Avoiding Common Mistakes in Social Security Disability Claims
Donald J. Chewning
Winter, Chewning & Geary, LLP

Introduction

Social Security disability hearings are unique proceedings. They are non-adversarial. They are usually very brief (seldom more than an hour long). They are informal and not subject to the rules of evidence. They are heard by judges who hear only Social Security disability and Supplemental Security Income (SSI) claims. The disability system operates with traffic court-level caseloads, but each case must be resolved with a well-articulated decision that is subject to further administrative review and ultimately judicial review in federal district court. The stakes are also tremendously high for the claimants. Most claimants are unemployed and have significant medical problems. Many are uninsured. The minimal level of financial security provided by Social Security disability or even SSI benefits can be life changing for the claimant. Access to healthcare through Medicaid or Medicare may be lifesaving.

While the stakes are high, the nature of the proceedings sometimes lulls lawyers into a sense of complacency. There is a common misperception that there is nothing that occurs in the administrative proceedings that cannot somehow later be undone. For a general practitioner who may have a caseload of personal injury, divorce and worker’s compensation cases, the small Social Security disability file which provides a relatively modest contingent fee may not get the attention it deserves.

As an attorney who practices only in the area of Social Security disability and SSI claims, I have had the opportunity to learn from my own mistakes, but also to see how others are conducting hearings through my appeal practice. I am frequently contacted by claimants who have lost at the ALJ stage. For whatever reason, many attorneys decline to pursue appeals further to the Appeals Council. Far too often, I am struck by errors and omissions made by previous counsel when listening to the audio of the hearings and reviewing the case file. The purpose of the following materials is to highlight some mistakes in the hope that general practitioners who wade into the waters of Social Security disability hearings more ably represent their claimants.

A. Fully Develop the Evidentiary Record. Typically, evidence in a Social Security disability claims file consists of medical records, forms completed by the claimant at the initial application and reconsideration stages, occasional third-party statements, reports of any consultative examinations, and forms completed by non-examining Social Security physicians and psychologists. If you do not supplement the record, the file that arrives at the hearing office from the state agency will essentially be the record before the judge. While the regulations and Social Security rulings put an obligation on the ALJ to fully develop the record, realistically it is up to the representative to provide additional evidence. Typically, the Social Security Administration (SSA) obtains no additional documentary evidence after the hearing request is filed.

1) Obtain and submit all material medical evidence. Surprisingly, the failure to give the judge all material medical evidence is the number one mistake that I see repeated by attorneys.
A representative simply must obtain a copy of all relevant treatment records. The failure to submit all material evidence at the hearing level frequently cannot be undone. While you can submit additional medical evidence to the Appeals Council, the Appeals Council does not typically remand cases based on that fact alone. Moreover, if there is a subsequent appeal to federal district court, only the record before the ALJ will be considered. While the new and material evidence that has been submitted to the Appeals Council may be part of the federal court transcript, under current Seventh Circuit precedent it typically cannot be used to undermine the ALJ’s rationale. See Eads v. Secretary of Dep’t of Health & Human Servs., 983 F.2d 815, 817-18 (7th Cir. 1993).

a) **Identify all relevant treatment sources.** The difficulty sometimes lies in getting accurate information from your client regarding where they have treated. Some networks of providers have an integrated system making obtaining medical records easy. Others keep records on a clinic-by-clinic basis, requiring that you quiz (sometimes interrogate) your client about all facilities where they have actually received treatment. Look out for references in medical records to other treatment providers your client may have failed to disclose to you. Communication with clients about where they have been treated and who they have seen is critical to developing a complete medical record.

b) **The records obtained by the state agency are probably incomplete.** Do not rely on the medical records that were obtained by the SSA in connection with the initial application and reconsideration stages. Like you, the SSA is reliant upon the claimant to identify treatment providers. If the client has provided incomplete information in the Disability Reports completed at the initial application and on appeal, Social Security will not obtain the records. Further, Social Security typically only orders records back a year prior to the alleged onset date. In some cases, ordering records back much further is appropriate. For instance, if your client has not had recent treatment due to lack of insurance or other reasons, the medical evidence necessary to establish the existence of an impairment may be quite old. Further, some conditions such as mental health problems and chronic pain conditions do not appear overnight, but rather develop gradually and may ultimately worsen to the point where a claimant can no longer work. Sometimes having a full view of the longitudinal medical record well before the claimant stopped working is critical to bolster the claimant’s credibility regarding their descriptions of their condition.

c) **Use caution in obtaining medical records that significantly predate the onset date.** Conversely, it will likely annoy some judges to receive volumes of old records of questionable relevance. By ordering records back many years, you may also unnecessarily end up with adverse medical evidence or evidence of anti-social behavior (e.g., DAA, prescription drug abuse, criminal behavior) that will unnecessarily taint your claimant in the eyes of a judge. You may feel ethically compelled to submit rather than withhold such evidence. (See below.) Throwing hundreds of pages of old medical records at the judge also may be self-defeating if your case hinges on more recent treatment records upon which you need the judge to focus.

d) **Advance the cost of ordering medical records.** Fortunately, for practitioners in this area of practice, Wisconsin statutes provide a discounted rate for the copies of medical records. Pursuant to Wis. Stat. § 146.83(1f)(am), a medical provider cannot charge an individual
appealing the denial of Social Security disability or SSI benefits more than the amount paid by
the SSA. SSA currently reimburses doctors at the rate of $26.00 per request.

e) **Update the medical records periodically prior to the hearing.** If you wait until
immediately before the hearing to order all of the records since the client has been denied at
reconsideration, you are likely to be surprised by new developments. The sooner you look at
the medical records, the sooner you will be able to get out ahead of any problems, such as adverse
medical opinions referenced in the doctor’s notes. You also need to review the most recent
medical evidence in order to know which doctors may be supportive of the disability claim and
from whom to request opinion evidence. (See below.) Also, even if you are in regular contact
with your client in getting updates regarding their treatment, clients invariably will fail to tell you
about outside referrals, emergency room visits, or other treatment. Ongoing review of the
medical evidence will alert you to evidence that is potentially missing. If you wait until
immediately before the hearing, you will find yourself in a mad scramble to find all of the
material medical evidence.

f) **Submit all medical evidence electronically.** If you are not already participating in Social
Security’s Electronic Records Express medical records submission system, you should contact
your local hearing office and sign up. You can also sign up for e-folder access, which I strongly
encourage. The Social Security disability system is an increasingly digital world. With a
scanner, Adobe Acrobat and an internet connection, disability hearings can be conducted largely
in a paperless fashion. Electronic submission is the only way to guarantee that the medical
evidence is in the hearing office's hands.

g) **Make sure all evidence submitted is marked as an exhibit.** Prior to or at the hearing make
sure all of the evidence you have submitted has been marked as an exhibit. Simply submitting
the medical evidence will merely result in the evidence being placed in the "Case Documents"
section of the hearing office file. Evidence is not officially part of the record until it has been
marked as an exhibit. While hearing office staff ordinarily marks all submitted evidence as
exhibits, if a critical piece of evidence falls through the cracks, it will not be addressed in the
judge’s decision and you will be left to the whim of the Appeals Council for relief. If you have
electronic access to the e-folder, you can see in real-time what evidence has been marked and
alert the judge to any evidence which should be added.

h) **Submit all adverse medical evidence?** What to do upon receipt of adverse medical
evidence is the subject of some debate among some practitioners. For instance, if a doctor has
issued an opinion limiting your client to light work, in a case where that would result in a denial,
what should you do? The regulations state: "You must provide evidence, without redaction,
showing how your impairment(s) affects your functioning during the time you say that you are
disabled, and any other information that we need to decide your claim." 20 C.F.R.
§§ 404.1512(c), 416.912(c) (emphasis added). Some attorneys take the view that they are not
responsible for providing evidence that dooms their client’s case. I believe that is an ethically
risky proposition. A disability hearing is a non-adversarial proceeding. Under SCR 20:3.3, an
attorney's duty of candor to the tribunal is heightened to include disclosure of all material facts:
"In an ex parte proceeding, a lawyer shall inform the tribunal of all material facts known to the
lawyer that will enable the tribunal to make an informed decision, whether or not the facts are
adverse." SCR 20:3.3(d) (emphasis added). In my opinion, the obligations imposed by the regulations and duty of candor to the tribunal require all material medical evidence be disclosed to the ALJ. Social Security has not provided much guidance in this realm. There have been allegations that one large disability representative firm was routinely withholding adverse evidence.¹ I make it a practice to advise my clients that all medical evidence will be disclosed to the ALJ, whether good, bad or ugly. Aside from avoiding the risk of being the possible subject of an investigation or ethics complaint, it also gives you credibility with the ALJ. Also, adverse evidence may not actually spell doom for the case if you can effectively counter it. For example, by contacting the treatment provider and obtaining clarification or obtaining countervailing medical opinions, you may be able to rescue the claim from the effects of adverse medical evidence.

i) Do not submit duplicate evidence. You are wasting the judge’s time by submitting multiple copies of the same reports, even if they are found in the files of multiple providers. The only instance in which submission of duplicate medical evidence is justifiable is if it is necessary to show a doctor who rendered a medical opinion had all of the material evidence before him. For instance, if a primary care physician is relying on evidence produced in treatment with specialists, it may be worthwhile to leave duplicate reports from the specialists that are found in the primary care physician’s file to demonstrate the primary care physician’s knowledge of what transpired under the specialist’s care.

2) Verify that your client's work history is accurately described. At step four of Social Security’s sequential evaluation process, the claimant bears the burden of proof of establishing that he or she lacks the residual functional capacity to return to their "past relevant work" (i.e., any work done at substantial gainful activity levels for a vocationally significant duration within fifteen years of the date of adjudication or the claimant’s date last insured). Information regarding the claimant’s past work is typically derived solely from the claimant alone. Unfortunately, claimants sometimes take a lackadaisical approach when answering questions regarding such matters at the initial application stage and too often the claimant's answers are incomplete. A claimant is asked for information regarding the amount of weight lifted, time spent standing, sitting, walking, etc., for each job. For some reason, claimants are more than likely to understate, rather than overstate, the physical exertional requirements of past jobs. For claimants 50 or older, this may be the critical fact in deciding their case. If a claimant has erroneously described a job as light when, in fact, it was performed at the medium level of work, the early answers to these questionnaires will be the basis for the past relevant work determination, unless you clarify it. If you spot an error in the claimant’s work history early, address it in your prehearing brief and be prepared to have the claimant explain it at the hearing. Also, be on the lookout for work reflected in the claimant’s earnings history (DEQY) not previously described in the work history questionnaire. It is better that you address any discrepancies prehearing rather than leave it to the ALJ to question why some period of earnings in the record has not been otherwise addressed.

a) Address the claimant's cash work. With respect to cash jobs, have your clients be prepared to be entirely forthcoming about any work that they have done that they may not have

reported to the IRS. Some claimants are under the erroneous belief that this evidence need not be disclosed because it was not reported for tax purposes. Explain that they will not have any adverse tax consequences as they are shielded by the Privacy Act during the Social Security disability hearing. On occasion, such cash work may be reflected in medical records (e.g., treatment for an on-the-job injury). Candor about under-the-table work will seldom hurt the claim, whereas deceit about such a topic is not only a federal crime, it will undermine your claimant’s credibility entirely.

b) Be prepared to address any post-onset work. If your client has engaged in part-time work or an unsuccessful work attempt since the alleged onset date, get earnings statements reflecting the hours worked and the dollars earned and submit them into the evidence. The claimant bears the burden of establishing that they have not engaged in substantial gainful activity. The easiest way to address this is to document for the judge what the claimant has actually earned and how much work was actually being performed.

B. Have a Theory of the Case. Before you enter the hearing room, you must be able to concisely articulate why your client meets Social Security’s standards for disability. Some judges allow for a brief opening statement. This is an excellent opportunity to set forth a theory of the case and demonstrate your command of the law and the facts. Unfortunately, I have heard cases in which the representative simply recites a list of medical conditions without explaining to the judge why they matter. The judge presumably knows what the medical evidence says. Part of your job is to distill the facts of the case down to a concrete theory of disability.

1) Know the Regulations and Rulings. Developing the theory of the case requires that you have core knowledge of Social Security Disability’s regulations and rulings. There are numerous primers available to instruct you if you are unfamiliar with the substance of Social Security disability law. I recommend Thomas Bush’s Social Security Disability Practice published by James Publishing and Charles Hall’s treatise of the same name published by West. Included within the regulations are the Listings of Impairments. See 20 C.F.R. Pt. 404, Subpt. P, App. 1. Although the listings are typically not the basis for a finding of disability at hearings, you should be familiar with them and how they may apply to the facts of your case. For most mental health cases, you can argue that your client should prevail at either step three or step five. Knowing how frequently-encountered listings – such as the listing for mental retardation (listing 12.05) – operate is absolutely essential in representing mentally ill claimants. More commonly cases are won or lost based on a claimant’s ability to meet the “grids” (i.e., the Medical Vocational Guidelines found at 20 C.F.R. Pt. 404, Subpt. P, App. 2). The grids circumvent the need for vocational expert (VE) testimony at step five in certain cases and are favorable to claimants ages 50 or older. Knowing how the grids operate is fundamental when representing a client who is 50 or older (or an illiterate or non-English speaker who is 45 or older). Lastly, familiarity with Social Security’s rulings, and in particular the "process unification rulings" issued in 1996 (SSR 96-1p through 96-9p) are absolutely necessary to effectively represent claimant’s in Social Security Disability and SSI claims.

2) If you don’t know where you are going, you are not likely to get there; nor are you likely to get the judge to follow. The universe of theories of disability is actually fairly limited. Usually you are arguing that your client meets or equals a listing, "grids out" due to his or her
age, education and work history or, in the case of most younger claimants, that they are simply incapable of full-time sedentary work. If your claim is premised on a step three listing-level argument, be prepared to offer the judge specific citations to the record indicating where medical evidence supporting the listing level impairment may be found. If you know your client will win simply by clearing step four, be prepared to articulate why the claimant cannot perform their past work. If you are asking that a treating source opinion be given controlling weight (see below), be ready to provide the exhibit number and articulate why the opinion supports a finding of disability. In cases that lack a medical opinion and are reliant on the claimant’s description of their impairments, you may be left with a relatively simple theory: namely, that your client’s anticipated credible testimony will establish the inability to perform regular and ongoing employment. In some cases it is a single impairment that is the backbone of your case. It may simply be the client’s need to elevate their legs that requires an accommodation not found in competitive work, or it may be the frequency and severity of migraine headaches that preclude regular attendance at employment. In other cases, there may be multiple impairments which in combination preclude even full-time sedentary work. For instance, if an individual is limited mentally to unskilled work, has a sedentary residual functional capacity (RFC) as determined by the state agency doctors, but also has significant manipulative limitations, you have a strong argument that the sedentary occupational base has been significantly eroded. See SSR 96-9p.

3) **Prepare a Prehearing Brief.** Getting a judge to focus on your theory of the case sometimes can only be accomplished through a prehearing brief. Some judges "require" them prior to the scheduling of a hearing. Some judges read them and are appreciative of them. Others ignore them entirely. Regardless, in the process of drafting a prehearing brief, you will ferret out the weaknesses of your case and hone the theory of your case. A good prehearing brief should not simply be a recitation of the medical evidence, but will also include a summary that is helpful in painting a picture of the claimant’s overall physical and/or mental health. A good brief should address the five-step sequential analysis, explaining why the claimant does not lose at steps one, two or four and why they should win at step three and/or five. A prehearing brief is an excellent place to address matters such as post-onset work and to preemptively address any issues with DAA lurking in the medical record. A prehearing brief is also a good place to articulate why an amended onset date is appropriate. Submit your prehearing brief early enough so that it is marked as an exhibit and catches the judge’s attention prior to the day of the hearing. One word of caution is to not make any concessions in the prehearing brief from which you may later wish to backtrack. For instance, even though you may be arguing that your claimant is disabled at step five, there is no reason to concede that the listings are not met or equaled. A judge may disagree with your assessment. It is also dangerous to try and classify your claimant’s past relevant work as light or sedentary if that classification is critical to your case. A VE may surprise you and conclude that a job that you had previously thought was sedentary is actually a light job, thus opening a path to a finding of disabled under the grids. Under those circumstances, you certainly would not want any unnecessary assertions in your prehearing brief deemed a stipulation to a lesser exertional level.

C. **Obtain a meaningful medical opinion from a treatment provider.** Under Social Security’s regulations and rulings, the opinions of treatment providers may be given special deference in the absence of conflicting medical evidence. The treating source rule provides "[i]f we find that a treating source's opinion on the issue(s) of the nature and severity of your
impairment(s) is well-supported by medically acceptable clinical and laboratory diagnostic
techniques and is not inconsistent with the other substantial evidence in your case record, we will
give it controlling weight." 20 C.F.R. § 404.1527(c)(2); 20 C.F.R. § 416.927(c)(2); see also
SSR 96-2p. In the absence of countervailing evidence, a well-grounded treatment provider’s
opinion should dictate the ALJ’s finding of a claimant’s residual functional capacity. In essence,
a treatment provider’s decision is given a presumption of validity if it is supported by the
acceptable medical evidence and is not contrary to other evidence in the file. If the only other
opinion evidence in the file are the opinions of a non-examining state agency doctor and/or
psychologist, a well-supported treating physician opinion should carry the day. Even if the
opinion is not deemed entitled to controlling weight, the ALJ must still consider the evidence and
explain what weight the treating source opinion is given. 20 C.F.R. § 404.1527(c)(2); 20 C.F.R.
§ 416.927(c)(2); SSR 96-2p.

1) The opinion must be well-supported by the medical records. In order for an opinion to be
well-supported, there must be some diagnostic or evaluative evidence in the file establishing the
claimant has a condition that would reasonably lead to the limitations described by a treatment
provider. But a confirmed diagnosis alone will not necessarily support the opinion if the medical
evidence suggests that the condition is not as severe as described in the opinion. If a treatment
provider's records routinely reflect a mild or asymptomatic condition, but the medical opinion
avers total incapacity, an ALJ can easily dismiss the treatment provider's opinion. If the treating
source's opinion is at odds with the underlying medical evidence, you cannot expect the treating
source rule to apply.

2) The more specific the limitations in the opinion, the better. In addition to being
supported by the treatment notes and diagnostic evidence, a good treating source statement must
address specific functional limitations. A conclusory statement by a doctor that the patient is
"disabled" is relatively meaningless. "Disabled" has different meanings and different contexts.
The level of "disability" necessary to receive a disabled parking permit is relatively minor in
comparison to the level of disability required to obtain benefits under the Social Security Act.
Social Security’s policy is that blanket statements regarding a claimant's inability to work are
statements on "issues reserved to the Commissioner" and not entitled to deference. 20 C.F.R.
§ 404.1527(d); 20 C.F.R. § 416.927(d); SSR 96-5p. While an ALJ must consider such
statements, id., such statements do little other than inform the ALJ that the doctor is supportive
of the disability claim.

3) Questionnaires to treatment providers are acceptable. It has become customary in the
practice of Social Security disability law to send doctors short questionnaires asking for a
medical opinion. These questions are often described as "RFC forms" or "Medical Source
Statements." The most widely-used questionnaires are found in Milwaukee attorney Tom Bush’s
Social Security Disability Practice published by James Publishing. The forms from Attorney
Bush's book are used widely and have been refined to address the areas of functioning most
relevant to a finding disability. I regularly use these forms or variations of them. Drawing a
doctor’s attention to the issues in a specific case and tailoring the form is helpful. You should
eliminate any questions from the "canned" questionnaires immaterial to the case. If the claimant
has no limitations regarding handling or reaching, you should not ask the doctor any questions
regarding manipulative limitations. A doctor too eager to help the patient may suddenly declare

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in a questionnaire that the claimant has a very restrictive use of his arms and hands, despite the absence of any medical evidence to support that claim. Avoid this problem by narrowing the focus of the questionnaire to those issues supported by the treatment notes. Remember, a shorter questionnaire is more likely to be completed by a busy doctor. You should also be prepared to pay a doctor for the time necessary to complete the form and provide opinion evidence.

4) **Narrative letters are helpful in explaining the link between the symptoms and limitations.** While treating source questionnaires are a staple of Social Security Disability practice, they are not a magic bullet. ALJs frequently deride opinions rendered in mere "check the box" forms. Doctors may also easily overstate the claimant’s functional limitations with a quick check of the box in a manner that undermines the opinion entirely. A medical opinion from a treating source can be "too good" in that it essentially decrees your claimant an invalid whereas the rest of the medical evidence and the client’s presentation at the hearing establish a more narrow set of impairments. A doctor who "shoots the moon" in a medical opinion is inviting the ALJ to disregard the opinion as being inconsistent with the objective medical evidence. While the questionnaires are helpful in directing the doctor's attention to vocationally relevant limitations, they may fail to link the claimant's symptoms to the functional limitations. A letter from a doctor explaining the medical diagnosis and symptoms and how they compare the claimant's functional ability (e.g. sit, stand, walk, lift, carry), is probably the most helpful form of medical opinion evidence. For instance, if a claimant has edema in his or her legs requiring that the claimant lift their legs at waist level or higher for a good bit of the day to alleviate swelling and pain, a questionnaire addressing a wide range of functional limitations may not be appropriate. It is likely the ALJ will agree that the claimant cannot stand or walk for long periods of time and the material issue in the case could be whether he or she can perform sedentary work. Under the circumstances, a letter narrowly addressing the limitations raised by the edema will be far more effective than a questionnaire, even if the form addresses leg elevation.

5) **Educate the treating source from whom you solicit an opinion.** Again, "disabled" and "disability" have different meanings in different contexts. A treatment provider may not consider the patient "disabled," but at the same time hold opinions that would justify an award of disability. If the claimant is over 50 years old and has a work history of only light or medium level jobs in the past, a finding of an RFC for sedentary unskilled work will typically result in a finding of disabled at step five. Thus, if you only need to establish that claimant is limited to sedentary work, it is sometimes helpful to explain that and to define "sedentary" for the doctor. It is unlikely that the doctor is aware that a restriction to sedentary work may result in a finding of disabled. A doctor may be reluctant to attach the word "disabled" to a claimant who obviously retains the ability to perform a desk job, but may be willing to acknowledge a limitation to sedentary work. At age 55, many claimants can be found disabled upon a finding of a light RFC. Yet, a doctor is not likely to declare a claimant "disabled" if he or she is still capable of light work. However, if your inquiry is focused on whether the claimant can do greater than light duty work, you may obtain a favorable opinion. Focusing the doctor's opinion in this manner may also help avoid sweeping statements about the claimant’s inability to work.

6) **Be careful what you ask for.** You should exercise some caution in requesting a medical opinion. A doctor may completely disagree that a claimant should be filing for disability. A treating source hostile to a disability claim can prove fatal. It is prudent to discuss with your
client whether he or she believes the doctor is supportive of the claim. If not, your client may be better off moving forward without a medical opinion than risking an adverse medical opinion. In my opinion, a treating source statement needs to be disclosed to Social Security whether favorable or adverse. Some attorneys justify withholding adverse treating source opinions on a "work product" theory. I believe that is a risky ethical proposition. Third party opinions are ordinarily only protected work product if they are the opinions of the non-testifying expert retained by the attorney to evaluate the claim. A treating source is much more akin to a fact witness or testifying expert. Any opinions rendered by such a witness would be discoverable in an ordinary civil matter. Thus, I customarily caution my clients that any adverse medical opinion evidence will be submitted and am selective when requesting medical opinions.

7) **Be creative if you are stonewalled.** Some doctors flatly refuse to complete questionnaires. Sometimes it is a clinic policy not to assist claimants in disability matters. I am aware of at least one physician who actually refuses to treat a patient who has a pending disability claim. In such situations, you obviously will not obtain a treating source opinion. In other cases, you may be able to obtain work restrictions from a doctor, but not answers to a questionnaire or a supportive letter. For some reason, doctors are willing to issue work restrictions as a routine matter, but are not willing to provide the same information if it is requested by an attorney. If it is a clinic-wide policy, sometimes the patient himself can obtain a favorable opinion by approaching the doctor directly during an office consultation. For this reason I always send a copy of any questionnaire sent to the doctor to the client instructing the client to bring it to the next appointment.

8) **Functional capacity evaluations may not be worth your client's money.** Sometimes physicians are willing to state that a claimant is "disabled," but are unwilling to provide any specific functional limitations. Such physicians will often require that a functional capacity evaluation (FCE) be completed. Ultimately, I leave the decision to pursue a FCE up to the client after consultation about the risks and benefits. FCEs can help or hurt your case. While they may be well-suited to address certain exertional limitations such as lifting and bending, they are poorly suited to address the claimant's ability to function on a full-time basis, day after day, week after week with chronic pain. It is not uncommon to have a client explain that on a good day they are fairly functional, and that he or she may be able to perform well on a two- or four-hour FCE, but will suffer the next day. An FCE will not capture that effect. Moreover, FCE's measure "self-limiting behavior" to an adverse effect of the claimant. If the claimant is unable or unwillingly to complete certain FCE tasks, even if it is due to pain or fatigue, they will be found to have self-limited and such a finding may be used against the claimant's credibility in an ALJ's decision. FCEs are also very expensive typically insurers will not pay for them. Most claimants are unable to afford an FCE on their own.

9) **Define and quantify the terms used in mental health questionnaires.** While psychiatrists and psychologists may believe the claimant is unable to work, they often have difficulty expressing what specific mental health related limitations prevent the claimant from working. Many "cookie-cutter" questionnaires follow Social Security's lead and use terms like "moderate" and "severe." ALJ's typically will not allow questioning of a VE based such a vague terminology. It is best to have a psychiatrist or psychologist quantify the claimant's functional limitations. For instance, a medical opinion indicating the claimant is likely to be off task 25% of
the time due to mental health impairments can be easily incorporated into the questioning of the VE at the hearing.

10) **Not all opinions are created equally.** It is very common in today's world of medical treatment for clients to see physician's assistants and nurse practitioners, as opposed to medical doctors or licensed psychologists. In the mental health field, social workers and licensed therapists routinely provide counseling services. While these opinions are important, they cannot be given controlling weight under the treating source rule because they are not from "acceptable medical sources." In a situation where a treating physician knows the claimant as well as a nurse practitioner or a physician's assistant, I ordinarily attempt to get the physician's opinion first. Most often, however, it is the physician assistant or nurse practitioner who knows the claimant best. In such cases, the nurse practitioner may be willing to provide a medical opinion and, often, the supervising physician will endorse the opinion. It is better to go in to your hearing with a supportive opinion even if it is not from an "acceptable medical source," than with no opinion at all. SSA has come to recognize the importance of these "other sources" to the modern health care system and has issued a ruling indicating the opinions should be considered and evaluated under the regulatory standards of 20 C.F.R. §§ 404.1527 and 416.927, and that they may even be given greater weight than the opinion of an acceptable medical source. SSR 06-03p.

11) **If you cannot obtain a medical opinion, not all hope is lost.** Do not give up a case simply because you cannot obtain a medical opinion to support the claim. ALJs should recognize the types of limitations that may reasonably stem from various medical conditions. The absence of a treating source's opinion simply means the resolution of the case will be even more dependent upon your client's credibility. If the medical evidence is otherwise supportive and your client can credibly explain the types of limitations that he or she has that could reasonably be expected to stem from the underlying physical or mental health problems, a good judge should find your claimant disabled despite the absence of a treating source opinion.

D. **Amend the Onset Date When Necessary to Conform to the Evidence.** When a Social Security disability or SSI applicant applies for disability, they are asked on what date their condition prevented them from working. In many cases, the answer is clear cut: the date of an accident or injury, the date of a surgery from which the claimant never recovered, or the date they were terminated from employment due to the inability to perform the job due to physical or mental problems. In many cases, however, the answer is not so clear. If the claimant had numerous periods of employment that were short-term or part-time work, their earnings record may allow for a disability claim that extends back many years. The SSA’s field office employees routinely calculate the date at which the earnings record reflects the last period of earnings at substantial gainful activity levels. SSA may also overlook periods of employment that are at substantial gainful activity (SGA) levels and determine they are unsuccessful work attempts. Thus, in some cases in which the claimant is not prepared to provide a date on which they are certain their condition prevented them from working, SSA will select a date as far back as the earnings record allows. This may pose a problem for you as the representative. The client may have inadvertently alleged an onset date that is wholly unsupportable. As you review the medical records, you may learn that they were engaged in non-work activities during the period of alleged disability completely inconsistent with the claim of disability. It may be apparent to
you that that claimant was not unable to work until much later in the period for which the claim was made. In such cases, it is often appropriate to amend the onset date to a date consistent with what is supported by the medical evidence and the claimant’s anticipated testimony at the hearing.

1) **Discuss possible amendment of the onset date with claimant.** Your client may actually be unaware of what date was actually alleged as his or her disability onset date. In such a case, spend time talking to the client to determine when he or she believes the condition worsened to the point that it precluded full-time work. Sometimes it is at or near the time the client decided to apply for disability benefits. Upon your review of the evidence, you may have dates in mind that are supported by treatment notes. If you determine that the onset date as originally alleged is unsupportable, you must first obtain your client’s informed consent before amending the onset date.

2) **A change in the claimant’s age category may warrant an amendment of the onset date.** Under Social Security’s rule, if a claimant cannot perform their past relevant work, they may be deemed to "grid out" under the Medical Vocational Guidelines upon reaching a new age category. Typically, this happens when the claimant turns age 50 or 55. For instance, a 49-year old claimant who is capable of performing sedentary work would be deemed not disabled, but the same claimant at age 50 may be deemed disabled, so long as he or she is incapable of performing his or her past jobs, is limited to sedentary work, and lacks skills transferrable to sedentary work. In such a case, it may be appropriate to amend the onset date to the claimant’s fiftieth birthday. Be mindful that judges do have some leeway in awarding benefits during the six months or so prior to a change in an age category under the "borderline" age category rules. If a judge is willing, the same claimant described above may be found disabled as early as age 49 and 6 months. A change in age category is the most common reason to amend an onset date.

3) **Know how amending the onset date will affect the claimant’s back benefit.** The claimant’s date of entitlement for Social Security disability claim will be the later of one year prior to the date of filing or five full calendar months following the date of disability. An SSI claimant’s benefits begin the first month in which the claimant was disabled after the claim was filed. Thus, a claimant who originally alleged a disability onset date of January 1, 2009, in an application filed in June 2011, could conceivably receive Social Security Disability benefits back to June 2010. If they amend their onset date, however, to January 1, 2011, their benefits will not begin until June 2011. The amendment thus results in a loss of one year’s worth of back benefits. The claimant must understand the implications of that amendment before the amended onset date is proposed to the ALJ.

4) **Explain to your client how an amendment of the onset affects Medicare eligibility.** For some claimants, the receipt of Medicare is the most critical component of an award of disability. For most cases, Medicare eligibility begins two years following the date of entitlement. Thus, in the above example, under the original onset date of January 1, 2009 alleged in a disability claim filed in June 1, 2011, the claimant will be entitled to Medicare as of June 2012; whereas, if the claim was amended to reflect an onset date of January 1, 2011, Medicare eligibility would not commence until June 2013.
5) **Amending the onset date may affect the dollar amount of the claimant’s monthly benefits.** Social Security uses a formula based on the claimant’s earnings record to calculate the Primary Insurance Amount (PIA), i.e., the monthly benefit amount. The PIA is not static. It changes over time based on Social Security’s formula. If the client amends his or her onset date, you need to advise that the benefit amount will likely be reduced if a later date of disability is alleged. If possible, it is the best practice to contact the local SSA and ask for a calculation of the PIA as of the original alleged onset date and the date of the proposed amendment. Only after the claimant is aware of the effects of the amendment on their benefits, are they giving knowing consent to the onset date amendment.

6) **At the hearing, be prepared to amend if such an indication is signaled by the ALJ.** Before going into the hearing, you should be aware of any issues that may call into question the claimant’s alleged onset date (e.g., receipt of unemployment compensation, limited treatment records, or work activity). If you and your client are prepared and certain of the date of an amendment, offer it to the judge prehearing so that the judge is made aware of the scope of the case as you intend to present it. Many times however, you will not know what the judge is thinking in terms of an amended onset date. Under Social Security’s new "secret ALJ" policy, you will not know the identity of the judge until you appear at the hearing office. Some judges strongly believe the receipt of unemployment compensation is inconsistent with a claim for disability. Others will ignore the issue entirely. Some judges will engage in open "negotiations" suggesting an onset date later than originally alleged. Others will not be so explicit, but may telegraph their intentions through comments to you. If an unforeseen amendment is suggested by the ALJ, request time off the record to consult with your client. You will be allowed to step out into the waiting room to address the onset date issue and inform your client of the consequences. Just because an ALJ proposes an amended onset date, the matter is not necessarily decided. You are free to reject a proposed amendment and risk an unfavorable decision; however, that is a risky strategic decision that must be left to the claimant. Advising your client to forgo an amendment proposed by the judge in exchange for an expressed or implied favorable decision and the award of benefits should only be done in very rare cases. If you have an additional onset date that you believe is supported by the evidence, be prepared to present it to the judge with citations to the record.

7) **Be mindful of the date last insured.** In order for a Title II claim to be successful, a claimant must prove the disability existed prior to the date last insured (DLI). Thus, if you are presented with the decision as to whether to amend the onset date, it cannot fall after the DLI. If you do so, the Title II claim will be dismissed and the benefits will be limited to a Title XVI (SSI) only claim. If the claimant is not financially eligible for SSI, amending the onset date past the DLI will terminate the claim in its entirety. In some rare cases, abandoning the Title II claim may be supported by the record. For instance if, at the suggestion of the field office, the claimant alleges an onset date that predates an otherwise remote DLI, there may be no hope of obtaining Title II benefits. Fighting for disability benefits when the medical record does not support it can undermine the claimant’s credibility. It can risk even the award of Title XVI benefits. Thus, in the rare cases where you conclude there is no possibility of a favorable Title II decision, advising your client to forego the Title II benefits and pursue SSI only may be the only rational choice. Proceed with extreme caution and make sure your client is fully advised of the consequences as they are giving up a claim not only to SSD benefits, but also Medicare. In a
case where the claimant is relinquishing Title II benefits, it is good practice to ensure there is an adequate colloquy with the claimant on the record at the hearing documenting under oath that he or she understands what he or she is giving up, and that it is being done freely, knowingly and voluntarily upon consultation with you.

8) **Document the claimant’s decision to amend the onset date.** It is a good practice to have the client acknowledge in writing that he or she is freely and voluntarily amending the onset date after receiving advice from you. If this is not adequately documented, you risk being subjected to accusations that you amended the onset date unilaterally. At times, the decision to amend the onset date can be made rather quickly in the midst of a hearing where written acknowledgment may not be possible. In such cases, the brief colloquy on the record between the judge, you and the claimant regarding the decision to amend the onset date is good practice.

E. **Have Your Client Ready to Testify.** If the claimant’s case hinges in any way on subjective symptoms – as most cases do – your client’s credibility and testimony may be key to the case. If the medical evidence establishes the existence of a condition which can reasonably cause the claimant’s claimed functional limitations, then the ALJ must evaluate the claimant’s credibility to determine whether the problems are as severe and significant as the claimant alleges. SSR 96-7p. Credibility is crucial in cases of chronic pain and mental health problems, where the subjective experience of the symptoms may vary widely among different individuals with the same diagnoses.

1) **ALJs differ considerably in how they question the claimant.** There are different styles of judging in disability hearings. Some judges seem very open minded and want to flesh out all aspects of the case and make the right decision. Others take a more adversarial approach in which they focus on the weak aspects of a case and, only if the client holds up under questioning, will the claimant be deemed disabled. Some judges turn the questioning over to you completely and allow you to build your case, asking only limited follow up questions. Given the new "secret ALJ" policy, a client must be prepared to address the full spectrum of possible styles of your local hearing office’s ALJ.

2) **Meet with your client prior to the day of the hearing.** Prepare your client by conducting a meaningful prehearing conference. Far too often, I encounter claimants who are represented by out-of-state firms who have never met with their attorney (or non-attorney representative) prior to the hearing. It is inconceivable to be adequately prepared to question clients regarding their daily activities, their experiences of pain or mental health symptoms and their work history without discussing these matters beforehand. You cannot build a level of trust crucial to a successful hearing when you are meeting for the first time outside of the hearing room.

3) **Advise your client to tell the truth.** It may seem axiomatic, but it is necessary to drive the point home that your client will be under oath and must be completely truthful in all aspects of the case. Many judges are looking for a reason to deny a claim. Of course there are obvious criminal consequences to providing false testimony under oath, but there are practical considerations as well. The client who skirts the truth on a non-consequential issue may give the judge sufficient reason to reject the client’s credibility otherwise. Most commonly, claimants are tempted to try to hide things they believe will get them into trouble in other contexts. A client
who is fully advised that he or she is protected from disclosure of any admissions made during the disability hearing is more likely to be fully candid about things that he or she would ordinarily not admit. For instance, a claimant who uses or has used street drugs may not be inclined to be honest with an authority figure such as a judge about such criminal behavior unless he or she is properly advised to tell the truth with impunity. Similarly, claimants who have worked "under the table" need to understand that there will be no IRS implications based on any testimony offered at the hearing.

4) **Advise your client to avoid exaggeration.** Being overly dramatic or histrionic about pain will get the claimant nowhere. A matter-of-fact description of what they experience is much more effective. Some clients with chronic pain and mental health problems may be inclined to exaggerate. They may believe their own statements regarding their inability to sit for 10 minutes, but then proceed to sit through an entire 45 minute hearing without standing, squirming or evincing any level of pain. A good discussion with your client at the prehearing meeting will help test the veracity of his or her claims of limitations and will spare your client from the effects of exaggerated functional limitations. If a client claims to be unable to sit for 10 minutes, yet sits in your office for an hour, confront him or her with that fact.

5) **Prepare your client to provide specific examples of limitations activities of daily living (ADLs).** The number one way that an ALJ can attack a claimant's credibility in a written decision is to highlight the claimant’s ability to perform ordinary and routine daily activities. Although the Seventh Circuit has cited this practice as being "deplorable" it is employed by almost every ALJ in written decisions denying benefits. *Bjornson v. Astrue*, 671 F.3d 640, 645 (7th Cir. 2012) ("The critical differences between ADLs and activities in a full-time job are that a person has more flexibility in scheduling the former than the latter, can get help from other persons . . . and is not held to a minimum standard of performance, as she would be by an employer. The failure to recognize these differences is a recurrent, and deplorable, feature of opinions by administrative law judges in social security disability cases.") A claimant's ability to do laundry, take care of a dog, and go to the grocery store will be extrapolated as the ability to work a full 40-hour week. While it may be a deplorable aspect of disability adjudication, it is reality of these proceedings. A client whose daily activities on the surface may seem regular and normal, may have structured activities in a such a way to avoid exacerbating pain. A claimant may also receive assistance from others that allows him or her to engage in otherwise seemingly normal ADLs. Only a client who understands that their daily life will be on trial in a disability claim will be prepared to appropriately and credibly qualify to ALJ’s question regarding their daily activities. For instance, an ALJ may ask a claimant whether he or she vacuums, which may elicit a simple "yes" answer from a claimant. But, if your client is prepared, he or she will be ready to explain details, such as if the vacuuming is limited, whether the vacuuming consists of a one-room apartment, or whether the vacuuming is done on an infrequent basis. You need to delve into these issues with your client in your prehearing meeting and get to the bottom of what their daily lives are really like. If the client receives significant assistance from friends and family, be prepared to question your client about that at the hearing. Encourage your client to answer each of the ALJ’s questions, but explain the importance of describing qualifications or limitations. It can frustrate an ALJ if your client does not answer a yes/no question with a "yes" or a "no," but it is entirely appropriate for your client to qualify his or her answers. Although there is nothing black or white about ADLs, complete and thorough answers may save your
client’s credibility from being dismembered by an ALJ in a written decision because of "concessions" that they are able to keep house and care for themselves.

6) **Bring adverse facts in the medical evidence to your client's attention.** Another unfortunate aspect to Social Security disability claims is that a claimant’s medical records are treated as an actual transcript of the claimant’s life. Doctors sometimes have their own perceptions and biases, and treatment notes are often dictated at the end of a long day of seeing patients. A doctor's dictation may only reflect part of what the claimant relayed to the doctor or, it may distort it. If, in your review of the records, you come across seemingly problematic statements made by your client, confront them with this evidence before the hearing. Do not let the judge be the first one to address these statements with the claimant. If your client is first presented with such impeaching evidence at the hearing, he or she could dig themselves a deeper hole.

7) **Have your client be prepared to acknowledge "bad" facts.** Sometimes there is simply no explanation of bad facts. For instance, if your client regularly smokes marijuana and this fact appears in the medical records, admonish your client to acknowledge it at the hearing. During the prehearing meeting, play the role of devil’s advocate and confront your client with the bad facts to see how they respond. If they are inclined to minimize or explain away the negative facts, encourage your client not to. Explain it is best to be truthful and candid in acknowledging the facts and not defensive. This most frequently arises in the context of drug or alcohol issues. A person who is obviously an alcoholic but denies it at the hearing may simply be in denial, but nevertheless makes a poor witness. Similarly, if a claimant has problems complying with doctor’s orders regarding the appropriate use of pain medication, if they are not candid about such issues, he or she may be viewed as a drug seeker.

8) **Ask your clients to articulate why they believe they are disabled.** Most ALJs ask a claimant why they cannot work. Regardless of how you have cast the case in your prehearing brief, an unprepared claimant will give an incomplete answer. This is not to suggest you should coach your client. Rather, you should ask him or her beforehand why they believe they cannot work. If your client gives an incomplete answer, explain the need to give a complete answer to the ALJ articulating all reasons why he or she cannot work. Be careful not to put words in your client’s mouth. To maintain your credibility with an ALJ, avoid "coaching your clients." There is a vast difference between making sure a client understands the importance of articulating the entire basis of their disability claim and telling your client what to say. A scripted client is not a credible witness, but a prepared client is.

F. **Be Prepared to Address Adverse Evidence.** Although disability hearings are non-adversarial proceedings, a representative must be prepared to counter the effects of adverse evidence that appears in the medical records, the client’s earnings statement, or other information divulged by the client. If you go to the hearing expecting a one-sided presentation of the evidence highlighting only the favorable aspects of the case, you will likely be blind-sided in one of two ways: 1) either the ALJ will elicit testimony regarding the adverse evidence, leaving you scrambling to prepare a rebuttal; or 2) the ALJ will remain silent and marshal the adverse facts in the written decision. Some ALJs are very candid about their feelings about certain facts. For instance, if your client has described a level of physical activity to treating physicians that is
inconsistent with the claim of disability, the ALJ may confront your client at the hearing about such entries in the medical records and offer an opportunity to explain. Other ALJs, however, will simply allow the claimant’s testimony to develop as it may and then will impeach the claimant’s credibility in the written decision deeming the claimant not disabled. It is the representative’s job to get out ahead of any bad facts as they appear in the medical records and to be prepared to confront them as best you can. Having your client prepared to address adverse medical evidence or other seemingly bad facts upon questioning from the ALJ (or through your own questioning) can defuse the situation. Examples of common adverse evidence that you may encounter are as follows:

1) **Drug addiction and alcoholism (DAA).** Since 1996, the burden has been on the claimant to establish that any ongoing drug or alcohol issues are not material to the claimant’s alleged disability. 42 U.S.C. § 423(d)(1)(C) ("An individual shall not be considered to be disabled . . . if alcoholism or drug addiction would . . . be a contributing factor material to the Commissioner's determination that the individual is disabled.") If the medical records contain any suggestion of ongoing DAA or even a history of abuse, your client should expect to testify about drinking habits or illegal street drug use. Unfortunately, even if the claimant has maintained sobriety for many years, medical records may continue to list an alcohol or drug problem as a current diagnosis. When possible, document sobriety through negative drug tests or outside evidence. Common experience tells us many alcoholics and drug addicts hide their activities. However, a recovering alcoholic who has been active in Alcoholics Anonymous or another treatment program can usually articulate the length of their sobriety, describe any relapses, and explain the steps they have taken to maintain their sobriety. In most cases, only a claimant’s willingness to openly discuss past DAA issues and provide convincing testimony regarding their sobriety can counteract any suspicion on the part of a treatment provider of ongoing use. DAA issues are most important in mental health cases, as it is often difficult for a treatment provider to determine whether the DAA is a cause of the mental health problems, a symptom, or simply a form of self-medication. In such cases, be aware of SSA’s policy regarding the combined effects of mental health and DAA problems as reflected in an emergency teletype issued in 1996 -- the only source of guidance SSA has provided in addressing this situation. SSA Emergency Teletype, No. EM-96-94 (Aug. 30, 1996) ("When it is not possible to separate the mental restrictions and limitations imposed by DAA and the various other mental disorders shown by the evidence, a finding of 'not material' would be appropriate.")

2) **Unemployment compensation.** Most disability claimants also apply for and receive unemployment compensation through the state. In doing so, claimants assert to the Wisconsin Department of Workforce Development that they are ready, willing and able to work. When the same claimant subsequently applies for Social Security Disability or SSI, he or she is alleging an inability to work. This inconsistency may be used by an ALJ to tarnish the credibility of an otherwise well-meaning claimant. Most claimants do not view the receipt of unemployment compensation while attempting to obtain Social Security Disability as being duplicitous. Rather, it is a matter of survival. Disability proceedings linger for many months, and sometimes even years. Until benefits are approved, many claimants lack alternative sources of income to provide food for themselves and their families. Many ALJs are mindful of this and do not focus on the receipt of unemployment compensation. For others, however, preventing "double dipping" is of great importance. If a judge has marked as an exhibit a printout of the claimant’s receipt of
unemployment compensation, be prepared to address it at the hearing. Even in a case where the medical evidence strongly supports disability, you may encounter an ALJ who will require the claimant to amend the onset date. Other ALJs use the receipt of unemployment compensation as an arrow in their quiver to challenge the claimant’s credibility. They may ignore the receipt of unemployment compensation in a strong case, but impeach a claimant in a weaker case. The representative must be prepared to address unemployment compensation, and amend the onset date if necessary. In some cases, the receipt of unemployment is not inconsistent with the theory of disability at all. For instance, if an individual 50 years or older would be disabled if limited to sedentary work, he or she may be ready, willing and able to engage in sedentary employment. Despite this, many ALJs are still unwilling to allow a claimant to draw both unemployment compensation and Social Security Disability for the same period of time. Be aware that there is no bright line rule prohibiting the receipt of both. There are LIRC decisions indicating that a claim for disability benefits is not inconsistent with a claim for unemployment compensation. *McDonald v. Bestech Tool Corp.*, No. 08608578WB (Wis. Labor & Indus. Rev. Comm’n Mar. 6, 2009) ("However, the fact that an individual is receiving social security disability benefits does not mean he is unable to work for purposes of unemployment eligibility. In fact, an individual who is claiming social security benefits does not necessarily lose those benefits if he returns to work, suggesting that eligibility for social security benefits and the ability to perform some work are not mutually exclusive.") Social Security’s official policy is that unemployment compensation is simply a factor, among many, to be considered when evaluating a claimant’s credibility in a claim for disability. Memorandum from Chief ALJ Frank A. Cristaudo to All Administrative Law Judges, No. 10-1258 (Aug. 9, 2010) ("ALJs should look at the totality of the circumstances in determining the significance of the application for unemployment benefits and related efforts to obtain employment.")

3) **ADLs.** As mentioned above, a claimant’s day-to-day activities can be used against them to undermine their credibility. If your client is able to go the grocery store alone and do laundry, those relatively meaningless facts may be used against a claimant in an ALJ's attempt to justify an unfavorable decision. I hesitate to call it "adverse evidence" but, as explained above, that can be the reality. Your client’s ability to do cleaning, cooking, shopping, yard work, snow removal, child care, and hobbies can be problematic evidence. If the ALJ does not give your client the opportunity to explain his or her answers, it is your job to elicit a complete description. If you do not, your client’s testimony regarding the ability to sweep, vacuum, bathe, etc., will appear in the ALJ’s decision as justification for a denial. Some ADLs rightfully defeat a disability claim. If your client is participating in a bowling league, you are not likely to prevail. However, if the ALJ is forced to resort to your client’s ability to fold laundry once a week as evidence of an ability to engage in prolonged and sustained substantial gainful activity, the fault lies with the disability adjudication process. If an ALJ relies too strongly on mundane ADLs to defeat your client's credibility, consider pursing an appeal to federal district court. As mentioned above, there is favorable Seventh Circuit case law in this area. See, e.g., *Bjornson*, 671 F.3d at 645. Also, it is not uncommon for ALJ decisions to be exceedingly sloppy in describing the claimant’s daily activities. If an ALJ’s decision omits any qualifying testimony offered by your client, be prepared to appeal. Quite frequently, an ALJ’s decision will ignore testimony elicited from a representative regarding limitations of ADLs. The ALJ may simply rely on "yes" answers given by the claimant.
G. **Question the Vocational Expert (VE) and challenge the VE testimony if necessary.**

The VE has two primary roles at the hearing. First, the VE will classify and describe the claimant's past relevant work. Second, the VE will respond to hypotheticals posed by the ALJ and opine whether the past relevant work could be performed by someone in a similar situation. The VE will identify other jobs available in the national and regional economies that can be performed consistent with the hypothetical(s). Try to establish your client's case on both of these points (steps four and five of the sequential analysis) by questioning the VE. If the VE's testimony is detrimental, challenge it through cross-examination. The following is intended to offer general guidance in directing you towards the areas of inquiry that you should pursue in questioning the VE.

1) **Make sure the VE properly identifies the jobs that constitute your client's past relevant work.** If it looks like your case could get hung up on step four, you must try and address the problem by questioning the VE. First, make sure that the jobs cited as past relevant work were actually performed at SGA levels and for a sufficient period of time to be vocationally relevant. Familiarize yourself with the concepts of SSR 82-62 which define "past relevant" work. If any jobs were done at below SGA levels or for very limited duration, make a record establishing those jobs should not be considered as past relevant work.

2) **Always ask the VE for the Dictionary of Occupational Titles (DOT) codes for jobs cited as past relevant work.** Every attorney practicing in this area of law should familiarize themselves with the job categories and the basic organization of the Dictionary of Occupational Titles and its companion volumes, most significantly The Selected Characteristics of Occupations (SCO). Pursuant to SSR 00-04p, a judge is required to ask the VE whether his or her testimony is consistent with the DOT. Any deviation from the DOT must be explained on the record. If you are not familiar with the DOT, you will be unprepared to identify inconsistencies of a VE's testimony and the DOT. In addition to being DOT competent, familiarize yourself with the concepts set forth in SSR 82-61 and 82-62 so as to be prepared to address step four issues. Preferably, you will have anticipated how the VE will characterize the jobs in advance and thus will be prepared to cross-examine the VE. Problematic VE testimony at step four will come up in two forms: (1) jobs classified as being less physically exertional than the job described by the client; and (2) jobs described at a greater skill level than as described by the client. If the VE's original testimony about past relevant work is a stumbling block to a favorable decision, question the VE with the intent of forcing him or her to identify DOT codes consistent with the work described by the client – preferably at a higher exertional level and lower skill level. Have an electronic version of the DOT ready to look up any DOT codes you did not anticipate. Be prepared to address them at the hearing and, if necessary, ask that the record be held open for you to address the vocational testimony in a post-hearing brief.

3) **At step five, ask the VE hypotheticals consistent with your theory of the case.** Assuming there is no step four issue, the primary goal is to solicit an answer from the VE in response to a hypothetical that finds no significant number of jobs that your client could perform. If the ALJ has not offered a hypothetical consistent with your theory of the case, you must pursue a line of questioning of the VE to eliminate the available jobs cited by the VE in response to the ALJ's hypotheticals. Your hypothetical must be grounded in the evidence of record. If you formulate a hypothetical including limitations with no grounding in the evidence of record, the ALJ is free to
disregard the VE's testimony in response to your questions. If you have a treating source opinion, develop a hypothetical around the limitations expressed therein. In formulating your questioning, add limitations individually to successive hypothetical questions, so that it is clear for the appellate record which limitations were determinative. Avoid using vague terms such as "moderate" in formulating your hypotheticals. ALJs will frequently come to the rescue of the VE and deem such questions vague unless you can define them. (Note: if your treatment providers have used vague terminology in describing your client's limitations, you will be left in a quandary as to how to define them in a manner grounded in the evidence.) It is best to quantify the limitations and restrictions in your hypothetical. As a practical matter, always ask the VE the percentage of the work day that an individual can be off-task and still be eligible for competitive employment. Similarly, always ask what the acceptable tolerance for absences is in the competitive work environment. Both of these questions address theories of disability available in most cases involving chronic pain, intermittent illness, or mental health problems.

4) **Ask for DOT codes for the step five jobs identified by the VE.** Ultimately, you will not prevail based on your own hypothetical questions of the VE if the judge does not agree with your assessment of the claimant’s RFC. In such a case, try and undercut the VE’s testimony as it relates to ALJ’s hypotheticals. At a minimum, you must make your record for appeal. Begin by nailing down the DOT codes for the jobs cited at step five. If possible, look up the DOT codes and question the VE on any inconsistencies on the exertional demands, skill levels and aptitudes of the jobs as defined by the DOT and the SCO. There are a number of software programs available that allow you to easily call up each DOT and cross-check what the VE is asserting. You will likely catch a VE offering a job inconsistent with the judge’s hypothetical, and you may be able to eliminate that job merely by highlighting the inconsistency. If you are unable to question the VE on these issues in the hearing, you can research the issues after the hearing. Ask that the record be held open for posthearing development.

5) **Consider challenging the reliability of the VE's job data.** At step five of the sequential analysis, SSA bears the burden of proving that there are a significant number of jobs in the regional and national economy that the claimant can perform given the RFC as determined by the ALJ. SSA meets that burden by relying on the VE's testimony regarding job numbers. The VE is, however, not a Delphic oracle whose answers cannot be questioned. There is a broad spectrum of competence among VEs. Some remain actively involved in vocational rehabilitation and job placement, the activities from which their expertise is purportedly derived. Others do nothing more than testify at Social Security disability hearings and rely solely on various published data sources for the job numbers they cite. The truth is, the available data on jobs is limited and inaccurate. Some VEs will engage in pure speculation. If questioned on the issue, they will fall back on their "experience." In other courts, the standard for expert testimony is controlled by *Daubert v. Merrell Dow Pharmaceuticals*, 509 U.S. 579 (1993). Such testimony would not stand up to scrutiny. Most VEs are too accustomed to being unchallenged. By educating yourself, you can be an even more effective advocate of your client’s claim by challenging the VE testimony. VE testimony can be challenged in a disability hearing on the grounds of reliability under Seventh Circuit precedent. "[T]he idea that experts should use reliable methods does not depend on Rule 702 alone, and it plays a role in the administrative process because every decision must be supported by substantial evidence." *Donahue v. Barnhart*, 279 F.3d 441, 446 (7th Cir. 2002). "Evidence is not 'substantial' if vital testimony has
been conjured out of whole cloth." There are a variety of avenues of challenging the reliability of VE testimony that you can develop and employ in the right cases. If the denial of your client's claim hinges on a handful of unskilled sedentary jobs with exotic titles existing in implausible numbers, you should seek to undermine those jobs by attacking the reliability of the VE job data. For instance, ask the VE to identify the source of the data. Learn about the commonly employed sources of data (e.g., the very official sounding U.S. Publishing Inc.'s *Occupational Employment Quarterly*). Learn the weaknesses of these data sources and question the VE's knowledge of the data's limitations. Ask the VE for copies of the source materials at the hearing. Consider requesting prehearing subpoenas for the job data in advance. Query whether the VE is citing numbers for full-time jobs only, or whether the numbers include part-time jobs. Ultimately, if you believe you have made a record undercutting the reliability of the VE's testimony through cross-examination, make a formal objection on the record. Ask for time to allow for post-hearing briefing and solidify your objection through the additional arguments in a brief. You will not prevail before the ALJ, but you will make a record that will be difficult for SSA to justify on appeal in federal court. A full exposition on such challenges to VE testimony is beyond the scope of this presentation. For further reading on the handling of VE testimony, I highly recommend Attorney David Traver's *Social Security Disability Advocate's Handbook* by James Publishing.

**H. Appeal to the Appeals Council when the case justifies it.** If you receive an unfavorable decision from an ALJ, your representation is not at an end. Many attorneys simply close their file upon receiving a denial and advise their clients to start over with a new application for benefits rather than file an appeal. Since the issuance of SSR 11-1p, that advice may make sense in particular cases, but relief from the Appeals Council is still worth pursuing in a great many cases. Unless I believe an appeal to the Appeals Council will work to the detriment of the claimant, I ordinarily file an appeal on a claimant’s behalf, brief the case and attempt to obtain a chance at another hearing. Even weak cases may be decided by faulty decisions. If there are significant flaws in the ALJ’s decision, a request for review is in order. In some cases, the Appeals Council will issue a favorable decision awarding the claimant benefits, but the ordinary relief that is granted is a remand for another hearing. Typically, this means the case will be sent back for another hearing before the same ALJ, but not always. Statistics show that the approval rate of cases by ALJs on remand from the Appeals Council is significantly higher than on cases heard in the first instance. While the case may have been weak, it could strengthen during the lengthy appeals process. While the claim is pending at the Appeals Council, your client will likely continue treating, and favorable medical evidence may result, making the case stronger for the second hearing. You will have be aware of and in a better position to address any perceived flaws with the claim on the second go around. If you have taken the case this far, and your client will not benefit by filing a new application, there is little reason to forego an appeal. You will be in a better position to argue the case on your client’s behalf rather than passing the case off to successor counsel. However, there is something to be said about a fresh set of eyes reviewing the case following a denial.

1) **Understand the implications of SSR 11-1p.** Prior to July 2011, there was no disincentive to pursuing an appeal to the Appeals Council. Effective July 28, 2011 though, Social Security issued SSR 11-1p complicating the decision as to whether to appeal. (See Appendix.) Under SSR 11-1p the claimant can no longer file a new application for the same type of benefits if they
appealed an unfavorable decision to the Appeals Council. Under the new rule, claimants must make a choice of foregoing their claim for back benefits and starting over with a new application or filing an appeal, and waiting over a year for a decision. If the Appeals Council denies a request for review, the claimant then must start over with a new application and has lost the opportunity to collect the back benefits preserved by the prior claim (except in the instance of a favorable decision in federal district court). At a minimum, the representative must advise the claimant of these options before terminating representation. Simply advising a client to start over with a new application is reckless. A Title II claimant may have an expired DLI, preventing a new application for Social Security benefits, leaving only the hope of preserving a claim through the appeals process. Most claimants do not understand the implications of the DLI issue and must be cautioned about filing a new claim that will effectively foreclose further pursuit of Title II benefits with an expired DLI.

2) **In some instances, an appeal to the Appeals Council does not make sense.** If the medical evidence is not particularly strong, and the claimant is approaching a change in age category that should result in a favorable decision upon a new application for benefits, it would be ill-advised to file an appeal, delaying the claimant’s receipt of benefits. For instance, if a claimant at age 49 receives a denial from an ALJ based on a step five denial due to their ability to perform sedentary work, relief from the Appeals Council will typically take a year or longer to be obtained, if it can be obtained at all. Such a claimant is probably best served by starting a new application for benefits in order to obtain a favorable decision upon their fiftieth birthday, provided they still have insured status.

3) **Advise your client of the lengthy wait time at the Appeals Council.** The Appeals Council typically takes 13 months or more to issue a decision. Your client should be made aware of that at the outset so they do not have any false expectations. Your client should also be made aware that a successful appeal ordinarily entails only a remand for a new hearing, not an award of benefits. Be aware that SSR 11-1p does allow for new applications to be pursued if there is a new medical condition that arises during the lengthy wait for an Appeals Council decision. Therefore, if a claimant becomes significantly ill or develops a new condition which would serve as a separate basis for disability, they may have cause for the Appeals Council to grant leave to file a new application for benefits while the appeal is pending.

4) **Appeal to exhaust administrative remedies.** If you have any intention of bringing your action to federal district court, an appeal to the Appeals Council is absolutely necessary. You cannot proceed to federal district court upon an unfavorable ALJ decision alone. You must first exhaust your administrative remedies.

5) **Submit any missing medical evidence to the Appeals Council.** Although you should have submitted all material medical evidence to the hearing judge, if new evidence comes to light at the last minute or post-hearing, submit it to the Appeals Council. The Appeals Council has the authority to grant relief upon the presentation of new and material evidence. The evidence must relate back to the period prior to the ALJ’s written decision. As explained above, if the Appeals Council denies a request for review, it will add the new evidence to the hearing file, but will not be considered by the federal district court in evaluating the ALJ’s decision.
6) **Obtain proof of filing your request for review.** The procedure at the Appeals Council involves filing a request for review (Form HA-520). This should be faxed to the appropriate branch of the Appeals Council and sent via certified mail within 65 days of the date of the ALJ’s decision. The Appeals Council is notorious for losing mail and faxes. Duplicating service by fax and certified mail is the best method of making sure that your request for review was received in a timely fashion. If you are prepared to brief the case in conjunction with the request for review, it may speed up the review process at the Appeals Council. If you are not prepared to brief the case, you can request a copy of the audio of the hearing to address any factual inaccuracies in the ALJ’s decision regarding what transpired at the hearing, and ask for additional time to submit a brief. Typically, the Appeals Council will then grant you 25 days to submit a brief.

7) **Understand the types of issues to which the Appeals Council is receptive and brief the case.** Appeals Council briefs are typically no more than letter briefs. They should be short and to the point. The analysts who review Appeals Council claims have a very heavy workload and your case will only get attention for a short time. Ordinarily, it is best to focus on procedural errors and omissions in the ALJ’s decision. Arguing that your claimant is actually disabled is fruitless. The focus must be on whether the ALJ correctly applied Social Security’s regulations and rulings. It is not uncommon to have the Appeals Council reverse on technical grounds and not address the merits of the claim at all. Federal circuit precedent is not important to the Appeals Council and the best arguments are grounded in the regulations. Common errors that result in reversal include the failure to address opinion evidence, opinions of state agency doctors or a treatment source, inconsistencies in the findings at step three in mental health cases (e.g. a moderate limitation in social functioning) and the absence of related restrictions in the RFC at steps four and five, factual errors, and the failure to address lay testimony or evidence. In essence, the sloppier the ALJ decision is, the greater chance for success at the Appeals Council.

I. **Appeal to federal district court.** If you have exhausted your administrative remedies by unsuccessfully appealing to the Appeals Council, do not be afraid to take a good case into federal district court. The full scope of the federal district court practice is well beyond the scope of these materials, but it suffices to say that too many attorneys are needlessly timid about litigating their clients' disability claims in federal district court. Federal case law, particularly in the Seventh Circuit, is very hostile to sloppily-written decisions and disingenuous reasoning by ALJs. Over the past several years, the Seventh Circuit has developed into the most claimant friendly federal circuit and has been more vocal in upbraiding SSA for poorly-written ALJ decisions. The fact that the Appeals Council has denied the request for review should not dissuade you from challenging the ALJ’s decision. The Appeals Council is typically focused on technical defects in ALJ decisions. Federal courts are much more receptive to arguments challenging the flawed reasoning employed by ALJs in denying claims otherwise supported by the medical evidence. Moreover, you will have the benefit of an attorney on the other side of the case. An attorney from the Office of General Counsel may review the ALJ’s decision and decide to voluntarily remand the case if it is unsupportable. If you fully brief and litigate the claim, you will learn more about the Social Security Disability adjudication law, procedure and strategy from doing federal district court cases than you can from ALJ hearing practice. After doing a few federal district court actions, you will come to view each Social Security Disability claim
that goes to a hearing as an exercise in making the record for a future federal court action. Viewing your cases in that light will make you a more effective advocate.