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Call for Submissions: Please contact N. David Kornfeld, ndksocialsecuritylaw@gmail.com to discuss any potential articles or submissions.

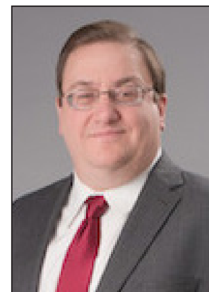
Message From the Chair

L. David Ferrari

Dear Section Colleagues,

Back in July 2015, following my appointment as Chairman of the Section, I made the following introductory statements to the Social Security Law Section on the Section website:

> As your new Section Chairman effective July 1, 2015, I would like to thank you for your membership in the Social Security Law Section of the Federal Bar Association. Many professional organizations vie for our time, treasure and talent. Besides other bar associations, there are associations for administrative law judges, Social Security Administration attorneys, claimants' representatives, and state agency personnel. Each of these organizations provides worthwhile benefits to its members.
>
> The Social Security Law Section of the FBA is unique because our membership is drawn from all groups involved in the adjudication of Social Security disability issues who are attorneys in good standing with their bar, including administrative law judges, district court judges, claimants' representatives and Social Security staff attorneys. For this reason, we can – and must – have a broader perspective. Our primary mission is to serve as advocates for a fair, effective, efficient and fully funded adjudicatory system.



L. David Ferrari

L. David Ferrari is the Chair of the Social Security Law Section and a practicing attorney with the Law Offices of Jeffrey S. Glassman, LLC in Boston, MA.

At the August meeting of the Section, one of the issues that we considered endorsing is the issue of Clean Reallocation. Clean Reallocation would require that Social Security Title 2 and Title 16 Trust funds be reallocated without any political entanglements. The issue however has become largely

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Letter from the Editor

N. David Kornfeld

N. David Kornfeld

For the past three decades N. David Kornfeld has practiced Social Security Disability Law in the Chicago area, representing both adults and children before the Social Security Administration as well as in Federal Court.

I am pleased to announce some wonderful news about our newsletter. First I was humbled when I learned that the Section received a meritorious newsletter award by the Federal Bar Association at the 2015 national convention in Salt Lake City. Second, I am very pleased to announce that the article which appeared in our Spring 2015 issue entitled *Long Term Disability Claims: A Primer for Social Security Attorneys,* written by Martina Sherman and William Reynolds, has been selected by the editors of *The Federal Lawyer,* the magazine of the Federal Bar Association, for publication in the December 2015 issue.

With respect to this issue I am very pleased with the articles appearing but I am always looking for more articles so if you have something in mind do not hesitate to email me at ndksocialsecuritylaw@gmail.com.

I am honored that the Social Security Administration Deputy Commissioner for Operations, Nancy Berryhill, chose to submit an article about the Administration's improved electronic filing system for disability appeals. Since July of 2013, Commissioner Berryhill has served in her current role; however she began her career many years ago with the Social Security Administration as a student employee. Throughout her distinguished career with Social Security, she has held many positions including Service Representative, Claims Representative, Operations Supervisor, District Manager, Area Director for the State of Illinois, and Deputy Regional Commissioner in Denver. Commissioner Berryhill later would serve as the Regional Commissioner for the Denver region, and then in the same capacity for the Chicago region.

I am also extremely pleased by the excellent contributions from Attorneys Julia Mariani, Daniel S. Jones, Avram L. Sachs, and Stacey Dembo. Attorney Stacey Dembo, a Chicago based attorney and former Chairman of the Chicago Bar Association Social Security Committee concentrates her practice in Social Security law; she graciously took over the role of providing the Federal Case Law Update for this issue and she has provided excellent summaries covering four recent circuit court cases, two from the Seventh, one from the Fourth, and one from the Ninth. Attorney Julia Mariani is a phenomenal writer and host of the brilliant website Disability Dunk Tank which creatively focuses on demystifying Social Security Disability issues for the layperson, with a sharp focus on the difficulties and prejudices faced all too often these days by those seeking benefits from the Administration. Her article in this issue focuses on what medical records often do not state. For more of Attorney Mariani's writing check out her website disabilitydunktank.com. Attorney Avram L. Sacks is an attorney in private practice in Skokie, IL, concentrating on Social Security law and benefits. He is a former Assistant Regional Counsel for the Social Security Administration, past editor of the CCH Social Security Law Reporter, and the author of two books on Social Security Law. A member of the National Academy of Elderlaw Attorneys and the National Organization of Social Security Claimant's Representatives, Avram frequently lectures on Social Security matters and advises clients on how to maximize their Social Security retirement benefits through optimal claiming strategies. We are very pleased to feature his article on the various software programs he has utilized, and the impact of recent changes with respect to benefit claiming strategies. Finally Attorney Daniel Jones has written about the history and genesis of the treating physician rule with respect to the ultimate opinion of disability and the approaches of the various circuits, both longitudinally and currently. He practices exclusively in Federal Court appeals of Social Security disability claims, having handled hundreds of such appeals before district courts across the country and before multiple circuit courts.

Finally, I have offered the last of my articles pertaining to the issue of suicide in Social Security Disability claims. I provide an update regarding my efforts to spur on research and I offer a modest proposal for the Administration to consider which may, just may, save at least one life.

Happy new year to one and all.

Best,
N. David Kornfeld

Social Security Administration Raises the Bar on the Internet Disability Appeals Application

Nancy Berryhill

The Social Security Administration (SSA) strives to provide world class, convenient customer service to individuals who come to us for help, including representatives who provide assistance in the process. Since the agency first established a presence on the Internet in 1993, we have increased and enhanced the services we provide online, including to those appealing a disability decision. In February 2004, SSA made online filing for disability appeals available with the introduction of the Disability Report (SSA-3441) portion of the internet Disability Appeals Application. In that first year, about 15,000 internet Disability Reports were filed. In FY 2007, the forms for requesting hearings (HA-501) and reconsiderations (SSA-561) were made available online, and more than 200,000 internet appeals were submitted. The online volumes have increased every year, with over 1 million in FY 2015, representing 45 percent of all 501/561s and 33 percent of all 3441s.

Earlier this year, SSA released a new and improved version of the Internet Disability Appeals Application. More than 90,000 applicants and representatives conveniently use our online appeals application each month. After listening to customer feedback, the new online appeals process is now easier to use and improves the speed and quality of our disability and non-disability decisions.

The application allows the customer to simultaneously submit either the Request for Reconsideration (i-561) or Request for Hearing by Administrative Law Judge (i-501), along with the Disability Report for Appeals (i-3441) to the Social Security Administration via the Internet.

The new enhancements improve the application's functionality and efficiency to provide better online service to customers. The new process:

- Allows customers to submit an appeal request and medical documentation simultaneously.
- Makes third party information automatically available in all appeal applications within a single session.
- Simplifies the screen language and saves time by propagating information from the appeal request to the disability report.
- Improves navigation and on-screen help links.
- Expands the user base to include customers with a Foreign, Army, Fleet or Diplomatic Post Office address.
- Allows the user to upload supporting documents to complete the application process, making the entire online process electronic.

In August 2015, the Social Security Administration hosted a webinar entitled: "Internet Disability Appeals Application Revitalizations and Attachment Utility Update." The webinar was designed to demonstrate to advocates, social service agencies, and representatives how to easily navigate the internet Disability Appeals Application and request their assistance in promoting this improved online service option. The webinar also included a live Q&A session.

The ability to file an appeal online is only one of a wide range of online services that our agency provides. Today people can file online for Title II Social Security retirement and disability benefits, as well as Medicare. In addition, SSA has plans to allow people to initiate Title XVI Supplemental Security Income (SSI) applications online in the future. Individuals age 18 and over can now open a secure, online mySocialSecurity account to have 24/7 access to their Social Security records. If still working, an individual can check their earnings record for accuracy, obtain future benefit estimates and access other tools to better plan for retirement. If already receiving monthly benefits, an individual can monitor their payments and make secure changes to their record such as a change of address or direct deposit information.

The agency's suite of online services allows people a choice in how they conduct business with us. They can either conduct their business online at their convenience, or for those who do not prefer online services, or whose cases may be too complex for an online experience, the traditional office and telephone services remain fully available.

To view the webinar presentation, please visit www.ssa.gov/multimedia/webinars/.

To file an appeal, visit secure.ssa.gov/iApplsRe/start.

Nancy Berryhill

Nancy Berryhill currently serves as the Social Security Administration Deputy Commissioner for Operations and has held this position since July of 2013.

Reserved to the Commissioner – Table for One?

Daniel S. Jones

Daniel S. Jones

Attorney Daniel S. Jones practices exclusively in Federal Court appeals of Social Security disability claims, having handled hundreds of such appeals before district courts across the country and before multiple circuit courts.

A commonly litigated issue in Federal Court appeals of denials of Social Security disability claims is whether the Administration gave appropriate weight to the opinion(s) which are offered from a claimant's treating physician(s). As explained in this article below, the majority of Federal Courts have now taken the approach that treating physician opinions that are dispositive as to the issue of disability may be rejected as deciding the issue of disability "reserved to the Commissioner." However, this party of one approach to deciding disability claims that prevents bringing the assessments of treating doctors to the decision table is contrary to both what is commonly referred to as the "Treating Physician Rule" at common law and the history of the Commissioner's own Regulations on weighing medical source opinions from acceptable medical sources.

History of Treating Physician Rule at Common Law

The origins of the Treating Physician Rule was first developed at Federal common law in multiple Circuit Courts. By way of history, the Administration did not have a specific Regulation regarding the weight to be accorded to a treating physician's opinion prior to 1991 (see the discussion section below entitled *The 1991 Treating Physician Regulation* for the Administration's approach beginning in 1991). Prior to 1991, the Federal Courts developed various tentative approaches to the deference to be afforded to a treating physician opinion. Some of the earliest decisions that found deference was due to a treating physician, cite the cases of *Teeter v. Flemming*, 270 F.2d 871 (7th Cir. 1959) and *Kerner v. Flemming*, 283 F.2d 916 (2d Cir. 1960). While neither opinion was explicit that deference was to be accorded treating physicians' opinions, such an interpretation is inferred from the Circuits' conclusions and the facts of these cases. The Fourth Circuit was the first to formulate any kind of explicit rule that gave greater deference to the opinion of a treating physician over other medical sources, holding rather modestly in the case of *Underwood v. Ribicoff*, 298 F.2d 850, 853 (4th Cir. 1962) that, "[c]onsideration here should be given to the fact that Howard was Claimant's treating physician, whereas Reeves saw him only once for a routine examination." Over time the Treating Physician Rule and the intricacies associated with the Rule developed differently and varied from Circuit to Circuit at common law as briefly summarized herein below.

The First Circuit never developed a body of common law that recognized a general deference to opinions from treating physicians—as would be recognized in every other Circuit. As early as 1972, in the case of *Brown v. Richardson*, 468 F.2d 1003, 1006-1007 (1st Cir. 1972), the Circuit issued a narrow holding that a non-examining physician who was not subject to cross-examination was insufficient to overcome the opinion of a treating physician under the facts presented. However, since that time the First Circuit has repeatedly found that the opinions of treating physicians are just one piece of evidence that must be weighed when considering the substantial evidence standard, with no particular deference or presumption due to their opinions. *See* e.g. *Sitar v. Schweiker*, 671 F.2d 19, 22 (1st Cir. 1982). In fact, the First Circuit "repeatedly refused to adopt any *per se* rule" that greater deference is due to the treating physicians' opinions. *Tremblay v. Sec. of HHS*, 676 F.2d 11, 13 (1st Cir. 1982).

On the other hand, the Second Circuit's Treating Physician Rule was almost certainly the most protective of treating physician opinions prior to the 1991 Regulation. The Rule was first recognized in *Gold v. Secretary of Health, Ed. and Welfare*, 463 F.2d 38 (2d Cir. 1972). In *Gold*, the Circuit held " 'The expert opinions of plaintiff's treating physicians as to plaintiff's disability ... are binding upon the referee if not controverted by substantial evidence to the contrary' " *Gold* at 42. Because of the Administration's apparent failure to apply the protections of the Treating Physician Rule in the Second Circuit on a consistent basis and resulting frequent reversals over the course of the next decade, by 1984 the Circuit pointed out that reversals on the basis of the Rule were "almost legion." *De Leon v. Sec. of HHS*, 734 F.2d 930, 937 (2d Cir. 1984). It only took three more years for the Circuit to find that, " 'Legion' should no longer be modified by 'almost.' We have relied upon the treating physician rule in 23 cases in which the administrative decision denying disability benefits has been either reversed or remanded." *Hidalgo v. Bowen*,

822 F.2d 294, 297 (2d Cir. 1987) (citing 23 cases that reversed determinations based on misapplication of the Treating Physician Rule).

The Third Circuit first adopted its version of the Treating Physician Rule in 1981 in the case of *Cotter v. Harris,* 642 F.2d 700 (3d Cir. 1981). The Circuit concluded that a treating physician is entitled to "substantial weight" citing a previous Second Circuit decision on the issue. *Cotter* at 704.

As noted above, in the *Underwood* case, the Fourth Circuit was the first to imply that deference was to be accorded to a treating physician's opinion. *Underwood* at 1160. Later, in the 1971 case of *Vitek v. Finch*, 438 F.2d 1157, 1160 (4th Cir. 1971), the Circuit stated, "this court has emphasized that the opinion of a claimant's treating physician is entitled to great weight, for it reflects an expert judgment based on a continuing observation of the patient's condition over a prolonged period of time."

The Fifth Circuit first recognized the Treating Physician Rule in 1981 in the case of *Fruge v. Harris*, 631 F.2d 1244 (5th Cir. 1980), holding that the testimony of a treating physician was entitled to "substantial weight" unless good cause is shown to the contrary. *Fruge* at1246.

The Sixth Circuit developed a Treating Physician Rule rather early, in 1967. In the lengthy opinion of *Branham v. Gardner*, 383 F.2d 614, 634 (6th Cir. 1967), the Sixth Circuit ultimately concluded that:

> The evidence of physicians who have been treating a patient over a long period of time and who state that he is totally incapacitated, is substantial evidence as compared with the evidence of physicians who have examined appellant on only one occasion, and whose reports are inconclusive, fragmentary, uncertain, and not contradictions of unqualified evidence that the patient is totally and permanently disabled.

The Seventh Circuit first adopted a version of the Treating Physician Rule in 1977. The Circuit found in the case of *Allen v. Weinberger*, 552 F.2d 781 (7th Cir. 1977) that "[o]nce it is determined that an impairment exists, the opinions of the treating physician are entitled to substantially greater weight than the impressions of a doctor who sees the claimant only once" (*Id* at 786) and also concluded that non-examining physician opinions "deserve little weight" in the face of treating opinions. *Allen* at 740.

The Eighth Circuit first addressed the Treating Physician Rule in 1979 in the case of *Hancock v. Sec. of Dept. Health, Ed. and Welfare*, 603 F.3d 739, 740 (8th Cir. 1979), relying upon the Seventh Circuit's holding in *Allen*, to find that "the report of a consulting physician who examined the claimant once does not constitute 'substantial evidence' upon the record as a whole, especially when contradicted by the evaluation of the claimant's treating physician." *Hancock* at *740*.

In *Murray v. Heckler,* 722 F.2d 499 (9th Cir. 1983), the Ninth Circuit relied on decisions by the Second, Fifth, and Sixth Circuit to conclude "[i]f the ALJ wishes to disregard the opinion of the treating physician, he or she must make findings setting forth specific, legitimate reasons for doing so that are based on substantial evidence in the record." *Murray* at 502.

The Tenth Circuit implicitly adopted the Sixth Circuit's articulation of the Treating Physician Rule in 1983, finding that treating sources were generally entitled to more weight than one-time examiners. *Broadbent v. Harris*, 698 F.2d 407 (10th Cir. 1983) citing *Allen*, *supra*. A year later, the Circuit relied upon the Ninth Circuit's articulation of the Rule in *Murray* to find that an ALJ must give "specific and legitimate" reasons for disregarding a treating physician's opinion, as well as the Eleventh Circuit's Rule articulated in *Wiggins v. Schweiker,* 679 F.2d 1387 (11th Cir. 1982), which held the treating physician was entitled to substantial weight unless there was good cause to the contrary. *Byron v. Heckler*, 742 F.2d 1232 (10th Cir. 1984) citing *Wiggins* at 1235.

The Eleventh Circuit was part of the Fifth Circuit until October 1, 1981, and thus, the Treating Physician Rule established by the Fifth Circuit in *Fruge* immediately became the law of the Circuit when it was established. *Bonner v. City of Prichard, Ala.*, 661 F.2d 1206 (11th Cir. 1981) (holding that all prior Fifth Circuit decisions were binding precedent in the Eleventh Circuit). The Circuit established its own rule only a year later. *Walden v. Schweiker*, 672 F.2d 835 (11th Cir. 1982). The Eleventh Circuit held that when there was no contrary or conflicting evidence, the treating physician's opinion, diagnosis, and medical evidence should be afforded "considerable weight." *Walden* at 840. The Circuit also subsequently found that generally a treating physician's opinion was entitled to more weight than a conflicting consulting physician's opinion. *Spencer O/B/O Spencer v. Heckler,* 765 F.2d 1090, 1093-1094 (11th Cir. 1985).

The District of Columbia Circuit was the last to develop a Treating Physician Rule, in 1984 in the case of *Narrol v. Heckler*, 727 F.2d 1303 (D.C. Cir. 1984). The Circuit there held that treating physicians should be afforded "substantial weight." *Narrol* at 1306 citing the Fifth Circuit's holding in *Fruge*.

The 1980 Regulation on Medical Opinions

In 1980, the Administration codified a succinct Regulation at 20 C.F.R. § 404.1527, which in 1991 would become the Code section that provided a uniform method for weighing physician opinions. The 1980 Regulation at § 404.1527 read in its entirety:

> We are responsible for determining whether you are disabled. Therefore, a statement by your physician that you are "disabled" or "unable to work" does not mean that we will determine that you are disabled. We have to review the medical findings and other evidence that support a physician's statement that you are "disabled."

RESERVED CONTINUED ON PAGE 14

Social Security Benefit Maximization Programs: A Useful Tool and a Trap for the Unwary

Avram L. Sacks[1]

Avram L. Sacks

Avram L. Sacks is an attorney in private practice in Skokie, Illinois, concentrating on Social Security law and benefits. He frequently lectures on Social Security matters throughout the country and advises clients on how to maximize their Social Security retirement benefits through optimal claiming strategies.

Baby boomer couples are thinking about retirement. The wills are in place, as are the advance directives and powers of attorney. They may or may not have met with a financial planner, but they know that they can count on Social Security to provide a large chunk of their post-retirement income. However, articles in the press have informed them that how they coordinate their benefit claims with their spouses can make a huge difference in the benefits they receive. Complicating this picture, the Bipartisan Budget Act of 2015 (PubL 114-74), signed into law on November 2, 2015, phased out several key claiming strategies employed to maximize Social Security retirement benefits, such as filing a restricted application for spousal benefits, and "claim and suspend." Couples nearing retirement age may be wary of financial planners eager to sell them a financial product, and, while accountants know the tax code inside and out, they are not likely to know so much about Social Security retirement benefits. So, they call you, their attorney, for guidance on when they should begin to take Social Security retirement credits. What do you do?

Like many advisors, you may size up their situation, and offer advice based on a gut feeling. Or, perhaps, you ask a few questions and do a back-of-the-envelope analysis that suggests one or more outcomes. The analysis is not trivial. What you and your clients may not know is that the way in which each of them claims a Social Security retirement benefit can result in a potential difference in combined cumulative lifetime benefits over their anticipated lifetimes by as much as $100,000 to $150,000 for a couple.

So, what is the best claiming strategy for maximizing Social Security retirement benefits over one's anticipated lifetime? A worker may claim a retirement benefit at any point from age 62 until age 70 (there is no advantage in ever delaying a claim past age 70); thus, there are 96 different months in which a claim for retirement benefits could be made. For a couple, where each spouse has the option of filing between age 62 and age 70, there are 4,560 combinations of when both spouses may claim benefits between age 62 and age 70! Even if one were to assume that no claim for benefits would be submitted to begin prior to full retirement age, which is currently age 66 (but gradually increasing to age 67 for those born after January 1, 1955), there are still 1,128 such combinations. Hence, determining what is the most optimal strategy for claiming Social Security retirement benefits cannot be properly done without using software that is able to determine which combination—which claiming strategy—yields the highest cumulative benefit over the anticipated lifetime of each spouse.

Arguably, the phase-out of certain benefit maximization techniques by the recent budget legislation, might obviate the need for benefit maximization software. [2] However, other strategies, including "switch" strategies involving widow's or widower's benefits, as well as optimizing benefit claims while still working in light of the so-called "earnings test," and identifying the best strategy in light of anticipated life expectancy still make benefit maximization software a useful tool when determining the most optimal time to claim a retirement benefit.

In recent years the production of benefit maximization software that is able to quickly identify the most optimal claiming strategy has become somewhat of a cottage industry. There are so many choices that it is not easy for a practitioner to know which one to use. In 2015, a newsletter of the National Academy of Elder Law Attorneys (NAELA) posted a press release announcing one such software program by Quicken, "Social Security Optimizer." That announcement was misunderstood by some to be an endorsement by NAELA and provoked a flurry of posts on the NAELA listserv about benefit maximization software. Because the newsletter article left an unintended impression that the software program deserved particular consideration by NAELA members, I looked closely at this software and reported my findings on the listserv. That, in turn, prompted a question as to whether I advised clients about benefit maximization ("yes!") and what products I preferred.

I will share here what I shared on the listserv, with an expanded discussion about the issues

a practitioner might encounter when using maximization software as well as what distinguishes the "good" software from the pretenders.

First, a preliminary note: It is beyond the scope of this article to discuss all that must be taken into account when performing a benefit analysis; it's not just about feeding numbers into a benefit calculator. An advisor must understand how benefits are calculated, know what benefits are available, and understand what factors serve to increase or reduce benefits. The advisor must also recognize that knowing what strategy maximizes cumulative retirement benefits over the anticipated life expectancies of both spouses is only one piece of information, albeit an important piece, that will enable a worker approaching retirement to make an informed decision about which strategy is best for the worker and his or her family. It's not an answer in and of itself. There are other considerations, including: retirement goals, relative health, income needs and the availability of other financial resources.

What Should a Good Program Include?

For those considering the use of benefit maximizing software who are willing to invest the time that it takes to learn how to use the software and recognize that there are issues that may not be handled by the software, what follows is what I look for in benefit maximization software:

1. **Annual entry of earnings for both spouses, or if relevant, for an ex-spouse.** The most accurate method for calculating a projected retirement benefit is one that requires entry of annual earnings for both spouses. Some programs only use current earnings as a basis for estimating future benefits, others will use the projected benefit amount as shown on a worker's Social Security earnings statement. Both methods are deficient. The first assumes a steady and gradual increase in wages over the worker's career. The second fails to take into account projected future earnings, and depending upon when the statement is obtained, it may not even reflect earnings for the most recent prior year. Knowing how much a worker expects to earn in future years impacts not only the amount of the worker's Primary Insurance Amount (PIA — unreduced benefit amount based on the worker's own work record; this is the amount paid as a disability benefit or, as a retirement benefit at full retirement age plus cost-of-living adjustments from age 62), future earnings may also serve to reduce a benefit payment on account of the Annual Earnings Test, if the claimant has not yet reached full retirement age. (Under the test, benefits paid prior to full retirement age are reduced if a beneficiary has earnings above certain thresholds. See Social Security Act §203(b), 20 CFR §404.415, *et seq.*, and POMS §RS 02505.240B. ("POMS" refers to Program Operations Manual System, the internal operating manual of the Social Security Administration, binding on all levels of administrative adjudication.)) A program that allows for annual entry of earnings should also allow for the entry of future earnings.

2. **Monthly cash flow.** Some software programs will provide a monthly cash flow, displaying the PIA, the benefit amount and, where applicable, the reduced PIA generated by the receipt of a pension due to non-covered earnings, *i.e.*, earnings not subject to tax under FICA (Federal Insurance Contributions Act) or SECA (Self-Employment Contributions Act). Some programs will only provide an annual cash flow, and some provide none. The advantage of a monthly cash flow that shows the PIA as well as the benefit actually paid is that it enables an advisor to see more easily how the program is handling benefits in terms of when benefits start and end and what deductions are being imposed. This in turn, enables an informed advisor to determine if the program is returning valid results. One program I use, Maximize My Social Security, treats all deaths as occurring at the end of the year; which, of course, could make a significant difference if the death actually occurred in January. Because the program does not provide a monthly cash flow, it took me a while to figure out what was going on. With an annual cash flow, it is not so easy to identify the month in which the program has determined benefits are to start, nor is it so readily apparent if required reductions are taking place.

3. **Treatment of pensions based on non-covered employment.** Under the Social Security Act, benefits may be reduced under the Windfall Elimination Provision (WEP) (see SSA §215(a)(7) and (d)(5), 20 CFR §404.213, POMS §RS 00605.360, et seq.) and the Government Pension Offset (GPO) (SSA §202(k)(5), 20 CFR §404.408a, POMS §GN 02608.000, et seq.) if a worker receives a pension based on earnings not subject to tax under FICA or SECA. Under the WEP, the benefit formula is altered depending upon how many years of "substantial earnings" for WEP purposes a worker has accrued. (See www.socialsecurity.gov/pubs/EN-05-10045.pdf for details.) In order to take into account proper application of the WEP and GPO, a benefit maximization program must be able to process the amount of the pension based on non-covered earnings and determine how many years of "substantial earnings," if any, a worker has accrued. Many benefit calculators, including one offered for consumer use at the SSA website, fail to account for the impact receipt of such a pension might have on Social Security benefits. Accordingly, a good benefit maximization program must allow for entry of annual earnings as well as the amount of any pension based on non-covered earnings, and when payment of that pension will begin. The program should also be able to take into account the rate of annual increase provided for by the pension plan.

PROGRAMS CONTINUED ON PAGE 18

Federal Case Law Update

Stacey Dembo

Stacey Dembo

Attorney Stacey Dembo, a Chicago based attorney, concentrates her practice in Social Security law where she represents both children and adults in Social Security matters. She is former Chairperson of the Chicago Bar Association Social Security Law Committee.

The Fourth Circuit finds that a limitation to simple, routine tasks, or to unskilled work does not sufficiently account for limitations in concentration, persistence and pace at Step 3. *Mascio v. Colvin*, 780 F.3d 632 (4th Cir. 2015).

Preliminary Statement

In *Mascio*, the Fourth Circuit Court of Appeals declined to adopt a per se rule requiring remand when the ALJ does not discuss functions that are "irrelevant and uncontested," but agreed with the Second Circuit that remand may be important when an ALJ does not assess a claimant's ability to perform relevant functions when contradictory evidence was in the record, or when the ALJ's analysis frustrates meaningful review because of other inadequacies.

The Court also agreed that when an ALJ restricts hypothetical questions to simple, routine tasks, or unskilled work, the ALJ has not sufficiently accounted for a claimant's limitations in concentration, persistence, and pace. The Court also held that the ALJ's lack of explanation about the claimant's limitations in concentration, persistence and pace did not translate into a meaningful functional limitation thereby warranting a remand.

The Court also noted that boilerplate language lacks credibility when an ALJ determines ability to work, and uses that to determine the claimant's credibility. The ALJ must analyze credibility elsewhere in the decision.

Function-By-Function RFC Analysis

The Court acknowledged that other circuits follow a "per se rule requiring remand when the ALJ does not perform any explicit function-by-function analysis." *Mascio v. Colvin*, 780 F.3d 632, 636 (4th Cir. 2015). However, the Court declined to adopt that rule because a "remand would prove futile in cases where the ALJ does not discuss functions that are 'irrelevant and uncontested.'" *Id.*, citing *Cichocki v. Astrue*, 729 F.3d 172, 177 (2d Cir. 2013)(per curium). Instead, the Court agreed with the Second Circuit holding that "[r]emand may be appropriate...where an ALJ fails to assess a claimant's capacity to perform relevant functions, despite contradictory evidence in the record, or where other inadequacies in the ALJ's analysis frustrate meaningful review." *Id.*

Concentration, Persistence and Pace

The Court also addressed the impact of limitations in concentration, persistence, or pace on the RFC. *Id.* at 637-638. Agreeing with other circuits, the Court said "an ALJ does not account 'for a claimant's limitations in concentration, persistence, and pace by restricting the hypothetical question to simple, routine tasks or unskilled work.'" *Winschel v. Comm'r of Soc. Sec., 631 F.3d 1176, 1180 (11th Cir. 2011)* (joining the Third, Seventh, and Eighth Circuits). The Court notes that "the ability to perform simple tasks differs from the ability to stay on task. Only the latter limitation would account for a claimant's limitation in concentration, persistence, or pace." *Id.* at 638. The Court held that the ALJ's lack of explanation as to why the claimant's limitation in concentration, persistence and pace did not translate into a limitation in the RFC necessitated a remand. *Id.*

Credibility Boilerplate

The Court took issue with the boilerplate credibility language that ALJ's often employ. *Id.* at 639. The Court agreed with the Seventh Circuit's holding in *Bjornson v. Astrue*, 671 F.3d 640 (7th Cir. 2012) that "this boilerplate 'gets things backwards' by implying 'that ability to work is determined first and is then used to determine the claimant's credibility." *Id.*; citing *Bjornson v. Astrue*, 671 F.3d 640, 645 (7th Cir. 2012). Further, the ALJ must compare the claimant's testimony of her functional limitations with the other evidence of record and not to the RFC. The Court went on to say that the error would be harmless if the ALJ properly analyzes credibility elsewhere in the decision.

The Ninth Circuit finds that an ALJ may reject a claimant's testimony about the severity of pain or other symptoms by providing specific, clear and convincing reasons to do so; merely reciting medical evidence in support of the RFC determination is not sufficient. *Brown-Hunter v. Colvin*, 798 F.3d 749 (9th Cir. 2015) and *Brown-Hunter v. Colvin*, – F.3d –, No. 13-15213, 2015 WL 6684997 (9th Cir. Nov. 3, 2015) amending.

Preliminary Statement

The Ninth Circuit held that when an ALJ determines that a claimant is not malingering and has an impairment which may reasonably produce the pain or symptoms alleged, the ALJ may reject the claimant's testimony about the severity of those symptoms only by providing specific, clear and convincing reasons to do so. An ALJ does not provide specific, clear and convincing reasons by merely reciting medical evidence in support of the RFC determination.

Credibility Analysis

The Ninth Circuit explicitly stated what an ALJ must do when analyzing a claimant's credibility. The Court stated "to ensure that our review of the ALJ's credibility determination is meaningful, and that the claimant's testimony is not rejected arbitrarily, we require the ALJ to specify which testimony she finds not credible, and then provide clear and convincing reasons, supported by evidence in the record, to support that credibility determination." *Brown-Hunter v. Colvin,* 798 F.3d 749, 751(9th Cir. 2015). *Brown-Hunter v. Colvin,* No. 13-15213, 2015 WL 6684997, at *1 (9th Cir. Nov. 3, 2015). The Court further noted that "a clear statement of the agency's reasoning is necessary because we can affirm the agency's decision to deny benefits only on the grounds invoked by the agency." *Stout v. Comm'r, Soc. Sec. Admin.*, 454 F.3d 1050, 1054 (9th Cir. 2006).

The ALJ in *Brown-Hunter* found generally that the claimant was not credible but did not specify which testimony she found credible and why. *Id.* The Court found this to be an error requiring remand because the omission precluded the Court from "conducting a meaningful review of the ALJ's reasoning." *Id.* Although the ALJ summarized the medical evidence supporting the RFC determination, "this is not the sort of explanation or the kind of 'specific reasons' we must have in order to review the ALJ's decision meaningfully." *Id.* at 6 OR *Id.* at 756.

Reviewing Court Cannot Make Independent Findings

Although the District Court identified inconsistencies that could have supported the ALJ's credibility determination, the Court noted that "the credibility determination is exclusively the ALJ's to make, and ours only to review." *Id.* Furthermore "a reviewing court may not make independent findings based on the evidence before the ALJ to conclude the ALJ's error was harmless." *Stout,* 454 F.3d at 1054. Rather, the reviewing court is "constrained to review the reasons the ALJ asserts." *Id.* at 4 OR *Id.* at 756; citing *Connett v. Barnhart,* 340 F.3d 871, 874 (9th Cir. 2003). Therefore, if an ALJ does not specify her reasons for finding a claimant's testimony not credible, the reviewing court will not be able to perform a meaningful review. *Id.* Therefore, such an omission is not a harmless error.

The Seventh Circuit finds that ALJs must consider the combined effects of a claimant's impairments on his ability to work. *Alaura v. Colvin,* 797 F.3d 503 (7th Cir. 2015).

Preliminary Statement

The Court in *Alaura* remanded an ALJ's determination to deny benefits based on the claimant's ability to perform light work because the ALJ's decision was not supported by substantial evidence. The claimant, who suffered from a plethora of impairments and limitations as a result of being "struck in the back of the head by an assailant wielding a barstool as a weapon," provided the Court with extensive documentation of his impairments from treating physicians. *Alaura v. Colvin,* 797 F.3d 503, 503 (7th Cir. 2015). The ALJ failed to consider the combined effects of his impairments, seemingly ignored non-trivial obstacles to employment, and failed to take advantage of available experts which would have given the ALJ a more comprehensive opinion on the claimant's ability to perform light work. The Court also engaged in a lengthy discussion regarding the validity of vocational expert testimony.

Obtaining Expert Opinion Evidence Regarding the Combined Effects of Impairments

The Court faulted the ALJ for failing to "consider the combined effects [of the claimant's impairments] on [his] ability to work. *Id.* at 506. The Court noted that an ALJ is "unlikely to be capable of assessing the interaction within and overall effect of such a collection of impairments" because the ALJ is not a doctor. *Id.* However, the Court faulted the ALJ for failing to tap "the stable of medical consultants used by the Social Security Administration to evaluate applicants for disability benefits" to "offer an opinion on [the claimant's ability to do various forms of light work on a full-time basis." *Id.*

Equating ADLs with Ability to Work

The Court also noted that the ALJ's decision "left unexplained" how being able to do a few, limited tasks would prepare the claimant for "full-time employment as a retail marker, hand packager, or addresser." *Id. at* 505-06.

Vocational Expert Testimony

Although dictum, the Court engaged in a lengthy discussion regarding "the source and validity of the statistics that vocational experts trot out in social security disability hearings." Id. at 507. After summarizing the manner in which vocational experts arrive at job numbers, the Court observed, "a vocational expert's stated number of jobs…seems likely…to be a fabrication." *Id.*

Once again, the Seventh Circuit again finds it problematic when an ALJ equates a claimant's ability to perform some activities of daily living with his ability to engage in gainful employment. *Price v. Colvin,* 794 F.3d 836 (7th Cir. 2015)

Preliminary Statement

In keeping with other recent Seventh Circuit cases, the

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Suicide in Social Security Disability Applicants and Recipients—An Update

N. David Kornfeld

N. David Kornfeld

N. David Kornfeld is an attorney with a main office in Evanston, Illinois in a practice concentrating in Social Security Law. Mr. Kornfeld also serves as the editor of this newsletter, and on the Federal Bar Association, Social Security Section Board.

A cursory perusal of our last two issues reveals that I have been pursuing the subject matter of suicides in Social Security disability claimants and recipients. This is a subject matter I have addressed and explored now in two recent articles for the Federal Bar Association Social Security News. The articles can be found on our Section website as follows:

www.fedbar.org/Image-Library/Sections-and-Divisions/Social-Security/winter2015.pdf

www.fedbar.org/Image-Library/Sections-and-Divisions/Social-Security/spring-2015.pdf

At this time, I want to update you with respect to my communication with the scientific community, as one of my goals was to encourage both dialogue and research. Initially, I wrote to the American Foundation for Suicide Prevention (AFSP). The AFSP Vice President of Research, Dr. Jill Harvaky-Friedman, suggested I check the AFSP list of funded studies and Scientific Advisors to see if there may be interested researchers. Dr. Harkavy-Friedman further indicated that the Foundation would welcome research applications on this topic. Following Dr. Harkavy-Friedman's suggestion I wrote to several researchers and received a number of promising responses.

I wrote to Dr. Jane Pearson, who is responsible for overseeing the suicide funding portfolio at the National Institute of Mental Health (NIMH) Suicide Research Consortium; she also has expressed interest in the topic. Dr. Pearson suggested that I join a Suicidology listserv, which I did. I posted links to my articles and engaged in dialogue with several experts in the field of Suicidology. In all honesty, I had never head of the term "Suicidology" before and I am going to venture that most of you who are reading this article have never heard of that term before. However there is an organization called the American Association of Suicidology and their motto reads "suicide prevention is everyone's business." What has so impressed me regarding the daily listserv postings is the dedication shown by so many who work in this difficult field; I have learned that so many scientists and practitioners are devoted to the admirable goal of studying and preventing suicides.

I also wrote to Dr. Elizabeth Rasch, who had authored a paper about deaths generally in Social Security cases and the need to prioritize certain cases, hoping to trigger possible research. See Rasch EK, Huynh M, Ho P-S, Heuser A, Houtenville A, Chan L: First in line: Prioritizing receipt of Social Security disability benefits based on likelihood of death during adjudication. Medical Care 2014; 52: 944–950. While she found my articles of great interest, she did not feel she was in a position to do any research into the subject but did provide some insight into the current state of suicidology research.

Any study would need to show that there are suicides above and beyond what is already known and several scientists pointed out confounding problems with collecting data for research. Dr. Rasch indicated that SSA does not use ICD codes to identify particular health conditions and there are no associated injury codes that include a code for suicide. SSA has their own system for coding conditions, which does not include a code for suicide. Thus, Dr. Rasch indicated there was no way of knowing the frequency of deaths from suicide in the study sample. She further pointed out that suicides are under-reported on death certificates generally, so even if SSA had a code for it, it would not reflect the magnitude of the problem. There are also several roadblocks to collecting valid data on suicides as it is true that some deaths from overdose situations might never be known for sure whether a death might be from suicide or whether it was an accidental overdose. Also families sometimes try to hide the real reason for the death on occasion for privacy reasons.

Several researchers I am in contact with have agreed with my hypothesis and concern about an increased rate in suicides by Social Security disability claimants or recipients. One psychologist agreed that the number of suicides among disability applicants and recipients would be higher and not mirror that of the general population given statistics which show that 35% of the beneficiaries and applicants suffer from mental illness. Also painful chronic illness, one of the main reasons why people become unable to work, is often one of the reasons that some people seek assisted sui-

cide. Hence from the start, this psychologist pointed out that applicants for Social Security disability have a greater share of those to be known to be at risk for suicide. Additionally I came across a study, which suggested that unemployment generally fuels a fifth of suicides worldwide. If unemployment generally has been found to be of such significance, it would seem to follow that disability related unemployment also poses a significant risk.

Yet as I pointed out to the various researchers, there has never been any research into the incidence of suicide in Social Security disability claimants or recipients. My hope is that ultimately one of the researchers may pursue this topic and that funding will become available for the study. My working thesis continues to be that there is a suicide epidemic which is only getting worse with increased denials and increased waiting times in the Social Security disability process. Since logically it would seem that increased delays and denials in the process has to have some type of adverse impact which should be able to be measured in some way. The extent to which the adverse impact results in more deaths from suicides is something that I continue to believe should be explored.

Recently there have been around 41,000 reported suicides in the United States per year. The Principles of Epidemiology in Public Health Practice, 2nd Edition, published by the Centers for Disease Control and Prevention in 2006 and updated in 2012, indicates an epidemic "refers to an increase, often sudden, in the number of cases of a disease above what is normally expected in that population in that area." I use the term epidemic as a corollary/amendment to the April 2014 New Yorker article entitled "The Neglected Suicide Epidemic" which cited the sharp rise in suicides since the year 2000 especially among middle aged Americans. The term "epidemic" is used in the suicide context with respect to veterans quite often. In article after article there are reports of 22 suicides per day. If you Google the terms suicide, veterans, epidemic—you will see what I am talking about. An example from one article from April of 2014 reads as follows:

> At least 22 veterans commit suicide each day, according to the Veterans Affairs Department. This adds up to more than 2,000 veterans killing themselves so far this year alone, and the military community is facing what advocates refer to as a suicide epidemic. (See the following article www.nationaljournal.com/defense/2014/04/03/how-can-government-battle-suicide-epidemic-among-veterans?mref=scroll)

As you surely know, claimants across the nation over the last year and a half have been confronted with unprecedented denials as outlined in my original article. Increased delays at all levels of the process have also returned. Hearing level cases in my area are typically remaining unassigned for well over a year, extending the anguish and uncertainty that my clients must endure. In this environment of increasing denial and delay, I continue to assert that we are going to be seeing more and more deaths from suicide. Dr. Paul Quinnett, a suicideologist and Clinical Professor at the University of Washington School of Medicine who has worked in the field of public mental health for 35 years was not surprised at seeing the reported "incidents of denials followed by preventable suicides. After all, when you slam the last door to survival in the face of the petitioner you slam the door to hope. How is this not like the delivery of a death sentence you must carry out yourself?" Dr. Quinnett also queried his colleagues whether my articles had "identified yet another known-at-risk group upon which our suicide prevention efforts should focus? And, if so, how can the National Alliance [National Action Alliance for Suicide Prevention] help in such an effort. . .?" To quantify the size of this at-risk population I have done some quick estimates on how many disability applicants and recipients may possibly be attempting and committing suicide. If individuals with disabilities simply reflect the same suicide rates as in the general U.S. population - 6 Social Security disability recipients and/or applicants kill themselves everyday with 150 others attempting suicide. If, as I suspect, disability applicants and claimants are more similar to the veterans population with an increased risk of suicide those numbers would jump up to 18 deaths and 450 attempts per day. In this later scenario approximately 1 in 6 suicides would be a disability benefits recipient or applicant. Numerous research scientists through my articles and correspondence have been apprised of the issue and several have expressed an interest in possibly studying the phenomenon. That is a positive first step. I will be eager to see whether any studies ultimately get funded, a central concern of some of the researchers who responded.

In my own case in October 2014, Congresswoman Janice D. Schakowsky, in response to the suicide of my client, sent a letter to Acting Commissioner of Social Security, Carolyn W. Colvin, regarding the delays experienced in the processing of claims for Social Security Disability benefits. As noted in the article, my client's appeal had remained pending and unassigned at the reconsideration level for approximately three months at the time of his death. The Commissioner responded regarding the delays in a letter to the Congresswoman. The Commissioner indicated that Social Security had started working with the Illinois DDS to reduce the number of pending cases. She also indicated that she wished to eliminate backlogs generally and actually apologized for the delay which took place in my client's case. That apology was conveyed to my client's surviving life partner, which he found personally significant and important, and so at least in my client's case there was indeed accountability. Delays are a huge problem generally and with respect to a vulnerable claimant silently contemplating suicide, the delays could be the last straw. I concede that I do not know if my client would have been saved had the DDS approved the claim initially or had the DDS moved with greater alacrity on reconsideration. I have asked myself this question quite often. I also discussed this repeatedly with my client's significant other

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The Play is the Thing

Julia Mariani

Don't think I haven't heard your snickers when I've divulged my bachelors degree in *dramatic literature*. I have heard them. In fact, I hear them now. To preserve myself, I attempt to summon the ancient pretensions of the theatre, but they gain me no swagger among esquires and justices.

"What does that even mean … *dramatic literature*?" a judge asked. "I've read a lot of Shakespeare," I say. I would have liked to say more.

I would have liked to articulate how the critical *reading* skills developed studying literature—specifically dramatic literature—are directly applicable to what we do as lawyers and judges when we read, of all things … medical records.

A play is a literary form consisting almost exclusively of dialogue between characters, and little else. It is by design incomplete. The purpose of a play is for it to be staged. The form is skeletal, gaunt— more a recipe to make a meal than the meal itself. Plays are difficult to read, much more difficult to understand than novels.

Novels are larded-up works that spoon-feed readers nourishing, explanatory prose. Novels have rich descriptions of history and geography, rhetorical portraiture of characters' physicality, personal and family history. Novelists explain what their characters think, what they know or don't, their motivations, limitations, abilities…. Novels are veritable smorgasbords dripping with fattening informational sauces upon which readers gorge themselves. This is why vacationers stretch out on beach towels with novels but not plays.

Good directors understand the skeletal nature of the form. Directors must have many skills, but the first among them is being able to read. And, I mean *read*. Read as if your professional life depends upon it – carefully and critically. When directors don't understand the play, they are little more than traffic cops moving actors here and there, hoping for no collisions.

In *Backwards and Forwards*: *A Technical Manual for Reading Plays,*[1] David Ball lays out invaluable advice on script analysis. While much of it may not be useful for lawyers and judges reading medical records, some is. Among the most useful pieces of advice that crosses over from script analysis to record analysis are understanding a play by use of information of the time and place it was written, by use of knowledge of the playwright, and by analysis of action—especially action in relation to obstacle.

Yes, I have read a lot of Shakespeare. And I read a lot of medical records. You're reading the Federal Bar Association's Social Security News; I suspect you read a lot of medical records too.

I have found *nothing* more difficult to read than medical records. Give me the most unstructured avant-garde play in the world like Beckett's *Waiting for Godot*, or *Hamlet* straight up, or those silly little ancient Greek satyr plays, and I will explain them more readily than I can the medical records from which we're supposed to determine disability.

A lawyer or judge contemplating medical records has a *much* harder job than a director contemplating a play. A play, while skeletal, has form—a beginning, middle and end—it has a cohesive point. Mercifully, it has a single, usually trustworthy, playwright. Among other things, medical records are disjointed, indecipherable, incoherent, inconsistent, error-filled, riddled with jargon, incomplete, and even just non-existent. And, unlike most playwrights, doctors can't write; or if they can, they don't do it in medical records. What doctors manage to scribble down is decidedly for their own ends – not ours.

Over-reliance on the evidentiary value of medical records leads to some *dramatically* bad decisions. Dramatically bad, like *'Springtime for Hitler: A Gay Romp With Adolf and Eva'* bad. Bad.

Lawyers and judges must have many skills, but the first among them is the ability to read. And, I mean *read*. Read as if *the lives of claimants,* depend upon it—carefully and critically.

Backwards and Forwards counsels that in analyzing script, and I would argue, in analyzing a record, "every kind of available information is useful. Background information on the author, the era, the artistic environment from which the script emerged …."

One of the greatest frustrations lawyers and judges have with medical records is the shocking lack of information in them. When records are decipherable, they say almost nothing actually useful to lawyers and judges. Claimants receive no treatment for impairments we're to assess, and when they do receive treatment, there is no documentation for the symptoms they report.

Julia Mariani

Julia Mariani is a graduate of Washington University School of Law; her practice area is primarily Social Security disability. Prior to becoming a lawyer, Ms. Mariani was a professional sign language interpreter, and freelance writer.

Lawyers and judges are at a loss for understanding how to manage these disconnects.

As *Backwards and Forwards* counsels, it is useful to look to background—to the historical time and place in which medical treatment is obtained, the environment in which medical records are produced, and the authors of those records and their motivation and purpose in producing and maintaining medical records.

The historical time and place in which treatment is obtained

As anyone reading this knows, Social Security defines "disability" as "the inability to do any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or has lasted or can be expected to last for a continuous period of not less than twelve months." In most, but not all, cases, this means that a person who meets this definition is unable to work full-time.

Economist John Murray explains in *Origins of American Health Insurance*[2] that since the industrial sickness funds of the industrial age, the 1942 Stabilization Act, and the post-World War II penetration of employer-based health insurance, health insurance has been inextricably linked to full-time employment in the United States.

The CDC's National Center for Health Statistics (NCHS) collects data on health insurance coverage because it is the primary determinant of access to health care, access *to* "usual sources of health care" (care not limited to that received in emergency rooms or clinics for the poor), and health outcomes. The NCHS Fact Sheet published July 2014, after implementation of the Affordable Care Act, documents that still "the major source of coverage for persons under age 65 is private employer-sponsored group health insurance."

As such, having a disability negatively impacts a person's ability to work, which will cause him or her to lose health insurance, and to have diminished funds with which to pay for medical care out-of-pocket, and so will have little or no access to health care, and then will not be able to document the disabling impairment with medical records, and then cannot prove the disability.

Joseph Heller had something to say of this type of conundrum:

> There was only one catch and that was Catch-22, which specified that a concern for one's safety in the face of dangers that were real and immediate was the process of a rational mind.
>
> Orr was crazy and could be grounded. All he had to do was ask and as soon as he did, he would no longer be crazy and would have to fly more missions. Orr would be crazy to fly more missions and sane if he didn't, but if he was sane he had to fly them. If he flew them he was crazy and didn't have to but if he didn't want to he was sane and had to.
>
> Yossarian was moved very deeply by the absolute simplicity of the clause of Catch-22 and let out a respectful whistle.[3]

Social Security ALJs routinely find claimants' complaints of their impairments, and the effects of those impairments, not credible because there are no medical records documenting the supposed impairments and the functional deficits they cause.

For example, in *Roddy v. Astrue*, 705 F.3d 631 (7th Cir. 2013), an ALJ both credited a claimant's assertion that "the last time she saw a physician was in 2005 because she has no insurance and cannot otherwise afford medical care," but also "rested his credibility determination on Roddy's failure to seek treatment" after the period she lacked health insurance. The case was remanded.

Contemplating the meaning of something that does not exist is problematic. Non-existence of evidence *is* evidence. But evidence of what?

In Arthur Conan Doyle's anthology of short stories, *The Memoirs of Sherlock Holmes*,[4] the story *Silver Blaze* has Holmes solving the theft of a racehorse the night before it was to race. Famously, it is the fact that no one Holmes interviewed mentioned that the resident watchdog had barked at any time in the night. To Holmes, this was evidence the horse was stolen by someone known to the dog.

Adjudicators often conclude that absence of medical evidence is evidence of absence of the impairment. And, they conclude that absence of medical evidence is evidence of a lack of credibility on the part of a claimant who speaks to the deficits emanating from the undocumented impairment. These conclusions are potentially correct, however, the historical time and place in which the evidence was *not* produced likely provides more convincing reasons why it wasn't produced.

The Centers for Disease Control (CDC), the National Institute of Health (NIH), and others recognize that arguably *the most pressing concern* in public health in the United States in the twenty-first century is lack of access to care. A Google search composed of "access to health care articles" pulls 359,000,000 hits on the topic. The gist of the concern from a public health standpoint is how it implicates treatment of manageable diseases, early detection of treatable, potentially terminal illnesses (such as cancer), and how risk for spread of dangerous communicable diseases is increased by lack of access to care.

Though health policymakers don't consider the evidentiary implications lack of access to health care has on the patients lacking that care, lawyers and judges must. Because of a lack of access to health care, many claimants of disability benefits cannot document their impairments sufficiently well to prove a disability.

This lack of evidence says very little about non-existence

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In the Federal Register, which published the final Regulation (45 Fed. Reg. 45, 163 (Aug 20, 1980)), the Administration responded to a comment on the proposed Regulation that suggested it was "impermissible in light of the substantial body of case law indicating that the uncontradicted conclusion of a physician is entitled to 'great weight.'" *Id.* at page 55576. In response, the Agency explained that the Regulation was only intended to mean that opinions by physicians are "not binding upon us," and that the Administration, not the treating physician, is "responsible for making the disability determination on the basis of the evidence." *Id.* The comments associated with the Regulation did not indicate that the then existing common law rules that generally afforded more weight to treating physicians than other medical sources, which existed in nearly every Circuit Court, were abrogated in any manner. To the contrary, the comments explicitly pointed out the Agency was required to comply with Court decisions that had "criticized us for not obtaining sufficient evidence" from physicians. *Id.*

The plain meaning of the new Regulation was clear: the ultimate conclusion that a claimant was "disabled" was to be made by the Administration, not by a claimant's treating physician. Nonetheless, statements from treating sources that a claimant was disabled or unable to work still needed to be considered under the existing common law rules regarding the weight to be afforded to treating medical sources and the Agency was still required to comply with Court decisions that addressed the Treating Physician Rule and properly develop the record with respect to those opinions. The few Court decisions that addressed the 1980 code at § 404.1527 viewed the new Regulation according to this meaning. In fact, in the years between 1980 and 1991 there are only 34 reported Circuit decisions that even discus 20 C.F.R. § 404.1527; the code section is not cited by a single reported decision in the Second, Fourth, Eighth or D.C. Circuits. Considering the fact the Regulation promulgated in 1980 was in effect for 11 years and that only 34 Circuit cases even mention the Regulation, and none discuss it in any detail, suggests that the Administration did not seek to advance a litigation position that treating physician opinions on disability could not be given weight because that determination was to be made exclusively by the Agency. In fact, not a single published Court decision concluded that a treating physician opinion on disability could be rejected merely because it was an opinion on disability.

The 1991 Treating Physician Regulation

In 1991, after formal rulemaking, the Administration promulgated a new and much more extensive Regulation at 20 C.F.R. § 404.1527 that purported to provide a uniform method for weighing the opinions of physicians, including treating, examining, and non-examining sources. *See Standards for Consultative Examinations and Existing Medical Evidence*, 56 Fed. Reg. 36932 (Aug 1, 1991). The Agency determined that there was a consensus among the Circuit Courts that: (1) "treating source evidence tends to have a special intrinsic value" because of the treating source's relationship with the claimant, and (2) "if the Secretary decides to reject such an opinion, he should provide the claimant with good reasons for doing so." *Id.* at 36934. The Administration explicitly stated that it "reserved" for itself opinions that a claimant is disabled. *Id.* at 36961 (to be codified at 20 C.F.R. § 404.1527(e)(1) at the time). In language that was similar to the prior code section, the new Regulation stated:

> Opinions that you are disabled. We are responsible for making the determination or decision about whether you meet the statutory definition of disability. In so doing, we review all of the medical findings and other evidence that support a medical source's statement that you are disabled. A statement by a medical source that you are "disabled" or "unable to work" does not mean that we will determine that you are disabled. *Id.*

The Administration preceded this code section by describing such opinions as "reserved" to the Agency. It also removed the final line of the prior similar code section that instructed adjudicators to "review the medical findings and other evidence that support a physician's statement that you are 'disabled.'" *See Conclusions by physicians concerning your disability*, 45 Fed. Reg. 45, 163 (Aug 20, 1980). However, the comments in the Federal Register stated:

> Paragraph (e) addresses the consideration of opinions on issues reserved to the Secretary. Except for editorial changes, paragraph (e)(1) is intended to be identical in meaning to the rule that was in the existing regulations §§ 404.1527 and 416.927.

56 Fed. Reg. 36932, 36937 (Aug 1, 1991). The Current Regulation was relettered so that subsection (e) of the Regulation now appears at subsection (d).

The comment makes clear that the Courts should give identical meaning to this new code section as was given to the prior Regulation at 20 C.F.R. § 404.1527 since the change in language was merely "editorial." Additional comments in the Federal Register also lend support to a conclusion that the new language did not indicate a change in the meaning of the Regulation, i.e., "if a treating source provides an opinion on a nonmedical issue…we will make every reasonable effort to recontact the source and obtain an explanation of the medical basis for that opinion," and "[w]e did not mean to require medical sources to use proper terminology…" *Id.*

As with the Regulation promulgated in 1980, the comments made the Administration's position clear. Although the ultimate conclusion that a claimant was "disabled" was to be made by the Agency, not by a claimant's treating physician,

statements that a claimant was disabled or unable to work from a treating source still needed to be considered, now under the new Regulation, which purportedly were a restatement of the common law on weighing such opinions. Despite this, following the promulgation of the 1991 Regulation, the Circuit Courts and District Courts started taking a different approach to opinions that a claimant was "disabled" or unable to work," by finding that because the determination of disability was "reserved" to the Commissioner, such opinions from medical sources could be rejected on this basis.

New Case Law Interpreting the 1991 Regulation

Citing the new Regulation, the Third Circuit concluded in *Johnson v. Comm'r of Soc. Sec.* 529 F.3d 198, 203 n.2 (3d Cir. 2008) that an opinion by a treating physician that the claimant was unable to perform his past work or other jobs was "not the sort of treating source medical opinion entitled to any kind of weight." There was no discussion of whether such an opinion must still be considered within the context of the evidence supporting the opinion. Instead, the Circuit suggested that the opinion may be rejected outright because the doctor gave an opinion on disability rather than specific medical limitations.

In the Fifth Circuit in the case of *Frank v. Barnhart*, 326 F.3d 618, 620 (5th Cir. 2003), the Court concluded that an opinion that a claimant is "disabled" or "unable to work" is never a medical opinion that can be given special significance or that requires analysis under the factors codified in 20 C.F.R. § 404.1527(d)(2)-(6) at the time, which must be applied when weighing medical opinions.

The Sixth Circuit relied upon the new Regulation in *Allen v. Comm'r of Soc. Sec.*, 561 F.3d 646, 651 (6th Cir. 2009) to conclude that the Agency's rejection of a treating physician on the basis that the opinion was one reserved to the Commissioner was itself a "good reason" for rejecting such an opinion. In *Bass v. McMahon*, 499 F.3d 506, 511 (6th Cir. 2007), the Sixth Circuit cited the new Regulation as a basis for properly rejecting an opinion on disability because such opinions were "ambiguous at best" when the treating physician found the claimant disabled for the purpose of a handicap parking sticker.

In the Seventh Circuit, the Court first found, in *Johansen v. Barnhart*, 314 F.3d 283 (7th Cir. 2002), that a treating physician's opinion on an inability to perform gainful activity even with a description of the claimant's pain was one "reserved to the Commissioner" and could be rejected on that basis. *Johansen* at 288. In *Skarbek v. Barnhart*, 390 F.3d 500 (7th Cir. 2004), the Seventh Circuit later stated that the Administration was also not required to recontact a treating source who opined a claimant was disabled so long as there is adequate evidence to support an opinion of no disability. *Skarbek* at 504. More recently, in the case of *Denton v. Astrue*, 596 F.3d 419, 424 (7th Cir. 2010), the Circuit also found that an opinion may be rejected on the basis that it is reserved to the Commissioner in conjunction with a lack of objective medical evidence.

None of these Circuits previously interpreted the Regulation as meaning more than that it reserved the final decision on disability to the Commissioner. Despite this fact, and without recognizing the commentary to the new Regulation published in the Federal Register that the language was an "editorial change," the Court opinions interpreting the Regulation suggested that a treating source's opinions on disability may be rejected without any detailed discussion of the opinion or further development of the record. This is contrary to the Commissioner's own commentary on the new Regulation and the lack of any earlier precedence interpreting the old Regulation in such a manner despite the Agency's statements that the language did not signal a change in the law.

Even the Circuits that had not explicitly addressed the Commissioner's earlier Regulation at 20 C.F.R. § 404.1527 followed the lead of the above Courts to signal opinions on disability could be discounted simply on the basis that they addressed an issue to be decided by the Agency. For example, the Second Circuit in *Snell v. Apfel*, 177 F.3d 128 (2d Cir. 1999) concluded that under the Commissioner's new Regulation, "[a] treating physician's statement that the claimant is disabled cannot itself be determinative." *Snell* at 133. The Court ultimately concluded that although an opinion from a treating physician could be rejected because it is on an issue reserved to the Commissioner, the Administration still must explain "why a treating physician's opinions are not being credited." *Snell* at 134. However, in a later opinion the Circuit in *Halloran v. Barnhart*, 362 F.3d 28 (2d Cir. 2004) suggested that a mere finding by the Administration that a treating source's opinion was on an issue reserved to the Commissioner was, itself, a sufficient explanation for "why" the opinion was not being credited. *Halloran*, at 32 (a conclusion by the treating physician that the claimant was unable to perform his previous job duties was a "factor[ ] … which tend[ed] to support or contradict the treating physician's opinion") (alteration by Court quoting 20 C.F.R. § 404.1527(d)(6)). This conclusion was only just recently reinforced in *Greek v. Colvin*, 802 F.3d 370, 374 (2d Cir. 2015) (holding that the District Court decided correctly that a treating physician's opinion on disability was not entitled to any weight "because only the Commissioner can make the final determination of disability under the Social Security Act").

The Eighth Circuit in the case of *Randolph v. Barnhart*, 386 F.3d 835 (8th Cir. 2004) also found it proper for the Administration to reject the detailed opinion from a treating physician on disability because it was on an issue reserved to the Commissioner. The Eighth Circuit bolstered its conclusion by pointing out that the treating source only saw the claimant for a limited period of time before offering an opinion, but did not find the need to discuss other factors of supportability. *Randolph* at 840.In a later opinion, *Ellis v. Barnhart*, 392 F.3d 988, 994-995 (8th Cir. 2005), the Circuit found that an Administrative Law Judge could "rightly" discredit a physician's opinion solely on the basis that it was an opinion that the claimant "could not work." However, in a recent opinion

the Eighth Circuit suggested that an opinion on disability may be rejected as one reserved to the Commissioner only when the "larger medical record" does not support the opinion. *Brown v. Astrue*, 611 F.3d 941 (8th Cir. 2010).

The Tenth Circuit initially addressed the issue circumstantially in three opinions. In *Castellano v. Sec. of HHS*, 26 F.3d 1027, 1029 (10th Cir. 1994), the Circuit cited the Regulation without application to the facts of the case. In *Barnett v. Apfel*, 231 F.3d 687, 690 (10th Cir. 2000), the Circuit cited the Regulation in conjunction with another Regulation (on acceptable medical sources) to find that the Commissioner properly rejected an opinion on disability from a chiropractor because he was not an acceptable source and because the opinion was reserved to the Commissioner. In *Cowan v. Astrue*, 552 F.3d 1182, 1189 (10th Cir. 2008), the Circuit cited the Regulation as supporting the Commissioner's determination of no disability when discussing the opinion of a physician who indicated he did not know if the claimant could return to his past work.

A Change in the Wind?

Over the course of the previous four years, two Circuits have rendered holdings suggesting a return to the plain meaning of the regulation—while the determination of disability is reserved to the Commissioner and not physicians, those opinions cannot be discounted on this basis and must be appropriately and comprehensively weighed against the remainder of the evidentiary record. The Tenth Circuit admonished the Commissioner in *Krauser v. Astrue*, 638 F.3d 1324 (10th Cir. 2011) for stating that a treating physician's opinions that the claimant could not perform even sedentary work was "reserved to the Commissioner," finding this conclusion "a prominent red herring…that should be identified so it plays no role in subsequent proceedings." *Krauser* at 1331-1332. The Court noted that the fact that medical opinions impact the Agency's determination of a claimant's RFC does not make them impermissible; it is did "medical opinions would be inherently useless in disability determinations." *Id.* at 1332. Certainly this is not what the Agency contemplated in promulgating detailed Regulation in 1991 regarding how the Agency should weigh medical opinions.

The year following the Tenth Circuit's decision, the Seventh Circuit stated in *Bjornson v. Astrue* 671 F.3d 640 (7th Cir. 2012) that a finding by the Agency that a treating physician's medical opinion on disability was discounted because the determination of disability is reserved to the Commissioner is based on an "imprecise" reading of the Regulation. *Bjornson* at 647. The Court concluded that reserving the determination of disability to the Commissioner is "not the same thing as saying such a statement is improper and therefore to be ignored…" *Id.* The Seventh Circuit later reaffirmed this holding in *Garcia v. Colvin*, 741 F.3d 758 (7th Cir. 2013).

Numerous District Courts, relying on these recent cases, have rendered holdings more consistent with the plain meaning of the Regulations, which state that medical opinions on issues relating to disability must still be appropriately weighed even though the final decision is made by the Commissioner. *See* e.g. *McGowan v. Astrue*, No. 11-cv-01145-WYD, 2012 WL 4356227 *4 (D.Colo. Sept. 24, 2012) (opinions from a treating physician on a claimant's RFC cannot be rejected as on an issue reserved to the Commissioner even if dispositive); *Bumgardner v. Comm'r of Soc. Sec.*, No. 6:12-cv-00018-Orl-31-TBS, 2013 WL 610343 *11, 15 (M.D.Fla. Jan. 30, 2013); *Corwin v. Astrue*, No. CIV-10-1019-M, 2011 WL 2928098 *3 (W.D. Okla. June 28, 2011) (legal reasoning that the decision of disability is reserved to the Commissioner cannot be applied to discount a medical opinion that did not simply address the decision of disability); *Jones v. Astrue*, No. 12 C 10070, 2014 WL 2458155 *9 (N.D.Ill. May 30, 2014) (there is a difference between saying a determination of disability is reserved for the Commissioner and failing to properly weigh medical opinions that may impact a finding of disability); *Boyer v. Comm'r of Soc. Sec.*, No. 4:13-CV-45-TLS, 2014 WL 4639512 *8 (N.D.Ind. Sept. 16, 2014) (finding ALJ may have erred by discounting medical opinion based on flawed conclusion that this is relevant to the fact that the determination of disability is reserved to the Commissioner); *Rawlings v. Colvin*, No. 3:14cv00159, 2015. WL 3970608 *4 (S.D.Ohio June 30, 2015) (it is "not a valid reason" to discount medical opinion on basis that determination is reserved to the Commissioner); *Martin v. Colvin*, No. 14-cv-1082-JPG-CJP, 2015 WL 5120800 *8 (S.D.Ill. 2015) (medical testimony is always relevant to the determination of disability and cannot be ignored even if that determination is reserved to the Commissioner).

Conclusion

The history of the Regulation at 20 C.F.R. § 404.1527(d), which state that opinions that are dispositive on the issue of disability are "reserved to the Commissioner" is merely a bureaucratic statement that gives the Administration the sole authority to make a final decision on a claimant's disability. It is a procedural rule rather than a rule that impacts the merits and relative weight that may be given to the opinions from treating sources. Confusingly, the subject matter on the Administration's authority is part of the same code section as one that primarily speaks to the substantive merits of deciding almost every claimant's case by discussing how adjudicators should weigh medical source opinions. The comments associated with the promulgation of the 1991 Regulation were clear that the phrase "reserved to the Commissioner," was merely an "editorial change" to the prior Regulation that stated opinions on disability from treating physicians were not binding, but still needed to be weighed appropriately in light of all of the medical findings of record and appropriately developed if they were inconclusive. Despite this, the Administration has adopted a position that the phrase "reserved to the Commissioner" means that opinions from treating physicians that a claimant "cannot work" or describing the claimant as "disabled" can be rejected on the basis of the words chosen by the medical source rather than on the evidentiary support.

This interpretation has, until recently, been furthered by unanimous opinions from the Circuit Courts of Appeals. Nothing in the Regulation or Social Security Act allows the Administration to abdicate its duty of appropriately weighing medical opinions even if the physician gives his opinion in the form of stating his patient is "disabled" or "unable to work." In other words, the Commissioner and ALJs implementing the Administration's law cannot discount medical opinions simply because they address a claimant's level of functioning. The Commissioner cannot sit alone at this table because she is not a medical expert capable of determining how a claimant's impairments limit work-related physical and mental functioning.

In fact, according to the Commissioner's own Regulation, "medical opinions" are entitled to significant weight. 20 C.F.R. § 404.1527(c)(2). Medical opinions "reflect judgments about the nature and severity of [a claimant's] impairment(s), including [a claimant's] symptoms, diagnosis and prognosis, what [a claimant] can still do despite impairment(s), and [a claimant's] physical or mental restrictions." 20 C.F.R. § 404.1527(a)(2). 20 C.F.R. §404.1527(d) specifies that the Commissioner will, "use medical sources, including your treating source, to provide evidence, including opinion, on the nature and severity of your impairment(s)." The Regulation provide a detailed method for how the Administration is to weigh medical source opinions based upon the evidentiary support provided by the treating physician and treatment relationship between the claimant and the medical source, as well as the medical source's specialty. 20 C.F.R. § 404.1527(c)(2)-(6). There is no magic language that allows the Commissioner to cast aside a medical opinion on disability without discussing the evidentiary support provided for that opinion or contrary opinions, if any. A more appropriate approach, consistent with the plain meaning of the Regulation, is that taken by the earlier decisions from the Circuit Courts recently revived under the holdings of the Seventh and Tenth Circuits. Under this approach, opinions that a claimant is "disabled" or "unable to work" may be rejected if not supported by the medical evidence or contradicted by other, better supported medical evidence. However, an opinion on disability may never be rejected simply because of the semantics used by the treating source. The opinions from acceptable medical sources must be invited to sit at the table when the Commissioner makes a determination on disability.

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PROGRAM continued from page 7

4. **Life expectancy for each spouse.** Any calculation of cumulative benefits must take into account each spouse's anticipated life expectancy. A benefit maximization program should permit the user to enter whatever life expectancy the user wishes to assign to each spouse.

5. **Rate of COLA increase.** Social Security benefits are subject to annual increases based on the rise of the consumer price index. A better program will permit the user to enter whatever long-range Cost-of-Living Adjustment (COLA) the user expects to be most likely. However, software programs tend to confine choices to increments of a tenth of a percent, a quarter of a percent or one-half of a percent. Programs that allow for greater refinement of the increment allow for greater flexibility.

6. **Rate of increase in national average wages.** The parameters used in the statutory benefit calculation formulas change from year to year due to increases in national average wages. (See www.ssa.gov/oact/COLA/Benefits.html and www.ssa.gov/oact/COLA/awifactors.html). When projecting what a future benefit might be for a given earnings record, Social Security actuaries use complex algorithms to project rates of increase in national average wages in order to know what parameters to use in a projected benefit formula for any given year in the future. A better benefit maximization program will allow the user to input whatever rate of increase is anticipated.

7. **Discount rate/real rate of return.** The more sophisticated software programs are able to determine the "present value" of future benefit payments. This helps to provide a more accurate comparison of the cumulative benefits expected from different claiming strategies. So, what is the present value of a future benefit payment? One way to determine its value is to apply to the benefit an expected rate of return for an investment of similar quality, such as a treasury inflation protected security, or "TIPS." For example, the yield of a 20-year TIPS on July 2, 2015, was 0.80%. So an advisor might wish to enter a real rate of return equivalent to 0.80% in order to determine the present value of anticipated benefits. As with the COLAs, a better software program will allow for entry of whatever rate of return is desired, although the ones that do account for the TIPS rate, tend to allow entry of a proposed rate in quarter percent or tenth of a percent increments.

8. **Alternate scenarios.** A program should allow for comparison of multiple claiming scenarios against the optimal scenario.

9. **Children's benefits.** In cases where there are minor children or individuals age 18 or older for whom disability prior to age 22 is established (*i.e.*, disabled adult children), the maximization program should be able to account for benefits that might be paid, including not only the children's benefits, but unreduced spousal benefits for a spouse under age 62, as well as mother's and father's benefits, which are payable to a widow(er) under full retirement age. In such cases, where more than two benefits may be paid to the same family, the family maximum rules may also be implicated. I am aware of only one product currently on the market that takes into account the benefits that may be awarded when minor children or adult disabled children are present: Maximize My Social Security (www.maximizemysocialsecurity.com/). Another product, Social Security Analyzer (www.ssanalyzer.com/site/pricing.php), will take into account benefits for minor children, but not for disabled adult children.

10. **RIB-LIM.** The Retirement Insurance Benefit Limitation (RIB-LIM) provision limits the reduction applied to a widow(er)'s benefit when the deceased wage earner was entitled to reduced retirement or disability benefits on account of retirement prior to full retirement age. (POMS RS §00615.320) This provision limits a reduction to no more than 17.5 percent of the deceased spouse's PIA on account of that spouse's early claiming. If a benefit maximization program fails to take this into account, it may determine that a widow(er)'s benefit is smaller than it would be under this provision.

11. **Prior or current receipt of disability benefits.** When a worker becomes eligible for disability benefits, the period of disability is referred to as a "disability freeze" (POMS §DI 25501.240). Because a beneficiary has little or no earnings during this period, these years are not included when computing benefit amounts for retirement benefits. I am not aware of any benefit maximization program that takes this into account. Additionally, if a beneficiary receives a disability benefit in the month prior to the month in which full retirement age is attained, the automatic conversion of the disability benefit to a retirement benefit at full retirement age prevents the beneficiary from effectively exercising a strategy in which the disabled worker would claim a spousal benefit. I am aware of only one program that currently takes into account this and other special rules relating to the current receipt of disability benefits, and that is Maximize My Social Security.

12. **Windexing.** No, this is not about using window cleaner on a benefit. Windexing (widow or widower's indexing) is an alternate method for calculating a widow or widower's benefit when a worker dies prior to age 62. Ordinarily, a widow or widower's benefit is derived from the worker's PIA in the year of his or her death. However, under "wind-

exing," the benefit may also derive from the PIA based on the earlier of the year in which the widow(er) reaches age 60 or the year the deceased would have attained age 62. (POMS §00615.301 and 00615.302) Not all benefit maximization programs take this into account.

A truly comprehensive benefit maximization program would include all of these elements, as well as an analysis of the tax impact of different strategies since, even at the highest income levels, only 85% of benefits received are subject to federal income tax. However, after looking at a number of benefit maximization programs on the market, I have yet to find a program that includes all of these elements. So, the challenge is to find a program that includes at least most of them.

At each of my talks at legal conferences on maximizing Social Security retirement benefits I post within my Power Point presentation a list of benefit maximization calculators that are available on the Internet. Every single one of them has deficiencies, including the two that I use. I looked at all of them and spoke with those who either created them or are the technical resource person behind the product. In one or two cases, my calls were never returned and what I know about the product is limited by what I could find online. There is at least one tool that I know exists, one that is distributed by Blackrock, that I have not been able to get ahold of. There are likely others, as well.

Two programs of choice

The two programs that I use have a learning curve and have their deficiencies as well. However, I use them because I believe they have fewer deficiencies than other products on the market, and, I use them in conjunction with an intake process during which I look for all the situations that I know the programs are not able to handle. If I encounter such a situation, I adjust for it.

As for the two programs that I use, they are Social Security Timing (www.socialsecuritytiming.com), and Maximize My Social Security (www.maximizemysocialsecurity.com). I chose these programs because the people behind them appeared to me to be the most knowledgeable in terms of their understanding of the Social Security retirement program, and took the time to carefully study and read through the POMS sections governing retirement benefits.

Social Security Timing

Social Security Timing is the software I demonstrated at the NAELA Summit in Newport Beach this past January. Subscriptions are offered at $49/month or $500/year. The provider also offers a 10-day free trial. It was developed by a financial planner, Joe Elsasser, who took the time to study most of the relevant portions of the POMS, particularly the RS and GN sections. When I quizzed him, early on, about various elements of the retirement program, he knew the correct answers. I like this software because it provides a month-by-month cash flow that displays for each month, the date, beneficiary age, applicable PIA, and benefit amounts that are individually payable to each spouse. It also shows, when applicable, the WEP PIA for each month. Because it shows the applicable PIA and does this for every month, it is easy for me to confirm that the program's result is correct. That's a major concern that I have for any program. With Social Security Timing, nothing is hidden. The monthly cash flow enables an advisor to easily determine if the program is starting a benefit correctly, and stopping a benefit correctly. I am also able to easily determine whether the program properly accounts for delayed retirement credits, early claiming, excess earnings, etc.

Social Security Timing also allows for entry of a client's annual earnings, rather than a PIA from the earnings statement (although you could enter a PIA, instead, if you so choose). In so doing, it is easy to add anticipated future earnings for as many years as you want. The program also allows an advisor to enter whatever long-range COLA the advisor wishes to use for anticipated COLAs as well as the real rate of return. The COLA that I enter is taken from the Annual Report of the Board of Trustees of the Old-Age, Survivors and Disability Trust Funds of the Social Security Administration ("OASDI Trust Funds Report"), Table V.C.1. The program also easily handles situations in which one or both spouses receive a pension or expects to receive a pension based on non-covered earnings (*i.e.*, earnings for which tax under FICA or SECA was NOT paid).

Social Security Timing does have some deficiencies. It does not calculate child's benefits. This is its biggest deficit, but it is not an issue in the vast majority of cases. It also does not test for all 4,560 benefit-claiming combinations from age 62 to age 70. Rather, it only looks at birth-month combinations. This could be an issue under certain fact patterns. (*E.g.* client is under full retirement age and works until a certain point that is not a birth month. The software will recommend a claim for the birth month prior to work cessation, but benefits will not be paid due to the earnings test, and the benefit will be reduced upon work cessation for an amount that is greater than what the reduction would have been had the claim been submitted for the month following work cessation). It also does not count quarters of coverage and thus, if a client has less than 40 quarters of coverage, it won't know that the individual lacks a sufficient number of credits to be insured under the Act and is therefore ineligible for a retirement benefit on his or her account. It also does not cut off earnings that are higher than the amount of benefits subject to tax under FICA or SECA. For prior years this is not a problem, because the annual earnings amount stated on any benefit statement from the Social Security Administration will not be greater than the amount subject to tax under FICA or SECA. However, for future earnings, one must be careful to not enter an amount that is higher than the projected threshold of earnings subject to tax for any given year. Table V.C.1 in the OASDI Trust Funds Report

has estimates for these future thresholds.

The program assumes wage growth is the same as the inflation rate. It isn't. The long-term inflation rate, as projected by Social Security actuaries, is currently 2.70%. These actuaries also expect wage growth to be between 3.83% and 3.92%. However, by using only the projected COLA, which is smaller, the result is really a more conservative estimate of benefit growth, which means that the software understates, rather than overstates, the amount a client gains by exercising a maximization strategy. (The Quicken program that I mentioned earlier estimated gains in excess of $300,000 with the hypothetical case that was demonstrated in the referenced article. I believe that overstates by at least $75,000, if not more, the maximum lifetime gains a couple can expect from a maximization program, even for workers at the highest ends of the economic scale).

Maximize My Social Security

The other program that I use is "Maximize My Social Security." There is no free trial with this software, but a money back guarantee is offered on the $200 annual subscription. This program was developed by Prof. Larry Kotlikoff, an economics professor at Boston University. He is known for PBS specials on this topic and writes extensively on the subject. Unlike Social Security Timing, his software DOES handle children's benefits and current receipt of disability benefits. That is its primary advantage. However, it does not produce monthly cash flows and that is a major drawback. The program does allow for entry of anticipated COLAs as well as the real rate of return, AND it also allows for entry of the anticipated growth in national average wages. The program's design also makes it easier to save multiple profiles for the same client without re-entry of all the earnings data. Still, the lack of a monthly cash flow is the primary reason I do not use the program for every client. Instead, I use it as a cross check for results and use it as well when children's benefits are implicated.

Another major deficiency of the program is that it assumes death (when considering life expectancies) always occurs in December of the year in which death is assumed. This skews the results in terms of higher cumulative benefits, and may change by a few months the recommended strategy, if it changes the strategy at all. Another deficiency is that cash flows reflect benefit amounts as of the month payment is received, rather than as of the month of accrual. Prof. Kotlikoff, however, believes that a receipt-based program facilitates cash-based retirement planning.

There are some other quirks. Social Security Timing does not account for "windexing," but Maximize My Social Security does. Although the latter program handles children's benefits, it does not take into account the combined family maximum where a child is entitled on the accounts of both parents. Neither program handles situations in which one or both spouses *previously* received disability benefits.

Both programs produce canned reports that may be given to a client. However, these reports often need modification in order to speak directly to issues of concern to the client. I always add a summary to the front of the report that more directly addresses a client's situation. I also tweak the canned text and correct errors (such as where a report processes a current COLA that I enter into the program but then, in error, refers to an anticipated COLA that is as mentioned in the previous year's Trustees' report).

If you decide to use either program, don't think you can just plug in the numbers and have it spit out a meaningful result if your client falls into one of these unusual cases:

1. Spouse dies prior to age 62
2. More than one prior spouse
3. Prior receipt of Social Security disability benefits
4. Receipt of public pension and between 20 and 30 years of "substantial earnings" covered under Social Security (as defined under the Social Security Act)

There may be other issues as well that I have yet to uncover. When these circumstances present, it will be necessary to perform some calculations by hand.

Social Security Analyzer

I recently became aware of another program that accounts for children's benefits, Social Security Analyzer, a product of Social Security Solutions. It comes in three versions, but the only potentially viable version is the most expensive version, the one with all the bells and whistles, with a $1,200/year licensing fee. Although this program held a lot of promise, for reasons explained below, one should avoid this program. This program attracted me for several reasons: it claims to analyze all 4,560 claiming combinations from age 62 to age 70; it has a nicely laid out monthly cash flow chart, and, it compares, on one page, side by side, the cumulative benefit for all claiming scenarios tested, including the cumulative benefit for short, average and long life expectancies for each tested scenario.

Although Maximize My Social Security is capable of handling situations involving disabled adult children, as well as minor children, Social Security Analyzer's handling of children's benefits is confined to situations involving minor children. A colored grid clearly shows the optimal strategy for any given life expectancy. Social Security Timing also does this, but the Social Security Analyzer grid is larger and more clearly marked. A 10-day free trial is offered for a lower level version of the software, but that version does not allow for comparison against user-defined scenarios, a major deficiency. My review of the Analyzer software is confined to the $1,200 version.

Comparing results from all three software programs for several different clients, it appears to me that Social Security Analyzer's cumulative benefit forecast is significantly higher than the results produced by the other two software programs. I suspect this has to do with different algorithms used to determine the present value of future benefits, but have not yet been able to verify this. All three programs calculated

identical PIA values for both and provided identical recommended strategies for the cases I tested (except where Social Security Timing failed to recommend, in the case mentioned above, that a worker with a shorter life expectancy should begin benefits upon cessation from work, rather than in the birth month preceding work cessation).

So, why is Social Security Analyzer a program to be avoided? While testing this program I discovered errors in one of the tables provided in the printed report. My initial query to the help desk about the errors went unanswered and a second letter to the help desk generated a short response from the Chief Operating Officer that she was refunding to me the full purchase price of the software because "Our software does not meet your needs and is not a fit for your practice." Of course, I had never requested a refund and had never suggested (at least, not at that point) that the software was not a fit for my practice. I then discovered that I was locked out of the two client accounts that I had created. Several attempts to reach out to both the COO and the CEO went unanswered.

Whether the errors that I found were a fluke, or a symptom of a deeper problem, we will never know, but the software provider's willingness to shut an advisor out of his client accounts in response to a question about accuracy suggests that the program is unreliable, if for no other reason than the unpredictable response of the company to legitimate questions.

In contrast to this response, the principals behind Social Security Timing and Maximize My Social Security have always responded when I questioned results provided by their programs. These questions have enabled me to uncover some of the program quirks that I mentioned above.

Conclusion

While determining the best Social Security benefit claiming strategy for a client is more than determining what strategy will maximize benefits over the anticipated lifetimes of a client and his or her spouse, knowing what strategy will maximize benefits provides an essential piece of information that is required to make an informed decision. Unfortunately, benefit maximization software has not yet reached a level of sophistication that will permit an advisor to enter earnings data and a few economic parameters, and then comfortably sit back and rely on the results without knowing what factors may serve to increase or reduce a client's benefits and the extent to which the software program being used for the analysis addresses those factors.

Among the nearly dozen programs that I have looked at, Social Security Timing and Maximize My Social Security take into account more factors that can increase and reduce benefits than most other programs, and have demonstrated a greater degree of reliability. Either of these programs can be a useful tool, but, proper use of the program requires much more than filling in some numbers and pressing a button to generate a report. An advisor needs to understand the theory behind any recommendation and must be prepared to question any anomalous result. The truly cautious advisor may want to consider acquisition of more than one program in order to ensure that any advice tendered reflects relatively consistent results across software platforms.

Finally, an advisor should also be prepared to spend a little bit of time learning how to use the program and what benefit rules (there are thousands of them!) the program fails to consider, particularly with respect to the rules to which I have referred in this article.

Endnotes

[1]It should be noted that I do not have a business relationship with any company that provides benefit maximization software. I do talk from time to time with the principals of both products that I use, usually to notify them of "quirks" that I have found. On occasion, I have been asked to help answer a question in an unusual case, which I do as a courtesy, without compensation. However, I fully pay for all software like everyone else.

[2]Under the new legislation, a restricted application for spousal benefits may only be filed by individuals who attain age 62 in 2015, *i.e.*, individuals born on or before January 1, 1954. Applications for a spousal benefit filed by individuals born on or after January 2, 1954, will now be deemed to also be an application for old-age benefits on one's own account, and vice versa. Previously, this deeming provision applied only to applications submitted prior to full retirement age. [PubL 114-74, §831(a), amending Soc. Sec. Act §202(r).] As before, the extension of the deeming provision does not apply to spouses with a "child-in-care," i.e., a minor child under age 16 or a disabled adult child. "File and Suspend," allowed a worker to claim a benefit and immediately suspend payment of the benefit so as to allow a spouse to claim a spousal benefit on the primary worker's account while, at the same time, the primary worker's benefit would accrue delayed retirement credits at the rate of a percent per month (8%/year) while the payment of the benefit was in suspense. The new legislation effectively banned this technique by prohibiting the payment of any benefit on the primary worker's account while payment of the primary worker's benefit is in suspense. This provision becomes effective on April 30, 2016. This technique could be employed only at or after full retirement age, currently, age 66. Thus, anyone who reaches age 66 no later than April 2016, i.e., anyone born May 1, 1950, or earlier, will be able to employ this technique so long as the request is submitted prior to April 30, 2016. The new law also prohibits the payment of retroactive benefits to anyone who has suspended benefits. Previously, one could claim a benefit at full retirement age, immediately suspend the benefit, and then, at a later date, if circumstances changed, such as receiving a diagnosis of a terminal illness, the worker could reinstate payment of the claim and receive a lump sum payment for the benefits that would have been paid up to that point had benefits not been suspended. [PubL 114-74, §831(b), adding new subsection (z) to Soc. Sec. Act §202.]

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Court in *Price v. Colvin,* 794 F.3d 836 (7th Cir. 2015) found it problematic that the ALJ equated the claimant's ability to perform some activities of daily living (ADLs) with the ability to engage in gainful employment. The Court found this particularly troubling due to the nature of the claimant's impairments, namely antisocial personality disorder and major depressive disorder. The Court also took issue with the ALJ's handling of the treating psychiatrist's opinion evidence. The Court was also bothered by the ALJ's failure to accurately assess evidence regarding the claimant's Global Assessment of Functioning scores in the context of his impairments and criminal background.

Equating ADLs with Ability to Work

The Court once again found it problematic that the ALJ inferred from the claimant's ability to perform some simple household chores that he could be gainfully employed. *Id.* at 840; see also *Hughes v. Astrue*, 705 F.3d 276, 278-79 (7th Cir. 2013). The Court criticized the inference here noting "it's easier—especially for someone with an antisocial psychiatric disorder—to work in one's own home, at one's own pace, at one's own choice of tasks, than to work by the clock under supervision in a place of business." *Id.* at 840.

Treating Physician Opinion Evidence

The Seventh Circuit noted that the ALJ discredited the claimant's treating psychiatrist's testimony "on the ground that it was based on what Price had told him." *Id.* at 839. However, the Court noted that allowing this type of justification to discredit a treating psychiatrist's opinion would be problematic because "psychiatric assessments normally are based primarily on what the patient tells the psychiatrist, so that if the judge were correct, most psychiatric evidence would be totally excluded from social security disability proceedings…" *Id.* at 840.

"Cherry picking" Evidence

Although the evidence of record demonstrated that the claimant had been given a range of Global Assessment of Functioning (GAF) scores, the ALJ "zeroed in on his scores between 50 and 68" to conclude that the claimant was recovering from his "various mental ailments" including antisocial personality disorder. *Id.* at 838. The Court found that the ALJ "cherry picked" the claimant's GAF scores and "overlooked the fact that the high scores, because attributable to [the claimant]'s being in jail, reinforced rather than undermined the diagnoses of antisocial personality disorder and paranoia. The judge ignored the plunge in [the claimant]'s GAF score to 33 after Price was released from jail, where he had felt safe (a symptom of his antisocial personality disorder)." *Id.* at 839.

SUICIDE continued from page 11

i.e. how much the Social Security denial and delay contributed to the suicide. Every situation is different, and in my client's case I simply do not have a definitive answer. In my conversations with my client's partner, the partner indicated my client was deeply troubled that his claim was denied as it called into question the real pain and suffering he was experiencing. It is the partner's belief that this Administration's invalidation did play a role with respect to my client's death.

Whether or not research ultimately establishes whether there is an increased rate amongst Social Security applicants and recipients, exploring ways to reduce the number of suicides and suicide attempts is imperative. That is where dialogue and compassion must take center stage.

To their credit, Social Security has actually recognized the problem of suicide in Social Security claimants and has taken steps that can, on the surface, be viewed as responsible and accountable. The HALLEX is a Social Security program manual guiding hearing office personnel with The Office of Disability Adjudication and Review (ODAR); a provision in the HALLEX affords "critical case" designation leading to "special processing" in cases where there is an indication that a claimant is suicidal. See HALLEX I-2-1-40. Presumably these cases should get expedited. Another manual called the POMS (Program Operations Manual System) instructs field office personnel to be "constantly alert" about suicidal claimants and to show the "utmost patience, sensitivity, and consideration in dealing with the potentially suicidal individual." See POMS DI 13005.070. Interestingly, this particular POMS states that "(t)o avert tragedies, field offices must take special care to assure that payments are not suspended improperly." This POMS provision further states that "psychiatrists tell us" that "it is extremely difficult to predict" suicides, which in turn makes it difficult to write specific guidelines. Nevertheless, the provision indicates that all personnel are to be "alert to the potential" and must "deal with it in a responsible manner" which can include "consideration of referral of such individuals to community agencies which may be available to assist in such situations." So to a certain extent the Administration, on paper, views itself as accountable and holds itself out as being responsible. Oftentimes suicides however are not broadcast ahead of time and simply come quietly with no advance warning. The warning signs of suicide risk are often ignored or missed. Dr. Quinnett pointed out to me that, "[w]e all know that suicide is poorly understood among healthcare providers, inclusive of every profession but psychiatry, so we know that suicide risk assessment, detailed histories of prior attempts and serious ideation, compli-

ance with treatment regimens for suicidality, etc., are under reported in most clinical documentation systems. They are also likely underreported in disability examinations…"

While I continue to advocate for research and for expediting the extraordinarily long wait-times currently plaguing disability applicants, at the very least I believe the Social Security Administration should be engaging in the simplest of suicide prevention and awareness efforts. One way to do this is to reach out to those at risk of attempting suicide and providing them with opportunities for help. In every Social Security award letter, determination, decision, and notice the Administration provides the 800 number for the Inspector General's Fraud Hotline. Fraud prevention is an important issue of course - but why not also provide toll-free numbers for suicide prevention. There are many suicide hotlines or online communities that provide immediate prevention aid by trained professionals including the National Suicide Prevention Lifeline (1-800-273-8255, also available in Spanish 1-800-784-2432). There are also state and local-level agencies/hotlines available for those contemplating suicide. I continue to believe that in our work with vulnerable individuals we can and should do our part in helping to diminish the problem through encouraging research and action, and therefore I urge the Administration to consider this simple step and to urge the Administration to focus their efforts on expediting the processing of claims at all administrative levels.

PLAY CONTINUED FROM PAGE 13

of an impairment, or lack of claimant credibility, and more about the state of health policy in the United States in the twenty-first century.

Lack of medical evidence should be *expected* when lack of access to health care is one of the most pressing concerns in public health. To conclude the impairment doesn't exist, and the claimant is lying to say that it does, is akin to Holmes concluding that because the dog did not bark, the dog stole the horse.

Social Security has considered the evidentiary implications of a lack of access to health care and counseled, in SSR 96-7p:

> … an individual's statements may be less credible if the level or frequency of treatment is inconsistent with the level of complaints …. However, the adjudicator must not draw inferences about an individual's symptoms and their functional effects from a failure to seek or pursue regular medical treatment without first considering other explanations that the individual may provide, or other information in the case record, that may explain infrequent or irregular medical visits or failure to seek medical treatment.

"Other explanations" includes the context and reality as it is in time, place, and circumstance. When these *other explanations* are not considered, decision-making is weakened considerably.

Consider *Hughes v. Astrue*, 705 F.3d 276 (7th Cir. 2013), in which the court criticized the ALJ's thought that "the applicant's failure to have sought medical treatment between 2003 and 2007 [is] inconsistent with her having a disabling medical condition. [The ALJ] noted [the claimant's] explanation that she hadn't had medical insurance or an income large enough to pay for medical treatment out of pocket, but [the ALJ] said she could have sought treatment in a hospital emergency room." The court expressed shock at the ALJ's dismissive "let them eat cake" attitude by saying, "[r]emarkably, [the ALJ] seemed unaware that emergency rooms *charge* for their services and are required to treat an indigent [person] only if the indigent is experiencing a medical emergency."

Such harsh criticism brings to mind David Sedaris' review of a Christmas play at Sacred Heart Elementary:

> Although the program listed no director, the apathetic staging suggested the limp, partially-paralyzed hand of Sister Mary Elizabeth Bronson, who should've been excommunicated after last season's disastrous Thanksgiving program. Here, again, the first through third-grade actors graced the stage with an enthusiasm most children reserve for a smallpox vaccination. One could hardly blame them for their lack of vitality, as the stingy, uninspired script consists not of springy dialogue but rather a deadening series of pronouncements.[5]

Had ALJ-ing been just the lesser day job of an aspiring theatre director, practiced in reading critically, practiced in considering how meaning is situated in a historical context, how reality figures in, maybe the ALJ would not have rendered such an uninspired puff of bunkum.

The Affordable Care Act and access to health care

Among other things, the Affordable Care Act (ACA)[6] aspired to addressing the problem of lack of access to health care. Indeed, health insurance reform enacted in Massachusetts, on which the ACA was partly modeled, has reduced the commonwealth's uninsured rate to just 5% of the population.

It is important to look closely at the reality of whether the ACA has actually improved access to care, and if so, *where* has it done so, and what is the quality of the care, or for our purposes, the quality of the medical records, to which poor and disabled people in the United States in the twenty-first century now have access.

Post ACA, access to health care is uneven throughout the United States. Access to health care varies from state to state, city to city, and varies again between urban and rural areas.

Even in the context of a single location, access to care can vary from the beginning of a fiscal year to the end of it.

Thirty-one state legislatures opted in to Medicaid Expansion under the ACA. Medicaid Expansion has increased the numbers of people who have basic Medicaid health insurance coverage in those states, however, for some the access to health care issue remains.

Health and Human Services' OIG inquired into variations from state to state and found wide variation among the states with respect to the requirements of physician availability in the program. OIG found that states range from requiring 1 primary care health provider for every 100 enrollees in Medicaid to requiring 1 primary care health provider for every *2,500* Medicaid enrollees. (*See, State Standards for Access to Care in Medicaid Managed Care*, September 2014.) Although it is useful to know whether a claimant is in a state that has opted in to the ACA's Medicaid Expansion program, the inquiry does not end there. It is important to know whether holding a Medicaid card in that claimant's circumstances *actually* provides access to health care.

Nineteen states did not opt in. Therefore lawyers and judges should be aware that if they are assessing disability, and medical records or the lack of them, in Alabama, Florida, Georgia, Idaho, Kansas, Louisiana, Maine, Mississippi, Missouri, Nebraska, North Carolina, Oklahoma, South Carolina, South Dakota, Tennessee, Texas, Virginia, Wisconsin, or Wyoming, that the residents of those states have no increased access to health care post-ACA.

Health clinics established for the care of people who are uninsured or who have Medicaid increase access to health care. However, health clinics sometimes change the criteria of who they will accept as patients periodically, based on the vagaries of grants and funding. A clinic may take all-comers when funding is available, and then when funding is depleted, on a specific date, *even in the midst of a fiscal year*, change its acceptance criteria such that it suddenly excludes some of the same patients it would have accepted the day before.

Usually the change involves initially accepting people who have no insurance at all, but later accepting only those who have at least Medicaid. Or clinics may reduce the geographic area they serve. Or clinics may reduce service and institute wait-lists, which can quickly extend out for months and even years.

It is important to know whether the realities of access to health care are affecting a particular claimant's access *actually*.

The Authors of Medical Records

Unlike playwrights, health care providers write medical records for their purposes and theirs alone. The purpose of writing a play is so that it will be staged. It is intended as communication with directors, actors, set and costume designers, et cetera. Medical records are notes physicians keep entirely for their own personal use. They are not necessarily intended to communicate to anyone other than the doctor making and keeping the record. If it is communication with others, it's with other health care providers, and perhaps insurance companies to facilitate reimbursement for services.

Medical records are not written for lawyers and judges, and do not achieve our ends.

We cannot expect the information we seek—documentation of patients' functional capacity, clarity about onset dates of disability, et cetera—to be in *their* records. When the information we seek for our purposes is not there, we should not conclude that the absence of the information means that there is an absence of the fact.

Consider this story an ALJ told me about a visit with his doctor after the judge broke his leg: the doctor said, "I don't want you working full days for six weeks minimum, and I need you to lie down for a few hours during the work day to elevate your foot. You've got a couch in your office, right? I'm worried about that swelling. I don't want you walking around and bearing weight on it. Use those crutches." The doctor then quickly scribbled something in the medical record. The ALJ asked, "what did you write?" The doctor looked at the record and said, "*doing well on current medication.*"

Had the judge been a claimant, he would have soliloquized the tribunal with truth, but would have been discredited by the record—a record written to serve a purpose unrelated to the purpose of documenting the functional limitations of which the doctor spoke.

The fact that health care providers do not document functional deficits does not mean the deficits do not exist. It means the functional deficits are not relevant to the doctor writing the medical record. It means the functional deficit has little or no bearing on how the physician is to treat the patient, or what the physician needs to be reminded of in a follow-up visit, or it is not relevant to the purpose of the physician being paid by the insurance. These are the doctor's criteria for what he or she writes.

From the vantage point of an adjudicator seeking very specific, technical, and legally relevant information, medical records are mostly white space and drivel. Personally, I'm relieved when they at least establish a "medically determinable impairment." Beyond that, their value is limited.

Daniel Kurland, who wrote *I Know What It Says … What Does It Mean? Critical Reading Skills for Critical Reading* asserts that "[a]ll written texts have three authors…. the human being who wrote the text…. an imagined author to whom we attribute intent and purpose in our attempt to understand a text [and] finally, each and every reader is the author of his or her own understanding of any given text."

Mr. Kurland writes that "[w]hen readers have no personal knowledge of the actual person who wrote a text they tend to create an imagined 'author' as an aid in their interpretation of that text … [but in so doing] there are inherent dangers."

As critical readers it is worth considering what author of medical records we have imagined, because that fictional

author is likely shaping comprehension.

Do we imagine a scientist? Our own physician? Do we imagine 30 Rock's Dr. Spaceman, a man of questionable credentials, who makes air quotes when he refers to himself as "doctor?" Do we imagine an intellectual, deep thinking, man or woman of letters … one who would never *not* have documented an obvious fact relevant to us? Do we imagine a person writing to us about what we want to know? Do we imagine a busy person who has just minutes to spend with each patient, and who is jotting a note to herself for later use—a note she herself may not be able to read or understand at the follow-up appointment?

Relevant Ethical Dilemmas of the Authors of Medical Records

The Journal of General Internal Medicine (June, 2001) published an article explaining that physicians encountering an uninsured or underinsured patient who requires treatment that the patient cannot afford is placed in an ethical dilemma. Some of the common solutions to these dilemmas cause physicians to write information in their records that is either incomplete or untrue; the result is that lawyers and judges can be misled by the erroneous information.

In the circumstance where a patient requires uncovered and expensive treatment, physicians often simply withhold suggestion of the required treatment. Then, of course, they do not document that the treatment is required.

Another method for managing the dilemma is for the physician to provide the required treatment, but document performance of a covered or cheaper treatment. This practice is called undercoding. This alleviates the dilemma by providing proper care to a patient, while also disburdening the patient from the full cost; but it violates federal law.

Both methods result in medical records that under-report, or downplay the seriousness of impairments.

It is important to remember that claimants of disability benefits in the United States in the twenty-first century are unlikely to have health insurance, and if they do, they are likely to have Medicaid. Medicaid provides limited coverage. As such, our claimants are the people likely to present this ethical quandary to physicians.

This real-world situation could affect the medical documentation of some of the most seriously impaired claimants. It could be the most seriously ill people who have the greatest difficulty documenting their disability.

We have here the computer science and mathematics adage: garbage in, garbage out.

Mathematician, philosopher, inventor, mechanical engineer, Charles Babbage – credited with originating the idea of a programmable computer – wrote in his book, *Passages from the Life of a Philosopher,* of his shock at the following question:

> *'Pray, Mr. Babbage, if you put into the machine wrong figures, will the right answers come out?' …*
>
> *[Babbage said of the question] I am not able rightly to apprehend the kind of confusion of ideas that could provoke such a question.*[7]

Over-reliance in the evidentiary value of medical records leads to some *dramatically* bad decisions. Adjudicators must be wary of medical records so that they don't fall prey to the newer adage: garbage in, gospel out.

Understanding Through Analysis of Action

So, what is a poor judge to do? If medical documentation, if words, have such fatal flaws (theatrical pun intended), where does one look for more reliable information?

One looks to … action.

Lawyers and judges are not given to looking away from words that can be cited and referenced. Words are how lawyers tether themselves to statute and story, to precedent and truth. Many would argue words are the most reliable, most essential tool of the trade.

C'mon, we know that is not true. He said, "x." She said, "y." Words! The tools of dissemblers!

Truth is more reliably revealed in action. Actions betray truth no matter what is said.

"Actions speak louder than words, and are more to be regarded."[8]

Indeed.

Ahhh … "indeed." The definition of "indeed" is: in fact; in reality; in truth; truly. The word originated in the Middle Ages where it was two words, "in deed." In *deed* … in action.

Truth is reliably revealed in actions. Directors and adjudicators can find truth in analyzing action.

In *Backwards and Forwards,* David Ball suggests that to understand a play, analyze the action ... rather than merely look to the words. Analyze what happens that makes something happen, that makes something happen, that makes something happen … consider the connections between events that compel action. And, understand the *obstacles* that stand in the way of characters' motivated actions.

I am not advocating considering mere "sit and squirm" action. I am advocating assessing action and circumstance in claimant's lives as they spill out truths necessarily detached from guile.

I will use the simplest of examples: the act of not working; and especially not working when there is no other source of income. This is a profound, and interesting act. It is only step one of the five-step sequential analysis, so we tend to skip by it as though it has no meaning. But it does have meaning, and potentially a lot of it.

To look at the act of not working *alone*—and stopping there—is not useful. But to look at the act in relation to the *obstacle* to the act, and the act done in the face of the obstacle, is how to tease out its value as a source of truth.

Consider "dramatic conflict." Dramatic conflict involves the collision between a character's (or claimant's) wants and the obstacles hindering the character (or claimant) from ob-

taining what he or she wants. Mr. Ball writes, "obstacles are easily ignored, unfortunately. Actors remember motivations, but not obstacles. But motivation not set against the energizing resistance of an obstacle results in words delivered slackly, automatically, slickly."

Of course Ball is writing about the craft of acting, about bringing a compelling truth to the stage. This is a bit to the side of our purposes, but is useful in the way reverse engineering is useful. Ball is interested in the process of projecting believable, compelling truths onto a stage, while we are at gleaning truth from assessment of action done on the … 'all the world's a stage' stage.

There are many reasons *not* to work. That motivation is well known to all. We relish our weekends; look forward to vacations … some fantasize about retirement. Not working means sleeping in, using our time as we fancy, lounging by the pool reading Shakespeare. Many of us could blurt out five reasons not to work within 15 seconds.

But we do work.

We work in part because the consequences of not working are too harsh. This is the obstacle, the *easily ignored obstacle*.

We, like actors, focus on the act, but ignore the obstacle – and it serves us as poorly as it does them.

Think for a moment of the obstacle. Think of how you would manage without your paycheck. Think of the worries you would have. Would you lose your home? Imagine having no place to sleep. Would you have transportation? Would you have to borrow money from relatives? How would you get your needs met? Do you have dependents whose wellbeing you would compromise? In what ways would you be dependent on others that would make you beholden to them? Would you feel shame? What exactly is involved in applying for Food Stamps? Would you think yourself less than other people?

Heigh ho! Heigh ho! It's off to work we go![9]

We work despite the motivation not to work because the obstacles are incomprehensibly severe.

As lawyers and judges assessing disability we encounter people who aren't working so frequently that we become inured to it. It is just the water we swim in, so we stop seeing it.

We see the act, but fail to consider it in the context of the *obstacle*. We fail to see that not working (act) despite the dire consequences of not working (obstacle), reveals important evidence of a truth of an inability to work. It indicates a medically determinable impairment so severe it prevents one from working … even if medical records inadequately document the fact.

We could run through examples of other acts to assess their evidentiary value as the acts are done despite obstacles. An interesting one would be going to a doctor at all when you have neither health insurance nor money to pay for it. Going to a doctor (act) when you can't afford to (obstacle) reveals truth—even if the resulting record isn't a fat novel with an omniscient narrator who tells us what it means.

ALJs analyze the act of not obtaining health care—isolated from the obstacles to obtaining health care—and read it to mean the claimant is unimpaired and lying. But it doesn't work the other way. Not obtaining it has meaning, but obtaining it doesn't; obtaining health care, despite the obstacles, is not afforded value as evidence. Once there is health care, we become like Mikhail Baryshnikovs leaping over the fact to get at those words … to the record that is, of course, inconclusive.

In the context of determining onset dates of disability, SSR 83-20 addresses situations when adjudicators must make inferences because "precise evidence is not available" and counsels that when precise medical evidence is not available—as it so often isn't—it is proper to look to other evidence, and to use other skills of discernment.

Other skills of discernment … indeed!

SSR 83-20 is a bit of *Backwards and Forwards*: *A Technical Manual for Adjudicating Disability*.

It recognizes that medical records are often absent or imprecise and gives judges a way to wriggle free of them. It is a grant of authority to make more thoughtful decisions. A grant that allows judges to consider history, to weigh facts as they exist in the real world of time and place, and to think how lack of access to health care has evidentiary implications.

Importantly, it allows judges to appreciate the human drama as it plays out realistically in the world, in the courtroom, and in the record … to look to action under the crush of obstacle and how it reveals truth.

"What does that even mean … *dramatic literature*?"
"I've read a lot of Shakespeare."

It's a relief finally to have been able to say a little more.

Endnotes

[1]David Ball, *Backwards and Forwards: A Technical Manual for Reading Plays* (Southern Illinois University Press, 1983).

[2]John E. Murray, *Origins of American Health Insurance: A History of Industrial Sickness Funds* (Yale Press, 2007).

[3]Joseph Heller, *Catch-22* (Simon & Schuster, 1961).

[4]Arthur Conan Doyle, *Silver Blaze,* in *The Memoirs of Sherlock Holmes* (Public Domain, 1894).

[5]David Sedaris, *Front Row Center with Thaddeus Bristol,* in *Christmas on Ice* (Little, Brown & Co., 1997).

[6]Patient Protection and Affordable Care Act, 42 U.S.C. § 18001 et seq. (2010).

[7]Charles Babbage, *Passages from the Life of a Philosopher* (Routledge, 1994).

[8]A.M.Davis, *Melancholy State of Province* in *Colonial Currency* Vol. III (Prince Society, 1911).

[9]Frank Churchill, Larry Morey, *Snow White and the Seven Dwarfs* (The Walt Disney, Co., 1937).

CHAIR CONTINUED FROM PAGE 1

moot with the early November federal budget deal, and is unlikely to be re-contested to at least 2017, if not 2022. Nonetheless, it may prove useful for our Board to have a position on this issue, so we may proceed to take a position very early for a change. A proposal by some in Congress is to merge the funds, ending the opportunity to use reallocation as a political football. As your Chairman, I will keep you updated with respect to this and other important issues and deal with them as they become relevant.

Also as part of my introductory statement I indicated:

> Our Webinar Committee is headed by Section Board member Jerrold A. Sulcove, a disability law attorney from the Pennsylvania area. We plan to produce a webinar on an emerging issue in Social Security disability law. If you have a suggestion for a topic, or would like to help with the webinar, please contact Jerry Sulcove. You do not have to be a Board member to be appointed to a committee! We will need the active participation of all members of the Section in this process. And we will also need more members. Please take a moment to identify a lawyer or ALJ whom you know who is not currently a member, and urge him or her to join the FBA and our Section today.

One final note of interest on possibly saving money for those with a daily Social Security practice! In the 42 states that charge for medical records, you may want to research the acronym HITECH which was passed by Congress in 2009, a change in HIPPA law. The Health Information Technology for Economic and Clinical Health Act ("HITECH Act") in part requires medical providers to send a disk of a patient's medical records (as opposed to paper copies) at significantly reduced costs. If the providers do not do so in a reasonable time, you can order and pay for them yourself, and seek the money back through a complaint. I plan to write an entire article on this issue in the future. In the meantime I hope this tip eventually saves you and your clients some money on medical records retrieval.

A Happy New Year to you all.

Sincerely yours,
L. David Ferrari, Attorney and Counselor at Law
Chairman, FBA Social Security Law Section

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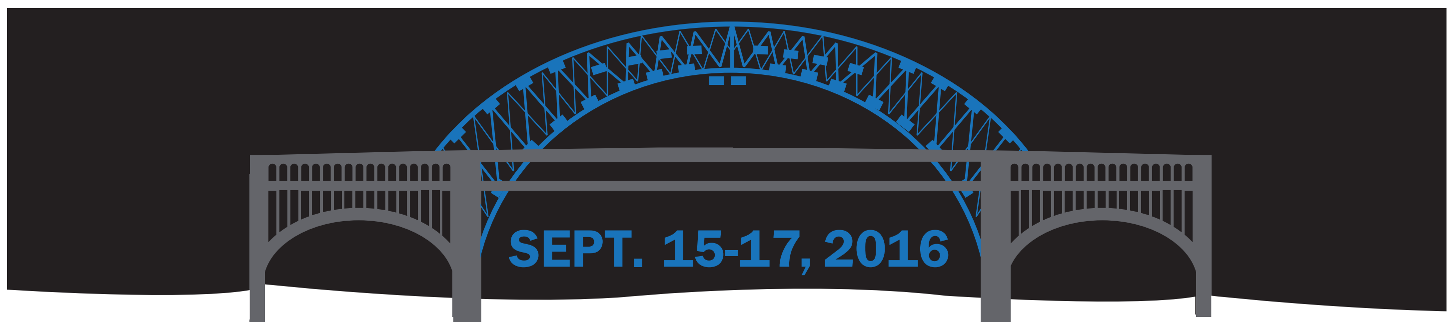

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