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Procedures

42 U.S.C. §405(g) and §1383(c)(3)[1] give the district court original jurisdiction to review final decisions of the Commission of Social Security Administration ("SSA") in Title II ("DIB") and Title XVI ("SSI") disability claims. Although Social Security cases are original civil actions, they take on the feel and form of appeals. Because of this, I will refer to them sometimes as "appeals" in these materials.

The Commissioner's decision becomes final after the Appeals Council ("AC") has issued its final decision denying review of an order by the Administrative Law Judge ("ALJ"). See 20 C.F.R. §404.981. After the claimant receives the final order, he or she has 60 days to initiate a law suit in the district court from the date that the AC *Notice of Action* is received. See 20 U.S.C. §405(g); 20 C.F.R.§404.981. The AC *Notice* always stipulates to a five-day window from the date of issue, at the end of which it is assumed that the claimant has received the *Notice*, unless he or she can show otherwise. Thus, the filing deadline is typically 65 days from the date of issuance. Venue for the action will almost always be the district court for the judicial district in which the plaintiff resides, and the plaintiff bears the burden to prove proper venue. See §405(g); *Alessandra v. Colvin*, 2013 WL 4046295 (W.D.N.Y., 2013).

To initiate a civil action in Vermont, the plaintiff must file a complaint, a civil cover sheet, and either pay the filing fee or obtain leave of the court to file *in forma pauperis ("IFP")*. See Fed. R. Civ. P. 3. The current filing fee is $400.00. If the plaintiff prevails and qualifies as a party under 28 U.S.C. §2412 (Equal Access to Justice Act), then he or she can recover the filing fee. However, most plaintiffs in disability actions will qualify for *IFP* status. Thus, filing for *IFP* status will usually be the most economical way to proceed. This requires that the plaintiff file a motion with a supporting affidavit. See 28 U.S.C. §1915. A complaint is not filed–and as a result a civil action is not commenced–until ***after*** the plaintiff has been granted *IFP* status or paid the filing fee. See *Celestine v. Cold Crest Care Center*, 495 F.Supp.2d 428 (S.D.N.Y. 2007). Thus, if there is any question whether the court will rule on the *IFP* motion prior to the lapsing of the 65-day period for an appeal, the plaintiff should pay the filling fee and file the *IFP* motion and affidavit contemporaneously. If the Court later grants *IFP* status, it should refund the filing fee.

A plaintiff my also ask the AC for additional time to initiate a civil action. See 20 C.F.R. §404.982. Requests must be in writing and should contain an explanation as to why the deadline for filing either was not or cannot be met. See id. When the extension is granted, it will usually be for 30 days. See *HALLEX* I-3-9-92.

The Case Management and Electronic Filing system ("CM/ECF") for Vermont is not set up to accept initial filings by parties. Therefore, a hard copy of the initial filing should be delivered to the clerk.

The complaint in a Social Security action is subject to the usual rules of notice pleading. It need not detail all issues that the plaintiff intends to raise. However, it should allege facts that

[1] The relevant statute is often referred to a section 205(g) of the Social Security Act.

establish jurisdiction, proper venue, the finality of an adverse agency decision, the timeliness of the action, and the nature of the dispute.

The only unique aspect of drafting a Social Security complaint is what to do with the plaintiff's Social Security number. Not surprisingly, SSA identifies cases by Social Security number. Therefore, the AC's *Notice of Action* always contains an instruction that, "the complaint should name the Commissioner of Social Security as the defendant and should include the Social Security number(s) shown at the top of this letter." However, federal rules mandate that Social Security numbers be redacted from any documents filed with the court out of privacy concerns. See Fed. R. Civ. P. 5.2. There are several potential solutions to this problem. The easiest solution, in my experience, is to redact the Social Security number in the complaint, consistently with rule 5.2, but then to identify the full Social Security number in a cover letter that is served on the U.S. Attorney's Office and the Social Security Administration with the summons and complaint.

After the complaint is filed, the court will issue three summonses. In Vermont, the district court has always issued its own summonses, even when I have filed draft summonses. This differs from the practice in other districts, some of which require represented plaintiffs file draft summonses. Because of Vermont's practice, I have stopped filing draft summonses in Social Security cases.

The current practice of the District Court in Vermont is to assign Social Security cases on a rotating basis among the Article III and magistrate judges. If the case is assigned to the magistrate, the clerk will send the plaintiff two copies of a *Consent to the Jurisdiction of the Magistrate* forms with the summonses. One is for the plaintiff to fill out and file. The other must be served on the U.S. Attorney's Office with a summons and complaint.

Consent to magistrate jurisdiction is voluntary. See Fed. R. Civ. P. 73(a). If either party does not consent to magistrate jurisdiction, the magistrate will write a *Report and Recommendation*, which must then be reviewed by the Article III judge assigned to the case. See Fed. R. Civ. P. 72. My current practice is always to consent to magistrate jurisdiction when asked. Because there has been such a proliferation of Social Security appeals over the last few years, I believe that the delays caused by withholding consent far outweigh the possible benefits of having a second bite at the apple. If the parties both consent to jurisdiction of the magistrate, appeals to the Second Circuit are taken directly from the magistrate's order and judgement. See Fed. R. Civ. P. 73(c).

For run-of-the-mill disability appeals, a summons and complaint must be served on three entities: the U.S. Attorney for the District of Vermont, the Office of the Regional Chief Counsel of the Social Security Administration for Region II, and the Attorney General of the United States. See Fed. R. Civ. P. 4(i)(1)(A). Those addresses are:

Social Security Administration
Office of General Counsel
Region II
26 Federal Plaza, Room 3904
New York, NY 10278

United States Attorney
District of Vermont
P.O. Box 570
Burlington, VT 05402-0570

U.S. Attorney General
U.S. Department of Justice
950 Pennsylvania Ave, NW
Washington, DC 20530-0001

Because the U.S. government is always a party to a Social Security action, the three agencies may be served via registered or certified U.S. mail. See Fed. R. Civ. P. 4(i)(1)(A). This is generally the easiest and quickest way to serve those agencies, although it currently costs in the neighborhood of $21.00 to do. If the plaintiff intends to serve these agencies in this way, it is good practice to notify the clerk of this intention when filing. When I have not given this notice in cases in which I have filed for *IFP* status, the clerk has sometimes forwarded the summonses and complaint to the Federal Marshals' office for service. This can take considerably more time than the U.S. mail.

After the summonses and complaints have been served, the plaintiff should file a certificate of service with the Court. Historically, Local Rule 9 has governed procedure for Social Security claims. However, since October 2016, the District Court has been running a pilot program under General Order 74 to make the process for Social Security cases more streamlined for both the parties and the court. During the pilot program, Local Rule 9 has been suspended.

Under General Order No. 74 the Commissioner need not file an answer but only a notice of appearance and the administrative record within 60 days. The plaintiff then has 60 days to file his or her motion for order reversing the Commissioner's decision with a separate statement of facts. Under the order, the motion may not exceed 15 pages and the statement of facts may not exceed 10 pages. However, the Court has informally told practitioners that as long as the total page court for the statement of facts and motion does not exceed 25 pages cumulatively, plaintiff's counsel may allocate the pages between the statement of fact and motion as the case demands without asking leave of the Court. The statement of facts must be presented in numbered paragraphs and supported by specific citations to the administrative record. It must reference facts as opposed to conclusions of law.

The Commissioner next has 60 days to file her motion for order affirming the Commissioner's decision. That motions may not exceed 15 pages. The Commissioner may either accept the plaintiff's statement of facts, or she can elect to supplement the statement. If the Commissioner chooses to supplement a fact already given by the plaintiff, she must designate the supplemental fact by reference to the plaintiff's numbered paragraphs with an additional alphabetical reference (e.g. 1(a)). If she wishes to add additional facts unrelated to the plaintiff's facts, she must use numbered paragraphs commencing with the next number after the plaintiff's last numbered paragraph (e.g. if the plaintiff's last numbered paragraph was 22, the Commissioner's first new fact would be number 23). The statement of supplemental and additional facts must also specifically reference pages in the administrative record and may not exceed 10 pages.

After the Commissioner files her motion, the plaintiff may file a reply not to exceed seven pages. Any facts cited to in the motions must also contain specific references to the administrative record.

Currently, oral argument is not scheduled for Social Security cases unless a party requests it, and the Court grants the request. After the parties have filed their motions and memoranda and oral argument – if granted – has occurred, the court will issue its *Order* and *Judgement*. If the

case has been assigned to the magistrate judge, but the parties have not consented to magistrate jurisdiction, then the magistrate will issue a *Report and Recommendation* prior to the *Order* and *Judgement*. The parties then have an opportunity to object to the *Report and Recommendation*. *Objections* must be filed within 14 days. See Fed. R. Civ. P. 72(b)(2).

Once *Judgment* has been entered, either party has 60 days to appeal. See Fed. R. App. P. 4(a)(1)(B). An appeal is taken by filing a notice with the District Court specifying the party taking the appeal, the *Judgment* or *Order* being appealed, and the court to which the appeal is being taken, which for Vermont cases would be the United States Court of Appeals for the Second Circuit. See Fed. R. App. P. 3(a), (c).

If the case is remanded, it goes first back to the AC. See 20 C.F.R. §404.983. The AC can grant the claim, but more typically will remand the claim for a new hearing. See id. If the new hearing results in another denial, then the procedures for any subsequent appeal are different. The claimant does not have to invoke review by the AC. Instead he or she may choose to do so by filing exceptions to the ALJ's decision with the AC within 30 days. See §404.984(b). The AC may also take up review of the claim on its own within 60 days. See §404.984(c). If neither the claimant nor the AC invokes the jurisdiction of the AC, then the claimant has another 60 days after the period during which the AC could take up jurisdiction to file a new complaint with the District Court.

One should not have to file a new complaint and pay a new filing fee if the case had been remanded under Sentence 6 of 42 U.S.C. §405(g). The Court never gives up jurisdiction in those cases and the Commissioner never answered the original complaint. Filing a motion to reopen the case should be sufficient to reinitiate proceedings at the federal level.

Substantive Issues

The Sequential Analysis, Burdens of Proof, and Standards of Review

The district court reviews the decisions of the Commissioner *de novo* to determine whether the Commissioner has applied the correct law and whether the decision is supported by substantial evidence. See *Balsamo v. Chater*, 142 F.3d 75, 79 (2d Cir.1998).

Social Security disability cases are determined by a sequential analysis. For adult claims, the steps are whether the claimant is working, whether he or she has a severe medical condition, whether he or she meets or equals a listed condition, whether he or she can perform past relevant work, and whether he or she can perform other work. See 20 C.F.R. §404.1520. The claimant has the burden of proving the first four steps, including the residual functional capacity finding that goes toward the analysis of both steps four and five. See *Poupore v. Astrue*, 566 F.3d 303 (2d Cir. 2009), overturning *Curry v. Apfel*, 209 F.3d 117 (2d Cir. 2000). The Commissioner has the burden to prove that the claimant can return to other work. See *Id.* If drug or alcohol abuse is an issue, the claimant bears the burden of proving that it is not material to disability. See *Cage v. Commissioner of Social Sec.*, 692 F.3d 118 (2d Cir. 2012).

If either party appeals the District Court's decision, then the Second Circuit reviews the appeal *de novo*. See *Shaw v. Chater*, 221 F.3d 126 (2d Cir. 2000); *Machadio v. Apfel*, 276 F.3d 103 (2d Cir. 2002). The two exceptions to this rule are for appeals of the District Court's remedy or award of attorney fees. See *Butts v. Barnhart*, 388 F.3d 377 (2d Cir. 2004), *Pierce v. Underwood*, 487 U.S. 552 (1988). In both instances, the District Court's decision is reviewed for abuse of discretion. See *id.*

Appealable Issues and Sources of the Law

This *Nutshell Guide* is intended to cover run-of-the-mill disability appeals–that is, appeals in which a claimant has been denied benefits and is challenging the Commissioner's application of the law to his or her particular claim. Of course, it is also possible to challenge the constitutionality of the Commissioner's actions and the laws that she applies. It is also possible to challenge the capacity of the Commissioner to create a particular rule or regulation. However, these types of claims have their own substantive and procedural concerns that are not addressed here.

Even with just a run-of-the-mill disability appeal, there are dozens and possibly hundreds of legal reasons why the Commissioner's denial might lead to a viable appeal. The legal sources for appealable issues include Title II and Title XVI of the Social Security Act (42 U.S.C. §§401—434, 1381—1383f), regulations adopted pursuant to the Administrative Procedures Act (20 C.F.R. §§404.1—2127, 416.101—2227), federal case law, Social Security Rulings (SSRs), and various and sundry policy memoranda of the Commissioner, the most prevalent of which are assembled in the *Program Operations Manual System (POMS)* and *Hearings, Appeals, and Litigation Law Manual (HALLEX)*.

The statute, regulations, and case law are all clearly binding on the Commissioner. Social Security Rulings are also binding, see 20 C.F.R. §402.35(b), and are some of the best sources for framing the Commissioner's legal duties, such as the duty to do a function-by-function analysis of the residual functional capacity (SSR 96-8p), and the need to explain apparent inconsistencies between vocational expert testimony and the *Dictionary of Occupational Titles* (SSR 00-4p). The *POMS* and *HALLEX* are not necessarily binding law. See *Tejada v. Apfel*, 167 F.3d 770 (2d Cir 1999). However, there are some issues, such as the treatment of composite jobs at step four (POMS DI 25005.020), for which these publications offer the clearest statement of the law.

Issue exhaustion before the Administration is not required to raise an issue in court. See *Sims v. Apfel*, 530 U.S. 103 (2000). Some issues almost never lead to appeals, especially at the federal level. For instance, appeals about insured status are very rare. (I have had one such case, which the Commissioner promptly took back under Sentence 6 once the problem was pointed out.) Other issues, such as the application of the treating-physician rule, appear very frequently. Some areas that may prove fruitful for an appeal include:

- Reasons for discounting the treating-physician opinion are not good reasons
- The ALJ does not properly weigh other medical-opinion evidence
- The ALJ substituted his lay opinion for competent medical opinion

- Failure to do a function-by-function analysis of the residual functional capacity (RFC)
- The ALJ fails to develop the record
- The claimant has new evidence that was not incorporated into the administrative record and there is good cause for not doing so
- Credibility finding relies on mischaracterizations of the record
- Credibility finding is not supported by substantial evidence
- The ALJ fails to make a credibility finding
- The RFC finding is not supported by substantial evidence
- The ALJ fails to consider material evidence
- Vocational-expert testimony is not consistent with *the Dictionary of Occupational Titles*, and the ALJ does not resolve the conflict
- Past work is not relevant work
- Past work is composite work and is not considered as generally performed at step four
- The ALJ's RFC finding does not match the hypothetical given to the vocational expert at the hearing
- The RFC finding does not reflect limitations attributable to all severe impairments
- The RFC finding does not reflect limitations due to non-severe impairments
- The ALJ does not do a proper psychiatric review technique
- The ALJ's finding that claimant does not meet or equal a listing is not supported by substantial evidence
- The vocational expert's testimony about the prevalence of work is too speculative
- Other work identified by the vocational expert does not exist in significant numbers in the national economy
- The ALJ did not do a proper drug abuse or alcoholism analysis

This list is by no means intended to be exhaustive.

Life after the Treating Physician Rule

Prior to March 27, 2017, the Administration gave special consideration to the opinions of treating physicians. A treating source's opinion about the nature and severity of an impairment was given "controlling weight" if it was "well-supported by medically acceptable clinical and laboratory diagnostic techniques and is not inconsistent with the other substantial evidence in [the] record." 20 C.F.R. §404.1527(c)(2). If not entitled to controlling weight, the opinion was given some extra weight under the factors for weighing medical opinion in general. Id. The agency always had to give a "good reason" for the weight it gave a treating physician opinion. Id.

However as of March 27, 2017, that rule has been removed from the agency's regulations and has been replaced with a factor test that emphasizes the "supportability" and "consistency" of the opinion rather than the clinical relationship. 82 Fed. Reg. 5844 – 84 (Jan. 18, 2017); 20 C.F.R. §404.1520c(b)(2). The clinical relationship is now only used as a factor if the treating

physician's opinion is found to be "equally persuasive" as other medical opinions. See §404.1520c(b)(3).

These new rules are clearly intended to deemphasize the importance of treating physician opinions, and to bring Social Security law closer in line with ERISA, where the treating physician has no special status. See *Black & Decker v. Nord*, 538 U.S. 822, 834 (2003) (Holding that the treating physician rule does not apply in the context of ERISA). However, it is unclear whether deemphasis of the clinical relationship will stick in the context of federal review of administrative decisions.

In its initial iterations, the treating physician rule was a creation of the Courts of Appeal, with the Second Circuit playing a principle role in its development. The administrative version of the rule was first adopted in compliance with orders from the Second Circuit and eventually through regulations adopted in 1991. See *Schisler v. Sullivan*, 3 F.3d 563, ___ (2d Cir. 1993).

Early caselaw in the Second Circuit established the principle that the expert opinion of a treating physician as to the existence of a disability was binding on the finder of fact unless contradicted by substantial evidence to the contrary. See e.g. *Gold v. Sec. of Health, Ed. & Welfare*, 463 F.2d 38, 42 (2d Cir. 1972), *Bastien v. Califano*, 572 F.2d 908, 912 (2d Cir. 1978), *Bluvband v. Heckler* 730 F.2d 886, 892 – 93 (1984).

The Administration did not immediately or consistently apply those rulings at the administrative hearing level; so starting in 1986, the Second Circuit made a series of decisions that lead to the development of the agency's version of the treating physician rule. See *Schisler v. Heckler*, 787 F.2d 76 (2d Cir. 1986) ("*Schisler I*"), *Schisler v. Bowen*, 851 F 2d 43 (2d Cir. 1988) ("*Schisler II*"), and *Schisler v. Sullivan*, 3 F.3d 563 (2d Cir. 1993) ("*Schisler III*").

In *Schisler I*, the Second Circuit addressed the problem that the Secretary of Health and Human Services did not appear to be applying the treating physician rule to administrative hearings which led to a large number of reversals by the district courts. See *Schisler I*, 787 F.2d at 82 – 83. In the course of litigation, the Secretary acquiesced and was ordered to inform his adjudicators to follow the treating physician rule. *Id* at 84.

In *Schisler II*, the Second Circuit then reviewed a Social Security Ruling ("SSR") that was designed to give instruction to adjudicators on the application of the treating physician rule. See *Schisler II*, 851 F.2d at 44 – 45. It ordered alteration to the SSR, including that the status of "treating physician" was based on the nature of the relationship and not its duration. *Id.* at 45 – 47. It considered language from previous Second Circuit caselaw that, "the opinions of non-examining medical personnel cannot, in themselves and in most situations, constitute substantial evidence to override" a treating physician's opinion but did not require incorporation of the language into the SSR. *Id.* at 45 – 47.

Schisler III then addressed the effect of the 1991 regulatory changes that replaced the SSR and codified the administrative version of the treating physician rule. In *Schisler III* the Second Circuit held that the treating physician rule as adopted by the Secretary was valid and binding on the courts. See *Schisler III* 3 F.3d at 568 – 69. It emphasized that because the

Secretary had resorted to the customary administrative process of adopting regulations, the results were entitled to deference so long as they were reasonable and not arbitrary, capricious or manifestly contrary to the statute. *Id.* at 568 – 69.

Now that the Commissioner has done away with the administrative version of the treating physician rule through the traditional administrative process of adopting regulations, where does that leave the treating physician opinion in the context of federal court review?

Two aspects for the post-1991 treating physician rule were consequences of general legal principles and it would seem unlikely that the Commissioner has the capacity to eliminate those features. The first is the principle that the treating physician opinion on a medical issue is binding on the administrative law judge absent another competent medical opinion that contradicts it. This comes from the simple fact that the administrative law judge is a finder of fact and not a medical expert. He or she cannot substitute his or her lay opinion for that of a competent medical expert on a medical issue. See e.g. *McBrayer v. Sec. of Health & Human Services* 712 F.2d 795, 799 (2d Cir. 1983), *Balsamo v. Chater*, 142 F.3d 75, __ (2d Cir. 1998.)

Secondly, under general principles of administrative law, the Commissioner must give adequate reasons why he or she is not following the treating physician opinion. This conclusion derives from the definition of substantial evidence review and the *Chenery* doctrine. One component of substantial evidence review is that "the substantiality of evidence must take into account whatever in the record fairly detracts from its weight." *Universal Camera Corp. v. N.L.R.B.*, 340 U.S. 474, 487 – 88 (1951). Under the *Chenery* doctrine, the Commissioner must give a written explanation of her decision that must be judged on its own terms and not with reference to *post hoc* rationalizations of what the Commissioner could have reasonably written. See *S.E.C. v. Chenery Corp.*, 318 U.S. 80, 92 – 93 (1943). The requirement that an ALJ give a "good reason" for not following the treating physician opinion derives from these basic administrative principles. It is also these principles that fundamentally distinguish Social Security cases from ERISA cases.

The greatest tension between the courts and the Administration has always been, and continues to be, the role of the non-examining medical consultant. Social Security uses them in almost every case, and in almost every denial the administrative law judge expressly relies on those opinions to deny benefits. The Administration wants to be able to rely on non-examining consultants in order to deny claims and wants the courts to uphold those denials. The new regulations are clearly an attempt to push the courts closer to the Administration's will. However, the courts have traditionally viewed opinions of non-examining physicians with great skepticism. See e.g. *Schisler II*, *Havas v. Bowen*, 804 F.2d 783, 786 (2d Cir. 1986); *Cruz v. Sullivan,* 912 F.2d 8 (2d Cir. 1990); *Vargas v. Sullivan*, 898 F.2d 293 (2d Cir. 1990).

Whether the agency's view on the reliability of non-examining experts will ultimately prevail is unclear, and subsequent cases may test the boundaries of the *Chevron* doctrine with respect to the treating physician rule. It is worth noting, however, that the Social Security Act gives the courts and not the Commissioner the capacity to decide what constitutes "substantial evidence." See 42 U.S.C. 405(g) (stating that courts have the power to reverse the

Commissioner's decision but that "The findings of the Commission of Social Security as to any fact, if supported by substantial evidence, shall be conclusive.") This would appear to give the courts great leeway to develop a jurisprudence of substantial evidence. There are good reasons to be skeptical of the opinions of non-examining experts. As the Commissioner's former regulation themselves note:

> Generally, we give more weight to medical opinions from your treating sources, since these sources are likely to be the medical professionals most able to provide a detailed, longitudinal picture of your medical impairment(s) and may bring a unique perspective to the medical evidence that cannot be obtained from the objective medical findings alone or from reports of individual examinations, such as consultative examinations or brief hospitalizations.

20 C.F.R. §404.1527(c)(2). This is as good an argument as any for favoring the treating physician. Non-examining physicians will always face limits in what they are able to say. They will only ever be able to comment on the objective medical findings in the record. Their opinions may be "supportable" and "consistent" within that confine, but they will always lack the unique perspective of the clinical relationship. Close disability cases often deal with subjective symptoms such as pain, fatigue, anxiety, or depression. It is precisely those cases in which a clinical perspective may be most illuminating. Hand-in-hand with the courts' skepticism of non-examining physicians runs a skepticism of denials based solely on the lack of objective medical evidence. See e.g. *Green-Younger v. Barnhart*, 335 F.3d 99 (2d Cir. 2003), *Donato v. Sec of Dep't of Health and Human Service*, 721 F.2d 414, 418 – 19 (2d Cir. 1983). It is because of these inherent limitations that the value of the non-examining physicians breaks down under substantial evidence review. Thus, there are reasons to believe that the Commissioner's attempt to shift the battle line many not hold.

However, even if the Commissioner can convince the courts that the opinions of non-examining physicians can be viewed more generally as substantial evidence, it still may not change the outcome of most appeals. Treating physician cases are rarely decided solely based on the of the physician's status as "treating" versus "examining" versus "non-examining." Usually, there is also some problem in the way that the administrative law judge handles the treating physician opinion. Often the discussion of the treating physician opinion is little more than boilerplate or contradicts the medical records. It is usually in the context of inadequate reasons given for dismissing the treating physician opinion that the opinion of the non-examining expert is also found to be insubstantial. Thus, it seems unlikely that the courts will change its approach in the majority of "treating physician" cases.

Important Second-Circuit Case Law

This section contains a summary of some of the important holdings by the United States Court of Appeals for the Second Circuit. They are assembled into rough categories.

Absence of an Express Rationale

- The absence of an express rationale does not prevent a court from upholding an ALJ's determination regarding appellant's claimed listed impairments, portions of the ALJ's decision and the evidence before him indicate that his conclusion is supported by substantial evidence. *Berry v. Schweiker*, 675 F.2d 464 (2d Cir. 1982).

- The ALJ does not need to state expressly his reasons for accepting the vocational expert's challenged testimony. *Brault v. Social Sec. Admin., Com'r*, 683 F.3d 443 (2d Cir. 2012).

- The ALJ's failure to expressly acknowledge the treating physician rule with respect to one treating physician was not reversible error when the Court could deduce that the ALJ did consider the opinion and explained its inconsistency to the record as a whole. *Halloran v. Barnhart*, 362 F.3d 28 (2d Cir. 2004).

- It is reversible error for the ALJ not do a psychiatric review technique when the court cannot discern a rationale for the ALJ's findings on mental impairments from the decision. *Kohler v. Astrue*, 546 F.3d 260 (2d Cir. 2008).

- The ALJ need not explicitly reconcile every conflicting shred of medical testimony. It is sufficient if the ALJ noted that he carefully considered the exhibits presented in evidence in reaching his decision. *Miles v. Harris*, 645 F.2d 122 (2d Cir. 1981).

- Failure to specifically address a witness's testimony is not error if, based on other evidence in the record, the ALJ could have considered and simply discounted testimony. *Mongeur v. Heckler*, 722 F.2d 1033 (2d Cir. 1983).

Administrative Record

- New evidence submitted to the Appeals Council following the ALJ's decision becomes part of the administrative record for judicial review when the Appeals Council denies review of the ALJ's decision. *Perez v. Chater*, 77 F.3d 41 (2d Cir. 1996).

- Case must be remanded if critical portions of the administrative record are significantly compromised. *Pratts v. Chater*, 94 F.3d 34 (2d Cir. 1996).

Credibility Findings

- Credibility finding based on a misreading of the claimant's statements is reversible error where the credibility finding is critical to the ALJ's decision. *Genier v. Astrue*, 606 F.3d 46 (2d Cir. 2010).

- To receive benefits under the Social Security Act, one need not be completely helpless, unable to function, or totally disabled. The mere fact that the claimant is mobile and able to engage in some light tasks at his or her home does not alone establish that he or she is able to engage in substantial gainful activity. *Gold v. Sec. of Health, Ed. and Welfare*, 463 F.2d 38 (2d Cir. 1972).

- Although such observations should be assigned only limited weight, there is no per se legal error where the ALJ considers physical demeanor as one of several factors in evaluating credibility. An ALJ should explore a claimant's poor work history to determine whether her absence from the workplace cannot be explained adequately (making appropriate a negative inference), or whether her absence is consistent with her claim of disability. *Schaal v. Apfel*, 134 F.3d 496 (2d Cir. 1998).

- The fact of a three-year time lapse in treatment does not negate the compelling evidence in the record as a whole that plaintiff was completely disabled. *Shaw v. Chater*, 221 F.3d 126 (2d Cir. 2000).

- The Commissioner must make credibility findings and these must be consistent with the medical records and other evidence. *Williams on Behalf of Williams v. Bowen*, 859 F.2d 255 (2d Cir. 1988).

Duty to Develop the Record

- The ALJ has a duty to compile a complete record and may not substitute his or her own opinion for that of a physician. *Brown v. Apfel*, 174 F.3d 59 (2d Cir. 1999).

- Where the claimant is unrepresented by counsel, the ALJ is under a heightened duty to scrupulously and conscientiously probe into, inquire of, and explore for all the relevant facts. *Echevarria v. Secretary of Health and Human Services*, 685 F.2d 751 (2d Cir. 1982).

- If the claimant does appear pro se, the ALJ has a duty to scrupulously and conscientiously probe into, inquire of, and explore for all the relevant facts. *Hankerson v. Harris*, 636 F.2d 893 (2d Cir. 1980).

- The ALJ has duty to develop medical evidence about alleged pain for pro se claimant. *Mimms v. Heckler*, 750 F.2d 180 (2d Cir. 1984).

- The ALJ must ask a pro se claimant whether he worked under special conditions before denying a claim based on income reflected on paystubs. *Moran v. Astrue*, 569 F.3d 108 (2d Cir. 2009).

- Because a hearing on disability benefits is a non-adversarial proceeding, the ALJ generally has an affirmative obligation to develop the administrative record even when the claimant is represented. *Perez v. Chater*, 77 F.3d 41 (2d Cir. 1996).

- The ALJ has the duty to order a consultative examination if it is needed to make an informed decision. *Tankisi v. Commissioner of Social Sec.*, 521 Fed.Appx. 29 (2d Cir. 2013).

- By statute, the ALJ is required to develop a claimant's complete medical history for at least a twelve-month period if there is reason to believe that the information is necessary to reach a decision. Moreover, "[i]t is the rule in our circuit that 'the ALJ, unlike a Judge in a trial, must affirmatively develop the record' in light of 'the essentially non-adversarial nature of a benefits proceeding,'" even if the claimant is represented by counsel. *Tejada v. Apfel*, 167 F.3d 770 (2d Cir. 1999).

Issues Not Reviewable

- Federal courts may review the Commissioner's decision not to reopen a disability application in two circumstances: where the Commissioner has constructively reopened the case and where the claimant has been denied due process. *Byam v. Barnhart*, 336 F.3d 172 (2d Cir. 2003).

Listings

- 12.05C: Absent evidence of a change in IQ, the presumption is that IQ is stable throughout a person's life (i.e., it was low in childhood if it is low as an adult). Deficits in adaptive functioning are a separate prong of the listing which must be supported by the evidence, even where the claimant's IQ is in the range of the listing. *Talavera v. Astrue*, 697 F.3d 145 (2d Cir. 2012).

Medical Evidence (Not Treating Source Opinions)

- The ALJ cannot arbitrarily substitute his own judgment for competent medical opinion. An ALJ is free to resolve issues of credibility as to lay testimony or to choose between properly submitted medical opinions, he/she is not free to set his/her own expertise against that of a physician. *Balsamo v. Chater*, 142 F.3d 75 (2d Cir. 1998).

- The ALJ has a duty to compile a complete record and may not substituting his own opinion for that of a physician. *Brown v. Apfel*, 174 F.3d 59 (2d Cir. 1999).

- In evaluating a claimant's disability, a consulting physician's opinion or report should be given limited weight. *Cruz v. Sullivan*, 912 F.2d 8 (2d Cir. 1990).

- The Secretary has the discretion to give a chiropractor's opinion the weight she believes it deserves based on the facts of the particular case. *Diaz v. Shalala*, 59 F.3d 307 (2d Cir. 1995).

- It is reversible error for the ALJ not do a psychiatric review technique when the court cannot discern a basis for the ALJ's findings on mental impairments elsewhere in the decision. *Kohler v. Astrue*, 546 F.3d 260 (2d Cir. 2008).

- The general rule is that written reports of medical advisors who have not personally examined the claimant deserve little weight in the overall evaluation of disability. *Vargas v. Sullivan*, 898 F.2d 293 (2d Cir. 1990).

- Genuine conflicts in the medical evidence are for the Commissioner to resolve. *Veino v. Barnhart*, 312 F.3d 578 (2d Cir. 2002).

- The ALJ must accept unrefuted medical evidence. *Williams on Behalf of Williams v. Bowen*, 859 F.2d 255 (2d Cir. 1988).

Residual Functional Capacity

- The ALJ has a duty to do a function-by-function analysis of the residual functional capacity. However, there is no *per se* rule that such an error is harmful. *Cichocki v. Astrue*, 729 F.3d 172 (2d Cir. 2013).

Right to Counsel

- The ALJ must inform the claimant of the right to counsel in writing and at the hearing, and the claimant's waiver of the right to counsel must be knowing and voluntary, but the information given need not be as detailed as in other Circuits. *Lamay v. Commissioner of Social Sec.*, 562 F.3d 503 (2d Cir. 2009).

Significant Number of Jobs

- VE testimony that claimant has transferable skills to do 150 jobs in the region in which claimant resides and 112,000 positions in the national economy is sufficient to meet the Commissioner's burden to show a significant number of jobs. *Dumas v. Scheiker*, 712 F.2d 1545 (2d. Cir 1983).

Treating-Physician Rule

- Relying on the testimony of a medical expert who did not have important medical evidence, in this case an MRI showing root impingement, is not a good reason to not

give controlling weight to the treating physician. *Burgess v. Astrue*, 537 F.3d 117 (2d Cir. 2008).

- The lack of specific clinical findings in the treating physician's report do not alone justify the ALJ's failure to credit the physician's opinion when the ALJ has not taken affirmative steps to fill in gaps in the treatment record. *Clark v. Commissioner of Social Sec.*, 143 F.3d 115 (2d Cir. 1998).

- A treating-physician's opinion does not need to be supported by objective evidence. However, if it is not supported by objective evidence, then the ALJ does not need to accept it uncritically and without evaluation, particularly where the record contains substantial contrary evidence. *Cruz v. Sullivan*, 912 F.2d 8 (2d Cir. 1990).

- Chiropractors cannot be afforded controlling weight under agency regulations. Rather, the Secretary has the discretion to give a chiropractor's opinion the weight she believes it deserves based on the facts of the particular case. *Diaz v. Shalala*, 59 F.3d 307 (2d Cir. 1995).

- The lack of objective evidence alone is not sufficient reason for not giving controlling weight to the treating-physician's opinion in fibromyalgia cases. Physician opinions on the limitations that a claimant has are not legal decisions reserved for the commissioner but opinions on the severity of an impairment. *Green-Younger v. Barnhart*, 335 F.3d 99 (2d Cir. 2003).

- Before the ALJ can reject an opinion of a pro se claimant's treating physician because it is conclusory, basic principles of fairness require that he inform the claimant of his proposed action and give him an opportunity to obtain a more detailed statement. *Hankerson v. Harris*, 636 F.2d 893 (2d Cir. 1980).

- A corollary to the treating-physician rule is that the opinion of a non-examining doctor by itself cannot constitute the contrary substantial evidence required to override the treating physician's diagnosis. *Hidalgo v. Bowen*, 822 F.2d 294 (2d Cir. 1987).

- The opinion of a treating physician is not binding if it is contradicted by substantial evidence and the report of a consultative physician may constitute such evidence. *Mongeur v. Heckler*, 722 F.2d 1033 (2d Cir. 1983).

- The opinion of a treating physician is given controlling weight if it is well supported by medical findings and not inconsistent with other substantial evidence. An ALJ cannot reject a treating physician's diagnosis without first attempting to fill any clear gaps in the administrative record. This Court has refused to uphold an ALJ's decision

to reject a treating physician's diagnosis merely on the basis that other examining doctors reported no similar findings. *Rosa v. Callahan*, 168 F.3d 72 (2d Cir. 1999).

- The ALJ must always give a good reason for the weight given to a treating physician, and failure to do so is legal error. *Schaal v. Apfel*, 134 F.3d 496 (2d Cir. 1998).

- The treating physician regulations are reasonable and not arbitrary, capricious, or manifestly contrary to the statute. *Schisler v. Sullivan*, 3 F.3d 563 (2d Cir. 1993).

- It is improper for the ALJ to discount the treating physician's opinion because of his "limited findings and the intermittent nature of his treatment." Such a reason falls far short of the standard for contradictory evidence required to override the weight normally assigned the treating physician's opinion. *Shaw v. Chater*, 221 F.3d 126 (2d Cir. 2000).

- Failure to provide good reasons for not crediting the opinion of a claimant's treating physician is a ground for remand. *Snell v. Apfel*, 177 F.3d 128 (2d Cir. 1999).

- A consulting physician's opinion is not supported by substantial evidence sufficient to override a treating physician opinion when it is not clear that the consulting physician reviewed all the records. *Tarsis v. Astrue*, 418 Fed.Appx. 16 (2d Cir. 2011).

Use of the Grids

- If the grids adequately reflect a claimant's condition, then their use to determine disability status is appropriate. But if a claimant's nonexertional impairments significantly limit the range of work permitted by his exertional limitations, then the grids obviously will not accurately determine disability status because they fail to take into account claimant's nonexertional impairments. Accordingly, where the claimant's work capacity is significantly diminished beyond that caused by his exertional impairment, the application of the grids is inappropriate. *Pratts v. Chater*, 94 F.3d 34 (2d Cir. 1996).

- Where significant non-exertional impairments are present at the fifth step in the disability analysis, application of the grids is inappropriate. Instead, the Commissioner must introduce the testimony of a vocational expert (or other similar evidence) that jobs exist in the economy that claimant can obtain and perform. *Rosa v. Callahan*, 168 F.3d 72 (2d Cir. 1999).

- Use of a vocational expert is not needed for non-exertional limitations that do not significantly limit the range of work permitted by exertional limitation. Where the ALJ finds that the claimant can perform unskilled work, including carrying out simple instructions, dealing with work changes and responding to supervision,

reliance on the GRID alone is permissible. *Zabala v. Astrue*, 595 F.3d 402 (2d Cir. 2010).

Vocational-Expert Testimony

- The ALJ is not required to do a Daubert-like inquiry about reliability of VE testimony. The ALJ does not need to state expressly his reasons for accepting vocational expert's challenged testimony. The ALJ is not required to grant claimant an opportunity to inspect and challenge the VE's evidence. *Brault v. Social Sec. Admin., Com'r*, 683 F.3d 443 (2d Cir. 2012).

- The ALJ must address VE testimony that conflicts with the *DOT*. There is no conflict with the *DOT* when the VE testimony that the claimant could return to past work is based on the claimant's testimony of how she did the work. *Jasinski v. Barnhart*, 341 F.3d 182 (2d Cir. 2003).

Tensions between the Chenery Doctrine and the Absence-of-an-Express-Rationale/Harmless-Error Rules

Social Security cases are appeals of administrative actions. Thus, the substantive arguments are always framed by basic principles of administrative law. On the one hand, plaintiffs enjoy the advantages of the *Chenery* doctrine, which stands for the dual principles that the reviewing court must be able to decipher the reasons for an agency's action from its written decision, and those reasons must be judged on their own merits. See *S.E.C. v. Chenery Corp.*, 318 U.S. 80 (1943). Thus, the reviewing court cannot accept *post hoc* rationalizations of the Commissioner's decision that depart from her stated reasons. See *Snell v. Apfel*, 177 F.3d 128 (2d Cir. 1999). Similarly, if the court cannot discern the Commissioner's reasons, then her decision will not stand. See e.g. *Kohler v. Astrue*, 546 F.3d 260 (2d Cir. 2008).

On the other hand, there comes a point at which a requirement that the Commissioner expound upon her reasons turns persnickety and over-burdensome. Thus, so long as a reviewing court can discern the reasons for each finding necessary to the decision and each finding is supported by substantial evidence, the court will not require more. The case law is littered with instances in which courts have held that the Commissioner's decision need not contain an express rationale for a finding, so long as the court can discern the underlying rationale somewhere in the decision. See e.g., *Berry v. Schweiker*, 675 F.2d 464 (2d Cir. 1982), *Brault v. Social Sec. Admin., Com'r*, 683 F.3d 443 (2d Cir. 2012); *Halloran v. Barnhart*, 362 F.3d 28 (2d Cir. 2004). Similarly, many cases hold that the Commissioner need not expressly address all evidence or arguments favorable to the claim, so long as the evidence upon which she relies is substantial. See e.g. *Brault v. Social Sec. Admin., Com'r*, 683 F.3d 443 (2d Cir. 2012) *Miles v. Harris*, 645 F.2d 122 (2d Cir. 1981); *Mongeur v. Heckler*, 722 F.2d 1033 (2d Cir. 1983).

There are exceptions to the above rules regarding the absence of an express rationale. The major one is, of course, the treating-physician rule. The Commissioner must always expressly

address a treating physician's opinions on the nature and severity of an impairment, and give good reasons for their afforded weight. See *Schaal v. Apfel*, 134 F.3d 496 (2d Cir. 1998). Failure to do so will usually lead to reversible error, unless, of courses, the treating physician's opinion does not help the claim, in which case the error becomes harmless. See e.g., *Zabala v. Astrue*, 595 F.3d 402 (2d Cir. 2010). In addition, there are a number of expositional rules that the Commissioner must follow. She must, for instance, go through a psychiatric review technique, undertake a function-by-function analysis of the residual functional capacity, and reconcile any inconsistencies between vocational testimony and the *DOT*. Failure to follow those expositional rules does not necessarily lead to reversible error. However, the ALJ who does not follow them runs the risk of leaving the reviewing court unable to discern the underlying rationale. See e.g., *Kohler v. Astrue*, 546 F.3d 260 (2d Cir. 2008).

The reviewing court will also have concerns with whether the Commissioner's errors make a difference to the outcome. Agency decisions are subject to the harmless-error rule, the same as any trial court decision. See *N.L.R.B. v. American Geri-Care, Inc.*, 697 F.2d 56 (2d Cir. 1982). Thus to prevail, the plaintiff must not only show that an error occurred, he or she must also convince the court that there is a significant chance that the outcome would be different were the error corrected. See *id.* However, harmless error is not an avenue for avoiding the *Chenery* doctrine. See *Spiva v. Astrue*, 628 F.3d 346 (7th Cir. 2010) (Judge Posner). Whether an error is harmless must be judged on the rationale of the decision itself and not on *post hoc* rationalizations of what the ALJ might have said to bolster the denial.

Remedies

The remedies available under §405(g) are modification or reversal of the Commissioner's decision, with or without a remand for rehearing. See 42 U.S.C. §405(g). Of course, the court also has the power to affirm. See id. There are two types or remands. Sentence 4 of §405(g) gives the court the power to remand after the answer has been filed, and the court has found reversible error. See id. Sentence 6 allows for remand before the answer upon a showing by the Commissioner of good cause or at any time for the consideration or taking of new evidence upon a showing by the plaintiff of good cause for the evidence not being incorporated into the administrative record. See id.

There is a jurisdictional difference between Sentence 4 and Sentence 6 remands. When the court remands a case under Sentence 4, it is giving up jurisdiction of the case and handing it back to the Commissioner. See *Melkonyan v. Sullivan*, 501 U.S. 89 (1991). In a Sentence 6 remand, the court retains jurisdiction of the case. See *id*. This distinction plays a critical role in the timing of a request for EAJA fees.

In principle, whether the court awards benefits or remands for another hearing depends upon whether there are gaps in the record after the Commissioner's errors have been exposed. If the court's review exposes a gap in the administrative record, then it must remand the case in order to fill in the gap. See *Pratts v. Chater*, 94 F.3d 34 (2d Cir. 1996). An award of benefits happens only where no gaps in the administrative record exist and the court has no apparent basis

to conclude a more complete record might support the Commissioner's denial. See *Rosa v. Callahan*, 168 F.3d 72, 82-83 (2d Cir. 1999). In practice, benefits are almost never awarded and cases are almost always remanded for another hearing. Perhaps this is out of an unstated deference to the Commissioner's special competence and expertise in matters of disability.

Carroll v. Secretary of Health and Human Services, 705 F.2d 638 (2d Cir. 1983), suggests that there is some room to argue for an award of benefits even if the court's review leaves a gap in step five of the sequential analysis, and the Commissioner should have taken appropriate steps to fill in that gap. However, whatever glimmer of hope *Carroll* offers to plaintiffs who have waited years and in some cases over a decade for the final resolution of their claims, it appears to be a wholly unique situation. The principle it announced is virtually never applied, as the far more common practice is to remand for a new hearing even when facing a gap at step five. See e.g., *Williams v. Apfel*, 204 F.3d 48 (2d Cir. 2000). In addition, the courts have made it clear that their role is not to offer relief from the excruciatingly slow process of disability determinations by providing a direct access to benefits. Absent a finding of substantial evidence in the record to show that a plaintiff is disabled, the courts do not award benefits because of delay alone. See *Bush v. Shalala*, 94 F.3d 40 (2d Cir. 1996).

Finally, if one were to appeal the district court's remedy, the Second Circuit would review the remedy for abuse of discretion rather than *de novo*. See *Butts v. Barnhart*, 388 F.3d 377 (2d Cir. 2004).

Attorney Fees

Equal Access to Justice Act (EAJA)

The Equal Access to Justice Act allows for the award of costs and a reasonable attorney fee and expenses to a prevailing party in a civil action brought against the United States. See 28 U.S.C. §2412(a), (b). An individual is a party under the Act if his or her net worth does not exceed $2,000,000.00. See §2412(d)(2)(B). A reasonable fee may not exceed $125.00 per hour, adjusted for the cost of living since March 1996, unless other special factors exist. See 28 U.S.C. §2412, Public Law 104-121, §232, Mar. 29, 1996, 100 Stat. 863. EAJA fees may also be claimed for the work of a paralegal at the market rate for paralegal services. See *Rachlin Sec. Service Co. v. Chertoff*, 553 U.S. 571 (2008).

Adjustments for inflation are generally calculated by reference to the Consumer Price Index ("CPI"), with the current cap on an attorney fee equaling $125.00 multiplied by the current CPI divided by the CPI in March 1996. The Bureau of Labor Statistics ("BLS") calculates many different CPIs. The two most common are the CPI-U and CPI-W. The CPI-U measures inflation for a set list of products. The CPI-W measures inflation in wages for urban wage-earnings and clerical workers. BLS also calculates each CPI nationally and for the various regions of the country. There is no clear guidance as to which CPI should be used for EAJA requests. Currently, the Social Security Administration calculates its cost-of-living adjustments based on

the national CPI-W. For that reason, I use this figure as well. In March of 1996, the national CPI-W was 152.9.[2]

To collect EAJA fees, the plaintiff must prevail, but thankfully achieving a remand is a sufficient victory to justify an EAJA award. See *Sullivan v. Hudson*, 490 U.S. 877 (1989). The court has the discretion to deny a request for EAJA fees if the Commissioner's position was substantially justified or other special circumstances exist that would make an award of fees unjust. See 28 U.S.C. §2412(d)(1)(A); see also *Scarborough v. Principi*, 541 U.S. 401 (2004). "Substantial justification" and "special circumstances" leave some room for debate as to whether a plaintiff should be awarded EAJA fees. However, EAJA fees will be justified in the overwhelming majority of cases in which the plaintiff prevails. The Commissioner's defense of a denial that is unsupported by substantial evidence does not amount to substantial justification. See *Ericksson v. Commissioner of Social Security*, 557 F.3d 79 (2d Cir. 2009). Similarly, a plaintiff's failure to develop an issue at the administrative level is not a special circumstance. See *Vincent v. Commissioner of Social Sec.*, 651 F.3d 299 (2d Cir. 2011). Of course, there are some circumstances that may lead the court to deem EAJA fees unwarranted. For instance, the introduction of new evidence that leads to a significantly later onset date of disability has lead the Second Circuit to conclude that an award of EAJA fees was unjustified. See *Rosado v. Bowen*, 823 F.2d 40 (2d Cir. 1987).

The motion for EAJA fees and costs, supported by the attorney's time sheets and affidavit, must be made within 30 days of the court's final judgement. See 28 U.S.C. §2412(d)(1)(B); *Melkonyan v. Sullivan*, 501 U.S. 89 (1991). A judgement is "final" when it is both final and not appealable. See 28 U.S.C. §2412(d)(2)(G). In Social Security cases, the parties have 60 days in which to appeal a judgement. See Fed. R. App. P. 4(a)(1)(B). It is common practice for the parties to negotiate and stipulate to an EAJA fee if the plaintiff has prevailed.

Sentence 6 remands are treated differently for the purposes of attorney fees. Because the court never gives up jurisdiction, a plaintiff cannot claim EAJA fees until after the case comes back to the district court, and final judgement is issued. See *Melkonyan*.

If both EAJA and §406(b) fees are awarded, then the court must order the attorney to refund the lesser of the two awards to the plaintiff. See *Gisbrecht v. Barnhart*, 535 U.S. 789 (2002). There is no direct precedent from the Second Circuit of which I am aware, but the Fifth Circuit has held that courts may not offset EAJA fees by §406(a) fees. See *Rice v. Astrue*, 609 F.3d 831 (5th Cir. 2010).

There is a major caveat when considering a federal appeal with the expectation of claiming EAJA fees when the client prevails. The fees and costs awarded under EAJA are payable to the client and not the client's attorney. See *Astrue v. Ratliff*, 560 U.S. 586 (2010). As a consequence, the right of the federal government to collect a federal debt or child support precedes the attorney's right to collect payment. See *id.* Therefore, if the client owes child support or a federal debt, the attorney will probably never benefit from any award of EAJA fees.

[2] See https://www.ssa.gov/oact/STATS/cpiw.html (last visited Mar. 15, 2016)

So beware. It is good practice to understand whether a client has a federal debt or owes child support prior to deciding whether to file a civil action.

As with the court's remedies, EAJA fee awards are reviewed for abuse of discretion, rather than *de novo*. See *Pierce v. Underwood*, 487 U.S. 552 (1988).

406(b) Attorney Fees

42 U.S.C. §406(a) covers awards of attorney fees by the Commissioner for representation before the Administration. 42 U.S.C. §406(b) covers attorney fees for representation in Social Security actions before the courts. §406(b) allows the court to determine and award a reasonable attorney fee, not in excess of 25% of the total of the past-due benefits. See §406(b)(1)(A). As a result of this statute, and the fact that very few Social Security claimants could ever afford to hire an attorney for an hourly fee regardless of outcome, nearly all representation of plaintiffs before the courts is done on a contingent-fee basis for 25% of past-awarded benefits. §406(b) differs from §406(a) in one significant way. Whereas §406(a) caps an approvable contingent-fee agreement for representation at $6,000.00, §406(b) contains no such cap. See §406(b).

The lodestar method for calculating fees does not apply to Social Security Disability cases. See *Gisbrecht v. Barnhart*, 535 U.S. 789 (2002). Instead, the court looks first to the contingent-fee agreement to test it for reasonableness. See *id.* The court may reduce the fee because of the character of the representation, the results achieved, or the fact that the fee would represent a windfall to the attorney. See *id.*

The general consensus among circuits is that an attorney may seek approval of §406(b) fees from the court after a case has been remanded and past-due benefits have been subsequently awarded by the Administration. See *McGraw v. Barnhart*, 450 F.3d 493 (10th Cir. 2006); *Bergen v. Comm'r of Soc. Sec.*, 444 F.3d 1281 (11th Cir. 2006); *Fenix v. Finch*, 436 F.2d 831 (8th Cir. 1971); *Conner v. Gardner*, 381 F.2d 497 (4th Cir. 1967). There is a split among circuits as to when §406(b) fees must be requested after a successful remand. Some circuits have held that Fed. R. Civ. P. 54(d)(2) governs the petition for §406(b) fees. See *Pierce v. Barnhart*, 440 F.3d 657 (4th Cir. 2006); *Bergen v. Commissioner of Social Sec.*, 454 F.3d 1273 (11th Cir. 2006). The problem with this approach is that rule 54(d)(2) requires requests for attorney fees be made within 14 days of judgment being entered by the court. For Sentence 4 remands, judgment will have been entered by the court long before the Commissioner ever awards any past-due benefits. It is thus impossible for the plaintiff to comply with the deadline. The circuits that apply this theory have not addressed this problem. See *Pierce*; *Berger*.

A second approach has been to invoke the court's power to grant extraordinary relief under Fed. R. Civ. P. 60(b)(6). See *McGraw v. Barnhart*, 450 F.3d 493 (10th Cir. 2006). Under this approach a plaintiff who has prevailed below need only file a §406(b) petition within a reasonable time after the Commissioner's decision awarding benefits. See *id.*

Another timing problem with requesting 406(b) fees is that there may be multiple awards, all of which may be subject to an attorney fee, and none of which are likely to be issued at the

same time. A claimant may have both a Disability Insurance claim and Supplemental Security Income claim, and may receive a Notice of Award for each that are issued weeks and sometimes months apart. They may also have minor children that are entitled to awards of their own. There is no guidance about what to do in such cases.

Because of the general uncertainty around the proper timing for requesting 406(b) fees, I generally file a motion asking the court to set a deadline under is authority in Fed. R. Civ. Pro. 83(b). I generally ask that the deadline be 30 days after the last expected Notice of Award is received.

The attorney is no limited to attorney fees of 25% of back-owed benefits from a combination of 406(a) and 406(b) fees. See *Culbertson v. Berryhill*, 139 S.Ct. 517, 522 – 23 (2019.) The court treats 406(b) fees separately and may not reduce those fees because of fees awarded under 406(a).

Appendix

Vermont Local Rule 9(a): Pleading Social Security Cases

(a) Social Security Cases. The following procedures govern all actions challenging a final decision of the Commissioner of the Social Security Administration filed under the Social Security Act, 42 U.S.C. § 405.

(1) ***Time for Filing Answer.*** Within 60 days after service of the complaint, the Commissioner must serve and file:

(A) an answer; and

(B) a certified copy of the administrative record, which may be in electronic form.

(2) ***Motion for Order Reversing the Commissioner's Decision.*** Within 60 days after the Commissioner files an answer, the plaintiff must serve and file:

(A) a Motion for Order Reversing the Commissioner's Decision or for other relief; and

(B) a supporting memorandum.

(3) ***Motion for Order Affirming the Commissioner's Decision.*** Within 60 days after the plaintiff files the Motion for Order Reversing the Commissioner's Decision, the Commissioner must serve and file:

(A) a Motion for Order Affirming the Decision of the Commissioner or for other relief; and

(B) a supporting memorandum.

(4) ***Reply Memorandum.*** Within 14 days after the Commissioner files the Motion for Order Affirming the Commissioner's Decision, the plaintiff may serve and file a reply.

(5) ***Further Reply Memorandum.*** If the plaintiff raises new issues or arguments in a reply memorandum, the Commissioner may serve and file a sur-reply within 14 days after service of the reply memorandum.

(6) ***Content of Motions and Memoranda.***

(A) Motions and memoranda must not exceed a total of 25 pages, and must meet the formatting requirements of Rule 10(a).

(B) The first section of the memorandum must include a summary of the case's procedural history and a brief summary of the relevant background facts, with page citations to the administrative record.

(C) The second section of the memorandum must include a concise statement of each issue for review, similar to an appellate brief; and must present the argument, discussing each issue in a separate subsection. The argument shall refer to the pertinent facts, if any, and shall include specific page citations to the administrative record for supporting evidence.

General Order No. 74

[Sample Civil Cover Page]

[Sample Complaint]

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF VERMONT

[Client], Plaintiff, v. Commissioner, Social Security Administration, Defendant	Civil Action No.:

COMPLAINT

NOW COMES Plaintiff, by and through [his/her] attorneys, Jarvis & Modun, LLP, and alleges the following:

1. The United States District Court has jurisdiction over this action under its authority in 42 U.S.C. § 405(g) and/or 42 U.S.C. §1383(c)(3) to review a final decision of the Commissioner of Social Security denying Plaintiff's application for Social Security Disability Insurance Benefits and Supplemental Security Income.
2. Plaintiff's Social Security number is [XXX-XX-1234].[1]
3. Plaintiff resides in Vermont in the town of [Town], county of [County].
4. Plaintiff's net worth at the time that this Action is commenced is less than two million dollars ($2,000,000.00) and [he/she] is therefore a party under 28 U.S.C. § 2412.

[1] The Social Security number is being partially redacted in the Complaint filed with the Court in compliance with Fed. R. Civ. P. 5.2. However, the Commissioner has requested in the Appeals Council's Notice of Action that Plaintiff's full Social Security number be included in the Complaint for identification purposes. In order to identify the claim, Plaintiff's full Social Security Number will be included in cover letters served with the summons and complaint to the U.S. Attorney's Office and Office of the Regional Counsel.

5. Plaintiff applied for Disability Insurance Benefits on [Date] under Title II of the Social Security Act, 42 U.S.C. 401 *et seq,* and Supplemental Security Income under Title XVI of the Social Security Act, 42 U.S.C. §1381 *et seq.*, by reason of [his/her] own disability.
6. After a hearing held on [Date], an Administrative Law Judge, acting under the Commissioner's authority, found that Plaintiff was not entitled to Disability Insurance Benefits and/or Supplemental Security Income in a written decision issued on [Date].
7. The Appeals Council issued a Notice of Action on [Date] in which it declined Plaintiff's request to review the Administrative Law Judge's decision.
8. The Commissioner's denial of benefits to Plaintiff is therefore final.
9. This Action is commenced within sixty-five (65) days of the date of the Notice of Appeals Council's Action and is therefore timely.
10. The Commissioner's findings and conclusions are not supported by substantial evidence.
11. The Commissioner's findings and conclusions are contrary to law, regulations, and policies.
12. [The Commissioner did not adequately develop the administrative record concerning Plaintiff's alleged disability.]
13. The Commissioner's position in denying Plaintiff's claim(s) is not substantially justified.
14. Plaintiff is disabled.

WHEREFORE, Plaintiff prays that this Court:

1. reverse the decision of the Commissioner; and
2. find Plaintiff entitled to disability benefits under Title II and/or Title XVI of the Social Security Act; or
3. remand the claim for further proceedings before the Commissioner; and

4. award costs and attorney's fees under 28 U.S.C. § 2412; and

5. grant other such relief as the Court may deem just and appropriate.

[Date]
Montpelier, Vermont

Respectfully submitted,
Jarvis & Modun, LLP
Attorneys for

By: _____

License No. [Number]
P.O. Box 545
Montpelier, VT 05601
(802) 540-1030

[Sample Letter to the Court with Initial Filing]

[Date]

Clerk, United States District Court
P.O. Box 945
Burlington, VT 05402

Re: [Social Security Plaintiff] v. Commissioner of the Social Security Administration

Dear Mr. Eaton:

Enclosed for filing please find:

(1) Civil Cover Sheet;
(2) Complaint; and
[Either] (3) Check for $400.00;
[Or] (3) Application and Affidavit to Proceed *In Forma Pauperis*.

[Please note that even though Plaintiff has filed for *In Forma Pauperis* status, he/she is electing to serve the Complaint and Summonses on the necessary parties himself/herself.] Therefore we request that the Court execute and issue three Summonses for service on the following parties:

Attorney General of the United States
U.S. Department of Justice
950 Pennsylvania Ave, NW
Washington, DC 20530-0001

United States Attorney
District of Vermont
P.O. Box 570
Burlington, VT 05402-0570

Social Security Administration
Office of General Counsel – Region II
26 Federal Plaza, Room 3904
New York, NY 10278

The answer to the Complaint should be served upon:

Jarvis & Modun, LLP
P.O. Box 545
Montpelier, VT 05601

Thank you for your attention to this matter.

Sincerely,

Craig A. Jarvis
Attorney at Law
jarvis@jarvis-modun.com
(802) 540-1030

Enclosures
cc: [Client]

[Sample Application to Proceed IFP]

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF VERMONT

[Client] Plaintiff, v. Commissioner, Social Security Administration, Defendant	Civil Action No.:

APPLICATION TO PROCEED *IN FORMA PAUPERIS*

Plaintiff, by and through [his/her] attorneys, Jarvis & Modun, hereby applies for leave of this Court to proceed *in forma pauperis* pursuant to 28 U.S.C. § 1915. In support of this application, Plaintiff submits [his/her] Affidavit in Support of Application to Proceed *in Forma Pauperis*. Plaintiff elects to restrict [his/her] application to the filing fee only. Plaintiff will effectuate service of process on the necessary parties.

[Date]
Burlington, Vermont

Respectfully submitted,
Jarvis & Modun
Attorneys for [Client]

By: _____

Craig A. Jarvis
P.O. Box 545
Montpelier, VT 05601
(802) 540-1030

[Sample IFP Affidavit]

[Sample Letters with Summonses and Complaints]

[Date]

Via Certified U.S. Mail

Eric S. Miller
United States Attorney's Office
P.O. Box 570
11 Elmwood Ave., 3rd Floor
Burlington, VT 05402-0570

Re: Disabled Client v. Commissioner of Social Security
Civil Case No.: 9:16-CV-00099
SSN: 000-00-0000

Dear Mr. Miller:

Enclosed, please find (1) a **Summons** and (2) a **Complaint** for the civil action referenced above. [In addition, I enclose (3) **Notice, Consent, and Reference of a Civil Action to a Magistrate Judge** form. If the Commissioner also consents to the U.S. Magistrate's jurisdiction, please sign the form and file it with the Court.]

Thank you for your attention to this matter.

Sincerely,

Craig A. Jarvis
Attorney at Law
jarvis@jarvis-modun.com
(802) 540-1030

Enclosures

[Date]

Via Certified U.S. Mail

Social Security Administration
Office of the General Counsel, Region II
26 Federal Plaza, Room 3904
New York, NY 10278

Re: Disabled Client v. Commissioner of Social Security
Civil Case No.: 9:16-CV-00099
SSN: 000-00-0000

Dear Sir/Madam:

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Craig A. Jarvis
Attorney at Law
jarvis@jarvis-modun.com
(802) 540-1030

Enclosures

[Date]

Via Certified U.S. Mail

Attorney General
U.S. Department of Justice
950 Pennsylvania Avenue, NW
Washington, DC 20530-0001

Re: Disabled Client v. Commissioner of Social Security
Civil Case No.: 9:16-CV-00099

Dear Sir/Madam:

Enclosed, please find (1) a **Summons** and (2) a **Complaint** for the civil action referenced above.

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Enclosures

[Sample Statement of Material Facts]

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF VERMONT

DISABLED CLIENT, Plaintiff	
	Civil Action No.: 9:16-CV-00099
v.	
COMMISSIONER OF SOCIAL SECURITY Defendant	

PLAINTIFF'S STATEMENT OF MATERIAL FACTS

The Plaintiff offers the following Statement of Material Fact pursuant to General Order 74.

1. Claimant was born on July 8, 1961. (AR at 167.) He was 49 years old as of his alleged onset date of February 12, 2011 and turned 50 years old shortly thereafter. (Id.)

2. His primary disability is degeneration of the lumbar spine, and he has a history of fusion surgery at L5-S1. (AR at 23.)

3. In his decision, ALJ Grant adopted the medical opinion of Dr. Treating Physician about Plaintiff's functional limitations. (AR 26.) Specifically, he found that Plaintiff could perform light exertional work, (i.e., lift 20 pounds occasionally and ten pounds frequently, except that he could only stand for four hours and walk for two hours). (AR 25.) He would also need to use a cane, but could carry small objects with one hand, and could frequently use hands and feet to operate controls. (Id.) He could never crawl, but could occasionally balance, stoop, bend, kneel, and crouch. (Id.) He should never be exposed to unprotected heights, but could frequently be exposed to moving mechanical parts, and could frequently drive. (Id.)

4. ALJ Grant found that Plaintiff could not return to his past relevant work with these restrictions. (AR 26.)

5. He found that he could return to other work. (AR 27.) As part of this analysis, he pointed out that if Plaintiff had been able to do a full range of light work, then the rules of the Medical-Vocational Guidelines would have directed a finding of "not disabled." (Id.) However, he noted that Plaintiff's abilities to perform all or substantially all of the requirements of light work had been significantly impeded by additional limitations. (Id.) To determine the extent to which these additional limitations eroded the occupational base for unskilled, light work, he relied on the testimony of a vocational expert who had identified "addresser, dowel inspector, and fishing reel assembler" as occupations that the Plaintiff could perform. (Id.)

6. In her testimony, the vocational expert testified that addresser, dowel inspector, and fishing reel assembler were all sedentary occupations. (AR 20.)

[Date]
Burlington, Vermont

Respectfully submitted,
Jarvis & Modun, LLP
Attorneys for Disabled Client

By: */s/ Craig A. Jarvis*

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[Sample Motion for Order Reversing the Commissioner's Decision]

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF VERMONT

DISABLED CLIENT, Plaintiff	
	Civil Action No.: 9:16-CV-00099
v.	
COMMISSIONER OF SOCIAL SECURITY Defendant	

PLAINTIFF'S MOTION FOR ORDER REVERSING THE COMMISSIONER'S DECISION

Now Comes Plaintiff, by and through his attorneys, Jarvis & Modun, LLP, and moves to remand for further consideration the final decision of the Commissioner denying his Title II and Title XVI disability benefits under the Social Security Act.

MEMORANDUM OF LAW

I. Statement of Jurisdiction

The United States District Court has original jurisdiction to review the final decisions of the Commissioner of Social Security Administration regarding entitlement to Title II and Title XVI disability benefits pursuant to 42 U.S.C. §§405(g) and 1383c(3).

II. Factual Statement

(a) Procedural History

Plaintiff applied for Disability Insurance Benefits (DIB) under Title II of the Social Security Act on February 24, 2011 and for Supplemental Security Income (SSI) under Title XVI of the Social Security Act on March 4, 2011, alleging that he became disabled on May 20, 2008.

(A.R. at 167 – 79.) An initial denial of his applications was issued March 30, 2011 (A.R. at 101.) and again upon reconsideration on May 26, 2011. (A.R. at 101.) On June 15, 2011, Plaintiff requested a hearing before an Administrative Law Judge (hereinafter "ALJ"). On May 21, 2012, a hearing was conducted by ALJ Benny Grant. (A.R. at 33.) ALJ Grant issued an unfavorable decision on May 25, 2012. (A.R. at 8.) Plaintiff requested review of the ALJ decision on July 25, 2012 from the Appeals Council. (A.R. at 15.) On August 20, 2013, the Appeals Council decided to take no action on request for review. (A.R. at 9 – 14.) After requesting an extension, Plaintiff filed a civil action with this Court.

IV. Analysis

A. Statement of the Issue

ALJ Grant has failed to show that Plaintiff can make a vocational adjustment to relevant work within the framework of the Medical-Vocational Guidelines after he turned 50 years of age.

B. Standard of Review

The District Court will review the final decision of the Commissioner for legal error and determine whether it is supported by "substantial evidence." See 42 U.S.C. § 1383c(3); 42 U.S.C. § 405(g); *Balsamo v. Chater*, 142 F.3d 75, 79 (2d Cir.1998); *Arnone v. Bowen*, 882 F.2d 34, 37 (2d Cir.1989). Substantial evidence is such evidence as a reasonable mind might accept as adequate to support a conclusion. See *Richardson v. Perales*, 402 U.S. 389, 401, 91 S.Ct. 1420, 1427 (1971).

C. Sequential Analysis

Disability is determined for each claimant by way of a five-step sequential analysis. The Commissioner first considers whether the individual is currently working; second, whether he or

she suffers from a severe impairment; third whether the impairment is listed at appendix one of 20 C.F.R § 404, subpart P; fourth, whether the impairment prevents the individual from continuing his or her past relevant work; and fifth, whether there is other work that exists in the national economy that he or she could perform, using the framework of the Medical-Vocational Guidelines at appendix two of 20 C.F.R § 404, subpart P. 20 C.F.R. §§ 404.1520; *See also Berry v. Schweiker*, 675 F.2d at 464, 467 (2d. Cir. 1982). The Commissioner considers each step in order so that she considers a subsequent step only if a decision could not be made in the preceding step. See 20 C.F.R.§404.1520(a)(4). The claimant bears the burden of proof for the first four steps; however the burden of proof at step five shifts to the Commissioner to show that a claimant can return to other work that exists in significant numbers in the national economy. See *Poupore v. Astrue*, 566 F.3d 303, 306 (2d Cir. 2009).

D. ALJ Grant has failed to show that Plaintiff can make a vocational adjustment to relevant work within the framework of the Medical-Vocational Guidelines after he turned 50 years of age.

At step five of the sequential analysis, most claims are decided using the Medical-Vocational Guideline ("the Grid") at 20 C.F.R. §404, subp. P, app. 2. The Grid is a set of rules that combine the factors of exertional limitations, age, previous work experience, and education that guide the adjudicator to a conclusion of "disabled" or "not disabled." See §404, subp. P, app. 2; see also SSR 83-10. If all four criteria contemplated by the rules are exactly met, then the Grid directs a finding of "disabled" or "not disabled" in accordance with that specific rule. See §404, subp. P, app. 2, rule 200.00(a); see also SSR 83-10, 1983 WL 31251. However, if none of the criteria are exactly met–for instance if the claimant has significant non-exertional limitations in addition to exertional limitations–then the Grid is used as a framework for guiding the adjudicator's decision. See §404, subp. P, app. 2; see also SSR 83-10; SSR 83-12, 1983 WL 31253; *Pratts v. Chater*, 94 F.3d 34 (2d Cir. 1996).

ALJ Grant found that Plaintiff was capable of the exertional capacities for light work, except that he has reduced capacities for walking and standing. (A.R. 25.) He also found several non-exertional limitations. (Id.) ALJ Grant acknowledges that Plaintiff's ability to do light work is substantially eroded by these limitations. (A.R. 27.) Therefore, Plaintiff falls between two exertional categories: light and sedentary.

When a claimant falls between two exertional categories, the ALJ must use the rules of the Grid as a framework. See SSR 83-12. This requires that the ALJ assess which rule is more indicative of the claimant's particular medical-vocational profile. See Id. If the claimant's abilities fall between two rules which reach the same conclusions, i.e. both "disabled" or both "not disabled" then the outcome is simple. The ALJ reaches the conclusion as directed by both rules. See Id. On the other hand:

> If the exertional level falls between two rules which direct opposite conclusions, i.e., "Not disabled" at the higher exertional level and "Disabled" at the lower exertional level, consider as follows:
> a. An exertional capacity that is only slightly reduced in terms of the regulatory criteria could indicate a sufficient remaining occupational base to satisfy the minimal requirements for a finding of "Not disabled."
> b. On the other hand, if the exertional capacity is significantly reduced in terms of the regularity definition, it could indicate little more than the occupational base for the lower rule and could justify a finding of "Disabled." Id.

ALJ Grant found that Plaintiff has a high-school education and that the transferability of skills was immaterial. (A.R. 26.) Therefore, when Plaintiff was under 50 years old, he fell between Grid rules 202.21 and 201.12. See 20 C.F.R. §404, subp. P, app. 2. These rules both direct a finding of "not-disabled." Therefore, as to the period of time that he was under 50, he was not disabled.

However, once Plaintiff turned 50, he then fell between rules 202.14 and 201.14. See 20 C.F.R. §404, subp. P, app. 2. Rule 202.14 directs a finding of "not disabled," but 201.14 directs a finding of "disabled." Id. Therefore, the ALJ must determine the degree to which the occupational base for light work is eroded by the additional exertional and non-exertional limitations, and assess how closely that occupational base resembles the occupational base for the full range of sedentary, unskilled work. The ALJ can only conclude that the claimant is not-disabled in such a situation if he can find that Plaintiff is able to do some light occupations that exist in significant numbers beyond the occupational base for sedentary work. See *Distansio v. Shalala*, 47 F.3d 348 (9th Cir. 1995).

ALJ Grant has not identified any light occupations that Plaintiff can do with his limitations. The occupations upon which he relies are all sedentary. (A.R. 20, 27.) Therefore, he has not carried the Commissioner's burden to show that Plaintiff can make a vocational adjustment to other work at step five of the sequential analysis once Plaintiff turned 50.

E. Conclusion

For the reasons stated above, Plaintiff asks that the denial of benefits be vacated and that the claim be remanded for further proceedings.

[Date]
Burlington, Vermont

Respectfully submitted,
Jarvis & Modun, LLP
Attorneys for Disabled Client

By: */s/ Craig A. Jarvis*

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Certificate of Service

I hereby certify that on [Date], a copy of the foregoing *Plaintiff's Motion for Order Reversing the Commissioner's Decision* was served via the ECF electronic case filing system upon, Staff Attorney, SAUSA, whose registered e-mail is staff.attorney@ssa.gov.

/s/ Craig A. Jarvis