprehensive study of Social Security regulations and related appellate court decisions is certainly justified if not demanded for ALJs, and that notion applies equally to the attorneys who handle these cases and those who entertain their appeals. ⊙

Hon. Jim Fraiser is a federal administrative law judge in Jackson, Miss. He formerly served as Hinds County assistant district attorney, as the owner of Fraiser Law Offices, as a Mississippi special assistant attorney general, and as director of Choctaw Legal Defense before joining the Page Mannino Law Firm. He became a judge in 2006. Judge Fraiser has authored four law review articles for the Mississippi Law Journal on Mississippi Tort Claims Act Law and DUI law, 10 articles for ALR 5th and ALR FED on a variety of civil and criminal law topics, two treatises for the National Business Institute Publications on tort claims act and school law, produced five plays, and written three novels, one short story collection, and 10 nonfiction books about the history, culture, and architecture of the Deep South. He is an adjunct professor for Mississippi College School of Law, teaching legal writing and appellate advocacy courses since 2005. The opinions expressed in this article are his alone and not those of the Social Security Administration. Much of this article was excerpted from my forthcoming law review article entitled "Weight Given To Treating Physician Opinions in Social Security Disability Cases: The Fifth Circuit's Interpretation of Sections 20 C.F.R. 404.1527(d)(2) & 416.927(d)(2)," Mississippi College Law Review. Vol. 31, Issue 3, 01/2013).

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length of the professional relationship with the client; 12) Awards in similar cases.

[69]215 Ct. Cl. 377, 380, 569 F.2d 565, 568 (1978).

[70]*E.g., Emeny v. United States*, 208 Ct. Cl. 522, 526 F.2d 1121, 1126-27 (1975) ($341,346 fee award where $221,880 in compensation was recovered); *Cloverport Sand & Gravel Co. v. United States*, 6 Ct. Cl. 178 (1984) (fee award was three times the principal recovery).

[71]*See Yancy v. United States*, 915 F.2d 1534 (Fed. Cir. 1990); *Emeny v. United States*, 526 F.2d 1121 (1975).

[72]*Presault v. United States*, 52 Fed. Cl. 667 (2002).

[73]28 U.S.C. § 2412(d)(1)(A).

[74]*E.g., Texas State Teachers Ass'n v. Garland Independent School Dist*, 489 U.S. 782, 791, 109 S. Ct. 1486, 1494 (1989).

[75]*Gavette v. Office of Personnel Management*, 808 F.2d 1456, 1467 (Fed. Cir. 1986).

[76]2102 WL 538, 602.

[77]*Broadders v. United States Army Corps of Engineers*, 380 F.3d 162 (4th Cir. 2004).

[78]52 Fed. Cl. 751, 756 (2002).

[79]102 Fed. Cl. 111, 114 (2011).

[80]*Dept. of the Army v. Blue Fox, Inc.*, 525 U.S. 255, 261 (1999); *Pacrim Pizza Co. v. Pirie*, 304 F.3d 1291, 1294 (Fed. Cir. 2002).

[81](28 U.S.C. § 1491 (a)(1)).

[82]102 Fed. Cl. 111 (2011).

[83]478 U.S. 310, 317 (1986).

[84]102 Fed. Cl. at 114-15.

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Endnotes

[1]The onset of disability is generally from the date alleged by the claimant in Title II cases or from the date the claimant filed his or her petition for disability in Title XVI cases, although this may sometimes become a controverted issue involving alleged onset date, work history, and medical evidence. For a full discussion of these issues, *see* SSR 83-20 and other materials that may all be accessed on the Social Security website www.ssa.gov.

[2]Substantial gainful activity is defined in 20 C.F.R. §§ 404.1572, 416.972 (2012). Often, this would constitute gross wages above a certain dollar amount in certain years, e.g., $1,000 per month in 2010 and $700 per month in 2000, although there are other factors to be considered, including available work-related expenses and different standards for self-employment earnings, as noted in 20 C.F.R. § 404.1574(a), .1575, .1576 (2012), and other issues, none of which are directly relevant to this Article.

[3]20 C.F.R. §§ 404.1505, .1508, .416.905, .908 (2102); *see also* Ruskell, (discussing severe impairments and the signs, symptoms, and medically acceptable clinical, diagnostic and laboratory findings essential to their determination).

[4]20 C.F.R. §§ 404.1525, 416.925 (2012).

[5]20 C.F.R. §§ 404.1545, 416.945 (2012); *see also* Ruskell, *supra* note 3, § 2:29 (discussing in detail RFC and its relevancy to the hearing process including the sequential evaluation).

[6]20 C.F.R. §§ 404.1545, 416.945; Ruskell, *supra* note 6, § 2:29 (an excellent discussion of these activities and their relevance to the sequential evaluation).

[7]20 C.F.R. §§ 404.1520(f), 416.920(f) (2012).

[8]20 C.F.R. §§ 404.1520(g), 416.920(g) (2012).

[9]For a more complete discussion of the role of the vocational expert, the Grids, and other vocational aspects of the process, *see* Ruskell, *supra* note 3, § 2:30 and 20 C.F.R. §§ 404.1561, 416.961 (2012).

[10]E.g., Sedentary is defined as sitting six hours in an eight-hour day and occasionally lifting objects no more than ten pounds. *See Ripley v. Chater*, 67 F.3d 552, 557 n.25 (5th Cir. 1995) and RUSKELL, supra note 6, § 2:30(a-f).

[11]Relevant sources for agency rulings and policies include Social Security Rulings (SSR), a series of precedential decisions published under the authority of the SSA Commissioner; Acquiescence Rulings, which explain how the Agency will apply a holding by a U.S. Court of Appeals that varies with SSA policies; the Program Operations Manual System (POMS), for use in internal SSA guidance for employees; and HALLEX, the Commissioner's procedures for carrying out policies and for guidance in the processing and adjudication of claims within the Agency.

[12]20 C.F.R. §§ 404.1512(d), 416.912(d) (2012).

[13]See *Clark v. Commissioner of Social Security*, 143 F.3d 115,118 (2d Cir. 1998) and *Goatcher v. U.S. Dept. of Health & Human Services*, 52 F.3d 288, 290 (10th Cir. 1995)(for the opinions cited by the Fifth Circuit in adopting its rationale in *Newton).* The Fifth Circuit's *Newton* rationale was subsequently followed in *Bordes v. Comm'r of Soc. Sec.*, 235 Fed. Appx. 853 (3rd Cir. 2007) and *Meyer v. Astrue*, 662 F.3d 700 (4th Cir. 2011).