Presenting the Case for Limitations in Attention and Concentration at a Hearing: Direct and Cross Examination Strategies

Friday, September 16, 2016

Albany Marriott

CLE Course Materials and NotePad®

Complete course materials distributed in electronic format online in advance of the program.

Sponsored by the

New York State Bar Association and The Committee on Legal Aid

This program is offered for education purposes. The views and opinions of the faculty expressed during this program are those of the presenters and authors of the materials. Further, the statements made by the faculty during this program do not constitute legal advice.

Lawyer Assistance Program 800.255.0569

NYSBA

Q. What is LAP?

A. The Lawyer Assistance Program is a program of the New York State Bar Association established to help attorneys, judges, and law students in New York State (NYSBA members and non-members) who are affected by alcoholism, drug abuse, gambling, depression, other mental health issues, or debilitating stress.

Q. What services does LAP provide?

A. Services are **free** and include:

- Early identification of impairment
- Intervention and motivation to seek help
- Assessment, evaluation and development of an appropriate treatment plan
- Referral to community resources, self-help groups, inpatient treatment, outpatient counseling, and rehabilitation services
- Referral to a trained peer assistant – attorneys who have faced their own difficulties and volunteer to assist a struggling colleague by providing support, understanding, guidance, and good listening
- Information and consultation for those (family, firm, and judges) concerned about an attorney
- Training programs on recognizing, preventing, and dealing with addiction, stress, depression, and other mental health issues

Q. Are LAP services confidential?

A. Absolutely, this wouldn't work any other way. In fact your confidentiality is guaranteed and protected under Section 499 of the Judiciary Law. Confidentiality is the hallmark of the program and the reason it has remained viable for almost 20 years.

Judiciary Law Section 499 Lawyer Assistance Committees Chapter 327 of the Laws of 1993

Confidential information privileged. The confidential relations and communications between a member or authorized agent of a lawyer assistance committee sponsored by a state or local bar association and any person, firm or corporation communicating with such a committee, its members or authorized agents shall be deemed to be privileged on the same basis as those provided by law between attorney and client. Such privileges may be waived only by the person, firm or corporation who has furnished information to the committee.

Q. How do I access LAP services?

A. LAP services are accessed voluntarily by calling **800.255.0569** or connecting to our website **www.nysba.org/lap**

Q. What can I expect when I contact LAP?

A. You can expect to speak to a Lawyer Assistance professional who has extensive experience with the issues and with the lawyer population. You can expect the undivided attention you deserve to share what's on your mind and to explore options for addressing your concerns. You will receive referrals, suggestions, and support. The LAP professional will ask your permission to check in with you in the weeks following your initial call to the LAP office.

Q. Can I expect resolution of my problem?

A. The LAP instills hope through the peer assistant volunteers, many of whom have triumphed over their own significant personal problems. Also there is evidence that appropriate treatment and support is effective in most cases of mental health problems. For example, a combination of medication and therapy effectively treats depression in 85% of the cases.

Personal Inventory

Personal problems such as alcoholism, substance abuse, depression and stress affect one's ability to practice law. Take time to review the following questions and consider whether you or a colleague would benefit from the available Lawyer Assistance Program services. If you answer "yes" to any of these questions, you may need help.

1. **Are my associates, clients or family saying that my behavior has changed or that I don't seem myself?**
2. **Is it difficult for me to maintain a routine and stay on top of responsibilities?**
3. **Have I experienced memory problems or an inability to concentrate?**
4. **Am I having difficulty managing emotions such as anger and sadness?**
5. **Have I missed appointments or appearances or failed to return phone calls? Am I keeping up with correspondence?**
6. **Have my sleeping and eating habits changed?**
7. **Am I experiencing a pattern of relationship problems with significant people in my life (spouse/parent, children, partners/associates)?**
8. **Does my family have a history of alcoholism, substance abuse or depression?**
9. **Do I drink or take drugs to deal with my problems?**
10. **In the last few months, have I had more drinks or drugs than I intended, or felt that I should cut back or quit, but could not?**
11. **Is gambling making me careless of my financial responsibilities?**
12. **Do I feel so stressed, burned out and depressed that I have thoughts of suicide?**

There Is Hope

CONTACT LAP TODAY FOR FREE CONFIDENTIAL ASSISTANCE AND SUPPORT

The sooner the better!

Patricia Spataro, LAP Director

1.800.255.0569

New York State Bar Association

FORM FOR VERIFICATION OF PRESENCE AT THIS PROGRAM

Pursuant to the Rules pertaining to the Mandatory Continuing Legal Education Program for Attorneys in the State of New York, as an Accredited Provider of CLE programs, we are required to carefully monitor attendance at our programs to ensure that certificates of attendance are issued for the correct number of credit hours in relation to each attendee's actual presence during the program. Each person may only turn in his or her form-you may not turn in a form for someone else. Also, if you leave the program at some point prior to its conclusion, you should check out at the registration desk. Unless you do so, we may have to assume that you were absent for a longer period than you may have been, and you will not receive the proper number of credits.

Speakers, moderators, panelists and attendees are required to complete attendance verification forms in order to receive MCLE credit for programs. Faculty members and attendees: please complete, sign and return this form along with your evaluation, to the registration staff **before you leave** the program.

You MUST turn in this form at the end of the program for your MCLE credit.

Presenting the Case for Limitations in Attention and Concentration at a Hearing: Direct and Cross Examination Strategies
Friday, June 16, 2016 | New York State Bar Association's Committee on Legal Aid, Albany Marriott, Albany New York

Name:
(Please print)

I certify that I was present for the entire presentation of this program

Signature: Date:

Speaking Credit: In order to obtain MCLE credit for speaking at today's program, please complete and return this form to the registration staff before you leave. **Speakers** and **Panelists** receive three (3) MCLE credits for each 50 minutes of presenting or participating on a panel. **Moderators** earn one (1) MCLE credit for each 50 minutes moderating a panel segment. Faculty members receive regular MCLE credit for attending other portions of the program.

NEW YORK STATE BAR ASSOCIATION

Live Program Evaluation (Attending In Person)
Please complete the following program evaluation. We rely on your assessment to strengthen teaching methods and improve the programs we provide. The New York State Bar Association is committed to providing high quality continuing legal education courses and your feedback is important to us.

Program Name: Presenting The Case for Limitations in Attention and Concentration at a Hearing:

Program Code: FRIDAPC2

Program Location: Albany Marriott, Albany - New York

Program Date: September 16, 2016

1. What is your overall evaluation of this program? Please include any additional comments.
☐ Excellent ☐ Good ☐ Fair ☐ Poor

Additional Comments____

2. Please rate each Speaker's Presentation based on **CONTENT** and **ABILITY** and include any additional comments.

	CONTENT				ABILITY			
	Excellent	Good	Fair	Poor	Excellent	Good	Fair	Poor
Louis M. Tarantino	☐	☐	☐	☐	☐	☐	☐	☐
Emilia Sicilia	☐	☐	☐	☐	☐	☐	☐	☐
Michael Telfer	☐	☐	☐	☐	☐	☐	☐	☐
Jennifer Karr	☐	☐	☐	☐	☐	☐	☐	☐
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(please turn over)

Additional comments (CONTENT)

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Additional comments (ABILITY)

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_____

3. Please rate the program materials and include any additional comments.
☐ Excellent ☐ Good ☐ Fair ☐ Poor

Additional comments

_____

_____

4. Do you think any portions of the program should be **EXPANDED** or **SHORTENED**? Please include any additional comments.
☐ Yes – Expanded ☐ Yes – Shortened ☐ No – Fine as is

Additional comments

_____

_____

5. Please rate the following aspects of the program: **REGISTRATION**; **ORGANIZATION**; **ADMINISTRATION**; **MEETING SITE** (if applicable), and include any additional comments.

	Please rate the following:				
	Excellent	Good	Fair	Poor	N/A
Registration	☐	☐	☐	☐	☐
Organization	☐	☐	☐	☐	☐
Administration	☐	☐	☐	☐	☐
Meeting Site (if applicable)	☐	☐	☐	☐	☐

Additional comments

_____

_____

6. How did you learn about this program?
☐ Ad in legal publication ☐ NYSBA web site ☐ Brochure or Postcard
☐ Social Media (Facebook / Google) ☐ Email ☐ Word of mouth

7. Please give us your suggestions for new programs or topics you would like to see offered

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NEW YORK STATE BAR ASSOCIATION
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Presenting the Case for Limitations in Attention and Concentration at a Hearing: Direct and Cross Examination Strategies

PROGRAM DESCRIPTION:

This session will address how to conduct an effective hearing before an SSA Administrative Law Judge (ALJ), focusing on issues related to limitations in attention and concentration in a work setting. It will also introduce proactive strategies to deal with issues that may arise at this type of hearing. And it will cover ways in which advocates can better elicit helpful testimony on direct examination, and sharpen skills necessary for cross examining SSA's vocational expert. Sample – or "mock" – direct and cross examinations will be conducted.

NEW YORK STATE BAR ASSOCIATION
2016 PARTNERSHIP CONFERENCE

DAP Workshop #3

PRESENTING THE CASE FOR LIMITATIONS IN ATTENTION AND CONCENTRATION AT A HEARING: DIRECT AND CROSS EXAMINATION STRATEGIES

AGENDA

September 16, 2016
11:00 a.m. – 12:30 p.m.

1.0 Transitional CLE Credits in Skills, .5 Professional Practice
Under New York's MCLE rule, this program has been approved for all attorneys, including newly admitted.

Panelists:
Louise M. Tarantino, Esq., Senior Attorney, Empire Justice Center
Jenna Karr, Esq., Staff Attorney, Empire Justice Center
Michael Telfer, Esq., Staff Attorney, Legal Aid Society of Northeastern New York
Emilia Sicilia, Esq., Director of Disability Benefits Advocacy, Urban Justice Center

INTRODUCTION

This session will address how to conduct an effective hearing before an SSA Administrative Law Judge (ALJ), focusing on issues related to limitations in attention and concentration in a work setting. It will also introduce proactive strategies to deal with issues that may arise at this type of hearing. And it will cover ways in which advocates can better elicit helpful testimony on direct examination, and sharpen skills necessary for cross examining SSA's vocational expert. Sample – or "mock" – direct and cross examinations will be conducted.

Appendices: *Appendix 1- sample ALJ decision*
Appendix 2 – sample Appeals Council brief

I. THEORY OF THE CASE - PREPARING THE CASE

1. At each step of your preparation for representation in an SSI/ SSD case, you need to develop and refine your theory of the case. Know what you need to prove to obtain a fully favorable decision and how you will prove each point. Be prepared to prove each step of the Sequential Evaluation and any other points relevant to the claim (e.g., Date Last Insured).

2. PRE-HEARING:

A. Interview the client to get as much information about background and substance of claim as you can. Ascertain treating sources, etc.; collect any documents (procedural, medical, etc.) that the client possesses; have client sign releases and Appointment of Representative forms (SSA 1696, available at www.ssa.gov). Evaluate any unexpressed or unevaluated impairments or limitations (psychiatric, intellectual, etc.); develop as necessary, with claimant's permission

B. Advise client whether: a) you will represent, or b) you will investigate for possible representation; and, if the latter, c) when and how the decision whether to represent will be made.

C. Collect as much documentation as possible. Follow-up requests when necessary.

D. Submission of evidence to district office: evidence can be submitted electronically. Keep a legible copy of anything submitted in case the material is lost.

E. Submission to state agency: first, find out the name of the analyst; then submit the material directly to that person by certified mail [RRR].

F. Submit an appointment of representative form on claimant's behalf if you want to be informed of the decision.

G. See SSA's Statement of Best Practices: https://www.ssa.gov/appeals/best_practices.html#&a0=1

3. **ALJ Hearing:**

A. Appointed Representative Services

1. ARS is an application that allows appointed representatives to view electronic folder (eFolder) documents in real time, to download eFolder contents including multimedia files, and upload medical evidence and other documents directly into a claimant's eFolder. Representatives may also download status reports with key information regarding their pending and recently closed cases.

2. https://www.ssa.gov/ar/#&sb=1

B. Review the file. Identify important facts, their sources and gaps that need to be filled:

1) The kind of claim (SSI, SSD, or both)

2) The application history (date of application, any prior applications, reasons for earlier denials)

3) The impairments alleged (any relevant listings)

4) The date of onset alleged; consistency of date with a) evidence or b) a Title II claim.

5) Date last insured (Title II only)

6) Claimant's current age, age at alleged onset and age category (for the Grids)

7) Claimant's ability to communicate in English, his or her education and literacy, any vocational training and whether it was ever used in a job setting

8) Past relevant work, including demands of each job; responsibilities; promotions or demotions; problems on jobs; on or off the books work; identity of co-workers etc., who might provide evidence; reasons for leaving jobs; ultimate reason for quitting work.

9) Current RFC, source of this information, clarity, completeness and consistency of conclusions.

10) Activities of daily living with or without assistance. Nature and extent of assistance needed.

11) Frequency, nature, and sources of treatment (names, specialty and locations of doctors, clinic card numbers, etc.); names and dosages of medications prescribed, with any side effects; use of any assistive devices (crutches, cane, brace, home attendant, etc.)

C. **Seek additional evidence:** Especially if claim has been pending a long time and most recent evidence in the file has become "old."

1) Send for more and more recent medical information or ask client to take RFC forms to treating sources for completion.

2) Contact any relevant people to obtain lay evidence

3) When writing to a treating source for opinion information

a. Explain the purpose for which the information is required: **Remember doctors are asked to write letters to get people back to work as well as**

to get people off work;

b. Do NOT assume the doctor understands what “disability" means in the context of Social Security or SSI.

c. Offer to assist the physician in writing/typing a draft of the letter or report or affidavit for signature.

NOTE: If the physician is reluctant to provide the information you need to prove disability explain:

d. The disability standards. Explain the requirements and how you think your client meets them.

e. The concept of RFC. Explain to the physician that Social Security considers RFC assessments to be medical opinions. Ask the physician to discuss functional limitations with the patient and report results which make medical sense to the physician.

f. Explain how age and lack of education impact on a functional assessment of disability (i.e., a claimant who is able to do sedentary work might still be found disabled under the Grids depending on her age, education and past work).

g. Explain that Social Security only considers full time, competitive work in determining disability. Remind the physician that a claimant who is not disabled must be able to work eight hours a day, five days a week, on a regular and sustained basis.

h. Travel. Remind the physician that, in order to work, the claimant must be able to travel, via available transportation to and from work, twice a day, five days a week, (including rush hour), regardless of weather conditions.

i. Lying down or frequently changing position: Remind the physician that very few jobs permit a claimant to lie down if he/she feels ill or to move around at will.

j. Pain and other symptoms: Remind the physician that a claimant can be found disabled based on subjective symptoms, as long as these symptoms are attributable to a medically ascertainable physical or psychiatric impairment.

k. Alternative Medical or Psychiatric Explanation. Ask the physician if the claimant's belief that he/she is unable to work despite the physician's belief to the contrary might be due to medical and/or psychiatric conditions not considered by the physician.

l. Continuing Disability Review. If the physician is concerned that the claimant will be allowed to remain on disability benefits indefinitely, explain that a recipient's disabled status is reviewed periodically, and that if the claimant is found to be able to resume work, benefits will be discontinued.

m. Consider helping client find new treating source if current physician is not cooperative.

n. Note that not all reports need be submitted. See Representative's Standards of Conduct, attached

D. **Do necessary research on medical and vocational issues:**

1) Check out the client's past jobs in Dictionary of Occupational Titles. Verify the exertional level of each job as performed in the national economy. If the client did something other than the duties identified in the DOT, the DOT job title may not be what the claimant actually did.

2) Become familiar with your client's diagnosed impairments; read medical texts, study the medical records, use Web resources; look up medications; do whatever you need to understand the medical issues.

E. **Review the Law:** Once you have identified the relevant issues, you may want to review both the regulations and the case law on those issues (and in NYS with the Manual of Second Circuit Disability Decisions). Start your research with the regulations, especially the Listings. Remember regulations and rules (POMS, SSRs, ARs and HALLEX) are all available at www.socialsecurity.gov . See *infra.*

1. Copy any case law or other authority you may want the judge to consider.

2. If a claimant suffers from an unusual condition, for example, educating the ALJ by submitting an article from a learned treatise might be helpful.

F. **Re-Interview the client after reviewing the SSA record or before the hearing, or both!**

1. Update medical treatment, evaluations and/or testing including medications, side effects, symptoms and limitations. Has anything changed? Is the client working?!?

2. Ask the client whether there is anyone else who might be able to provide evidence (friend, relative, former employer or co-worker, home attendant, etc.). This is especially important if client's deficits impair coherent and informative testimony.

3. Clarify and check on facts such as age, education, past work (especially any

inconsistencies in the record). Review with client the Social Security forms in the record which he or she signed: ascertain accuracy of information and if there are any significant inconsistencies assist client to credibly explain them. ASK ABOUT SUBSTANCE ABUSE…make sure it is not an issue and, if it is, prepare the client to deal with at the hearing.

4. If additional evidence is needed, consider best way to obtain it: a) sending the client for additional evaluations; b) giving client RFC form(s) to take to his/her doctor for completion

5. Answer any questions the client has (or promise to get back to him or her with answers).

6. If the hearing is not happening immediately after the interview, set up an meeting date for the hearing preparation

G. Requesting SUBPOENA:

1. If it is impossible to get information from treating source, consider requesting that the ALJ issue a subpoena.

2. Requirements: An explanation in writing why the information is essential and why it cannot be obtained in any other way. Request must be submitted at least 5 days prior to hearing, [(20 C.F.R. 404.950(d); 416.1450(d); HALLEX I-2-5-78]. An ALJ may issue a subpoena on his own motion whenever he deems it appropriate.

3. An ALJ must rule at the hearing or in writing on any request for a subpoena. HALLEX I-2-5-78.

4. Subpoenas may be affected by HIPAA requirements. See 45 CFR 160 *et seq.*

H. **Final preparation before hearing**

1) Review and revise your theory of the case.

2) Abstract the file to determine what the issues are, what the evidence is, and whether the evidence is sufficient and credible on each issue; and if not, what else you need and how you will get it.

3) .Make sure you have evidence to support each element of your theory.

4) Note any discrepancies (medical/functional/factual) that need to be resolved with the client and/or his or her physicians before the hearing and figure out how to get them resolved.

5) Prepare questions for the hearing.

6) Prepare for testimony of ME or VE (See sections VIII and IX)

7) Consider writing a pre-hearing memo for the judge (or even only for yourself) setting forth your theory of the case and identifying the supporting evidence.

8) Submit whatever evidence you can well before the hearing, with a cover letter and a pre-hearing memo.

9) Consider whether claim is strong enough to ask for an "on the record" (OTR) decision early on in the process

1. Procedures for OTR requests vary from ODAR to ODAR – know yours!
2. See SSA's "Best Practices" guide for OTR requests
    a. https://www.ssa.gov/appeals/best_practices.html#&a0=1

I. **Prepare your Client** (in person) i**mmediately before the hearing**

1) Make sure your client knows the date, time, and place of the hearing, how to get there, and to get there at least a half hour in advance (With disorganized or other- wise difficult clients, call the day before the hearing to make sure s/he hasn't forgotten).

2) Explain the hearing process to the client, including a description of the room, what will happen, who will be present, that the hearing is private, to listen carefully to each question, to say if a question does not make sense, if s/he doesn't know the answer or can't remember.

3) Review with your client the definition of disability and explain in lay terms what s/he must prove to win.

4) Explain the importance of detail and quantification (e.g., if the judge asks why you can't work, don't say "Because I'm sick" say "Because of my arthritis" or "Because of pains in my legs"; if the judge asks how often you see your doctor, don't say "Whenever I get an appointment" say "About once a month or once every three months;" if the judge says how long can you stand, don't say "not very long" - say "one hour" or "five minutes").

5) Explain to your client the importance of telling the truth and appearing credible, e.g., believable, not inconsistent. The more specific the client can be, with concrete examples, the more believable s/he will be.

6) Question your client as to any discrepancy between the documentary evidence and his/her testimony: ["I have a heart condition" v. no medical evidence of heart condition or treatment; "I have constant chest pain" v. no indication in medical record that claimant ever complained of chest pain, etc.]

7) **If DAA is an issue, make sure you know what your client's past and current situation is, and what other impairments may exist irrespective of substance abuse. If DAA is in the client's record, you will have to deal with it.**

8) Go through your prepared questions and correct your client's answers and your questions as you go along.

J. **Prepare yourself again**.

1) Make any necessary revisions to your theory of the case based on your hearing prep with your client.

2) Make sure you have all the evidence you need (or know when you can get it and are prepared to ask to keep the record open, if necessary.

3) Make sure you know the file.

II. Preparing for Expert testimony: an overview

1. The hearing notice will advise if an ME or VE has been scheduled to appear at your claimant's hearing. If either is scheduled, call the ALJ's assistant to obtain a copy of the witnesses' credentials. With respect to an ME, is the doctor's specialty consistent with the claimant's principle complaint? If not, consider whether you want to challenge them.

2. If an ME and/or VE is scheduled to testify, evaluate the record in terms of the issues they will be asked to consider. Prepare for their testimony.

   i. <u>For a VE</u>: evaluate the physical and/or mental demands of each of the claimant's past relevant jobs; look up each job in the DOT; compare how your claimant described his/her work with the DOT description; consider what functions(exertional and nonexertional) were essential to each job; compare those requirements with claimant's current RFC; consider whether claimant has any skills and whether they are transferable, and, if so, whether anything would prevent the claimant from utilizing those skills currently. Does the Grid apply? If so, does it help? If not, are there nonexertional impairments that preclude use of the Grid? Consider the claimant's age and education? At what level of exertion can the claimant win? How severe is each nonexertional impairment? In what ways do they limit activity necessary to performance of any type of work that would win the claim?

   ii. <u>For an ME</u>: evaluate the medical evidence, especially focusing on objective test results and diagnoses. Look up each diagnosed condition in an appropriate medical text. What objective findings and symptoms are related to each diagnosis? Does the record support claimant's contentions of pain, weakness, fatigue or any other subjective symptom? Look up each medication in the

Physician's Desk Reference (PDR) or another relevant source. What is it prescribed for? Does the dosage prescribed suggest any thing about severity? What RFC does the treating physician give? Is that opinion supported by relevant findings? How close are CE findings to treating source findings? Are CE findings generally consistent with treating source findings? How close is any DDS RFC to the treating source RFC? Is the duration requirement met?

III. THE HEARING

1. Duration: Hearings generally last from 20 minutes to 2 hours, depending on the judge, the advocate, the witnesses and the issues.

2. Procedure: The procedure is generally informal. The rules of evidence do not apply. In most cases, the judge will do direct examination of your client, only letting you come in to do cross-examination of your own client. The judge will also question any experts first, letting you cross-examine. HOWEVER, be prepared in case the judge asks you do the direct.

3. Video Teleconferencing (VTC):

   A. 20 C.F.R. §§ 404.936(c) & 416.1436(c); HALLEX I-5-1-16

   B. Claimants can object to VTC hearing

      1) 200 C.F.R. §§ 404.936(d) & 416.1436(d), written objections must be submitted within thirty days of the initial notice–often well before clients obtain representation.
      2) Regulations allow a claimant to assert good cause for failure to make a timely objection.

   C. Claimants cannot object to use VTC for expert witnesses

      1) 20 C.F.R. §§ 404.936(c)(2) & 416.1436(c)(2)
      2) Witnesses, including vocational and medical experts, may also appear telephonically

4. Participants: ALJ, his/her assistant (to operate tape recorder), claimant, claimant's witnesses (if any); medical expert and/or vocational expert.

5. Elements of hearing:

   A. Turning on the tape recorder to make a record;

   B. ALJ introduction and opening statements (will vary from judge to judge);

   C. Identifying the exhibits of record, asking for objections or submission of any additional evidence

D. Swearing witness(es)

E. Admission of evidence (objections may be offered).

F. Representative opening statement may be optional or ALJ may request representative to state his or her theory of the case.

G. Testimony: claimant generally testifies first, followed by claimant's witnesses (if any), and ALJ's witness(es) (if any). Each witness may be cross-examined following his or her direct testimony.

H. ALJ may do initial examination of claimant or ask representative to examine the claimant. Representatives should always be prepared to do the examination if asked.

I. Objections: May be interposed at any point at which the ALJ commits error. For example, if the ALJ prohibits questioning of a witness on a relevant point or the submission of relevant evidence, an objection should be made on the record and restated in closing argument (and, if necessary, argued subsequently to the Appeals Council and/or on judicial review).

J. Offers of proof: To make sure the record is complete, where an ALJ prohibits a line of questioning or refuses to accept evidence, the advocate may make "an offer of proof." This merely means that the advocate states on the record what she or he expects the witness to testify to if allowed to do so or what the excluded evidence would show if admitted to the record. An offer of proof allows a reviewing entity (the Appeals Council or a Court) to understand the significance of the material that has been excluded, and, therefore, to better evaluate whether error was committed.

K. Motions: Motions are requests that something be done or not done. For example, to keep the record open for submission of additional evidence; for one or more post hearing consultative examinations; for time to submit a written closing argument, etc.

L. Closing argument: If the record is complete and no post-hearing activity is needed, and the issues are not extremely complicated, presentation of oral argument is appropriate.

1) Be succinct and to the point. Explain the basis on which the case can be paid and respond to any unresolved issue raised during the course of the hearing and then stop. Anything more should be dealt with by a written closing argument.

2) If the record is not complete, the history or issues complicated, or there has

been expert testimony to which you wish to respond, a written closing argument is a better choice. Request a specified period of time to submit a written closing. If additional evidence is anticipated, ask for sufficient time to realistically receive and review such records.

Hearing decision: ALJs usually do not indicate how they will decide at the end of the hearing and it may take weeks to months to receive a written decision. If anything significant changes for the claimant after the hearing but before the decision is issued, additional evidence can be submitted to the ALJ

IV. More Hearing Preparation Tips – Direct Examination

A. Ethical considerations

B. Mental impairment cases

a. Review basic demands of work
   i. understand, carry out, and remember simple instructions;
   ii. make judgments that are commensurate with the functions of unskilled work, i.e., simple work-related decisions.
   iii. respond appropriately to supervision, coworkers and work situations; and
   iv. deal with changes in a routine work setting.

b. 20 C.F.R. § 416.921(b)(3)-(6)

c. POMS DI 25020.010
   i. https://secure.ssa.gov/apps10/poms.nsf/lnx/0425020010

d. Other areas for direct examination – see materials for DAP Session #2 – Section III, Cross-Examining VEs

C. Drug or Alcohol Addiction (DAA) Issues?

a. See *Cage v. Commissioner of Social Security*, 692 F.3d 118 (2d Cir. 2012)
   i. Claimant has burden of proving DAA immateriality
   ii. Commissioner does not have to produce medical opinion of materiality

b. SSR 13-2p – Evaluating Cases Involving Drug Addiction and Alcoholism (DAA)

i. http://socialsecurity.gov/OP_Home/rulings/di/01/SSR2013-02-di-01.html
ii. See also *SSA Consolidates DAA Policies*- http://www.empirejustice.org/issue-areas/disability-benefits/rules--regulations/ssa-consolidates-daa-policies.html#.U9LBSMsg-70

D. Credibility

a. Review factors

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

b. 20 C.F.R. §§ 404.1529 & 416.929 – How We Evaluate Symptoms

c. SSR 16-3p

i. Evaluation of Symptoms in Disability Claims, rescinding SSR 96-7p
ii. https://www.ssa.gov/OP_Home/rulings/di/01/SSR2016-03-di-01.html
iii. SSA is eliminating the use of the term “credibility” from its sub-regulatory policy, as the regulations do not use this term. In doing so, SSA clarifies clarify that subjective symptom evaluation is not an examination of an individual's character.
iv. Consistent with SSA regulations, the agency instructs its adjudicators to consider all of the evidence in an individual's record when they evaluate the intensity and persistence of symptoms after they find that the individual has a medically determinable impairment(s) that could reasonably be expected to produce those symptoms. The adjudicators evaluate the intensity and persistence of an individual's symptoms to determine how symptoms limit ability to perform work-related activities for an

adult and how symptoms limit ability to function independently, appropriately, and effectively in an age-appropriate manner for a child with a title XVI disability claim.

d. Credibility of claimant versus that of the witnesses (i.e., family members)?
   i. *See, e.g. Dodrill v. Shalala,* 12 F.3d 915, 919 (9th Cir. 1993) (lay witnesses can be found credible even if claimant not
   ii. *Cf.* *Briggs ex rel. Briggs v. Massanari*, 248 F.3d 1235, 1239 (10th Cir.2001) (If the child claimant is unable to adequately describe his symptoms, the ALJ must accept the testimony of the person most familiar with the child's condition).

E. Pace of questioning

F. Leading questions

G. Compound questions

H. Listen to the answers!

I. Dealing with surprises

V. Mock Hearing

A. Sample case distributed and introduced

B. Direct examination of claimant and witness

C. Cross examination of VE

D. Review and critique

Presenting the Case for Limitations in Attention and Concentrations at a Hearing: Direct and Cross Examination Strategies

Biographies

Louise M. Tarantino

Louise M. Tarantino, a senior attorney at the Empire Justice Center, is a graduate of the State University of New York at Buffalo School of Law. She focuses her practice in Social Security and disability law. Ms. Tarantino is a member of the New York State Bar Association and serves on its Committee on Issues Affecting People with Disabilities. She is a contributing author of the committee's publication, *Representing People With Disabilities*. She is also a contributing author of *Benefits Management for Working People with Disabilities: An Advocate's Manual*. Ms. Tarantino is admitted to practice in New York and the District of Columbia. She is a frequent lecturer and trainer on Social Security and Supplemental Security Income issues.

Emilia Sicilia

Emilia Sicilia is the Director of Disability Benefits Advocacy at the Urban Justice Center's Mental Health Project. She represents individuals with mental illness in appealing the denial of disability benefits in their individual claims, and in impact litigation against the Social Security Administration. She has served as co-counsel in the class action lawsuits *Martinez v. Astrue*, which challenged SSA's policy of suspending and denying benefits based on an outstanding warrant, and *Padro v. Astrue*, which alleged bias by five administrative law judges in SSA's Queens hearing office. Prior to joining the Urban Justice Center, Ms. Sicilia worked at Paul, Weiss, Rifkind, Wharton & Garrison. She is a graduate of the University of Wisconsin Law School and Wesleyan University.

Michael Telfer

Michael Telfer has been a Staff Attorney with the Legal Aid Society of Northeastern New York's Disability Advocacy Project since 2013. From 2012 to 2013 he was an Associate Attorney with Olinsky Law Group. He represents clients who have been denied Social Security disability benefits before ODAR, the Appeals Council, and the U.S. District Court for the Northern District of New York. He has also drafted briefs for clients appealing the denial of Social Security disability benefits in multiple federal district courts across the country as well as the U.S. Court of Appeals for the Second Circuit. He is a graduate of the University at Albany and Albany Law School. He is admitted to practice in New York State and before the U.S. District Court for the Northern District of New York.

Jennifer Karr

Jennifer Karr is a staff attorney at the Empire Justice Center in the Rochester office. She represents clients appealing the denial of disability benefits before ODAR and the Appeals Council. Prior to joining Empire Justice, she practiced disability law at the Legal Aid Society of Northeastern New York and worked for the New York State Department of Labor. She is admitted to practice in New York, and is a member of the state and women's Bar Associations. She graduated from the David A. Clarke School of Law (UDC) and the George Washington University.

SOCIAL SECURITY ADMINISTRATION
Office of Disability Adjudication and Review

DECISION

IN THE CASE OF	**CLAIM FOR**
[redacted] (Claimant)	Supplemental Security Income
(Wage Earner)	[redacted] (Social Security Number)

JURISDICTION AND PROCEDURAL HISTORY

This case is before the undersigned Administrative Law Judge on remand from the Appeals Council. On December 20, 2012, the undersigned held a video hearing (20 CFR 416.1436(c)). The claimant appeared in Plattsburgh, NY, and the undersigned presided over the hearing from Albany, NY. Stephen P. Davis, an impartial vocational expert, also appeared at the hearing. The claimant is represented by Peter Racette, an attorney.

In its remand order, the Appeals Council directed the undersigned to (1) obtain additional evidence concerning the claimant's impairments in order to complete the administrative record; (2) further evaluate the claimant's mental impairments in accordance with the special technique described in 20 CFR 416.920a; (3) give further consideration to the claimant's maximum residual functional capacity and provide appropriate rationale with specific references to evidence of record in support of the assessed limitations; and (4) obtain a vocational expert to clarify the effects of the assessed limitations on the claimant's occupational base. The undersigned Administrative Law Judge has complied with the requirements set for in the remand order dated March 30, 2012.

The claimant is alleging disability since February 6, 2010.

ISSUES

The issue is whether the claimant is disabled under section 1614(a)(3)(A) of the Social Security Act. Disability is defined as the inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment or combination of impairments that can be expected to result in death or that has lasted or can be expected to last for a continuous period of not less than 12 months.

Although supplemental security income is not payable prior to the month following the month in which the application was filed (20 CFR 416.335), the undersigned has considered the complete medical history consistent with 20 CFR 416.912(d).

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After careful consideration of all the evidence, the undersigned concludes the claimant has not been under a disability within the meaning of the Social Security Act since March 12, 2010, the date the application was filed.

APPLICABLE LAW

Under the authority of the Social Security Act, the Social Security Administration has established a five-step sequential evaluation process for determining whether an individual is disabled (20 CFR 416.920(a)). The steps are followed in order. If it is determined that the claimant is or is not disabled at a step of the evaluation process, the evaluation will not go on to the next step.

At step one, the undersigned must determine whether the claimant is engaging in substantial gainful activity (20 CFR 416.920(b)). Substantial gainful activity (SGA) is defined as work activity that is both substantial and gainful. "Substantial work activity" is work activity that involves doing significant physical or mental activities (20 CFR 416.972(a)). "Gainful work activity" is work that is usually done for pay or profit, whether or not a profit is realized (20 CFR 416.972(b)). Generally, if an individual has earnings from employment or self-employment above a specific level set out in the regulations, it is presumed that she has demonstrated the ability to engage in SGA (20 CFR 416.974 and 416.975). If an individual engages in SGA, she is not disabled regardless of how severe her physical or mental impairments are and regardless of her age, education, and work experience. If the individual is not engaging in SGA, the analysis proceeds to the second step.

At step two, the undersigned must determine whether the claimant has a medically determinable impairment that is "severe" or a combination of impairments that is "severe" (20 CFR 416.920(c)). An impairment or combination of impairments is "severe" within the meaning of the regulations if it significantly limits an individual's ability to perform basic work activities. An impairment or combination of impairments is "not severe" when medical and other evidence establish only a slight abnormality or a combination of slight abnormalities that would have no more than a minimal effect on an individual's ability to work (20 CFR 416.921; Social Security Rulings (SSRs) 85-28, 96-3p, and 96-4p). If the claimant does not have a severe medically determinable impairment or combination of impairments, she is not disabled. If the claimant has a severe impairment or combination of impairments, the analysis proceeds to the third step.

At step three, the undersigned must determine whether the claimant's impairment or combination of impairments is of a severity to meet or medically equal the criteria of an impairment listed in 20 CFR Part 404, Subpart P, Appendix 1 (20 CFR 416.920(d), 416.925, and 416.926). If the claimant's impairment or combination of impairments is of a severity to meet or medically equal the criteria of a listing and meets the duration requirement (20 CFR 416.909), the claimant is disabled. If it does not, the analysis proceeds to the next step.

Before considering step four of the sequential evaluation process, the undersigned must first determine the claimant's residual functional capacity (20 CFR 416.920(e)). An individual's residual functional capacity is her ability to do physical and mental work activities on a sustained basis despite limitations from her impairments. In making this finding, the undersigned must

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consider all of the claimant's impairments, including impairments that are not severe (20 CFR 416.920(e) and 416.945; SSR 96-8p).

Next, the undersigned must determine at step four whether the claimant has the residual functional capacity to perform the requirements of her past relevant work (20 CFR 416.920(f)). The term past relevant work means work performed (either as the claimant actually performed it or as it is generally performed in the national economy) within the last 15 years or 15 years prior to the date that disability must be established. In addition, the work must have lasted long enough for the claimant to learn to do the job and have been SGA (20 CFR 416.960(b) and 416.965). If the claimant has the residual functional capacity to do her past relevant work, the claimant is not disabled. If the claimant is unable to do any past relevant work or does not have any past relevant work, the analysis proceeds to the fifth and last step.

At the last step of the sequential evaluation process (20 CFR 416.920(g)), the undersigned must determine whether the claimant is able to do any other work considering her residual functional capacity, age, education, and work experience. If the claimant is able to do other work, she is not disabled. If the claimant is not able to do other work and meets the duration requirement, she is disabled. Although the claimant generally continues to have the burden of proving disability at this step, a limited burden of going forward with the evidence shifts to the Social Security Administration. In order to support a finding that an individual is not disabled at this step, the Social Security Administration is responsible for providing evidence that demonstrates that other work exists in significant numbers in the national economy that the claimant can do, given the residual functional capacity, age, education, and work experience (20 CFR 416.912(g) and 416.960(c)).

FINDINGS OF FACT AND CONCLUSIONS OF LAW

After careful consideration of the entire record, the undersigned makes the following findings:

1. The claimant has not engaged in substantial gainful activity since March 12, 2010, the application date (20 CFR 416.971 *et seq.*).

2. The claimant has the following severe impairments: morbid obesity, bilateral knee pain, insomnia, depression, anxiety, bipolar disorder, not otherwise specified (NOS) and borderline intellectual functioning (20 CFR 416.920(c)). (20 CFR 416.920(c)).

The record documented that the claimant was diagnosed with borderline intellectual functioning by Paula Yellin, Ed.D., a school psychologist. Dr. Yellin administered the Wechsler Intelligence Scale for Children, Revised (WISC-R), in 1995 when the claimant was 16 years old, and reported that the claimant achieved a Verbal IQ of 72, Performance IQ of 77, and a Full Scale IQ of 72 (Exhibit 5E).

Maurice Racine, M.D., a treating physician, diagnosed the claimant with morbid obesity, insomnia, bilateral knee pain, anxiety and depression. Dr. Racine prescribed medications and recommended increased walking and weight reduction (Exhibit 1F).

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Nader Wassef, M.D., performed a consultative internal medicine examination, and diagnosed the claimant with morbid obesity and left knee pain (Exhibit 13F).

Brett T. Hartman, Psy.D., performed a consultative psychiatric evaluation, and diagnosed the claimant with a bipolar disorder (NOS) (Exhibit 15F).

The record also documented that the claimant had been diagnosed with borderline diabetes, asthma, hypothyroidism, right carpal tunnel syndrome, social phobia, vitamin deficiency and left knee torn meniscus.

The claimant reported to Dr. Wassef that although she was diagnosed with borderline type 2 diabetes, it was well controlled with diet. The claimant also reported that she had a history of asthma and used inhalers. However, she could not remember the last time she had an asthma attack. Although Dr. Wassef opined that the claimant should not be exposed to extremes in temperature, secondhand smoke, perfumes, chemicals or any type of respiratory irritant (Exhibit 13F), the claimant did not testified that her asthma caused any functional limitations . At the consultative psychological evaluation, the claimant reported that she was diagnosed with asthma in 1990, but only had mild symptoms (Exhibit 15F). In addition, treatment records from her treating physician's assistant, did not document any problems with ongoing asthma or that any medication had been prescribed from August 2011 through March 2012. The claimant also testified that she did not take any medications for diabetes (Testimony). Furthermore, the claimant was prescribed medication by her treating physician for hyperthyroidism and was recommended to take vitamins for her vitamin deficiencies (Exhibit 1F). The record does not indicate that these conditions caused any limitations of function and the claimant did not allege any difficulties with these diagnoses. Therefore, the undersigned has determined that her borderline type 2 diabetes, asthma, hypothyroidism and vitamin deficiencies are nonsevere.

Dr. Racine reported that the claimant had right wrist inflammation and positive Tinel's sign and diagnosed the claimant with right carpal tunnel syndrome. Dr. Racine advised the claimant to avoid prolonged computer work. The claimant was prescribed right wrist splints and additional testing. However, the claimant no showed for her next three visits and electrodiagnostic testing ruled out carpal tunnel syndrome. Dr. Racine no longer diagnosed the claimant with right carpal tunnel syndrome, but instead diagnosed her with right wrist pain and prescribed over-the-counter medication (Exhibit 1F). In June 2010, the claimant underwent extensive cardiac work-up due to atypical chest pain. However, she was ruled out for acute coronary syndrome by virtue of negative serial troponin values, her EKGs showed normal sinus rhythm without ischemic changes and her chest discomfort had spontaneously resolved following administration of medication in the emergency room. She also received Ambien and had a lengthy course of sleep through the morning. She denied any episodes of exertional chest discomfort, increased shortness of breath or an increased case of fatigability. The claimant was diagnosed with atypical chest discomfort and additional testing was requested (Exhibit 25F). However, the claimant did not report any ongoing issues related to her atypical chest discomfort and did not testify to any heart condition. Therefore, the undersigned has concluded that her right wrist pain and atypical chest discomfort does not cause more than minimal limitations of function and is nonsevere.

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The claimant reported that she became very anxious when she was in crowds and did not like meeting new people. She becomes very panicky when she was in a crowed grocery store, and had left full carts of groceries in the store due to palpitations, cold sweats and trembling. However, she had not had any recent attacks. Dr. Hartman diagnosed the claimant with social phobia and opined that she had only mild difficulties relating adequately with others (Exhibit 15F). Therefore, the undersigned finds that her social phobia only caused mild limitations with mental functioning and is nonsevere.

The claimant further alleged that she had a torn meniscus in her left knee. However, MRI of the left knee revealed no evidence of a ligamentous or meniscal injury. Dr. Racine diagnosed the claimant with left knee pain and referred the claimant to an orthopedist for evaluation. Dr. Racine also recommended weight reduction with increased walking and prescribed over-the-counter medication (Exhibit 1F). The record documented that the claimant failed to follow through with her treating physician's recommendations and there is no evidence in the file of a diagnosis of a left knee torn meniscus. Although Dr. Wassef diagnosed the claimant with left knee pain and torn meniscus in the left knee, he did not perform any diagnostic testing of the left knee. In addition, upon physical examination, Dr. Wassef reported that the claimant had full range of motion of the knees bilaterally and she had full and equal muscle strength in the lower extremities bilaterally. Dr. Wassef also reported that her joints were stable and nontender without any evidence of redness, heat, swelling or effusion (Exhibit 13F). Although the record does document that the claimant does have some knee pain, there is no evidence of a torn meniscus or any treatment for serious pain symptoms other than over-the-counter medication. Therefore, the undersigned Administrative Law Judge finds no documented diagnostic findings of a left knee torn meniscus and is therefore considered nonsevere.

In July 2011, Sabieli Kabeli, M.D., a treating sleep study specialist, performed diagnostic testing and reported that the results showed evidence consistent with moderately severe obstructive sleep apnea. Dr. Kabeli also diagnosed the claimant with an intrinsic sleep disorder. The claimant was prescribed a CPAP machine and sleep medication. Dr. Kabeli specifically advised the claimant to be cautious when driving and to never drive while sleepy or tired. On follow-up examination, the claimant reported that she felt more refreshed and had more energy, but still napped a couple hours during the day when the children left for school. However, she only occasionally felt drowsy during the day, but overall was making progress (Exhibit 28F). At hearing, the claimant was specifically questioned regarding her sleep problems. She testified that she slept a lot better with the CPAP machine and sleep medication and indicated that she had no further significant difficulties. Therefore, the undersigned finds her medically determinable obstructive sleep apnea and intrinsic sleep disorder does not cause more than minimal limitations of function and with proper treatment is, therefore, considered nonsevere.

The claimant presented to the emergency room on November 16, 2011, due to abdominal pain with nausea and vomiting. CT scan of the abdomen and pelvis showed evidence of acute diverticulitis. The claimant was administered medication and upon stabilization, discharge instructions documented a diagnosis of diverticulitis. The claimant was discharged with prescribed medications and follow-up with her treating physician was recommended (Exhibit 29F). However, the claimant had not mentioned any limiting functional restrictions caused by any digestive disorders. Therefore, her medically determinable diverticulitis does not cause

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more than minimal, if any, limitations of function and is considered nonsevere (Exhibits 22F and 29F).

3. The claimant does not have an impairment or combination of impairments that meets or medically equals the severity of one of the listed impairments in 20 CFR Part 404, Subpart P, Appendix 1, as the pertinent listings including listing 1.00, referable to musculoskeletal disorders and listing 12.00, referable to mental disorders, require specific findings which are not present (20 CFR 416.920(d), 416.925 and 416.926).

The severity of the claimant's mental impairments, considered singly and in combination, do not meet or medically equal the criteria of listings 12.04, 12.05, 12.06, and 12.08. In making this finding, the undersigned has considered whether the "paragraph B" criteria ("paragraph D" criteria of listing 12.05) are satisfied. To satisfy the "paragraph B" criteria ("paragraph D" criteria of listing 12.05), the mental impairments must result in at least two of the following: marked restriction of activities of daily living; marked difficulties in maintaining social functioning; marked difficulties in maintaining concentration, persistence, or pace; or repeated episodes of decompensation, each of extended duration. A marked limitation means more than moderate but less than extreme. Repeated episodes of decompensation, each of extended duration, means three episodes within 1 year, or an average of once every 4 months, each lasting for at least 2 weeks.

In activities of daily living, the claimant has mild to moderate restriction. The claimant reported that she was able to get her children up and prepare them for school, performed chores, watched television and visited her sister and mother. The claimant reported that she was able to prepare meals and that there had been no change in her cooking habits and she went shopping at least twice a month for about an hour each time. She reported that she enjoyed reading, watching television and playing cards. The claimant also reported that her current daily activities included walking, household chores and socializing (Exhibit 6E). In addition, the claimant reported that she was able to take care of all her personal needs including dressing, bathing and grooming. She reported that she was able to perform all household chores, including cooking, cleaning, laundry and shopping, but received a lot of help from her children (Exhibit 15F). At hearing, the claimant testified that she stayed in bed all day, cried all the time and that she did nothing at all for at least two weeks or longer, including no household chores, and that this occurred at least 15 days a month. She also reported that she had difficulty lifting heavy objects, carrying a lot of things at one time, she had trouble with eye-to-hand coordination and she felt as though her hands would give out on her (Testimony).

In social functioning, the claimant has mild to moderate difficulties. The claimant reported that she became very anxious when she was in a crowd and did not like meeting new people. The claimant reported that she becomes very panicky when she was in a crowed grocery store, and had left full carts of groceries in the store due to palpitations, cold sweats and trembling. However, she had not had any recent attacks. Dr. Hartman opined that she had only mild difficulties relating adequately with others (Exhibit 15F). The claimant also reported that she enjoyed social activities, spending time with others and that she had never lost a job due to difficulty getting along with others (Exhibit 6E). The state agency found that the claimant was

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moderately limited with asking simple questions and requesting assistance and with accepting instructions and responding appropriately to criticism (Exhibit 19F).

With regard to concentration, persistence or pace, the claimant has moderate difficulties. Although the claimant had a history of poor academic performance and was diagnosed with borderline intellectual functioning with difficulties especially in reading and mathematics, she testified that she enjoyed reading romance books. The claimant testified that she read books very slowly and would have to reread some sections, but was otherwise able to follow along and understood most if not all of what she had read (Testimony). Dr. Hartman determined that the claimant's attention and concentration was intact and she was able to do the counting without any difficulties and performed well with calculations and serial 3s. In addition, Dr. Hartman reported that the claimant had intact memory skills and was able to recall objects without any difficulties. Dr. Hartman also opined that the claimant had intact attention and concentration and she had the ability to make appropriate decisions with only mild difficulties maintaining a regular schedule (Exhibit 15F). The state agency found that the claimant had moderate limitations with her ability to complete a normal workweek without interruptions from psychologically based symptoms and perform at a consistent pace as well as moderate difficulty concentrating (Exhibit 19F).

As for episodes of decompensation, the claimant has experienced no episodes of decompensation, which have been of extended duration.

Because the claimant's mental impairments do not cause at least two "marked" limitations or one "marked" limitation and "repeated" episodes of decompensation, each of extended duration, the "paragraph B" criteria ("paragraph D" criteria of listing 12.05) are not satisfied.

The undersigned has also considered whether the "paragraph C" criteria of 12.04, 12.06, and 12.08 are satisfied. In this case, the evidence fails to establish the presence of the "paragraph C" criteria. As noted above, the claimant has not had any episodes of decompensation that required an extended period of hospitalization; she has not been diagnosed with any residual disease that had resulted in such marginal adjustment that even a minimal increase in mental demands or change in the environment that would be predicted to cause the claimant to decompensate; and, she had never had a history of one or more years' inability to function outside of a highly supportive living arrangement, with an indication of continued need for such an arrangement.

The limitations identified in the "paragraph B" ("paragraph D" criteria of listing 12.05) criteria are not a residual functional capacity assessment but are used to rate the severity of mental impairments at steps 2 and 3 of the sequential evaluation process. The mental residual functional capacity assessment used at steps 4 and 5 of the sequential evaluation process requires a more detailed assessment by itemizing various functions contained in the broad categories found in paragraph B of the adult mental disorders listings in 12.00 of the Listing of Impairments (SSR 96-8p). Therefore, the following residual functional capacity assessment reflects the degree of limitation the undersigned has found in the "paragraph B" mental function analysis.

Turning back to listing 12.05, the requirements in paragraph A are met when there is mental incapacity evidenced by dependence upon others for personal needs (e.g., toileting, eating,

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dressing, or bathing) and inability to follow directions, such that the use of standardized measures of intellectual functioning is precluded. In this case, these requirements are not met because the claimant is not dependent upon others for personal needs such as toileting, eating, dressing or bathing and she is able to follow simple directions.

As for the "paragraph B" criteria, they are not met because the claimant does not have a valid verbal, performance, or full scale IQ of 59 or less. The record documented that the claimant had intelligence testing that resulted in a Full Scale IQ of 85 and a Performance IQ of 87 (Exhibit 37F).

Finally, the "paragraph C" criteria of listing 12.05 are not met because the claimant does not have a valid verbal, performance, or full scale IQ of 60 through 70 and a physical or other mental impairment imposing an additional and significant work-related limitation of function. As described above, the claimant had intelligence testing that resulted in a Full Scale IQ of 85 and a Performance IQ of 87 (Exhibit 37F). Therefore, the "paragraph C" criteria is not met.

4. After careful consideration of the entire record, the undersigned finds that the claimant has the residual functional capacity to perform light work as defined in 20 CFR 416.967(b) except she can lift and carry 20 pounds occasionally and ten pounds frequently; she can sit, stand and walk for two hours each at a time for a total of sitting for eight hours out of an eight-hour workday, standing for six hours out of an eight-hour workday and walking for six hours out of an eight-hour workday; no climbing ladders or scaffolding; occasional climbing stairs, stooping, crouching, crawling, kneeling and balancing; frequent operation of foot controls bilaterally; occasional unprotected heights and moving mechanical parts; she can do simple, rote, unskilled work; make simple work-related decisions; have frequent, but not constant interaction with others; and she can work in an environment where there are only occasional minor changes in the work setting.

In making this finding, the undersigned has considered all symptoms and the extent to which these symptoms can reasonably be accepted as consistent with the objective medical evidence and other evidence, based on the requirements of 20 CFR 416.929 and SSRs 96-4p and 96-7p. The undersigned has also considered opinion evidence in accordance with the requirements of 20 CFR 416.927 and SSRs 96-2p, 96-5p, 96-6p and 06-3p.

In considering the claimant's symptoms, the undersigned must follow a two-step process in which it must first be determined whether there is an underlying medically determinable physical or mental impairment(s)--i.e., an impairment(s) that can be shown by medically acceptable clinical and laboratory diagnostic techniques--that could reasonably be expected to produce the claimant's pain or other symptoms.

Second, once an underlying physical or mental impairment(s) that could reasonably be expected to produce the claimant's pain or other symptoms has been shown, the undersigned must evaluate the intensity, persistence, and limiting effects of the claimant's symptoms to determine the extent to which they limit the claimant's functioning. For this purpose, whenever statements about the intensity, persistence, or functionally limiting effects of pain or other symptoms are not

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substantiated by objective medical evidence, the undersigned must make a finding on the credibility of the statements based on a consideration of the entire case record.

The claimant alleged an inability to work due to depression, insomnia, morbid obesity and left knee pain. The claimant reported that at times she did not feel well due to pains in her knees and had difficulty with prolonged walking, climbing stairs and kneeling. The claimant reported that she was only able to walk for 15 minutes at a time before she needed to stop and rest for four minutes and then she could continue. However, the claimant reported that she was able to perform all household chores including cleaning, shopping, laundry and childcare. The claimant also reported that she enjoyed playing cards and socializing, reading and watching television. Furthermore, the claimant reported that the reason she stopped working was due to a lay off (Exhibits 4E and 6E).

After careful consideration of the evidence, the undersigned finds that the claimant's medically determinable impairments could reasonably be expected to cause the alleged symptoms; however, the claimant's statements concerning the intensity, persistence and limiting effects of these symptoms are not entirely credible for the reasons explained in this decision.

In 2004, the claimant was court-ordered to attend a psychological/ parenting assessment that was performed by Barbara Silman, M.S. Dr. Silman reported that despite her higher performance IQs, she had deficits in visual perception and visual motor abilities. However, she appeared to be performing academically at a level higher than test results would predict, particularly true in mathematics in which computation was seen as a strength, and that she had benefited from her special education placements. The claimant reported that she had a history of hitting her head on the dashboard when she was a child, but had no further treatment associated with it. She also reported that she was doing fairly well until two years ago when she was diagnosed with depression and was prescribed medications. She reported that her energy dropped significantly and she was unable to provide adequate care and supervision for her three children, even with support. However, her three children had been in foster care since October 2003 due to issues with supervision and care revolving around some boyfriends, who she met on-line, and were in-and-out of the home, which caused the lack of energy and active supervision on her part. Dr. Silman reported that the claimant achieved an overall Full Scale IQ score that was within the low average range. Dr. Silman further opined that given the history of a possible head injury, learning disabilities in written language and reading and her verbal processing deficits, it is possible that there was a neurological basis for her deficits. Therefore, while she could not be found eligible for services at this time, it was highly recommended that further neuropsychological testing be done to clarify her status as an individual with neurologically based learning disabilities. However, her General Adaptive Composite (GAC) was determined to be at a 69,which is indicative of skills that were overall at the upper end of the mildly retarded range. Dr. Silman also reported that the claimant's learning disabilities and her history of questionable judgment and reliability were other negative indicators as was her difficulty attending to two or more things at a time. However, this was only just a bit more difficult for her than the average person. Dr. Silman's overall impression was that while the claimant had some work to do on improving these areas, she was demonstrating overall adequate parenting skills and seemed to have the motivation to successfully parent her children (Exhibit 21F).

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The undersigned has accorded Dr. Silman some weight in assessing the claimant's residual functioning capacity, as it was documented that the claimant had some problems with learning disabilities in written language and reading and she had verbal processing deficits, she had a GAC of 69, which is indicative of skills performed at the upper end of the mildly retarded range. She also had a slight difficulty attending to two or more things at a time, she demonstrated overall adequate parenting skills and seemed to have the motivation to successfully parent her children.

In a prior consultative psychological evaluation, the record indicated that the claimant had driven to the evaluation in her own car. She reported that she had difficulty sleeping and would get up and play video games, because they helped to relax her, but would have problems getting up in the morning. However, once she got her children off to school, she would go back to bed and would sleep for several hours without any difficulties. She described symptoms of depression and that she had difficulties managing her three special needs children. She reported that her disabled boyfriend helped her with the cooking and housework. She also described experiencing panic attacks that only manifested a shortness of breath and would disappear as soon as she left the store. On good days, she reported that she spent her spare time on the internet, which was relaxing, and socialized with family and friends or she would "cultivate" new acquaintances in the "chat rooms." In addition, the claimant reported that she was needed at home with her family for the foreseeable future. Sally Summerell, Ph.D., reported that the claimant was neatly and appropriately dressed, her manner was tense, but friendly, her responses were brief, but adequate and her remarks were brief, but clearly articulated, relevant and coherent. The claimant reported that she had an impairment to her memory, concentration and ability to focus relating to her emotional condition. However, informal tests failed to reveal any deviation from normal limits. Her anxiety was manifested in her clenched fists and rigid posture as well as her inability to remember personal details. However, Dr. Summerell reported that the claimant displayed a full range of affect. Her long and short-term memory, concentration, and calculations as assessed informally were within normal limits and her insight and judgment appeared adequate. Dr. Summerell diagnosed the claimant with major depressive disorder, chronic and attention deficit hyperactivity disorder. Dr. Summerell opined that the claimant had limitations in personal and social adjustment as she was living on public assistance, which was barely enough to meet her family needs, she lived in an over-crowded apartment and lack privacy, which all contributed to her stress. The examiner further opined that the claimant had emotional problems, along with complicated family problems, that she would be unemployable in the foreseeable future (Exhibit 2F).

The undersigned has accorded Dr. Summerell partial weight in assessing the claimant's residual functioning capacity, as her clinical findings showed that the claimant's ability to communicate was adequate and she was clearly articulated, relevant and coherent. Informal tests failed to reveal any deviation from normal limits, she displayed a full range of affect, her long and short-term memory, concentration, and calculations were within normal limits and her insight and judgment appeared adequate, which is not consistent with severe disabling symptomatology that caused her to be unemployable.

In 2006, the record documented that the claimant was psychiatrically hospitalized for nine days due to suicidal thoughts and thoughts of killing her children. The claimant reported that she

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experienced increased stress due to "family rivalry." She reported that she cared for several special needs children living in the household and that finances were limited. The claimant was treated with medication management and psychotherapy sessions. Upon stabilization, Kausar Chaudry, M.D., a hospital staff psychiatrist, diagnosed the claimant with major depressive disorder, severe and ADHD. However, her mental status at the time of discharge was that she was alert and oriented to the time, place, and person and she had good attention span and concentration with no memory impairment. Her gait was steady with no evidence of any psychomotor dysfunction, she was cooperative throughout, she made good eye contact, her mood was euthymic and her affect was appropriate, congruent, and reactive. In addition, her speech was spontaneous with normal rate rhythm and volume as well as fluent and comprehensible. Dr. Chaudry further reported that the claimant's thought processes were goal directed, logical, and linear, she denied having ideas of references, dilutions, hallucinations, suicidal ideations, plans, or intentions. She also denied having homicidal ideations, plans, or intentions. Her fund of knowledge was age appropriate and she verbalized an understanding of the need to be compliant with the use of psychiatric medications, keeping follow-up appointment and keeping up with the plan, increase outdoor activities and to be more candid with family members (Exhibit 4F).

The undersigned has accorded Dr. Chaudry great weight in assessing the claimant's residual functioning capacity, as treatment records documented that after only nine days of inpatient hospitalization, the claimant mental status was essentially normal and that ongoing mental health treatment was recommended.

The claimant attended mental health treatment for only a very brief amount of time and upon termination, dated September 2006, the claimant reported that she was able to manage her symptoms with only minimal problems and she no longer needed any services. At a therapy session, the claimant reported that she wanted to stay home with her children, who had just returned from foster care, and did not want to look for a job. She also reported that she remembered how working gave her something to do each day and that it gave her a sense of accomplishment. In May 2010, the record also documented that the claimant was referred to mental health counseling due to her allegations of depression and mood swings. However, the claimant reported that her issues were being treated by her primary care physician. In addition, a discharge summary indicated that no further mental health treatment was indicated at this time (Exhibits 5F and 12F).

Dr. Racine reported that the claimant had a body mass index (BMI) of 55 and diagnosed her with morbid obesity. Dr. Racine referred the claimant for a gastric bypass consultation and recommended weight reduction and exercise. The claimant also reported difficulty sleeping. Dr. Racine diagnosed the claimant with insomnia and prescribed medication. In 2008, the claimant reported that she had fallen and experienced left knee pain. Complete left knee x-ray revealed a normal left knee. MRI of the left knee showed no evidence of any ligamentous or meniscal injury. In 2009, the claimant reported continued left knee pain. Dr. Racine reported that she had limited range of motion and tenderness with palpation of the left knee. Dr. Racine referred the claimant to an orthopedist and recommended over-the-counter Tylenol for pain. Dr. Racine also diagnosed the claimant with anxiety and depression and prescribed psychotropic medication. In a Medical Examination for Employability Assessment, Julie Steele Goodwin, PA-C, a treating physician's assistant working in conjunction with Dr. Racine, reported that the claimant had been

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[redacted]

diagnosed with bilateral knee pain, depression, insomnia and morbid obesity. Ms. Goodwin assessed that the claimant was only moderately limited with walking, standing, lifting, carrying, pushing, pulling, bending and climbing stairs. However, Ms. Goodwin assessed that the claimant had no evidence of any limitations with sitting, seeing, hearing, speaking or using her hands. In addition, the claimant also had no evidence with limitations concerning mental functioning. Ms. Goodwin assessed that the claimant's left knee pain was due to morbid obesity and limited her to only performing walking and standing to 20 minutes at a time. Ms. Goodwin also acknowledged that the claimant had no treatment history, no current treatment programs and she had not been referred to any mental health programs or physical therapy programs. At the most recent visit, in March 2010, the claimant reported that she had bilateral leg pain with increased pain in the right leg from the interior patella to the ankle. Radiographic report of the right tibia and fibula revealed a normal right tibia and fibula. Dr. Racine diagnosed the claimant with right and left leg pain with palpable lesions and prescribed additional testing (Exhibits 1F, 11F, 23F and 24F).

The undersigned finds the above assessment not inconsistent with the totality of the evidence in the medical record and has accorded Dr. Racine great weight in assessing the claimant's residual functioning capacity, as treatment record showed no diagnostic abnormalities and the claimant was prescribed over-the-counter medication. Although Ms. Goodwin is not an acceptable medical source, pursuant to Social Security Regulations, the Administrative Law Judge may consider their assessments along with the objective evidence in the record. In this case, the Administrative Law Judge acknowledges that Ms. Goodwin personally saw the claimant and finds the assessment and observations of Ms. Goodwin are entitled to some weight.

The record documented that the claimant weighed 326 pounds and was five feet four inches tall. The claimant reported that she had a history of left knee pain and had difficulty with prolonged standing and walking as well as bending and kneeling. However, she was able to perform cooking and cleaning every day, laundry four times a week, shopping monthly, showered five times a week, bathed once a week and dressed herself every day. The claimant also reported that she enjoyed watching television and socializing with friends. Dr. Wassef reported that the claimant had a normal gait, could walk on heels and toes without any difficulties, performed a full squat, had a normal stance, used no assistive devices, needed no help changing for the examination or getting on and off the examination table and she was able to rise from a chair without any difficulty. Dr. Wassef reported that the claimant had a normal physical examination including full range of motion of all major joints including cervical spine, lumbar spine, shoulders, elbows, forearms, wrists, hips, knees and ankles bilaterally. Dr. Wassef reported that the claimant had full and equal muscle strength in the upper and lower extremities as well as full and equal grip strength in the upper extremities bilaterally and she had intact hand and finger dexterity. There was no redness, heat, swelling or effusion and her joints were all stable and nontender. Dr. Wassef diagnosed the claimant with morbid obesity, asthma, insomnia and left knee pain. The examiner concluded that the claimant was morbidly obese and she experienced left knee pain (Exhibit 13F).

The undersigned finds the above assessment not inconsistent with the totality of the evidence in the medical record and has accorded Dr. Wassef great weight in assessing the claimant's residual functioning capacity, as he performed an extensive examination and concluded that the claimant

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was morbidly obese and that she experienced knee pain, but did not indicate any significant limitations of function.

The record documented that the claimant was diagnosed with borderline intellectual functioning by Paula Yellin, Ed.D., a school psychologist. Dr. Yellin administered the Wechsler Intelligence Scale for Children, Revised (WISC-R), in 1995 when the claimant was 16 years old, and reported that the claimant achieved a Verbal IQ of 72, Performance IQ of 77 and a Full Scale IQ of 72 (Exhibit 5E).

The claimant reported that she graduated from high school with an Individualized Educational Plan (IEP) diploma and had been enrolled in special education classes throughout her schooling. The claimant reported that she use to perform factory work from 1996 to 2004, and no longer worked due to being laid off in 2004. She reported that she received mental health treatment in the past, but was now being treated exclusively by her treating physician. In addition, the claimant reported that she had only mild physical symptoms due to left knee pain, bilateral carpal tunnel syndrome and asthma. The claimant reported that she had only mild difficulty falling asleep and would awaken about four times during the night due to either pain or stress. The claimant reported that she had struggled with depression since her brother's suicide in 1996. She acknowledged a variety of symptoms including sadness, social isolation, crying spells, feelings of guilt, hopelessness and irritability. She reported low self-esteem and that she had always been self- conscious of her weight, became overwhelmed easily and she had poor concentration. The claimant also reported having manic symptoms such as a high degree of agitation, restlessness and she would become more sociable as well as impatient, and had a history of reckless behavior during this time. The claimant reported that she became very anxious when she was in crowds and did not like meeting new people. The claimant reported that she becomes very panicky when she was in a crowed grocery store, and had left full carts of groceries in the store due to palpitations, cold sweats and trembling. However, she had not had any recent attacks. Dr. Hartman reported that the claimant had a slow gait, posture was slouched, motor behavior was only somewhat restless, affect was anxious and her mood was dysphoric. However, Dr. Hartman reported that she was well-groomed, eye contact was appropriate, speech was fluent and clear, thought processes were coherent and goal directed and she was oriented times three. In addition, Dr. Hartman reported that her intellectual functioning appeared to be in the borderline range with a deficient general fund of information. However, her attention and concentration appeared to be intact and her memory skills were intact. Dr. Hartman diagnosed the claimant with a bipolar disorder (NOS) and opined that the claimant had only moderate problems learning new tasks and dealing appropriately with the normal stressors of life and mild difficulties maintaining a regular schedule and relating adequately with others. Dr. Hartman further opined that the claimant was able to follow and understand simple directions and instructions, maintain attention and concentration and she had the ability to make appropriate decisions (Exhibit 15F).

The undersigned finds the above assessments not inconsistent with the totality of the evidence in the medical record and has accorded Drs. Yellin and Hartman great weight in assessing the claimant's residual functioning capacity, as Dr. Yellin concluded that the claimant achieved IQ scores that support the above-described residual functional capacity. In addition, Dr. Hartman performed an extensive psychological evaluation and opined that the claimant had only mild to moderate difficulties, which also supports the residual functional capacity as described above.

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After careful review of the entire evidence of record, the State agency found that the claimant had no marked limitations and would be only moderately limited with the ability to maintain attention and concentration for extended periods, complete and normal workday or workweek without interruptions from psychologically based symptoms, ask simple questions and request assistance, accept instructions and respond appropriately to criticism from supervisors, respond appropriately to changes in the work setting and travel to unfamiliar places or use public transportation. However, the claimant is able to understand, remember and carryout simple instructions as well as detailed instructions. She has the ability to remember locations and work-like procedures, sustain an ordinary routine and make simple work-related decisions. Furthermore, she has the ability to get along with co-workers and peers, maintain socially appropriate behavior, be aware of normal hazards and take precautions and set realistic goals (Exhibit 19F).

Although, the State agency physician was a non-examining physician and his opinion does not as a general matter deserve as much weight as those of examining or treating physicians, his opinion does deserve some weight as it is consistent with the evidence of record. The residual functional capacity conclusions reached by the physicians employed by the State Disability Determination Services supported a finding of not disabled. Although those physicians were non-examining, and therefore their opinions do not as a general matter deserve as much weight as those of examining or treating physicians, those opinions do deserve some weight, particularly in a case like this in which there exist a number of other reasons to reach similar conclusions (as explained throughout this decision).

On November 9, 2010, the claimant reported that she had been out of her medications for about six weeks and felt depressed with suicidal thoughts due to a friend losing his wife and that she was unable to be with him. However, she described her sleep was "okay" and that her appetite was fair. Mental status evaluation demonstrated that she was alert and oriented times three, her affect was appropriate, she was cooperative, she maintained eye contact and her speech was normal. An emergency room physician concluded that her symptoms were only moderate and upon medication management, her symptoms improved and she was discharged on this same day with prescribed medications and follow-up with mental health services was recommended (Exhibit 26F).

In May 2011, the claimant requested a refill of her sleep medication and acknowledged that Ambien was the only medication that work and that she experienced continued anxiety and depression as well as joint pain. However, physical examination of her upper and lower extremities revealed no loss of strength or motion, no sensory deficits or instability and she had full range of motion. Scott Liberty, P.A., a treating physician's assistant, diagnosed the claimant with anxiety, depression and an ongoing diagnosis of insomnia and prescribed continued medications. In August 2011, Mr. Liberty specifically questioned the claimant with regards to obtaining mental health treatment. The claimant reported that she had been seen by a mental health professional, but was told that she did not need to be seen and denied any specific complaints at this time. Mr. Liberty prescribed 30 tablets of Ambien and Lorazepam with no refills and recommended follow-up appointment in three months. However, the claimant did not follow-up until five months later and requested a refill of her sleep medication. Mr. Liberty

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advised the claimant that long-term use of sleep medication was not encouraged and prescribed an adjustment with her sleep medication with only 30 tablets and no refills. On follow-up examination, the claimant reported feeling depressed and was tearful. She also reported that she had difficulty getting out of bed the day before. Mr. Liberty prescribed increased medication (Exhibit 32F).

Although Mr. Liberty is not an acceptable medical source pursuant to Social Security Regulations, the Administrative Law Judge may consider their assessments along with the objective evidence in the record. In this case, the undersigned Administrative Law Judge concludes that Mr. Liberty personally saw the claimant periodically and that his assessments are consistent with other treating physicians and is accorded some weight.

On November 28, 2011, the claimant sought emergency room treatment due to feeling depressed and that she felt sorry for herself. The claimant reported that days before, she had been crying all the time, had thoughts of harming herself and she had a feeling that her mother-in-law, who had passed, was calling for help. She also reported poor concentration, poor level of energy and she felt hopeless. Javier Vargas, M.D., a hospital staff psychiatrist, initially diagnosed the claimant with a major depressive disorder, chronic and severe with suicidal ideation. Dr. Vargas also concluded that the claimant had a Global Assessment Functioning (GAF) of 35, which is indicative of a person who has an impairment in reality testing or communication or major impairment in several areas, such as work or school, family relations, judgment, thinking or mood. However, after only five days of medication management and psychotherapy sessions, the claimant responded well to medications and was more bright and was able to participate with the program without any difficulties. Upon discharge, her mental status was described as pleasant, cooperative, good eye contact with no abnormal movements and she denied any thoughts of suicidal or homicidal ideations. In addition, she denied any delusions, auditory or visual hallucinations, mood was fine, affect was full, she was oriented times three, she had concentration with serial 7s and her judgment and insight were fair. Most specifically, Dr. Vargas concluded that the claimant's GAF had improved to a 71, which is indicative of a person who if symptoms are present they are transient and expectable, reactions to psychosocial stressors, no more than slight impairment in social, occupational or school functioning (Exhibit 30F).

The undersigned has accorded Dr. Vargas great weight in assessing the claimant's residual functioning capacity, as the record documented that the claimant had significant improvement after only five days following prescribed medication and therapy sessions.

Following her psychiatric hospitalization, the claimant attended mental health treatment. The claimant reported that she was feeling down because her father was ill and sadly passed. She reported that she was mourning his death. Patrick Hicks, LMSW, a treating therapist, reported that the claimant had a normal motor behavior and a dysthymic and anxious mood, but she had a normal thought stream, was oriented times three and average insight and judgment. Mr. Hicks also reported that the claimant had only mild impairment with concentration. Mr. Hicks assessed the claimant with a major depressive disorder and a generalized anxiety disorder. Mr. Hicks further assessed the claimant was not over the loss of her recently deceased father and would benefit from medication management and individual therapy sessions (Exhibit 31F).

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Although Mr. Hicks is not an acceptable medical source pursuant to Social Security Regulations, the Administrative Law Judge may consider their assessments along with the objective evidence in the record. In this case, the undersigned Administrative Law Judge concludes that Mr. Hicks personally saw the claimant and that his assessments are consistent with other treating physicians and is accorded some weight.

Due to inconsistencies contained in the record and to further clarify the claimant's physical impairments, the undersigned secured further medical opinion from Jose Rabelo, M.D., a highly trained specialist in internal medicine and is specially trained in Social Security regulations, policies and an expert in determining physical residual functional capacity. In July 2012, Dr. Rabelo was provided a review of the entire pertinent evidence of record and concluded that the claimant was morbidly obese at 326 pounds and 64 inches tall. There had been no hospital admissions but she had been to the emergency room for left knee pain since 2005 and there had been mention of a torn meniscus of the left knee. However, her activities of daily living are not very reduced, her gait is normal, she was able to walk on toes and heels without difficulties, her lungs were clear, she had full range of motion of the lumbosacral spine, negative straight leg raising bilaterally and she had full strength in upper and lower extremities with no sign of joint inflammation, no motor or sensory deficits and no evidence of motor atrophy. Radiographic reports of the left knee revealed no fractures or effusion, alignment and joint spaces were preserved and the impression was a negative study. Considering the entire evidence of record along with the claimant's body habitus and obesity with knee pain, she had a residual functional capacity to lift and carry 20 pounds frequently. Dr. Rabelo opined that the claimant was also able to perform sitting for eight hours, standing for six hours and walking for six hours in an eight-hour workday. She could perform all reaching, handling, fingering, feeling, pushing and pulling and she could frequently operate foot controls. Although she should never climb scaffolds, she could occasionally climb stairs and ramps, balance, stoop, kneel, crouch and crawl. Dr. Rabelo also opined that the claimant could be occasionally exposed to unprotected heights and moving mechanical parts, but she could continuously operate a motor vehicle, exposed to humidity or wetness, exposure to respiratory irritants, extremes in temperature, vibrations and she was able to work in very loud conditions. Furthermore, Dr. Rabelo opined that the record supported that she had the ability to go shopping, travel without a companion, ambulate without an assistive device, use standard public transportation, prepare simple meals and feed herself and care for her personal hygiene (Exhibit 35F).

The undersigned has accorded Dr. Rabelo great weight in assessing the claimant's residual functioning capacity, as he based his opinion on the available evidence of record and his opinion supports the above-described residual functional capacity.

In addition, due to the claimant's sporadic mental health issues, the undersigned obtained further medical opinion, by way of a psychiatric interrogatory that was performed by Aaron Satloff, M.D., a board-certified psychiatrist and an expert in determining mental residual functional capacity with specialized training in Social Security Regulations and Polices. In July 2012, Dr. Satloff performed a complete review of the claimant's pertinent medical evidence and opined that the claimant had only mild to moderate difficulties functioning on a daily basis. However,

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she had the ability to understand simple instructions, maintain attention and concentration, relate adequately with others and adapt to changes (Exhibit 36F).

The undersigned has accorded Dr. Satloff great weight in assessing the claimant's residual functioning capacity, as he based his opinion on the available evidence of record and his opinion supports the above-described residual functional capacity.

In August 2012, the claimant was referred to a psychological evaluation that was performed by Richard F. Liotta, Ph.D. The claimant reported that her depression was quite bad as well as physical issues, including hypothyroidism, carpel tunnel syndrome, diverticulitis, and that her kidneys were not good and she was going to be seeing a doctor for that. She reported that was previously hospitalized due to depression and she was unable to handle what was going on with her father and that her depression had gotten worse. She had gone to Clinton County Mental Health and Behavioral Health Services North in the past and that she was currently on a waiting list to get back into mental health treatment. She reported that increased medications do not work and that all she wants to do is sit and cry. She sees a doctor at Urgent Care and was prescribed medications, but her body gets used to the medications and they no longer help. She reported that she lived with her son and was able to get along well with people and did not report this as problematic. She did not report being haunted by things from her past and does not report any posttraumatic stress symptoms. She also denied any history of alcohol or substance problems, impulsivity, or anger problems. The claimant reported that she had difficulty reading and comprehending what she had read and that she did not work regularly. Dr. Liotta reported that the claimant was an obese woman, but she was appropriately and casually dressed, her hygiene was adequate, her speech was clear and coherent and there was no loosening of associations. The claimant reported that when her depression gets really bad, she hears yelling from one voice that someone needs help, which occurred repeatedly. She reported that she worried a great deal, continued to mourn over her father, she became nervous a lot when around other people and she reported that she experienced some social phobic problems. She reported that her appetite was erratic, but she denied any obsessive-compulsive symptoms. Dr. Liotta reported that the claimant's mood was markedly depressed, she was easily tearful and she was tearful frequently during the evaluation. She reported depressive symptoms including crying, insomnia, loss of interest in activities, diminished appetite, diminished pleasure in activities, and suicidal ideation at times. In regards to bipolar symptoms, she reported that she could be up and down in her moods, but that being down was more prominent for her but she has times when she is up and when she feels as though she can handle things, and where she is more sociable and talkative and has less need for sleep. She also reported significant anxiety symptoms, but that they do not appear to be terribly frequent. She reported that her stress tolerance was very low, she becomes overwhelmed and she had some social phobic symptoms and some generalized anxiety symptoms. In regards to cognitive functioning, she reported poor memory, difficulty recalling what she had done or what she had read, she forgets appointments for herself and her son and her abstracting ability was very low based on similarities and proverbs. However, she was able to perform serial 3s, she was able to recall 3/5 words immediately and 3/5 on a second trial. Testing revealed that the claimant had significant problems on a list-learning task and story memory tasks scoring in the extremely low range on immediate memory. Her attention skills were also extremely low based on a digit span task and a coding task. Her delayed memory was also extremely low and test results indicated that she had trouble holding on to

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information that had been presented to her previously. Dr. Liotta further reported that her presentation in the testing and in the mental status examination suggested significant intellectual deficits and that her immediate memory, delayed memory, and attention were all in the extremely low range. Dr. Liotta opined that her cognitive skills were further diminished by her depression and when she was depressed and/or anxious, she would likely not function to her potential particularly on tasks requiring attention, concentration, and memory. Dr. Liotta concluded that the results indicated that she had significant difficulty with attention, concentration and with learning new tasks, but that her insight and judgment were fair. In addition, further testing revealed that the claimant had particular difficulty in processing auditory presented information and that her level of depression made her quite inconsistent in her ability to attend and concentrate. Dr. Liotta opined that her general level of functioning overall appeared to be typically lower than would be anticipated given her IQ scores. However, the claimant reported that she was able to take care of her activities of daily living and that her son helped with some tasks around the house. In regards to social functioning she can get along adequately with people but had some social phobic symptoms at times. Dr. Liotta diagnosed the claimant with a major depressive disorder recurrent, rule out bipolar disorder, currently moderate severity, anxiety disorder not otherwise specified with some social phobic and generalized features and low stress tolerance, expressive language disorder, attention deficit hyperactivity disorder primarily inattentive type and developmental coordination disorder, primarily by history. Dr. Liotta determined that the claimant had a current GAF 45 and that her GAF for the past year was likely 49, which is indicative of a person who has serious symptoms or any serious impairment in social, occupational, or school functioning. However, she would be able to handle her own funds. In a Medical Source Statement, Dr. Liotta opined that the claimant had marked limitations in her ability to understand, remember, carryout and make judgments on complex work-related instructions and decisions, but she had only moderate limitations with understanding, remembering, carrying out and making judgments simple work-related instructions and directions. Dr. Liotta opined that the claimant had marked limitations with her ability to respond appropriately to usual work situations, moderate limitations with interacting appropriately with the public and only mild limitations interacting appropriately with supervisors and coworkers. In addition, Dr. Liotta opined that that the claimant had a low stress tolerance, her expressive language deficits and auditory deficits would also interfere with the claimant's social functioning at times and her ability to consistently perform work-related activities was significantly limited (Exhibits 37F and 38F).

The undersigned has accorded Dr. Liotta very little weight in assessing the claimant's residual functioning capacity, as he only examined one time and apparently relied quite heavily on the subjective report of symptoms and limitations provided by the claimant, and seemed to uncritically accept as true most, if not all, of what the claimant reported. Yet, as explained elsewhere in this decision, there exist good reasons for questioning the reliability of the claimant's subjective complaints.

In sum, the above residual functional capacity assessment is supported by the claimant's ability to perform and maintain good activities of daily living as described by examining health providers. The claimant described activities, which are not limited to the extent one would expect, given her complaints of disabling symptoms and limitations. The claimant reported that

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she had anxiety, depression and bipolar disorder and had difficulty meeting new people and being in large crowds. However, there is evidence that the claimant has not been compliant in attending mental health treatment, which suggests that the symptoms may not have been as limiting as the claimant has alleged in connection with this application. The claimant reported that her symptoms were minimal and that she did not need any mental health treatment (Exhibit 5F). The claimant also testified that her doctor took her out work because she was unable to handle the stress and emotional demands of work. However, the record documented that the claimant was laid off from working and she did not look for other work because she wanted to stay home with her children (Exhibit 5F). The claimant has provided inconsistent information regarding the severity and treatment undergone for the allegedly disabling impairments. Although the inconsistent information provided by the claimant may not be the result of a conscious intention to mislead, nevertheless the inconsistencies suggest that the information provided by the claimant generally may not be entirely reliable. The claimant reported that she had been seen by an orthopedic specialist, had two MRIs that showed she had a torn meniscus and that she was told she should use a cane (Exhibit 13F). However, there is no indication in the file or in any forms that were completed on behalf of her application for benefits, that she had a torn meniscus, used any assistance devices nor was there an MRI that confirmed a tom meniscus. The claimant reported that she went to the emergency room twice for severe exacerbations of asthma (Exhibit 13F). However, the record documented only one emergency room visit, in 2004, for a sore throat and she was prescribed antibiotics (Exhibit 9F). The claimant has not generally received the type of medical treatment one would expect for a totally disabled individual. The record reveals relatively infrequent trips to the doctor for the allegedly disabling symptoms as well as frequent cancellations and no shows. The record does not contain any opinions from any treating physician indicating that the claimant is disabled or even has limitations greater than those determined in this decision. Furthermore, there is evidence in the file that the claimant was doing better with medications but had been noncompliant with mental health treatment and did not follow through with recommendations from her treating physician, which shows that her alleged impairments are not as disabling as alleged. The claimant testified at hearing that she was unable to get out of bed 15 days out of 30 due to severe psychiatric problems. However, her only indication of such severe symptoms was in March 2012, when she reported that she was feeling depressed and tearful and that she had difficulty getting out of bed the day before (Exhibit 32F), which does not support her allegations of severe disabling mental health problems. The claimant testified that she had never had a driver's license. However, in a consultative psychological evaluation, performed in October 2005, the claimant reported that she had driven to the evaluation in her own car (Exhibit 2F). In 2011, Dr. Kabeli specifically advised the claimant to be cautious when driving and to never drive while sleepy or tired (Exhibit 28F). In August 2012, the claimant reported to a psychological examiner that she was currently on a waiting list to get back into mental health treatment (Exhibit 37F). However, she had not attended any mental health treatment at all. In addition, at hearing, which was held five months later, she testified that she had sought mental health treatment, but had not obtained any because she was on a waiting list. These inconsistencies further undercut her testimony. Given claimant's lack of credibility on these matters, her testimony as a whole is given little to no weight in establishing his residual functional capacity. She reported that she had difficulty sleeping and would get up and play video games, because they helped to relax her, but would have problems getting up in the morning. However, once she got her children off to school, she would go back to bed and would sleep for several hours without any difficulties (Exhibit 2F).

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The claimant has not generally received the type of medical treatment one would expect for a totally disabled individual. The record indicates that the claimant stopped working due to a business-related layoff rather than because of the allegedly disabling impairments. Further, there is no evidence of a significant deterioration in the claimant's medical condition since that layoff. The claimant has been prescribed and has taken appropriate medications for the alleged impairments, which weighs in the claimant's favor, but the medical records reveal that the medications have been relatively effective in controlling the claimant's symptoms. Lastly, in rendering this decision, the undersigned Administrative Law Judge has also considered the claimant's obesity pursuant to the guidelines set forth in SSR 02-1p.

5. The claimant is unable to perform any past relevant work (20 CFR 416.965).

The claimant has past relevant work as an assembly worker (Exhibit 4E). The vocational expert testified that the claimant was unable to perform her past relevant work due to performing more than occasional standing and frequent contact with others. Accordingly, the claimant is unable to perform past relevant work.

6. The claimant was born on November 6, 1968 and was 41 years old, which is defined as a younger individual age 18-49, on the date the application was filed (20 CFR 416.963).

7. The claimant has at least a high school education and is able to communicate in English (20 CFR 416.964).

8. Transferability of job skills is not an issue in this case because the claimant's past relevant work is unskilled (20 CFR 416.968).

9. Considering the claimant's age, education, work experience, and residual functional capacity, there are jobs that exist in significant numbers in the national economy that the claimant can perform (20 CFR 416.969 and 416.969(a)).

In determining whether a successful adjustment to other work can be made, the undersigned must consider the claimant's residual functional capacity, age, education, and work experience in conjunction with the Medical-Vocational Guidelines, 20 CFR Part 404, Subpart P, Appendix 2. If the claimant can perform all or substantially all of the exertional demands at a given level of exertion, the medical-vocational rules direct a conclusion of either "disabled" or "not disabled" depending upon the claimant's specific vocational profile (SSR 83-11). When the claimant cannot perform substantially all of the exertional demands of work at a given level of exertion and/or has nonexertional limitations, the medical-vocational rules are used as a framework for decisionmaking unless there is a rule that directs a conclusion of "disabled" without considering the additional exertional and/or nonexertional limitations (SSRs 83-12 and 83-14). If the claimant has solely nonexertional limitations, section 204.00 in the Medical-Vocational Guidelines provides a framework for decisionmaking (SSR 85-15).

If the claimant had the residual functional capacity to perform the full range of light work, a finding of "not disabled" would be directed by Medical-Vocational Rule 202.20. However, the claimant's ability to perform all or substantially all of the requirements of this level of work has

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been impeded by additional limitations. To determine the extent to which these limitations erode the unskilled light occupational base, the Administrative Law Judge asked the vocational expert whether jobs exist in the national economy for an individual with the claimant's age, education, work experience, and residual functional capacity. The vocational expert testified that given all of these factors the individual would be able to perform the requirements of representative occupations such as: a table worker, Dictionary of Occupational Title (DOT) number 734.687-014, considered light exertional demand, is unskilled with a Specific Vocational Preparation (SVP) of 2, with 249,000 positions in the national economy, 23,000 in the state economy with a 25 percent erosion factor due to not being able to remain in one position; investigator dealer accounts, DOT number 241.367-038, considered light exertional demand, is unskilled with a SVP of 2, with 211,000 positions in the national economy and 36,000 in the state economy; and as an assembler of electrical equipment , DOT number 729.687-010, considered light exertional demand, is unskilled with a SVP of 2, with 215,000 positions in the national economy, 4,000 in the state economy with a 25 percent erosion factor due to not being able to remain in one position.

Pursuant to SSR 00-4p, the undersigned has determined that the vocational expert's testimony is consistent with the information contained in the Dictionary of Occupational Titles.

Based on the testimony of the vocational expert, the undersigned concludes that, considering the claimant's age, education, work experience, and residual functional capacity, the claimant is capable of making a successful adjustment to other work that exists in significant numbers in the national economy. A finding of "not disabled" is therefore appropriate under the framework of the above-cited rule and SSRs 83-10, 83-12, 96-9p and 85-15.

10. The claimant has not been under a disability, as defined in the Social Security Act, since March 12, 2010, the date the application was filed (20 CFR 416.920(g)).

DECISION

Based on the application for supplemental security income filed on March 12, 2010, the claimant is not disabled under section 1614(a)(3)(A) of the Social Security Act.

/s/ Carl E Stephan

Carl E Stephan
Administrative Law Judge

January 25, 2013
Date

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March 21, 2013

Appeals Council
Office of Disability Adjudication and Review, SSA
5107 Leesburg Pike
Falls Church, Va 22041-32551

Re: [redacted]

Dear Appeals Council:

This letter- brief is submitted in support of [redacted]'s Request for Review of the January 25, 2013 unfavorable hearing decision denying Ms. [redacted] March 12, 2010 claim for SSI benefits. The unfavorable decision should be reversed because the ALJ failed to consider several severe impairments; because the ALJ's residual functional capacity assessment is not supported by substantial evidence and is erroneous as a matter of law; and because the determination that Ms. [redacted] is capable of work existing in the national economy is not supported by substantial evidence and is erroneous as a matter of law. The Appeals Council should reverse the hearing decision and, given the evidence of disability, issue a decision finding that Ms. [redacted] is disabled.

INTRODUCTION

Ms. [redacted] is currently 44 years old. She has a high school diploma, but was in special education throughout her schooling and earned only an Individualized Education Program (IEP) diploma, not a general education diploma. She has past relevant work as an assembly line worker. The Administrative Law Judge initially denied Ms. [redacted] SSI claim in a July 20, 2011 unfavorable decision. Exh. 3A. That determination was vacated by the Appeals Council and the case remanded for further consideration of Ms. [redacted]'s residual functional capacity and the extent to which her non-exertional limitations erode the occupational base for light work. Exh. 4A.

The January 25, 2012 unfavorable decision found that Ms. [redacted] has not performed substantial gainful activity since the filing of the SSI claim; has the severe impairments of morbid obesity, bilateral knee pain, insomnia, depression, anxiety, bipolar disorder, and borderline intellectual function; that the severity of Ms. [redacted] impairments did not meet or equal a Listing; that Ms. [redacted] had the residual functional capacity to do light work limited to rote, unskilled work involving simple work-related decisions, frequent but not constant interaction with others, and only minor changes in the work setting; that she was unable to perform any past relevant work; and that she was capable of performing other work in the national economy.

SEVERITY OF NEUROLOGICAL CONDITIONS

The Administrative Law Judge's failure to find that Ms. [redacted] Expressive Language Disorder, Attention Deficit/Hyperactivity Disorder, and Developmental Coordination Disorder are severe is erroneous as a matter of law and unsupported by substantial evidence. These conditions were each diagnosed in a January 17, 2005 Neuropsychological Evaluation. Exh 2F at pages 15-21. As in 2011 vacated hearing decision, the January 25, 2013 unfavorable decision failed to even mention this evaluation or discuss the conditions found in the evaluation.

The Neuropsychological Evaluation was performed because the Clinton County Department of Social Services had placed Ms. [redacted] children in foster care as Ms. [redacted] was not providing adequate care and supervision to the children. Exh. 21F at page 2; Exh. 2F at page 15. Ms. [redacted] was first given a psychological evaluation at Sunmount Developmental Disabilities Service Office, where it was determined that although Ms. [redacted] had been classified as mentally retarded throughout her schooling, she actually had a low average full scale IQ. Exh. 4F at page 4. The Sunmount report noted, however, that Ms. [redacted] adaptive functioning scores were in the range of mild mental retardation, that she had clear and significant difficulty processing verbal language, and that she had sustained a possible head injury in a motor vehicle accident. Exh. 21 F at 3-4. The Sunmount evaluation concluded that a neuropsychological assessment should be done to assess whether there was a neurological impairment as a basis for disability. Id. at page 4.

The neuropsychological evaluation concluded that Ms. [redacted] was deficit in three areas of visuospatial processing and problem-solving—sustained attention, expressive language and sensorimotor skills. Exh. 2F at page 20. The report stated that Ms. [redacted] attention was adequate in brief segments of time, but she had difficulty maintaining attention. Id. The report also found that Ms. [redacted] sensiormotor functions were significantly deficient, with severely impaired tactile discrimination bilaterally, slow learning of manual motor sequences, and very slow graphomotor speed. Id. at page 19. The report also found that Ms. [redacted] was limited in verbal reasoning, had trouble holding verbal concepts in mind and working them through due to weak auditory working memory and weakly developed verbal conceptualization and reasoning. Id. at page 20.

The hearing decision failed to even consider the Neuropsychological Evaluation—the evaluation simply is not mentioned in the hearing decision, despite a similar failing in the 2011 hearing decision having been noted in the prior Request for Review. See Exh. 10B at page 5. This is a significant failing, as Ms. [redacted] limited attention, deficit motor function, and expressive language deficits all have significant impact on her work-related function. As will be shown infra, the vocational expert testified at the remand hearing that Ms. [redacted] would not be capable of performing work in the national economy if she is off task even 20% of the time. As will also be shown infra, two of the three occupations the vocational expert identified in response to the Administrative Law Judge's hypothetical require frequent reaching and handling, tasks Ms. [redacted] cannot perform given her slow learning of manual motor sequences and very slow motor speed. Ms. [redacted] neurological conditions are severe because they have significant impact on her residual functional capacity, yet the conditions and the evaluation are not even mentioned or considered in the hearing decision.

RESIDUAL FUNCTIONAL CAPACITY

The residual functional capacity determination is also not supported by substantial evidence and is erroneous as a matter of law. In addition to failing to consider the effects of Ms. [redacted] neurological conditions on her residual functional capacity, the fundamental problem with the residual functional determination is that it finds Ms. [redacted] can sustain function for the equivalent of a full-time job despite numerous indications to the contrary in the record. This is accomplished by a selective reading of the opinion evidence, taking the opinion evidence out of context, and an outright astounding weighing of two crucial pieces of opinion evidence.

Turning first to the astounding, the hearing decision gives great weight to an opinion by a non-examining physician which is remarkable in its superficiality while giving no weight to a well-reasoned and supported opinion by a consultative examiner. The hearing decision violates 20 C.F.R. 416.927(c)(3) by doing so.

The hearing decision gives great weight to an opinion by Dr. Aaron Satloff (Exh. 36) that Ms. [redacted] has the ability to understand simple instructions, maintain attention and concentration, relate adequately with others, and adapt to changes. Hearing Decision at page 16-17. The weight accorded Dr. Satloff's opinion is simply inexplicable. Dr. Satloff is a non-examining physician. Furthermore, when asked to cite the particular medical signs, laboratory findings, or other factors supporting his opinion on degree of limitation, Dr. Satloff merely states: "19F". Exh. 36 at page 3 and page 5. No particular signs, findings or factors are identified at all. Even more astounding is Exhibit 19F itself—a form completed by another non-examining physician. Despite the wealth of evaluations and opinions contained in a voluminous record addressing Ms. [redacted] multiple mental and neurological impairments, Dr. Satloff manages to cite the opinion of the other non-examining physician as the sole and only support for his conclusions. Dr. Satloff's opinion is remarkable only for its superficiality and its distinct lack of support, yet it is given great weight in the hearing decision. Under 416.927(c)(3), the more citation to signs, symptoms and findings, the more weight is given to an opinion. Dr. Satloff provides no citation to signs, symptoms or findings, yet his opinion is given great weight. Under 416.927(c)(3), the better an explanation is given for an opinion, the more weight is given to that opinion. Dr. Satloff gives no explanation for his opinion save a terse reference to another non-examining physician, yet his opinion is given great weight. Under 416.927(c)(3), the weight given to a non-examining physician depends on the degree to which supporting evidence is provided. Dr. Satloff provides no supporting evidence, yet his opinion is given great weight. The weight given Dr. Satloff's opinion is simply inexplicable.

As remarkable as the great weight given to Dr. Satloff's superficial opinion is the "very little weight" given to the opinion by Dr. Richard Liotta (Exh. 37F and Exh. 38F). Hearing Decision at page 18. The hearing decision found that Dr. Liotta "relied quite heavily on the subjective report of symptoms and limitations provided by the claimant, and seemed to uncritically accept as true, most, if not all, of what the claimant reported." Id. This is a spurious and unsupported conclusion.

Dr. Liotta begins his narrative report with a thorough review of the mental and neurological evaluations in the record, including that of Dr. Satloff. Exh. 37F at pages 1-4. Dr.

Liotta's report specifically cites the findings in these evaluations in commenting "her history and the information reviewed suggest the likelihood of more functional deficits than Dr. Satloff concluded she had..." Id. at page 4. Moreover, Dr. Liotta did more than simply report what Ms. [redacted] told him during the evaluation. Dr. Liotta conducted a mental status examination, which included his observations of Ms. [redacted] dress, hygiene, speech, associations and mood. Id. at page 6. Dr. Liotta administered tests based on similarities and proverbs ("abstracting ability very low"); serial 3s ("able to do serial 3s though extremely slowly"); and two trials of word recall ("able to recall 3/5 words immediately and 3/5 on a second trial"). Id. Dr. Liotta administered the Repeatable Battery for the Assessment of Neuropsychological Status (RBANS), an individually administered test for cognitive decline, to get more information regarding Ms. [redacted] cognitive functioning. Id. The RBANS showed that Ms. [redacted] was more than two standard deviations below the mean on immediate memory, language, attention, and delayed memory. Id. She was nearly three deviations below the mean on attention. Id.

Dr. Liotta did not simply uncritically accept what Ms. [redacted] told him—he conducted a thorough review and evaluation including objective tests to reach his conclusion. Based on the mental status examination and the RBANS, Dr. Liotta concluded that consistency is likely to be a significant problem for Ms. [redacted] due to the demonstrated significant deficits in memory, attention and concentration. Id. at page 8. Asked to assess Ms. [redacted] ability to do mental work-related activities, Dr. Liotta stated she had moderate limitations on the ability to understand, remember, and carry out simple instructions and make judgments on simple work-related decisions and marked limitation on the ability to understand, remember and carry out complex instructions and the ability to make judgments on complex work-related decisions. Exh. 38F at page 1. Dr. Liotta cited the significant difficulty with attention, concentration, and memory in his narrative report and noted the sustained ability to perform all these tasks is particularly problematic. Id. Dr. Liotta also found that Ms. [redacted] had marked limitation in the ability to respond to usual work settings and changes in the work setting, citing low stress tolerance and noted again that the ability to consistently perform work-related activities is significantly limited. Id. at page 2.

Pursuant to the standards of 416.927(c)(3), Dr. Liotta's opinion should be accorded great weight: his evaluation cited specific medical signs, findings and test results for his conclusion. He has provided a thorough explanation and support for his conclusions, including a detailed review of the mental health records, objective testing, and a mental status examination.

Turning next to the opinions taken out of context, the Hearing Decision accords "great weight" to statements made in discharge summaries from in-patient psychiatric treatment Ms. [redacted] received in 2006 and 2011 (Exh. 4F; Exh. 30F). Hearing Decision at page 11 and page 15.

On June 18, 2006 Ms. [redacted] was admitted to the CVPH Medical Center's Mental Health Unit. Exh. 4F. She was admitted "on a 939 from the ECC." Exh. 4F at page 5. New York Mental Hygiene Law 939 is the section of state law under which an individual can be involuntarily admitted to psychiatric in-patient treatment. The statute provides that an individual may be involuntarily admitted only if a staff physician determines that the person is likely to be a danger to themselves or others if not involuntarily admitted for treatment. When discharged from the CVPH Mental Health Center 10 days later, on June 27, 2006, the discharge physician

noted that her mental status was good. However, this discharge summary is conducted to determine if the patient presents a danger to themselves or others, not whether the person is capable of basic mental work activities or sustaining competitive work. Similarly, Ms. [redacted] was again involuntarily admitted to the CVPH Mental Health Unit from November 28, 2011 until December 2, 2011. (Exh. 30F). Similarly, the discharge physician found that Ms. [redacted] mental status was good. Id. page 2. The Hearing Decision treats these discharge summaries as though they offered opinions regarding Ms. [redacted] basic mental work activities and her ability to sustain competitive work. The discharge summaries indicate that Ms. [redacted] was no longer considered an imminent threat to commit suicide. The discharge summaries certainly do not support the conclusion that she is capable of competitive work activities, nor do they purport to do so.

In short, the residual functional capacity determination is not supported by substantial evidence. While Ms. [redacted] is capable of maintaining her attention and concentration for short periods, she is not capable of sustaining attention and concentration for the sustained period contemplated in SSR 96-8p—8 hours per day, five days per week or the equivalent. She is not capable of performing simple work activity on an ongoing basis.

WORK WHICH EXISTS IN THE NATIONAL ECONOMY

In response to a hypothetical question by the Administrative Law Judge asking if there was work in the national economy for an individual capable of light work limited to rote, unskilled work involving simple work-related decisions, frequent but not constant interaction with others, and only minor changes in the work setting, the vocational expert identified three occupations: Investigator, Dealer Accounts (DOT Code 241.367-038); Table Worker (DOT Code 734.687-014) and Assembler, Electrical Accessories (DOT Code 729.687-010). The vocational expert further testified that a person with the limitations in the hypothetical would not be capable of performing any work in the national economy, including the three identified occupations, if they were to have more than one unscheduled absence from work per month or if the individual was off task 20% or more of the work time.

The residual functional capacity erroneously established by the Administrative Law Judge fails to account for Ms. [redacted] inability to remain on task for more than 80% of the work day and her inability to consistently perform even simple work activities. As noted by Dr. Liotta and the Neuropsychological Evaluation, Ms. [redacted] will not be able to maintain her attention for 80% of an 8 hour workday. She will not be able to avoid unscheduled absences due to her anxiety and depression. Indeed, either one of her involuntary psychiatric admissions would have resulted in the loss of any of the occupations identified by the vocational expert.

Additionally, she is not able to perform any of the three occupations identified by the vocational expert. The Dictionary of Occupational Titles (DOT) and Selected Characteristics of Occupations Defined in the Dictionary of Occupational Titles (SCO) descriptions of the three occupations are attached hereto. The Investigator, Dealer Accounts position is simply beyond the simple work limitations expressed in the Administrative Law Judge's residual functional capacity evaluation and hypothetical. The occupation may be unskilled, but it requires Reasoning Development commensurate with solving practical problems and dealing with a variety of concrete variables in situations where only limited standardization exists and

interpreting a variety of instructions in written, oral, diagrammatic, or schedule form; requires Mathematical Development commensurate with computing discount, interest, profit and loss, commissions, markup and selling price, ratio, proportion and percentage; and requires Language Development commensurate with a wide variety of reading, writing and public speaking abilities. DOT at page 212, 1010-11 (Reasoning Development at Level 4, Mathematical Development at Level 3 and Language Development at Level 4). Ms. [redacted] is not capable of these levels of function given her Borderline Intellectual Function and Expressive Language Disorder. The Table Worker and Assembler positions both require Frequent Reaching and Handling. SCO at page 284. Ms. Gokey is not capable of this given her Developmental Coordination Disorder.

CONCLUSION

The unfavorable hearing decision is not supported by substantial evidence and is erroneous as a matter of law. Given the testimony of the vocational expert regarding jobs available in the national economy for a person with Ms. [redacted] limitations, the hearing decision should be vacated and benefits awarded. If this case is remanded for any reason, it should be assigned to a different Administrative Law Judge. The weighting of the evidence in the hearing decision, as well as the failure to consider the Neuropsychological Evaluation in two different hearing decisions, shows that the Administrative Law Judge authoring the January 25, 2013 hearing decision is biased against Ms. [redacted] claim.

Sincerely,

Peter Racette
Deputy Director