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EVIDENCE, PROCEDURE, AND CERTIFICATION FOR PAYMENT

SEC. 205. *[42 U.S.C. 405]* (b)(1) The Commissioner of Social Security is directed to make findings of fact, and decisions as to the rights of any individual applying for a payment under this title. Any such decision by the Commissioner of Social Security which involves a determination of disability and which is in whole or in part unfavorable to such individual shall contain a statement of the case, in understandable language, setting forth a discussion of the evidence, and stating the Commissioner's determination and the reason or reasons upon which it is based. Upon request by any such individual or upon request by a wife, divorced wife, widow, surviving divorced wife, surviving divorced mother, surviving divorced father, husband, divorced husband, widower, surviving divorced husband, child, or parent who makes a showing in writing that his or her rights may be prejudiced by any decision the Commissioner of Social Security has rendered, the Commissioner shall give such applicant and such other individual reasonable notice and opportunity for a hearing with respect to such decision, and, if a hearing is held, shall, on the basis of evidence adduced at the hearing, affirm, modify, or reverse the Commissioner's findings of fact and such decision. Any such request with respect to such a decision must be filed within sixty days after notice of such decision is received by the individual making such request. The Commissioner of Social Security is further authorized, on the Commissioner's own motion, to hold such hearings and to conduct such investigations and other proceedings as the Commissioner may deem necessary or proper for the administration of this title. In the course of any hearing, investigation, or other proceeding, the Commissioner may administer oaths and affirmations, examine witnesses, and receive evidence. Evidence may be received at any hearing before the Commissioner of Social Security even though inadmissible under rules of evidence applicable to court procedure.

(2) In any case where—

> (A) an individual is a recipient of disability insurance benefits, or of child's, widow's, or widower's insurance benefits based on disability,
> (B) the physical or mental impairment on the basis of which such benefits are payable is found to have ceased, not to have existed, or to no longer be disabling, and
> (C) as a consequence of the finding described in subparagraph (B), such individual is determined by the Commissioner of Social Security not to be entitled to such benefits,

any reconsideration of the finding described in subparagraph (B), in connection with a reconsideration by the Commissioner of Social Security (before any hearing under paragraph (1) on the issue of such entitlement) of the Commissioner's determination described in subparagraph (C), shall be made only after opportunity for an evidentiary

hearing, with regard to the finding described in subparagraph (B), which is reasonably accessible to such individual. Any reconsideration of a finding described in subparagraph (B) may be made either by the State agency or the Commissioner of Social Security where the finding was originally made by the State agency, and shall be made by the Commissioner of Social Security where the finding was originally made by the Commissioner of Social Security. In the case of a reconsideration by a State agency of a finding described in subparagraph (B) which was originally made by such State agency, the evidentiary hearing shall be held by an adjudicatory unit of the State agency other than the unit that made the finding described in subparagraph (B). In the case of a reconsideration by the Commissioner of Social Security of a finding described in subparagraph (B) which was originally made by the Commissioner of Social Security, the evidentiary hearing shall be held by a person other than the person or persons who made the finding described in subparagraph (B).

(3)(A) A failure to timely request review of an initial adverse determination with respect to an application for any benefit under this title or an adverse determination on reconsideration of such an initial determination shall not serve as a basis for denial of a subsequent application for any benefit under this title if the applicant demonstrates that the applicant, or any other individual referred to in paragraph (1), failed to so request such a review acting in good faith reliance upon incorrect, incomplete, or misleading information, relating to the consequences of reapplying for benefits in lieu of seeking review of an adverse determination, provided by any officer or employee of the Social Security Administration or any State agency acting under section 221.

(B) In any notice of an adverse determination with respect to which a review may be requested under paragraph (1), the Commissioner of Social Security shall describe in clear and specific language the effect on possible entitlement to benefits under this title of choosing to reapply in lieu of requesting review of the determination.

EVIDENCE, PROCEDURE, AND CERTIFICATION FOR PAYMENT

SEC. 205. *[42 U.S.C. 405]* (g) Any individual, after any final decision of the Commissioner of Social Security made after a hearing to which he was a party, irrespective of the amount in controversy, may obtain a review of such decision by a civil action commenced within sixty days after the mailing to him of notice of such decision or within such further time as the Commissioner of Social Security may allow. Such action shall be brought in the district court of the United States for the judicial district in which the plaintiff resides, or has his principal place of business, or, if he does not reside or have his principal place of business within any such judicial district, in the United States District Court for the District of Columbia. As part of the Commissioner's answer the Commissioner of Social Security shall file a certified copy of the transcript of the record including the evidence upon which the findings and decision complained of are based. The court shall have power to enter, upon the pleadings and transcript of the record, a judgment affirming, modifying, or reversing the decision of the Commissioner of Social Security, with or without remanding the cause for a rehearing. The findings of the Commissioner of Social Security as to any fact, if supported by substantial evidence, shall be conclusive, and where a claim has been denied by the Commissioner of Social Security or a decision is rendered under subsection (b) hereof which is adverse to an individual who was a party to the hearing before the Commissioner of Social Security, because of failure of the claimant or such individual to submit proof in conformity with any regulation prescribed under subsection (a) hereof, the court shall review only the question of conformity with such regulations and the validity of such regulations. The court may, on motion of the Commissioner of Social Security made for good cause shown before the Commissioner files the Commissioner's answer, remand the case to the Commissioner of Social Security for further action by the Commissioner of Social Security, and it may at any time order additional evidence to be taken before the Commissioner of Social Security, but only upon a showing that there is new evidence which is material and that there is good cause for the failure to incorporate such evidence into the record in a prior proceeding; and the Commissioner of Social Security shall, after the case is remanded, and after hearing such additional evidence if so ordered, modify or affirm the Commissioner's findings of fact or the Commissioner's decision, or both, and shall file with the court any such additional and modified findings of fact and decision and, in any case in which the Commissioner has not made a decision fully favorable to the individual, a transcript[98] of the additional record and testimony upon which the Commissioner's action in modifying or affirming was based. Such additional or modified findings of fact and decision shall be reviewable only to the extent provided for review of the original findings of fact and decision. The judgment of the court shall be final except that it shall be subject to review in the same manner as a judgment in other civil actions. Any action instituted in accordance with this subsection shall survive notwithstanding any change in the person occupying the office of Commissioner of Social Security or any vacancy in such office.

REPRESENTATION OF CLAIMANTS

SEC. 206. *[42 U.S.C. 406]* (a)(1) The Commissioner of Social Security may prescribe rules and regulations governing the recognition of agents or other persons, other than attorneys as hereinafter provided, representing claimants before the Commissioner of Social Security, and may require of such agents or other persons, before being recognized as representatives of claimants that they shall show that they are of good character and in good repute, possessed of the necessary qualifications to enable them to render such claimants valuable service, and otherwise competent to advise and assist such claimants in the presentation of their cases. An attorney in good standing who is admitted to practice before the highest court of the State, Territory, District, or insular possession of his residence or before the Supreme Court of the United States or the inferior Federal courts, shall be entitled to represent claimants before the Commissioner of Social Security. Notwithstanding the preceding sentences, the Commissioner, after due notice and opportunity for hearing, (A) may refuse to recognize as a representative, and may disqualify a representative already recognized, any attorney who has been disbarred or suspended from any court or bar to which he or she was previously admitted to practice or who has been disqualified from participating in or appearing before any Federal program or agency, and (B) may refuse to recognize, and may disqualify, as a non-attorney representative any attorney who has been disbarred or suspended from any court or bar to which he or she was previously admitted to practice. A representative who has been disqualified or suspended pursuant to this section from appearing before the Social Security Administration as a result of collecting or receiving a fee in excess of the amount authorized shall be barred from appearing before the Social Security Administration as a representative until full restitution is made to the claimant and, thereafter, may be considered for reinstatement only under such rules as the Commissioner may prescribe.[113] The Commissioner of Social Security may, after due notice and opportunity for hearing, suspend or prohibit from further practice before the Commissioner any such person, agent, or attorney who refuses to comply with the Commissioner's rules and regulations or who violates any provision of this section for which a penalty is prescribed. The Commissioner of Social Security may, by rule and regulation, prescribe the maximum fees which may be charged for services performed in connection with any claim before the Commissioner of Social Security under this title, and any agreement in violation of such rules and regulations shall be void. Except as provided in paragraph (2)(A), whenever the Commissioner of Social Security, in any claim before the Commissioner for benefits under this title, makes a determination favorable to the claimant, the Commissioner shall, if the claimant was represented by an attorney in connection with such claim, fix (in accordance with the regulations prescribed pursuant to the preceding sentence) a reasonable fee to compensate such attorney for the services performed by him in connection with such claim.

(2)(A) In the case of a claim of entitlement to past-due benefits under this title, if—

> (i) an agreement between the claimant and another person regarding any fee to be recovered by such person to compensate such person for services with respect to

the claim is presented in writing to the Commissioner of Social Security prior to the time of the Commissioner's determination regarding the claim,
(ii) the fee specified in the agreement does not exceed the lesser of—
(I) 25 percent of the total amount of such past-due benefits (as determined before any applicable reduction under section 1127(a)), or
(II) $4,000, and
(iii) the determination is favorable to the claimant,

then the Commissioner of Social Security shall approve that agreement at the time of the favorable determination, and (subject to paragraph (3)) the fee specified in the agreement shall be the maximum fee. The Commissioner of Social Security may from time to time increase the dollar amount under clause (ii)(II) to the extent that the rate of increase in such amount, as determined over the period since January 1, 1991, does not at any time exceed the rate of increase in primary insurance amounts under section 215(i) since such date. The Commissioner of Social Security shall publish any such increased amount in the Federal Register.

(B) For purposes of this subsection, the term “past-due benefits” excludes any benefits with respect to which payment has been continued pursuant to subsection (g) or (h) of section 223.

(C) In any case involving—

(i) an agreement described in subparagraph (A) with any person relating to both a claim of entitlement to past-due benefits under this title and a claim of entitlement to past-due benefits under title XVI, and
(ii) a favorable determination made by the Commissioner of Social Security with respect to both such claims,

the Commissioner of Social Security may approve such agreement only if the total fee or fees specified in such agreement does not exceed, in the aggregate, the dollar amount in effect under subparagraph (A)(ii)(II).

(D) In the case of a claim with respect to which the Commissioner of Social Security has approved an agreement pursuant to subparagraph (A), the Commissioner of Social Security shall provide the claimant and the person representing the claimant a written notice of—

(i) the dollar amount of the past-due benefits (as determined before any applicable reduction under section 1127(a)) and the dollar amount of the past-due benefits payable to the claimant,
(ii) the dollar amount of the maximum fee which may be charged or recovered as determined under this paragraph, and
(iii) a description of the procedures for review under paragraph (3).

(3)(A) The Commissioner of Social Security shall provide by regulation for review of the amount which would otherwise be the maximum fee as determined under paragraph (2) if, within 15 days after receipt of the notice provided pursuant to paragraph (2)(D)—

> (i) the claimant, or the administrative law judge or other adjudicator who made the favorable determination, submits a written request to the Commissioner of Social Security to reduce the maximum fee, or
> (ii) the person representing the claimant submits a written request to the Commissioner of Social Security to increase the maximum fee.

Any such review shall be conducted after providing the claimant, the person representing the claimant, and the adjudicator with reasonable notice of such request and an opportunity to submit written information in favor of or in opposition to such request. The adjudicator may request the Commissioner of Social Security to reduce the maximum fee only on the basis of evidence of the failure of the person representing the claimant to represent adequately the claimant's interest or on the basis of evidence that the fee is clearly excessive for services rendered.

(B)(i) In the case of a request for review under subparagraph (A) by the claimant or by the person representing the claimant, such review shall be conducted by the administrative law judge who made the favorable determination or, if the Commissioner of Social Security determines that such administrative law judge is unavailable or if the determination was not made by an administrative law judge, such review shall be conducted by another person designated by the Commissioner of Social Security for such purpose.

(ii) In the case of a request by the adjudicator for review under subparagraph (A), the review shall be conducted by the Commissioner of Social Security or by an administrative law judge or other person (other than such adjudicator) who is designated by the Commissioner of Social Security.

(C) Upon completion of the review, the administrative law judge or other person conducting the review shall affirm or modify the amount which would otherwise be the maximum fee. Any such amount so affirmed or modified shall be considered the amount of the maximum fee which may be recovered under paragraph (2). The decision of the administrative law judge or other person conducting the review shall not be subject to further review.

(4) Subject to subsection (d), if the claimant is determined to be entitled to past-due benefits under this title and the person representing the claimant is an attorney, the Commissioner of Social Security shall, notwithstanding section 205(i), certify for payment out of such past-due benefits (as determined before any applicable reduction under section 1127(a)) to such attorney an amount equal to so much of the maximum fee as does not exceed 25 percent of such past-due benefits (as determined before any applicable reduction under section 1127(a)).

(5) Any person who shall, with intent to defraud, in any manner willfully and knowingly deceive, mislead, or threaten any claimant or prospective claimant or beneficiary under this title by word, circular, letter or advertisement, or who shall knowingly charge or collect directly or indirectly any fee in excess of the maximum fee, or make any agreement directly or indirectly to charge or collect any fee in excess of the maximum fee, prescribed by the Commissioner of Social Security shall be deemed guilty of a misdemeanor and, upon conviction thereof, shall for each offense be punished by a fine not exceeding $500 or by imprisonment not exceeding one year, or both. The Commissioner of Social Security shall maintain in the electronic information retrieval system used by the Social Security Administration a current record, with respect to any claimant before the Commissioner of Social Security, of the identity of any person representing such claimant in accordance with this subsection.

(b)(1)(A) Whenever a court renders a judgment favorable to a claimant under this title who was represented before the court by an attorney, the court may determine and allow as part of its judgment a reasonable fee for such representation, not in excess of 25 percent of the total of the past-due benefits to which the claimant is entitled by reason of such judgment, and the Commissioner of Social Security may, notwithstanding the provisions of section 205(i), but subject to subsection (d) of this section, certify the amount of such fee for payment to such attorney out of, and not in addition to, the amount of such past-due benefits. In case of any such judgment, no other fee may be payable or certified for payment for such representation except as provided in this paragraph.

(B) For purposes of this paragraph—

> (i) the term “past-due benefits” excludes any benefits with respect to which payment has been continued pursuant to subsection (g) or (h) of section 223, and (ii) amounts of past-due benefits shall be determined before any applicable reduction under section 1127(a).

(2) Any attorney who charges, demands, receives, or collects for services rendered in connection with proceedings before a court to which paragraph (1) is applicable any amount in excess of that allowed by the court thereunder shall be guilty of a misdemeanor and upon conviction thereof shall be subject to a fine of not more than $500, or imprisonment for not more than one year, or both.[114]

(c) The Commissioner of Social Security shall notify each claimant in writing, together with the notice to such claimant of an adverse determination, of the options for obtaining attorneys to represent individuals in presenting their cases before the Commissioner of Social Security. Such notification shall also advise the claimant of the availability to qualifying claimants of legal services organizations which provide legal services free of charge.

(d) ASSESSMENT ON ATTORNEYS.—

(1) IN GENERAL.—Whenever a fee for services is required to be certified for payment to an attorney from a claimant's past-due benefits pursuant to subsection (a)(4) or (b)(1), the Commissioner shall impose on the attorney an assessment calculated in accordance with paragraph (2).

(2) AMOUNT.—

(A) The amount of an assessment under paragraph (1) shall be equal to the product obtained by multiplying the amount of the representative's fee that would be required to be so certified by subsection (a)(4) or (b)(1) before the application of this subsection, by the percentage specified in subparagraph (B).

(B) The percentage specified in this subparagraph is—

(i) for calendar years before 2001, 6.3 percent, and

(ii) for calendar years after 2000, such percentage rate as the Commissioner determines is necessary in order to achieve full recovery of the costs of determining and certifying fees to attorneys from the past-due benefits of claimants, but not in excess of 6.3 percent.

(3) COLLECTION.—The Commissioner may collect the assessment imposed on an attorney under paragraph (1) by offset from the amount of the fee otherwise required by subsection (a)(4) or (b)(1) to be certified for payment to the attorney from a claimant's past-due benefits.

(4) PROHIBITION ON CLAIMANT REIMBURSEMENT.—An attorney subject to an assessment under paragraph (1) may not, directly or indirectly, request or otherwise obtain reimbursement for such assessment from the claimant whose claim gave rise to the assessment.

(5) DISPOSITION OF ASSESSMENTS.—Assessments on attorneys collected under this subsection shall be credited to the Federal Old-Age and Survivors Insurance Trust Fund and the Federal Disability Insurance Trust Fund, as appropriate.

(6) AUTHORIZATION OF APPROPRIATIONS.—The assessments authorized under this section shall be collected and available for obligation only to the extent and in the amount provided in advance in appropriations Acts. Amounts so appropriated are authorized to remain available until expended, for administrative expenses in carrying out this title and related laws.

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[112] See Vol. II, P.L. 106-170, §406(c), for a GAO study and report on the administration of attorneys' fees.

See Vol. II, P.L. 108-203, §303, with respect to a nationwide demonstration project providing for extension of fee withholding procedures to non-attorney representatives; and §304, with respect to a GAO study regarding the fee payment process for claimant representatives.

[113] P.L. 108-203, §205, added the two sentences preceding the footnote indicator, starting with “Notwithstanding...” through “...the Commissioner may prescribe.”, effective March 2, 2004.

[114] See Vol. II, P.L. 96-481, with respect to an award of attorney fees and other expenses.

DISABILITY INSURANCE BENEFIT PAYMENTS

Disability Insurance Benefits

SEC. 223. *[42 U.S.C. 423]* (a)(1) Every individual who—

(A) is insured for disability insurance benefits (as determined under subsection (c)(1)),
(B) has not attained retirement age (as defined in section 216(l)),
(C)[253] if not a United States citizen or national—
(i) has been assigned a social security account number that was, at the time of assignment, or at any later time, consistent with the requirements of subclause (I) or (III) of section 205(c)(2)(B)(i); or
(ii) at the time any quarters of coverage are earned—
(I) is described in subparagraph (B) or (D) of section 101(a)(15) of the Immigration and Nationality Act,
(II) is lawfully admitted temporarily to the United States for business (in the case of an individual described in such subparagraph (B)) or the performance as a crewman (in the case of an individual described in such subparagraph (D)), and
(III) the business engaged in or service as a crewman performed is within the scope of the terms of such individual's admission to the United States.
(D) has filed application for disability insurance benefits, and
(E)[254] is under a disability (as defined in subsection (d))

shall be entitled to a disability insurance benefit (i) for each month beginning with the first month after his waiting period (as defined in subsection (c)(2)) in which he becomes so entitled to such insurance benefits, or (ii) for each month beginning with the first month during all of which he is under a disability and in which he becomes so entitled to such insurance benefits, but only if he was entitled to disability insurance benefits which terminated, or had a period of disability (as defined in section 216(i)) which ceased, within the 60-month period preceding the first month in which he is under such disability, and ending with the month preceding whichever of the following months is the earliest: the month in which he dies, the month in which he attains retirement age (as defined in section 216(l)), or, subject to subsection (e), the termination month. For purposes of the preceding sentence, the termination month for any individual shall be the third month following the month in which his disability ceases; except that, in the case of an individual who has a period of trial work which ends as determined by application of section 222(c)(4)(A), the termination month shall be the earlier of (I) the third month following the earliest month after the end of such period of trial work with respect to which such individual is determined to no longer be suffering from a disabling physical or mental impairment, or (II) the third month following the earliest month in which such individual engages or is determined able to engage in substantial gainful activity, but in no event earlier than the first month occurring after the 36 months following such period

of trial work in which he engages or is determined able to engage in substantial gainful activity. No payment under this paragraph may be made to an individual who would not meet the definition of disability in subsection (d) except for paragraph (1)(B) thereof for any month in which he engages in substantial gainful activity, and no payment may be made for such month under subsection (b), (c), or (d) of section 202 to any person on the basis of the wages and self-employment income of such individual. In the case of a deceased individual, the requirement of subparagraph (C) may be satisfied by an application for benefits filed with respect to such individual within 3 months after the month in which he died.

(2) Except as provided in section 202(q) and section 215(b)(2)(A)(ii), such individual's disability insurance benefit for any month shall be equal to his primary insurance amount for such month determined under section 215 as though he had attained age 62 in—

> (A) the first month of his waiting period, or
> (B) in any case in which clause (ii) of paragraph (1) of this subsection is applicable, the first month for which he becomes entitled to such disability insurance benefits,

and as though he had become entitled to old-age insurance benefits in the month in which the application for disability insurance benefits was filed and he was entitled to an old-age insurance benefit for each month for which (pursuant to subsection (b)) he was entitled to a disability insurance benefit. For the purposes of the preceding sentence, in the case of an individual who attained age 62 in or before the first month referred to in subparagraph (A) or (B) of such sentence, as the case may be, the elapsed years referred to in section 215(b)(3) shall not include the year in which he attained age 62, or any year thereafter.

Filing of Application

(b) An application for disability insurance benefits filed before the first month in which the applicant satisfies the requirements for such benefits (as prescribed in subsection (a)(1)) shall be deemed a valid application (and shall be deemed to have been filed in such first month) only if the applicant satisfies the requirements for such benefits before the Commissioner of Social Security makes a final decision on the application and no request under section 205(b) for notice and opportunity for a hearing thereon is made, or if such a request is made, before a decision based upon the evidence adduced at the hearing is made (regardless of whether such decision becomes the final decision of the Commissioner of Social Security). An individual who would have been entitled to a disability insurance benefit for any month had he filed application therefor before the end of such month shall be entitled to such benefit for such month if such application is filed before the end of the 12th month immediately succeeding such month.

Definitions of Insured Status and Waiting Period

(c) For purposes of this section—

(1) An individual shall be insured for disability insurance benefits in any month if—
(A) he would have been a fully insured individual (as defined in section 214) had he attained age 62 and filed application for benefits under section 202(a) on the first day of such month, and
(B)(i) he had not less than 20 quarters of coverage during the 40-quarter period which ends with the quarter in which such month occurred, or
(ii) if such month ends before the quarter in which he attains (or would attain) age 31, not less than one-half (and not less than 6) of the quarters during the period ending with the quarter in which such month occurred and beginning after he attained the age of 21 were quarters of coverage, or (if the number of quarters in such period is less than 12) not less than 6 of the quarters in the 12-quarter period ending with such quarter were quarters of coverage, or
(iii) in the case of an individual (not otherwise insured under clause (i)) who, by reason of section 216(i)(3)(B)(ii), had a prior period of disability that began during a period before the quarter in which he or she attained age 31, not less than one-half of the quarters beginning after such individual attained age 21 and ending with the quarter in which such month occurs are quarters of coverage, or (if the number of quarters in such period is less than 12) not less than 6 of the quarters in the 12-quarter period ending with such quarter are quarters of coverage;
except that the provisions of subparagraph (B) of this paragraph shall not apply in the case of an individual who is blind (within the meaning of "blindness" as defined in section 216(i)(1)). For purposes of subparagraph (B) of this paragraph, when the number of quarters in any period is an odd number, such number shall be reduced by one, and a quarter shall not be counted as part of any period if any part of such quarter was included in a period of disability unless such quarter was a quarter of coverage.
(2) The term "waiting period" means, in the case of any application for disability insurance benefits, the earliest period of five consecutive calendar months—
(A) throughout which the individual with respect to whom such application is filed has been under a disability, and
(B)(i) which begins not earlier than with the first day of the seventeenth month before the month in which such application is filed if such individual is insured for disability insurance benefits in such seventeenth month, or (ii) if he is not so insured in such month, which begins not earlier than with the first day of the first month after such seventeenth month in which he is so insured.
Notwithstanding the preceding provisions of this paragraph, no waiting period may begin for any individual before January 1, 1957.

Definition of Disability

(d)(1) The term “disability” means—

> (A) inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months; or
> (B) in the case of an individual who has attained the age of 55 and is blind (within the meaning of “blindness” as defined in section 216(i)(1)), inability by reason of such blindness to engage in substantial gainful activity requiring skills or abilities comparable to those of any gainful activity in which he has previously engaged with some regularity and over a substantial period of time.

(2) For purposes of paragraph (1)(A)—

> (A) An individual shall be determined to be under a disability only if his physical or mental impairment or impairments are of such severity that he is not only unable to do his previous work but cannot, considering his age, education, and work experience, engage in any other kind of substantial gainful work which exists in the national economy, regardless of whether such work exists in the immediate area in which he lives, or whether a specific job vacancy exists for him, or whether he would be hired if he applied for work. For purposes of the preceding sentence (with respect to any individual), “work which exists in the national economy” means work which exists in significant numbers either in the region where such individual lives or in several regions of the country.
> (B) In determining whether an individual's physical or mental impairment or impairments are of a sufficient medical severity that such impairment or impairments could be the basis of eligibility under this section, the Commissioner of Social Security shall consider the combined effect of all of the individual's impairments without regard to whether any such impairment, if considered separately, would be of such severity. If the Commissioner of Social Security does find a medically severe combination of impairments, the combined impact of the impairments shall be considered throughout the disability determination process.
> (C) An individual shall not be considered to be disabled for purposes of this title if alcoholism or drug addiction would (but for this subparagraph) be a contributing factor material to the Commissioner's determination that the individual is disabled.

(3) For purposes of this subsection, a “physical or mental impairment” is an impairment that results from anatomical, physiological, or psychological abnormalities which are demonstrable by medically acceptable clinical and laboratory diagnostic techniques.

(4)(A) The Commissioner of Social Security shall by regulations prescribe the criteria for determining when services performed or earnings derived from services demonstrate an

individual's ability to engage in substantial gainful activity. No individual who is blind shall be regarded as having demonstrated an ability to engage in substantial gainful activity on the basis of earnings that do not exceed an amount equal to the exempt amount which would be applicable under section 203(f)(8), to individuals described in subparagraph (D) thereof, if section 102 of the Senior Citizens' Right to Work Act of 1996 had not been enacted. Notwithstanding the provisions of paragraph (2), an individual whose services or earnings meet such criteria shall, except for purposes of section 222(c), be found not to be disabled. In determining whether an individual is able to engage in substantial gainful activity by reason of his earnings, where his disability is sufficiently severe to result in a functional limitation requiring assistance in order for him to work, there shall be excluded from such earnings an amount equal to the cost (to such individual) of any attendant care services, medical devices, equipment, prostheses, and similar items and services (not including routine drugs or routine medical services unless such drugs or services are necessary for the control of the disabling condition) which are necessary (as determined by the Commissioner of Social Security in regulations) for that purpose, whether or not such assistance is also needed to enable him to carry out his normal daily functions; except that the amount to be excluded shall be subject to such reasonable limits as the Commissioner of Social Security may prescribe.

(B) In determining under subparagraph (A) when services performed or earnings derived from services demonstrate an individual's ability to engage in substantial gainful activity, the Commissioner of Social Security shall apply the criteria described in subparagraph (A) with respect to services performed by any individual without regard to the legality of such services.

(5)(A) An individual shall not be considered to be under a disability unless he furnishes such medical and other evidence of the existence thereof as the Commissioner of Social Security may require. An individual's statement as to pain or other symptoms shall not alone be conclusive evidence of disability as defined in this section; there must be medical signs and findings, established by medically acceptable clinical or laboratory diagnostic techniques, which show the existence of a medical impairment that results from anatomical, physiological, or psychological abnormalities which could reasonably be expected to produce the pain or other symptoms alleged and which, when considered with all evidence required to be furnished under this paragraph (including statements of the individual or his physician as to the intensity and persistence of such pain or other symptoms which may reasonably be accepted as consistent with the medical signs and findings), would lead to a conclusion that the individual is under a disability. Objective medical evidence of pain or other symptoms established by medically acceptable clinical or laboratory techniques (for example, deteriorating nerve or muscle tissue) must be considered in reaching a conclusion as to whether the individual is under a disability. Any non-Federal hospital, clinic, laboratory, or other provider of medical services, or physician not in the employ of the Federal Government, which supplies medical evidence required and requested by the Commissioner of Social Security under this paragraph shall be entitled to payment from the Commissioner of Social Security for the reasonable cost of providing such evidence.

(B) In making any determination with respect to whether an individual is under a disability or continues to be under a disability, the Commissioner of Social Security shall consider all evidence available in such individual's case record, and shall develop a complete medical history of at least the preceding twelve months for any case in which a determination is made that the individual is not under a disability. In making any determination the Commissioner of Social Security shall make every reasonable effort to obtain from the individual's treating physician (or other treating health care provider) all medical evidence, including diagnostic tests, necessary in order to properly make such determination, prior to evaluating medical evidence obtained from any other source on a consultative basis.

(6)(A) Notwithstanding any other provision of this title, any physical or mental impairment which arises in connection with the commission by an individual (after the date of the enactment of this paragraph[255]) of an offense which constitutes a felony under applicable law and for which such individual is subsequently convicted, or which is aggravated in connection with such an offense (but only to the extent so aggravated), shall not be considered in determining whether an individual is under a disability.

(B) Notwithstanding any other provision of this title, any physical or mental impairment which arises in connection with an individual's confinement in a jail, prison, or other penal institution or correctional facility pursuant to such individual's conviction of an offense (committed after the date of the enactment of this paragraph) constituting a felony under applicable law, or which is aggravated in connection with such a confinement (but only to the extent so aggravated), shall not be considered in determining whether such individual is under a disability for purposes of benefits payable for any month during which such individual is so confined.

(e)(1) No benefit shall be payable under subsection (d)(1)(B)(ii), (d)(6)(A)(ii), (d)(6)(B), (e)(1)(B)(ii), or (f)(1)(B)(ii) of section 202 or under subsection (a)(1) of this section to an individual for any month, after the third month, in which he engages in substantial gainful activity during the 36-month period following the end of his trial work period determined by application of section 222(c)(4)(A).

(2) No benefit shall be payable under section 202 on the basis of the wages and self-employment income of an individual entitled to a benefit under subsection (a)(1) of this section for any month for which the benefit of such individual under subsection (a)(1) is not payable under paragraph (1).

Standard of Review for Termination of Disability Benefits

(f) A recipient of benefits under this title or title XVIII based on the disability of any individual may be determined not to be entitled to such benefits on the basis of a finding that the physical or mental impairment on the basis of which such benefits are provided has ceased, does not exist, or is not disabling only if such finding is supported by—

(1)substantial evidence which demonstrates that—
(A)there has been any medical improvement in the individual's impairment or combination of impairments (other than medical improvement which is not related to the individual's ability to work), and
(B)the individual is now able to engage in substantial gainful activity; or
(2) substantial evidence which—
(A) consists of new medical evidence and a new assessment of the individual's residual functional capacity, and demonstrates that—
(i) although the individual has not improved medically, he or she is nonetheless a beneficiary of advances in medical or vocational therapy or technology (related to the individual's ability to work), and
(ii) the individual is now able to engage in substantial gainful activity, or
(B) demonstrates that—
(i) although the individual has not improved medically, he or she has undergone vocational therapy (related to the individual's ability to work), and
(ii) the individual is now able to engage in substantial gainful activity; or
(3) substantial evidence which demonstrates that, as determined on the basis of new or improved diagnostic techniques or evaluations, the individual's impairment or combination of impairments is not as disabling as it was considered to be at the time of the most recent prior decision that he or she was under a disability or continued to be under a disability, and that therefore the individual is able to engage in substantial gainful activity; or
(4) substantial evidence (which may be evidence on the record at the time any prior determination of the entitlement to benefits based on disability was made, or newly obtained evidence which relates to that determination) which demonstrates that a prior determination was in error.

Nothing in this subsection shall be construed to require a determination that a recipient of benefits under this title or title XVIII based on an individual's disability is entitled to such benefits if the prior determination was fraudulently obtained or if the individual is engaged in substantial gainful activity, cannot be located, or fails, without good cause, to cooperate in a review of the entitlement to such benefits or to follow prescribed treatment which would be expected to restore his or her ability to engage in substantial gainful activity. In making for purposes of the preceding sentence any determination relating to fraudulent behavior by any individual or failure by any individual without good cause to cooperate or to take any required action, the Commissioner of Social Security shall specifically take into account any physical, mental, educational, or linguistic limitation such individual may have (including any lack of facility with the English language). Any determination under this section shall be made on the basis of all the evidence available in the individual's case file, including new evidence concerning the individual's prior or current condition which is presented by the individual or secured by the Commissioner of Social Security. Any determination made under this section shall be made on the basis of the weight of the evidence and on a neutral basis with regard to the individual's condition, without any initial inference as to the presence or absence of disability being drawn from the fact that the individual has previously been determined to be disabled. For purposes of this subsection, a benefit under this title is based on an individual's disability if it is a

disability insurance benefit, a child's, widow's, or widower's insurance benefit based on disability, or a mother's or father's insurance benefit based on the disability of the mother's or father's child who has attained age 16.

Continued Payment of Disability Benefits During Appeal

(g)(1) In any case where—

> (A) an individual is a recipient of disability insurance benefits, or of child's, widow's, or widower's insurance benefits based on disability,
> (B) the physical or mental impairment on the basis of which such benefits are payable is found to have ceased, not to have existed, or to no longer be disabling, and as a consequence such individual is determined not to be entitled to such benefits, and
> (C) a timely request for a hearing under section 221(d), or for an administrative review prior to such hearing, is pending with respect to the determination that he is not so entitled,

such individual may elect (in such manner and form and within such time as the Commissioner of Social Security shall by regulations prescribe) to have the payment of such benefits, the payment of any other benefits under this title based on such individual's wages and self-employment income, the payment of mother's or father's insurance benefits to such individual's mother or father based on the disability of such individual as a child who has attained age 16, and the payment of benefits under title XVIII based on such individual's disability, continued for an additional period beginning with the first month beginning after the date of the enactment of this subsection[256] for which (under such determination) such benefits are no longer otherwise payable, and ending with the earlier of (i) the month preceding the month in which a decision is made after such a hearing, or (ii) the month preceding the month in which no such request for a hearing or an administrative review is pending.

(2)(A) If an individual elects to have the payment of his benefits continued for an additional period under paragraph (1), and the final decision of the Commissioner of Social Security affirms the determination that he is not entitled to such benefits, any benefits paid under this title pursuant to such election (for months in such additional period) shall be considered overpayments for all purposes of this title, except as otherwise provided in subparagraph (B).

(B) If the Commissioner of Social Security determines that the individual's appeal of his termination of benefits was made in good faith, all of the benefits paid pursuant to such individual's election under paragraph (1) shall be subject to waiver consideration under the provisions of section 204. In making for purposes of this subparagraph any determination of whether any individual's appeal is made in good faith, the Commissioner of Social Security shall specifically take into account any physical, mental, educational, or linguistic limitation such individual may have (including any lack of facility with the English language).

Interim Benefits in Cases of Delayed Final Decisions

(h)(1) In any case in which an administrative law judge has determined after a hearing as provided under section 205(b) that an individual is entitled to disability insurance benefits or child's, widow's, or widower's insurance benefits based on disability and the Commissioner of Social Security has not issued the Commissioner's final decision in such case within 110 days after the date of the administrative law judge's determination, such benefits shall be currently paid for the months during the period beginning with the month preceding the month in which such 110-day period expires and ending with the month preceding the month in which such final decision is issued.

(2) For purposes of paragraph (1), in determining whether the 110-day period referred to in paragraph (1) has elapsed, any period of time for which the action or inaction of such individual or such individual's representative without good cause results in the delay in the issuance of the Commissioner's final decision shall not be taken into account to the extent that such period of time exceeds 20 calendar days.

(3) Any benefits currently paid under this title pursuant to this subsection (for the months described in paragraph (1)) shall not be considered overpayments for any purpose of this title (unless payment of such benefits was fraudulently obtained), and such benefits shall not be treated as past-due benefits for purposes of section 206(b)(1).

Reinstatement of Entitlement

(i)(1)(A) Entitlement to benefits described in subparagraph (B)(i)(I) shall be reinstated in any case where the Commissioner determines that an individual described in subparagraph (B) has filed a request for reinstatement meeting the requirements of paragraph (2)(A) during the period prescribed in subparagraph (C). Reinstatement of such entitlement shall be in accordance with the terms of this subsection.

(B) An individual is described in this subparagraph if—

> (i) prior to the month in which the individual files a request for reinstatement—
> (I) the individual was entitled to benefits under this section or section 202 on the basis of disability pursuant to an application filed therefor; and
> (II) such entitlement terminated due to the performance of substantial gainful activity;
> (ii) the individual is under a disability and the physical or mental impairment that is the basis for the finding of disability is the same as (or related to) the physical or mental impairment that was the basis for the finding of disability that gave rise to the entitlement described in clause (i); and
> (iii) the individual's disability renders the individual unable to perform substantial gainful activity.

(C)(i) Except as provided in clause (ii), the period prescribed in this subparagraph with respect to an individual is 60 consecutive months beginning with the month following the

most recent month for which the individual was entitled to a benefit described in subparagraph (B)(i)(I) prior to the entitlement termination described in subparagraph (B)(i)(II).

(ii) In the case of an individual who fails to file a reinstatement request within the period prescribed in clause (i), the Commissioner may extend the period if the Commissioner determines that the individual had good cause for the failure to so file.

(2)(A)(i) A request for reinstatement shall be filed in such form, and containing such information, as the Commissioner may prescribe.

(ii) A request for reinstatement shall include express declarations by the individual that the individual meets the requirements specified in clauses (ii) and (iii) of paragraph (1)(B).

(B) A request for reinstatement filed in accordance with subparagraph (A) may constitute an application for benefits in the case of any individual who the Commissioner determines is not entitled to reinstated benefits under this subsection.

(3) In determining whether an individual meets the requirements of paragraph (1)(B)(ii), the provisions of subsection (f) shall apply.

(4)(A)(i) Subject to clause (ii), entitlement to benefits reinstated under this subsection shall commence with the benefit payable for the month in which a request for reinstatement is filed.

(ii) An individual whose entitlement to a benefit for any month would have been reinstated under this subsection had the individual filed a request for reinstatement before the end of such month shall be entitled to such benefit for such month if such request for reinstatement is filed before the end of the twelfth month immediately succeeding such month.

(B)(i) Subject to clauses (ii) and (iii), the amount of the benefit payable for any month pursuant to the reinstatement of entitlement under this subsection shall be determined in accordance with the provisions of this title.

(ii) For purposes of computing the primary insurance amount of an individual whose entitlement to benefits under this section is reinstated under this subsection, the date of onset of the individual's disability shall be the date of onset used in determining the individual's most recent period of disability arising in connection with such benefits payable on the basis of an application.
(iii) Benefits under this section or section 202 payable for any month pursuant to a request for reinstatement filed in accordance with paragraph (2) shall be reduced by the amount of any provisional benefit paid to such individual for such month under paragraph (7).

(C) No benefit shall be payable pursuant to an entitlement reinstated under this subsection to an individual for any month in which the individual engages in substantial gainful activity.

(D) The entitlement of any individual that is reinstated under this subsection shall end with the benefits payable for the month preceding whichever of the following months is the earliest:

(i) The month in which the individual dies.
(ii) The month in which the individual attains retirement age.
(iii) The third month following the month in which the individual's disability ceases.

(5) Whenever an individual's entitlement to benefits under this section is reinstated under this subsection, entitlement to benefits payable on the basis of such individual's wages and self-employment income may be reinstated with respect to any person previously entitled to such benefits on the basis of an application if the Commissioner determines that such person satisfies all the requirements for entitlement to such benefits except requirements related to the filing of an application. The provisions of paragraph (4) shall apply to the reinstated entitlement of any such person to the same extent that they apply to the reinstated entitlement of such individual.

(6) An individual to whom benefits are payable under this section or section 202 pursuant to a reinstatement of entitlement under this subsection for 24 months (whether or not consecutive) shall, with respect to benefits so payable after such twenty-fourth month, be deemed for purposes of paragraph (1)(B)(i)(I) and the determination, if appropriate, of the termination month in accordance with subsection (a)(1) of this section, or subsection (d)(1), (e)(1), or (f)(1) of section 202, to be entitled to such benefits on the basis of an application filed therefor.

(7)(A) An individual described in paragraph (1)(B) who files a request for reinstatement in accordance with the provisions of paragraph (2)(A) shall be entitled to provisional benefits payable in accordance with this paragraph, unless the Commissioner determines that the individual does not meet the requirements of paragraph (1)(B)(i) or that the individual's declaration under paragraph (2)(A)(ii) is false. Any such determination by the Commissioner shall be final and not subject to review under subsection (b) or (g) of section 205.

(B) The amount of a provisional benefit for a month shall equal the amount of the last monthly benefit payable to the individual under this title on the basis of an application increased by an amount equal to the amount, if any, by which such last monthly benefit would have been increased as a result of the operation of section 215(i).

(C)(i) Provisional benefits shall begin with the month in which a request for reinstatement is filed in accordance with paragraph (2)(A).

(ii) Provisional benefits shall end with the earliest of—

(I) the month in which the Commissioner makes a determination regarding the individual's entitlement to reinstated benefits;
(II) the fifth month following the month described in clause (i);
(III) the month in which the individual performs substantial gainful activity; or
(IV) the month in which the Commissioner determines that the individual does not meet the requirements of paragraph (1)(B)(i) or that the individual's declaration made in accordance with paragraph (2)(A)(ii) is false.

(D) In any case in which the Commissioner determines that an individual is not entitled to reinstated benefits, any provisional benefits paid to the individual under this paragraph shall not be subject to recovery as an overpayment unless the Commissioner determines that the individual knew or should have known that the individual did not meet the requirements of paragraph (1)(B).

Limitation on Payments to Prisoners

(j) For provisions relating to limitation on payments to prisoners, see section 202(x).

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[252] See Vol. II, P.L. 96-265, §505(a) [as amended by P.L. 101-239], with respect to experiments and demonstration projects regarding work activity of disabled beneficiaries, and §505(c), with respect to the Secretary's report to Congress on the experiments and demonstration projects conducted.

See Vol. II, P.L. 97-248, §278(d), with respect to deemed entitlement for hospital insurance benefits purposes.

See Vol. II, P.L. 106-170, §302, with respect to demonstration projects providing for reductions in disability benefits based on earnings.

[253] P.L. 108-203, §211(b)(2), added this subparagraph (B), applicable to benefit applications based on social security account numbers issued on or after January 1, 2004.

[254] P.L. 108-203, §211(b)(1), redesignated the former subparagraph (C) as subparagraph (D) and the former subparagraph (D) as subparagraph (E).

[255] October 19, 1980 [P.L. 96-473; 94 Stat. 2263].

[256] January 12, 1983 [P.L. 97-455; 96 Stat. 2497].

PAYMENTS AND PROCEDURES

Payment of Benefits

SEC. 1631. *[42 U.S.C. 1383]* (C)(i) In any case where payment is made under this title to a representative payee of an individual or spouse, the Commissioner of Social Security shall establish a system of accountability monitoring whereby such person shall report not less often than annually with respect to the use of such payments. The Commissioner of Social Security shall establish and implement statistically valid procedures for reviewing such reports in order to identify instances in which such persons are not properly using such payments.

(ii) Clause (i) shall not apply in any case where the representative payee is a State institution. In such cases, the Commissioner of Social Security shall establish a system of accountability monitoring for institutions in each State.

(iii) Clause (i) shall not apply in any case where the individual entitled to such payment is a resident of a Federal institution and the representative payee is the institution.

(iv) Notwithstanding clauses (i), (ii), and (iii), the Commissioner of Social Security may require a report at any time from any representative payee, if the Commissioner of Social Security has reason to believe that the representative payee is misusing such payments.

PAYMENTS AND PROCEDURES

Payment of Benefits

SEC. 1631. *[42 U.S.C. 1383]* (D)(i) A qualified organization may collect from an individual a monthly fee for expenses (including overhead) incurred by such organization in providing services performed as such individual's representative payee pursuant to subparagraph (A)(ii) if the fee does not exceed the lesser of—

(I) 10 percent of the monthly benefit involved, or
(II) $25.00 per month ($50.00 per month in any case in which an individual is described in subparagraph (A)(ii)(II).

The Commissioner of Social Security shall adjust annually (after 1995) each dollar amount set forth in subclause (II) of this clause under procedures providing for adjustments in the same manner and to the same extent as adjustments are provided for under the procedures used to adjust benefit amounts under section 215(i)(2)(A), except that any amount so adjusted that is not a multiple of $1.00 shall be rounded to the nearest multiple of $1.00. Any agreement providing for a fee in excess of the amount permitted under this clause shall be void and shall be treated as misuse by the organization of such individual's benefits.

(ii) For purposes of this subparagraph, the term "qualified organization" means any State or local government agency whose mission is to carry out income maintenance, social service, or health care-related activities, any State or local government agency with fiduciary responsibilities, or any community-based nonprofit social service agency, which—

(I) is bonded or licensed in each State in which the agency serves as a representative payee; and
(II) in accordance with any applicable regulations of the Commissioner of Social Security—
(aa) regularly provides services as a representative payee pursuant to subparagraph (A)(ii) or section 205(j)(4) or 807 concurrently to 5 or more individuals; and
(bb) demonstrates to the satisfaction of the Commissioner of Social Security that such agency is not otherwise a creditor of any such individual.

The Commissioner of Social Security shall prescribe regulations under which the Commissioner of Social Security may grant an exception from subclause (II)(bb) for any individual on a case-by-case basis if such exception is in the best interests of such individual.

(iii) Any qualified organization which knowingly charges or collects, directly or indirectly, any fee in excess of the maximum fee prescribed under clause (i) or makes any

agreement, directly or indirectly, to charge or collect any fee in excess of such maximum fee, shall be fined in accordance with title 18, United States Code, or imprisoned not more than 6 months, or both.

(iv) In the case of an individual who is no longer eligible for benefits under this title but to whom any amount of past-due benefits under this title has not been paid, for purposes of clause (i), any amount of such past-due benefits payable in any month shall be treated as a monthly benefit referred to in clause (i)(I).

SSR 65-33c: SECTION 206. -- REPRESENTATION OF CLAIMANT -- FEE FOR SERVICES -- VIOLATION

20 CFR 404.975, 404.976, 404.977, and 404.977a

SSR 65-33c

UNITED STATES OF AMERICA v. LEWIS and HICKS, 235 F. Supp. 220 (1964)

> Whether the services performed in the preparation of a self-employment tax return are services performed in connection with a claim before the Secretary for which the charging of a fee would be subject to regulation by the Secretary under section 206 of the Act, depends upon whether the real purpose of determining the self-employment income is to knowingly further a claim then made or to be made before the Social Security Administration.

WILSON, *District Judge:*

* * * * * *

An issue of law that merits careful consideration is raised upon behalf of the defendant Lewis with respect to her conviction upon Counts 3 thru 6. The defendant is charged in these counts with charging fees in excess of that permitted by law for services to social security applicants in connection with the claim for social security benefits. The defendant contends that such charges as were made by her were for work performed in the preparation of the subject's income or self-employment tax returns and not for any representation before the Social Security Administration. The defendant further contends that the law does not purport to authorize the Social Security Administration to regulate fees with respect to services performed in the filing of tax returns, including self-employment tax returns, and that charges for such tax services could not constitute a criminal offense.

The difficulty with the defendant's contentions in this respect is twofold. In the first place, a dispute of fact exists under the record in this case whether the fees charged were solely for services in regard to tax work, as testified by the defendant, or whether in fact the fees charged were at least in part for services rendered the social security applicant in other respects in the presentation and processing of his claim before the Social Security Administration. In the second place, it cannot be held as a matter of law that charges for services performed in regard to preparation of self-employment tax returns could not under any circumstances constitute a violation of the law regulating fees charged for

services performed in connection with any claim before the Social Security Administration.

The statute here involved, 42 U.S.C. § 406, provides in relevant part:

> "* * * The Secretary may, by rule and regulation, prescribe the maximum *fees which may be charged for services performed in connection with any claim before the Secretary* under this subchapter, and any agreement in violation of such rules and regulations shall be void. Any person who shall * * * knowingly charge or collect directly or indirectly any fee in excess of the maximum fee, or make any agreement directly or indirectly to charge or collect any fee in excess of the maximum fee, *prescribed* by the Secretary shall be deemed guilty of a misdemeanor * * *".

The regulation governing fees adopted in accordance with the above statute, to the extent that the same is relevant to the present discussion, is as follows:

> "The fee that an attorney or other person may charge the claimant for representing him in matters before the social security administration must be approved by the social security administration in all cases except (exceptions not applicable). * * * "

In light of the issue now before the Court, it is apparent that the significant language in the above statute is the phrase "service performed in connection with any claim before the Secretary". The word "services" does not necessarily exclude tax services. Neither does it necessarily include tax services. Rather, such inclusion or exclusion must depend upon the facts of the particular case. Whether a fee charged for preparation of the self-employment tax return would or would not be subject to regulation would depend upon whether, under the facts of the particular case, such service might properly be considered a "service performed in connection with any claim before the Secretary". If the real purpose of determining self-employment income was to knowingly further a claim then made or to be made before the Social Security Administration, such would constitute a "service" the fee for which may be regulated. On the other hand, if there was no evidence that the real purpose of the service performed in the determination of the self-employment income was knowingly performed in furtherance of a claim then made or to be made before the Social Security Administration, such work would not constitute a service the fee for which was subject to regulation.

Under the record in this case there was evidence from which a jury could conclude on each count that the tax work performed by the defendant Lewis was in fact a service knowingly performed in connection with a claim before the Social Security Administration. In each instance there was evidence that (a) the applicant initially came to or was referred to the defendant for assistance in making a social security claim, (b) application was made for social security benefits immediately before or after the tax work was performed, (c) the tax returns filed were delinquent returns and reflected only delinquent self-employment tax which would have the effect of establishing social

security eligibility, and (d) even though the defendant contended no charge was made for additional services, but only for the tax work, in most instances the defendant performed additional services in connection with the claim before the Social Security Administration. The Court is therefore of the opinion that under the record in this case a jury issue existed under Counts 3, 4, 5, and 6 as to whether the fee charged by the defendant was one subject to regulation under 42 U.S.C. § 406.

Having fully considered the defendants' motions for new trial, the Court is of the opinion that the motions should be overruled as to each count thereof.

An order will enter accordingly.

SSR 66-19c: SECTIONS 205(b) and (g) and 206(a). -- JUDICIAL REVIEW -- ATTORNEY'S FEE FIXED BY ADMINISTRATION

20 CFR 404.975-404.976

SSR 66-19c

WATSON AND PLANK *V.* CELEBREZZE, 246 F.Supp. 764 (E.D. Tenn., 8/25/65)

> Where the amount of the attorney's fee for representing the claimant in a proceeding before the Secretary has been set by the Administration, *held*, that determination of the fee is not a "decision" within the meaning of section 205(b) of the Social Security Act and, therefore, is not subject to judicial review as provided for by section 205(g) of the Act.

WILSON, *District Judge*:

This case is before the Court upon three pending motions. The original motion filed was the motion of the defendant to dismiss the plaintiff's complaint. The plaintiffs have in turn filed a motion to strike the defendant's motion to dismiss. This will be treated as the plaintiffs' response to the defendant's motion to dismiss. Finally, the plaintiffs have filed a motion for summary judgment.

Considering first the defendant's motion to dismiss, this motion is based upon the contention that the complaint fails to state a claim upon which relief can be granted. The complaint, which is brought in the names of Manly A. Watson and Forest G. Plank, alleges that Plank, after having been denied social security benefits, engaged Manly A. Watson to represent him for a fee to be fixed by the Social Security Administration; that the said attorney spent eight and a half months time on the case, involving 15 to 20 hours work, including his appearance before the Hearing Examiner, which resulted in a decision establishing a period of disability for which it awarded disability insurance benefits to Plank; that pursuant thereto Plank received two checks totaling $3,057.60 for accrued benefits, that there was still due the sum of $219.00 and that Plank would continue to receive $78.00 per month; that the Hearing Examiner had approved an attorney fee of only $300.00 despite the fact that the attorney petitioned for a fee of not less than $450.00; that the fee was totally inadequate and that Plank was in agreement with respect to its inadequacy; that the Social Security Administration by the allowance of inadequate attorney fees south to prevent or discourage claimants from using counsel and that the plaintiff requested the Court to award his attorney a fee on not more than

$1,017.60 nor less than $754.41 (being or ¬ respectively of $3,017.60) subject to a credit of $300.00 heretofore paid, with the award of attorney fees being adjusted accordingly if the additional sum of $219.00 were found to be due unto Plank. (It is conceded in the Government's brief that the additional sum of $219.00 was due unto Plank and had been duly paid.)

It is the contention of the defendant in support of its motion that this an action brought under 42 U.S.C., Sec. 405(g) for judicial review of an allowance of attorney fees, as set by the Social Security Administration, and that such an action cannot be maintained in the name of the attorney. The complaint, however, does not allege any statutory basis for jurisdiction in this court and none is cited by the plaintiff. However, assuming, as contended by the defendant, that jurisdiction is based upon Sec. 405(g) of Title 42, U.S.C., the said section of the Social Security Act permits a claimant "after any final decision of the secretary made after a hearing at which he was a party" to obtain review in the District Court of the administrative decision. It has been held, and it appears to this Court correctly so, in the case of *Goodell v. Fleming*, (D.C., W.D.N.Y., 1959) 179 F.Supp 806, that an attorney could not obtain a review in the District Court under the Social Security Act, Sec. 405(g), of a decision of the Social Security Administration awarding attorney fees for services rendered a claimant for benefits. This decision is based upon the statutory language contained in Sec. 405(g) limiting the judicial review to a "party" in the proceedings before the Social Security Administration.

However, the complaint here is filed not only in the name of the attorney but also in the name of the social security claimant. It is apparent, however, that the real party in interest is the attorney. While the claimant may have joined in the petition, it is apparent that in the award of attorney fees it was the attorney and not the claimant who was adversely affected by the decision.

The only provision contained in the Social Security Act for judicial review of action of the Secretary is that contained in 42 U.S.C. 405(g) wherein it is provided that a claimant may seek a court review of "any final decision of the Secretary made after a hearing at which he was a party". By 42 U.S.C. 405(h) it is expressly provided that:

> "No finding of fact or decision of the Secretary shall be reviewed by any person, tribunal or governmental agency except as herein provided."

It would appear clear from the foregoing that this Court would not have jurisdiction under the Social Security Act to review a decision of the Secretary favorable to a claimant, though it may have been adverse to his attorney. Since the attorney was not a "party" to the proceedings before the Secretary and would therefore have no standing to seek a judicial review of a decision adverse to him under Section 405(g) [*Goodell v. Fleming*, 179 F.Supp. 806; *Chernock v. Celebrezze*, 241 F.Supp. 520 (1965); affirmed by *Chernock v. Gardner*, 360 F.2d 257 (1966)] jurisdiction cannot be conferred merely by joining the claimant as a nominal party, when the attorney remains the only real party in interest.

* * * * * * *

Having concluded that this Court is without jurisdiction to review the subject matter of the petition herein, the motion of the defendant to dismiss this action will be sustained. It will therefore be unnecessary to consider further the plaintiff's motion for summary judgment.

An order will enter accordingly.

(PPS-68)

SSR 82-39

SSR 82-39: TITLES II AND XVI -- USE OF TRUST OR ESCROW ACCOUNTS IN COLLECTION OF ATTORNEY FEES

PURPOSE: To state the policy on the use of trust or escrow accounts in collecting attorney fees for representation before the Social Security Administration (SSA).

CITATIONS (AUTHORITY): Sections 206(a), 207, and 1631(d)(2) of the Social Security Act; Section 413(b) of the Black Lung Benefits Act (part B of Title IV of the Federal Coal Mine Health and Safety Act of 1969, as amended); Regulations No. 4, sections 404.1720 through 404.1740; Regulations No. 10, sections 410.686b through 410.587a; Regulations No. 16, sections 416.1520 through 416.1540.

PERTINENT HISTORY: Legal organizations and individual attorneys have asked whether the use of trust or escrow accounts as a means of collecting attorney fees in connection with Social Security and black lung claims is consistent with the fee provisions of the law and regulations.

As a condition for undertaking representation, some attorneys solicit from Social Security or black lung claimants a deposit of money in a trust or escrow account as a means or assuring payment of the attorney's fees. The claimant may be asked to place funds into a trust or escrow account at the commencement of representation on a noncontingency fee basis, or in connection with a contingency fee agreement. In title XVI claims especially, some agreements may call for the claimant to deposit the first benefit check into a trust or escrow account pending approval of a fee by the Social Security Administration.

In regard to title II, title XVI, and black lung claims, the law provides that the Secretary may, by "rule and regulations, prescribe the maximum fees which may be charged" for services performed in connection with such claims, and that any agreement violating that rule or regulation would be void. the law also prohibits the charging or collecting of a fee, directly or indirectly, in excess of the maximum fee prescribed by the Secretary.

In certain cases the term "fees which may be charged" could be interpreted to include any amounts exacted by an attorney from a claimant's property, whether by way of a retainer, deposit in a trust or other escrow account. etc. If, however, the exaction is more than security for payment of a potential debt, it should not be considered a "fee". For example,

a sum deposited under a trust or escrow agreement, which the claimant willingly entered into, could not legally be characterized as a "fee" if the agreement explicitly states that any money in excess of the fee authorized by SSA will be returned to the claimant when SSA approves a fee or when the claimant pays the attorney an amount SSA approves as a fee.

Applicable to title II, title XVI, and black lung benefits, the law provides that: "The right of any person to any future payment under this title shall not be transferable or assignable, at law or in equity . . ." This provision prohibits payment directly by SSA to a transferee or assignee of the claimant or someone else on his or her behalf. However, this provision doe snot preclude a claimant from using the benefits after receipt, any more than it precludes a claimant from using any other personal property as he or she sees fit. Thus, the placement of a claimant's funds (whether from benefit payments or other sources) into a trust or escrow account prior to and contingent upon SSA's authorization of a fee for the attorney's services is not a transfer or assignment within the meaning of the law.

Beyond these considerations, the fee provisions of the law that apply to title II and black lung claims differ significantly in one respect from the provisions applicable in title XVI claims. In title II and black lung cases, to assure that the claimant's attorney will be paid at least a part of the fee SSA approves, the law requires SSA to directly pay the attorney the authorized fee (up to a statutorily prescribed limit) our of the claimant's past-due benefits. In title XVI claims, there is no such statutory authority which could serve to encourage attorney representation. Thus, establishment of escrow and trust accounts, under agreements willingly entered into, is a mechanism that may encourage representation of claimants in title XVI claims, where otherwise the prospect of attorney representation would not exist.

As noted above, in title II and black lung claims, the law mandates that SSA will directly pay to an attorney the amount of the authorized fee (up to the prescribed limit) out of the claimant's past-due benefits in cases where a title II or black lung claimant and his or her attorney have entered into a trust or escrow account agreement, the money deposited in the trust or escrow account may have been paid over to the attorney, in accordance with such agreement, after SSA's award of benefits to the claimant but before direct payment of the authorized fee out of past-due benefits. Were SSA to make direct payment to the attorney out of past-due benefits without taking into account the money paid to the attorney out of the trust or escrow account, it would be highly probable that the attorney would have "collected" a total fee in excess of the fee authorized by SSA, and thus find himself in violation of the fee provisions of the law and regulations. Therefore, while the law mandates direct payment of attorney fees in title II and black lung cases, that mandate need not be construed so rigidly as to force SSA to make a fee payment when it is known that that payment, when added to monies already collected would place an attorney in violation of the law and SSA's own regulations.

POLICY STATEMENT: Consistent with Social Security law and regulations, an attorney may solicit from Social Security and black lung claimants whom he or she represents before SSA a deposit of money into a trust or escrow account as a means of assuring payment of the fee for services in connection with such representation; *provided that*:

> a. the claimant willingly entered into the trust or escrow agreement and willingly deposited the money in the trust or escrow account; and
> b. none of the money in the account is paid over to the attorney unless and until SSA has authorized a fee for the attorney, and then only in an amount up to, but not exceeding, the authorized fee; and
> c. any funds in the account in excess of the authorized fee will be refunded promptly to the claimant.

At the time the attorney petitions for a fee, the amount of money held in the trust or escrow account must be disclosed to SSA.

In title II and black lung cases, when the amount authorized by SSA as an attorney's fee is less than the total of (1) the money paid to the attorney from a trust or escrow account, and (2) the amount withheld from the claimant's past-due benefits the direct payment of the attorney's fee, SSA will reduce the amount of direct payment to the attorney by the amount that such total exceeds the authorized fee.

> EXAMPLE: If the authorized fee is $1000, but the combined total of escrow payment ($600) and withheld benefits ($600) is $1200, SSA will pay $400 directly to the attorney out of withheld benefits and will release the remainder of withheld benefits ($200) to the claimant.

If the total of withheld past-due benefits and money paid from a trust or escrow account is equal to or less than the amount of the authorized fee, there will be no reduction in the amount paid tot he attorney from past-due benefits.

EFFECTIVE DATE: This policy is applicable to all claims or proceedings pending before SSA as of the publication of this policy statement in any claim or proceeding where this policy was applied prior to the publication of this policy statement, such action will be deemed to have been taken properly and in accordance with interim procedures existing at that time.

DOCUMENTATION: A copy of the trust or escrow agreement or proof that any money from the trust or escrow account in excess of the authorized fee has been returned to the claimant must be provided to SSA upon request.

CROSS-REFERENCES: OHA Handbook, section 1-264(4); POMS sections GN03920.001, GN03920.070, GN03970.005

SSR 86-10c: SECTION 206(a) OF THE SOCIAL SECURITY ACT (42 U.S.C. 406(a)) JUDICIAL REVIEW -- ATTORNEY'S FEE FIXED BY ADMINISTRATION -- CONSTITUTIONALITY

20 CFR 404.1720, 404.1725, and 404.1730(b)(1)

SSR 86-10c

Siler v. Heckler, 583 F. Supp. 1110 (N.D. Georgia 1984)

The plaintiff was an attorney who had successfully represented a claimant for Social Security benefits. The plaintiff and the claimant had agreed that the plaintiff would receive as his attorney's fees 25 percent of the claimant's past-due benefits. Therefore, the plaintiff requested $4,761.10 as his attorney's fees. After reviewing the plaintiff's claim and examining the nature and extent of the work performed, the Secretary concluded, under 42 U.S.C. 406(a), that $600.00 was a reasonable award of attorney's fees. The plaintiff appealed to the district court and he contended that the Secretary's denial of the attorney's fees agreed upon between the plaintiff and the claimant constituted a denial of due process and an interference with contract. The district court noted that, even though it did not have jurisdiction to review the amount of the attorney's fees awarded by the Secretary, it did have jurisdiction to determine whether the plaintiff had stated a constitutional claim upon which relief could be granted. The court found that 42 U.S.C. 406(a) gives the Secretary broad authority to determine what is a reasonable fee in any particular case. The court noted that, although the statute clearly represents a congressional intent that an attorney who has successfully represented a claimant be reasonably compensated for his or her efforts, it also reflects a congressional concern that the attorney not receive an unmerited windfall at the expense of the needy persons the Social Security Act was intended to benefit. Notwithstanding the contractual agreement between the attorney and the claimant for an amount higher than that fixed by the Secretary, the district court stated that it agreed with the Fourth and Eighth Circuits that the statutory scheme provided by Congress does not deprive an attorney of property or liberty in violation of the Fifth Amendment. In the cases decided in those circuits, the courts found that any contractual fee agreement between an attorney and a Social Security claimant is conditioned on the statutory requirement that the Secretary determines the reasonableness of the fee. The district court also rejected the

plaintiff's due process challenges to the fee determination procedure and to the administrative appeals process. Given the weight and persuasiveness of the authority rejecting the plaintiff's constitutional claims and the absence of any cases supporting them, the district court *held* that the plaintiff had failed to state a claim upon which relief could be granted and that the Secretary was entitled to judgment as a matter of law.

FORRESTER, District Judge:

This action is before the court on defendant's motion for summary judgement. Plaintiff is an attorney who successfully represented a claimant for Social Security benefits. Claimant and plaintiff had agreed that plaintiff would receive as legal fees twenty-five percent of whatever sum claimant recovered from the Social Security Administration. The claimant's claim was upheld and an award of past due benefits in excess of $20,000 was made. Plaintiff requested $4,761.10 as his attorney's fees. However, the Secretary after reviewing plaintiff's claim and examining the nature and extent of the work performed, concluded that the sum of $600 was a reasonable award of attorney's fees. Plaintiff protested the award and filed an application for a review by the Appeals Council. The Appeals Council, and then the Administrative Law Judge (ALJ) affirmed the decision of the Secretary. Plaintiff then filed his action in this court asking that the decision of the ALJ and the Appeals Council be reviewed, reversed and set aside. In an order dated November 29, 1983 this court held that it had no jurisdiction to review the amount of the award of fees by the Secretary. *Silver* v. *Heckler*, 578 F. Supp. 744 (N.D.Ga. 1983). However, relying upon *Califano* v. *Sanders*, 430 U.S. 99, 108-09, 97 S.Ct. 980, 985-986, 51 L.Ed.2d 192 (1976), the court found that it did have jurisdiction to hear "colorable" constitutional claims. Although courts from other circuits had already ruled on constitutional claims similar to those made by plaintiff and found that they were not colorable, this court found no controlling authority in this circuit on the issue. In the absence of such controlling authority, the court declined to find that the constitutional claims plaintiff had raised were not colorable. Instead, the court found that it did have subject matter jurisdiction "to determine whether the allegations of plaintiff's complaint, taken as true, state a constitutional claim upon which relief can be granted." Because matters outside the pleadings were referred to, the motion to dismiss was converted to one for summary judgment. It is that motion which is presently before the court.

Plaintiff's basic contentions are that the Secretary's denial of the attorney's fees agreed upon between plaintiff and his client constitutes a denial of due process and an interference with contract. However, every court which has examined the arguments raised by plaintiff has rejected them. E.g., *Thomason* v. *Schweiker*, 692 F.2d 333 (4th Cir. 1982); *Copaken* v. *Secretary of Health, Education & Welfare*, 590 F.2d 729 (8th Cir. 1979); *Pepe* v. *Schweiker*, 565 F. Supp. 97 (E.D. Pa. 1983);*Byrd* v. *Harris*, 509 F. Supp. 1222 (E.D. Tenn. 1981). Congress has expressly given the Secretary authority to prescribe the maximum fees allowable to attorneys representing claimants for Social Security benefits. 42 U.S.C. § 406(a) provides, in pertinent part:

> The Secretary may, by rule and regulation, prescribe the maximum fees which may be charged for services performed in connection with any claim before the Secretary under this subchapter, and any agreement in violation of such rules and regulations shall be void. Whenever the Secretary, in any claim before him for benefits under this subchapter, makes a determination favorable to the claimant, he shall, if the claimant was represented by an attorney in connection with such claim, fix (in accordance with regulations prescribed pursuant to the preceding sentence) a reasonable fee to compensate such attorney for the services performed by him in connection with such claim. If as a result of such determination, such claimant is entitled to past-due benefits under this subchapter, the Secretary shall, notwithstanding Section 405(i) of the Title, certify for payment (out of such past-due benefits) to such attorney *an amount equal to whichever of the following is the smaller* (a) Twenty-five percentum of the total amount of such past-due benefits, (b) *the amount of the attorney's fee so fixed*, or (c) the amount agreed upon between the claimant and such attorney as the fee for such attorney's service. . . . (Emphasis added).

This statute requires the Secretary to pay the attorney who has represented a successful claimant the *smallest* of three possible amounts: (1) Twenty-five percent of the total benefit award, (2) the fee agreed upon between attorney and claimant, or (3) a reasonable fee fixed by the Secretary. The statute clearly represents a congressional intent that the attorney representing a successful claimant be reasonably compensated for his efforts. However, the statute also shows a congressional concern that the attorney not receive an unmerited windfall at the expense of the needy persons the act was intended to benefit. The Secretary is given broad discretion to determine what is a reasonable fee in any particular case. See *Copaken* v. *Secretary of Health, Education & Welfare*, 590 F.2d 729, 731 (8th Cir. 1979).

This court agrees with the Eighth and Fourth Circuits that the statutory scheme provided by Congress does not deprive the attorney of any interest protected by the Constitution. "Congressional regulation of the amount of fees granted attorneys representing claimants for benefits created by an act of Congress does not deprive an attorney of property or liberty in violation of the fifth amendment." *Copaken* v. *Secretary of Health, Education & Welfare*, 590 F.2d 729 (8th Cir. 1979) (citing *Hines* v. *Lowery*, 305 U.S. 85, 59 S.Ct. 31, 831 L.Ed. 56 (1938)). This is true notwithstanding the fact that the attorney and the client might have a contractual agreement for an amount higher than that fixed by the Secretary. As the Fourth Circuit observed in *Thomason* v. *Schweiker*, 692 F.2d 333 (4th Cir. 1982)

> The appellant's fifth amendment argument is predicated upon the appellant's property interest in the contractual fee arrangement between the attorney and client. The contract is conditioned, however, on the statutory requirement that the fee be reasonable. Also implicit in the contract is the fact that the Secretary determines the reasonableness of the fee. The private interest of the attorney, therefore, is not in the twenty-five percent fee to which the claimant agreed,b ut to

> a reasonable fee set by the ALJ which is not to exceed twenty-five percent of back benefits. *Id*. at 336.

Further, as the court observed in *Pepe* v. *Schweiker*, 565 F. Supp. 97 (E,D. Pa. 1983):

> As 42 U.S.C. § 406 sets forth, an attorney is entitled only to a reasonable fee as determined by the Secretary. Any fee contract with a Social Security claimant is conditioned on these statutory requirements. This statutory provision, which ought to be known by those accepting disability cases, and which furthers a congressional purpose in avoiding the undue depletion of a claimant's benefits, does not constitute an unconstitutional appropriation of plaintiff's property. *Id*, at 98-99.

The courts have also rejected plaintiff's due process challenges to the fee determination procedure and tot he administrative appeals process. *See Thomason* v. *Schweiker*, 692 F.2d at 336; *Copaken* v. *Secretary of Health, Education & Welfare,* 590 F.2d at 732. The court agrees with those courts that the determination of a reasonable fee has been committed by Congress to the agency best situated to make the determination and that the statute provides for meaningful administrative review of the reasonableness of the fee without an evidentiary hearing.

Although none of the cases discussed above are directly controlling on this court, the court is persuaded by their logic and adopts their ultimate conclusions that plaintiff has not stated any constitutional claims upon which relief can be granted. The cases cited by plaintiff in his reply brief to the motion of all pre-date the 1968 amendments to 42 U.S.C. § 406(a) which gave the Secretary the power to award reasonable fees. See Pub. L. No. 90-248, 1967 U.S. Code Cong. & Admin. News (81 Stat 821) 923, 993. Since the cases plaintiff relies on pre-date the statute which is at issue in this case, they are inapposite. Given the weight and persuasiveness of the authority rejecting plaintiff's constitutional claims and the absence of any cases supporting them, this court holds that plaintiff has failed to state a claim upon which relief can be granted and that defendant is entitled to judgment as a matter of law.

In sum, defendant's motion for summary judgment is GRANTED. This action is hereby DISMISSED.

(PPS-67)

SSR 82-41

SSR 82-41: TITLES II AND XVI: WORK SKILLS AND THEIR TRANSFERABILITY AS INTENDED BY THE EXPANDED VOCATIONAL FACTORS REGULATIONS EFFECTIVE FEBRUARY 26, 1979

PURPOSE: To further explain the concepts of "skills" and "transferability of skills" and to clarify how these concepts are used in disability evaluation.

CITATIONS (AUTHORITY): Sections 223(d)(2)(A) and 1614(a)(3)(B) of the Social Security Act; Regulations No. 4, sections 404.1520(f), 404.1545, 404.1561, 404.1563, 404.1565, 404.1566 and 404.1568; Regulations No. 16, sections 416.920(f), 416.945, 416.961, 416.963, 416.965, 416.966 and 416.968; and Appendix 2, Subpart P of Regulations No. 4, sections 200.00(b), 201.00(e), 201.00(f), 202.00(e) and 202.00(f).

PERTINENT HISTORY: The law states that, to be found disabled, a worker must have a medically determinable physical or mental impairment(s) of such severity that he or she is not only unable to do previous work but cannot, considering his or her age, education and work experience, engage in any other kind of substantial gainful work which exists in the national economy. Skills and their transferability relate to "work experience" in the definition of disability and to people's abilities to do occupations different from those they did before becoming impaired. Claims which require consideration of an applicant's ability to adjust to other work are addressed in the last step of the sequential evaluation process as it is explained in the regulations.

In February 1979, the regulations were amended to consolidate all policies for adjudicating disability claims in which an individual's vocational factors; i.e., age, education and work experience, must be considered in addition to the medical condition. At that time, the medical-vocational guidelines were introduced as Appendix 2 into the regulations and became binding at all levels of adjudication and appeal. There have been some misinterpretations and misapplications of the regulations relating to determining the skill levels of jobs and whether or not skills are transferable. In addition, there is a need to clarify the definition of semiskilled work (especially in relation to unskilled work) and to more fully explain how work skills are acquired and what jobs they may be

transferable to under the regulations. There also appears to be come confusion regarding the nature of the evidence necessary to support findings as to skill levels and transferability.

Policy statements on these issues will enable all components of the Social Security Administration to better understand and apply the provisions of the regulations properly and consistently.

POLICY STATEMENT: The topics discussed below expand upon the disability regulations.

1. *When transferability of work skills is at issue.* Transferability of skills is an issue only when an individual's impairment(s), though severe, does not meet or equal the criteria in the Listing of Impairments in Appendix 1 of the regulations but does prevent the performance of past relevant work (PRW), and that work has been determined to be skilled or semiskilled. (PRW is defined in regulations sections 404.1565 and 416.965.) When the table rules in Appendix 2 are applicable to a case, transferability will be decisive in the conclusion of "disabled" or "not disabled" in only a relatively few instances because, even if it is determined that there are no transferable skills, a finding of "not disabled" may be based on the ability to do unskilled work.

2. *Skills, skill levels, and their potential for being transferred to other occupations.*

a. What a *"skill" is.* A skill is knowledge of a work activity which requires the exercise of significant judgment that goes beyond the carrying out of simple job duties and is acquired through performance of an occupation which is above the unskilled level (requires more than 30 days to learn). It is practical and familiar knowledge of the principles and processes of an art, science or trade, combined with the ability to apply them in practice in a proper and approved manner. This includes activities like making precise measurements, reading blueprints, and setting up and operating complex machinery. A skill gives a person a special advantage over unskilled workers in the labor market.

Skills are not gained by doing unskilled jobs, and a person has no special advantage if he or she is skilled or semiskilled but can qualify only for an unskilled job because his or her skills cannot be used to any significant degree in other jobs. The table rules in Appendix 2 are consistent with the provisions regarding skills because the same conclusion is directed for individuals with an unskilled work background and for those with a skilled or semiskilled work background whose skills are not transferable. A person's acquired work skills may or may not be commensurate with his or her formal educational attainment.

b. What *"transferability" is.* Transferability means applying work skills which a person has demonstrated in vocationally relevant past jobs to meet the requirements of other skilled or semiskilled jobs. Transferability is distinct from the usage of skills recently learned in school which may serve as a basis for direct entry into skilled work (Appendix 2, section 201.00(g)).

c. *Determination that a job is unskilled.* Unskilled occupations are the least complex types of work. Jobs are unskilled when persons can usually learn to do them in 30 days or less. The majority of unskilled jobs are identified in the Department of Labor's *Dictionary of Occupational Titles (DOT).* It should be obvious that restaurant dishwashers are unskilled. It may not be self-evident that other jobs can be learned in 30 days or less, such as sparkplug assembler, school-crossing guard and carpenter's or baker's helper (laborers). In these cases, occupational reference materials or specialists should be consulted. (State agencies may use vocational consultants, specialists or vocational evaluation workshops to assist in resolving complex vocational issues; and vocational experts may be consulted for this purpose at the hearing and appeals levels. In this Program Policy Statement, the term vocational specialist (VS) describes all vocational resource personnel.)

d. *Determination that a job is semiskilled and whether skills are transferable to other jobs.* Semiskilled occupations are more complex than unskilled work and distinctly simpler than the more highly skilled types of jobs. They contain more variables and require more judgment than do unskilled occupations. Even though semiskilled occupations require more than 30 days to learn, the content of work activities in some semiskilled jobs may be little more than unskilled. Therefore, close attention must be paid to the actual complexities of the job in dealing with data, people, or objects and to the judgments required to do the work.

The regulations definition of semiskilled work in regulations sections 404.1568(b) and 416.968(b) states that semiskilled jobs "may require alertness and close attention . . . coordination and dexterity . . . as when hands or feet must be moved quickly to do repetitive tasks." These descriptive terms are not intended, however, to illustrate types of skills, in and of themselves. The terms describe worker traits (aptitudes or abilities) rather than acquired work skills.

Skills refer to experience and demonstrated proficiency with work activities in particular tasks or jobs. In evaluating the skill level of PRW or potential occupations, work activities are the determining factors.

Worker traits to be relevant must have been used in connection with a work activity. Thus, in the regulations, the trait of alertness is connected with the work activities of close attention to watching machine processes, inspecting, testing, tending or guarding; and the traits of coordination and dexterity with the use of hands or feet for the rapid performance of repetitive work tasks. It is the acquired capacity to perform the work activities with facility (rather than the traits themselves) that gives rise to potentially transferable skills.

At the lower level of semiskilled work (next to unskilled) are jobs like those of a chauffeur and some sewing-machine operators. Also at the lower level of semiskilled work would be such jobs as room service waiter, in which the worker serves meals to guests in their rooms, taking silverware, linen, plates and food on a tray or cart and then removing the equipment from rooms after guests have eaten. Transferability of skills is not usually found from this rather simple type of work. When job activities are at this minimal level of skill, an adjudicator or administrative law judge (ALJ) can often, without assistance, make the

determination that the worker has very little vocational advantage over an unskilled person and does not have transferable skills.

Slightly more complex, at a *higher level of semiskilled work,* are jobs like that of a nurse aide, who may also serve food to people. A nurse aide ordinarily performs other tasks which do not provide a special advantage over unskilled workers, such as dusting and cleaning rooms, changing bed linens, and bathing, dressing and undressing patients. The only duties which suggest transferable skills are those related to "nurse" rather than "aide" -- taking and recording the rates of temperature, pulse and respiration; and recording food and liquid intake and output. However, these occasional or incidental parts of the overall nurse aide job, which are a small part of a higher skilled job (nurse), would not ordinarily give a meaningful vocational advantage over unskilled. The extent of such duties, however, may vary with individual nurse aides.

On the other hand, a semiskilled general office clerk (administrative clerk), doing light work, ordinarily is equally proficient in, and spends considerable time doing, typing, filing, tabulating and posting data in record books, preparing invoices and statements, operating adding and calculating machines, etc. These clerical skills may be readily transferable to such semiskilled sedentary occupations as typist, clerk-typist and insurance auditing control clerk.

e. *Determination that a job is skilled and whether skills are transferable to other jobs.* Skilled occupations are more complex and varied than unskilled and semiskilled occupations. They require more training time and often a higher educational attainment. Abstract thinking in specialized fields may be required, as for chemists and architects. Special artistic talents and mastery of a musical instrument may be involved, as for school band instructors. Practical knowledge of machinery and understanding of charts and technical manuals may be needed by an automobile mechanic. The president or chief executive officer of a business organization may need exceptional ability to deal with people, organize various data, and make difficult decisions in several areas of knowledge.

At a lower level of skilled work are jobs like bulldozer operator, firebrick layer, and hosiery knitting machine operator. Where the skills in (and transferability of skills from) jobs like these are at issue, occupational reference sources or a VS should be consulted as necessary.

At the upper end of skilled work are jobs like architect, aircraft stress analysis, air-conditioning mechanic, and various professional and executive or managerial occupations. People with highly skilled work backgrounds have a much greater potential for transferability of their skills because *potential* jobs in which they can use their skills encompass occupations at the same and lower skill levels, through semiskilled occupations. Usually the higher the skill level, the more the potential for transferring skills increases. Consultation with a VS may be necessary to ascertain whether and how these skills are transferable.

3. Documentation of *skills and skill levels.*

a. *Sources of job information.* A particular job may or may not be identifiable in authoritative reference materials. The claimant is in the best position to describe just what he or she did in PRW, how it was done, what exertion was involved, what skilled or semiskilled work activities were involved, etc. Neither an

occupational title by itself nor a skeleton description is sufficient. If the claimant is unable to describe PRW adequately, the employer, a coworker or a member of the family may be able to do so.
Skills, levels of skills and potential occupations to which skills from PRW may be transferred are for the adjudicator of ALJ to determine (with the assistance, when required, of a VS or occupational reference sources).
b. *Determination of skill levels of past work.* In many cases, the skill level of PRW will be apparent simply by comparing job duties with the regulatory definitions of skill levels. This is especially true with most unskilled and most highly skilled work. Job titles, in themselves, are not determinative of skill level. Where it is not apparent, the adjudicator or ALJ should consult vocational reference sources; e.g., the DOT and its supplements. A VS is sometimes required to assist the adjudicator or ALJ in determining the skill level of past work.
4. *Application of the concept of transferability.*
a. *How transferability is determined in general.* Where transferability is at issue, it is most probable and meaningful among jobs in which: (1) the same or a lesser degree of skill is required, because people are not expected to do more complex jobs than they have actually performed (i.e, from a skilled to a semiskilled or another skilled job, or from one semiskilled to another semiskilled job); (2) the same or similar tools and machines are used; and (3) the same or similar raw materials, products, processes or services are involved. A complete similarity of all these factors is not necessary. There are degrees of transferability ranging from very close similarities to remote and incidental similarities among jobs.
Generally, the greater the degree of acquired work skills, the less difficulty an individual will experience in transferring skills to other jobs except when the skills are such that they are not readily usable in other industries, jobs and work settings. Reduced residual functional capacity (RFC) and advancing age are important factors associated with transferability because reducedRFC limits the number of jobs within an individual's physical or mental capacity to perform, and advancing age decreases the possibility of making a successful vocational adjustment.
b. *Medical factors and transferability.* All functional limitations included in the RFC (exertional and nonexertional) must be considered in determining transferability. For example, exertional limitations may prevent a claimant from operating the machinery or using the tools associated with the primary work activities of his or her PRW. Similarly, environmental, manipulative, postural, or mental limitations may prevent a claimant from performing semiskilled or skilled work activities essential to a job. Examples are watchmakers with hand tremors, house painters with severe allergic reactions to paint fumes, craftsmen who have lost eye-hand coordination, construction machine operators whose back impairments will not permit jolting, and business executives who suffer brain damage which notably lowers their IQ's. These factors as well as the general capacity to perform a broad category of work (e.g., sedentary, light or medium) must be considered in assessing whether or not a claimant has transferable work skills. If an impairment(s) does not permit acquired skills to be used, the issue of transferability of skills can be easily resolved.

c. *Special provisions made for transferability.* To find that an individual who is age 55 or over and is limited to sedentary work exertion has skills transferable to sedentary occupations, there must be very little, if any vocational adjustment required in terms of tools, work processes, work settings or the industry. The same is true for individuals who are age 60 and older and are limited to light work exertion. Individuals with these adverse vocational profiles cannot be expected to make a vocational adjustment to substantial changes in work simply because skilled or semiskilled jobs can be identified which have some degree of skill similarity with their PRW. In order to establish transferability of skills for such individuals, the semiskilled or skilled job duties of their past work must be so closely related to other jobs which they can perform that they could be expected to perform these other identified jobs at a high degree of proficiency with a minimal amount of job orientation.

Generally, where job skills are unique to a specific work process in a particular industry or work setting, e.g., carpenter in the construction industry, skills will not be found to be transferable without the need for more than a minimal vocational adjustment by way of tools, work processes, work settings, or industry. On the other hand, where job skills have universal applicability across industry lines, e.g., clerical, professional, administrative, or managerial types of jobs, transferability of skills to industries differing from past work experience can usually be accomplished with very little, if any, vocational adjustment where jobs with similar skills can be identified as being within an individual's RFC.

The "Example of a hypothetical case analysis" (item 5) below illustrates a situation where carpentry skills could be considered transferable to light work for an individual of advanced age but not transferable for an individual approaching retirement age because the potential jobs identified would require more than "very little" by way of a vocational adjustment.

The regulations also provide that when skills are so specialized or have been acquired in such an isolated vocational setting (like many jobs in mining, agriculture or fishing) that they are not readily usable in other industries, jobs, and work settings, they will be considered not transferable. An adjudicator should recognize that transferability of skills is not likely for persons whose past work is unusual or isolated. Some examples are placer miners, beekeepers, or spear fishermen. However, VS assistance may be required for less obviously unusual occupations in isolated vocational settings.

5. *Example of a hypothetical case analysis.* A disability applicant worked as a carpenter in the construction industry. As described by the claimant, his job was medium work in terms of the exertional level and skilled work in terms of job complexity. The skilled work functions performed by the claimant in his carpentry job included the study of blueprints, sketches or building plans for information needed in constructing, erecting, installing and repairing structures and fixtures of wood, plywood and wallboard, using saws, planes and other handtools and power tools.

The applicant was found to be unable to do his PRW because of a cardiovascular impairment with an RFC which prevents medium exertion. There are no other

impairments which might cause additional functional limitations and interfere with the transferability of his carpentry skills.

A decisionmaker in a State agency or in the Office of Hearings and Appeals finds that the former carpenter now has the RFC for at least a full range of light work exertion and that he is age 57, not yet close to retirement age (the age group 60-64 as defined in the regulations). The adjudicator as the finder of fact or the VS as the provider of evidence may be unable to identify closely related light occupations, preferably in the construction industry.

If unable to do so, he or she would then do further research. The research might show that there are several semiskilled light job possibilities in various worker trait groups and industries. For example, cabinet assembler and hand shaper are "manipulating" occupations in the furniture industry. Rip and groove machine operator is an "operating-controlling" occupation in the furniture industry. Box repairer in the wooden box industry and grader in the woodworking industry are two "sorting, inspecting, measuring and related work" occupations. All of these involve tools, raw materials and activities similar to those of the past carpentry work. The adjudicator alone or with the assistance of a VS is able to establish that the potential occupations exist in significant numbers in the national economy.

If the decisionmaker were to find that the carpenter has the RFC for a full range of light work exertion but (to change one fact in the example) is closely approaching retirement age, the provision in section 202.00(f) of Appendix 2 requiring little, if any, vocational adjustment would apply. Under the circumstances the VS could state, and the decisionmaker could find, that the claimant's carpentry skills cannot be transferred with very little, if any, vocational adjustment required in terms of tools, work processes, work settings or the industry.

Should the decision maker find that the former carpenter, at any age, is now limited to sedentary work exertion, he or she would most likely find few occupations performed in the seated position which utilize the specific work sills learned and used in construction carpentry and may be unable to find transferability.

6. *Findings of fact in determinations or decisions involving transferability of skills.* When the issue of skills and their transferability must be decided, the adjudicator or ALJ is required to make certain findings of fact and include them in the written decision. Findings should be supported with appropriate documentation.

When a finding is made that a claimant has transferable skills, the acquired work skills must be identified, and specific occupations to which the acquired work skills are transferable must be cited in the State agency's determination or ALJ's decision. Evidence that these specific skilled or semiskilled jobs exist in significant numbers in the national economy should be included (the regulations take administrative notice only of the existence of unskilled sedentary, light, and medium jobs in the national economy). This evidence may be VS statements based on expert personal knowledge or substantiation by information contained in the publications listed in regulations sections 404.1566(d) and 416.966(d). It is important that these finds be made at all levels of adjudication to clearly establish

the basis for the determination or decision for the claimant and for a reviewing body including a Federal district court.

EFFECTIVE DATE: Final regulations expanding the vocational factors regulations were published in the *Federal Register* on November 28, 1978, at 43 FR 55349, effective February 26, 1979. They were rewritten to make them easier to understand and were published on August 20, 1980, at 45 FR 55566. The policies in this PPS also became effective on February 26, 1979.

CROSS-REFERENCES: Program Operations Manual System, Part 4 (Disability Insurance State Manual Procedures) sections DI 2093, 2105.D, 2380.E, 2382, 2384, 2387.B.4. and 5, 2388.B and C, 2389, 2390, 2863 and 3027.C.2.

(PPS-72)

SSR 82-61

SSR 82-61: TITLES II AND XVI: PAST RELEVANT WORK -- THE PARTICULAR JOB OR THE OCCUPATION AS GENERALLY PERFORMED

PURPOSE: To clarify the policy in determining whether a claimant can perform his or her past relevant work, i.e., whether the claimant retains the residual functional capacity (RFC) to perform the physical and mental demands of the kind of work he or she has done in the past.

CITATIONS (AUTHORITY): Sections 223(d)(2)(A) and 1614(a)(3)(B) of the Social Security Act, as amended; Regulations No. 4, sections 404.1520(e), 404.1545, 404.1561 and 404.1565(a); Regulations No. 16, sections 416.920(e), 416.945, 416.961 and 416.965(a).

PERTINENT HISTORY: The part of the law pertaining to past relevant work provides that as a part of the requirements for a finding of disability a claimant must have a medically determinable physical or mental impairment of such severity that he or she is not able to do his or her previous work. Sections 404.1520(e) and 416.920(e) of the regulations state as follows:

> "Your impairment must prevent you from doing past relevant work. If we cannot make a decision based on your current work activity or on medical facts alone, and you have a severe impairment, we then review your residual functional capacity and the physical and mental demands of the work you have done in the past. *If you can still do this kind of work,* we will find that you are not disabled." (Underscoring added.)

The regulations further state, in sections 404.1565(a) and 416.965(a), that work experience applies (is relevant) when it was done within the last 15 years, lasted long enough for the person to learn to do it and was substantial gainful activity.

A basic program principle is that a claimant's impairment must be the primary reason for his or her inability to engage in substantial gainful work. This reflects the intent of Congress that there be a clear distinction between disability benefits and unemployment

benefits. Congress has also expressed the intent that disability determinations be carried out in as realistic a manner as possible.

Three possible tests for determining whether or not a claimant retains the capacity to perform his or her past relevant work are as follows:

> 1. Whether the claimant retains the capacity to perform a past relevant job based on a broad generic, occupational classification of that job, e.g., "delivery job," "packaging job," etc.
> Finding that a claimant has the capacity to do past relevant work on the basis of a generic occupational classification of the work is likely to be fallacious and unsupportable.
> While "delivery jobs," or "packaging jobs," etc., may have a common characteristic, they often involve quire different functional demands and duties requiring varying abilities and job knowledge.
> 2. Whether the claimant retains the capacity to perform the particular functional demands and job duties peculiar to an individual job as he or she actually performed it.
> Under this test, where the evidence shows that a claimant retains the RFC to perform the functional demands and job duties of a particular past relevant job as he or she actually performed it, the claimant should be found to be "not disabled."
> 3. Whether the claimant retains the capacity to perform the functional demands and job duties of the job as ordinarily required by employers throughout the national economy.
> (The *Dictionary of Occupational Titles* (DOT) descriptions can be relied upon -- for jobs that are listed in the DOT -- to define the job as it is *usually* performed in the national economy.) It is understood that some individual jobs may require somewhat more or less exertion than the DOT description.
> A former job performed in by the claimant may have involved functional demands and job duties significantly in excess of those generally required for the job by other employers throughout the national economy. Under this test, if the claimant cannot perform the excessive functional demands and/or job duties actually required in the former job but can perform the functional demands and job duties as generally required by employers throughout the economy, the claimant should be found to be "not disabled."

POLICY STATEMENT: Under sections 404.1520(e) and 416.920(e) of the regulations, a claimant will be found to be "not disabled" when it is determined that he or she retains the RFC to perform:

> 1. The actual functional demands and job duties of a particular past relevant job; or
> 2. The functional demands and job duties of the occupation as generally required by employers throughout the national economy.

EFFECTIVE DATE: Final regulations covering this policy were published in the *Federal Register* on August 20, 1980 (45 FR 55566).

FURTHER INFORMATION: A properly completed SSA-3369- F6, Vocational Report, may be sufficient to furnish information about past work. There may be cases involving significant variations between a claimant's description and the description shown in the DOT. In some instances, an apparent variation may result from an incomplete or inaccurate description of past work. Employer contact or further contact with the claimant, may be necessary to resolve such a conflict. Also composite jobs have significant elements of two or more occupations and, as such, have no counterpart in the DOT. Such situations will be evaluated according to the particular facts of each individual case. For those instances where available documentation and vocational resource material are not sufficient to determine how a particular job is usually performed, it may be necessary to utilize the services of a vocational specialist or vocational expert.

CROSS-REFERENCES: Program Operations Manual System, Part 4 (Disability Insurance State Manual Procedures) sections DI 2041, 2068, 2093, 2105D, 2380D, and 2383A.

(PPS-80)

SSR 82-62

SSR 82-62: TITLES II AND XVI: A DISABILITY CLAIMANT'S CAPACITY TO DO PAST RELEVANT WORK, IN GENERAL

PURPOSE: To state the policy and explain the procedures for determining a disability claimant's capacity to do past relevant work (PRW) as set forth in the regulations, and to clarify the provisions so that they will be consistently applied.

CITATIONS (AUTHORITY): Sections 223(d)(2)(A) and 1614(a)(3)(B) of the Social Security Act, as amended; Regulations No. 4, Subpart P, sections 404.1505(a), 404.1520(e), 404.1560, 404.1561, 404.1562, and 404.1565; and Regulations No. 16, Subpart I, sections 416.905(a), 416.920(e), 416.960, 416.961, 416.962, and 416.965.

INTRODUCTION: To be found disabled under the law, an individual (except for a title II widow, widower, or surviving divorced spouse, or a title XVI child younger than age 18) must have a medically determinable physical or mental impairment(s) of such severity that he or she is not only unable to do his or her previous work but cannot, considering his or her age, education, and work experience, engage in any other kind of substantial gainful work which exists in the national economy. The regulations provide a sequential evaluation process for determining disability. In the fourth step of this process, consideration is given to the individual's capacity to perform PRW. Sections 404.1520(e) and 416.920(e) of the regulations state as follows:

> *"Your impairment must prevent you from doing past relevant work.* If we cannot make a decision based on your current work activity or on medical facts alone, and you have a severe impairment, we then review your residual functional capacity [RFC] and the physical and mental demands of the work you have done in the past. If you can still do this kind of work, we will find that you are not disabled."

POLICY STATEMENT:

The Relevance of Past Work

The term "work experience" means skills and abilities acquired through work previously performed by the individual which indicates the type of work the individual may be expected to perform. Work for which the individual has demonstrated a capability is the best indicator of the kind of work that the individual can be expected to do. Sections 404.1565(a) and 416.965(a) of the regulations state as follows: "We consider that your work experience applies [i.e., is relevant] when it was done within the last 15 years, lasted long enough for you to learn to do it, and was substantial gainful activity [SGA]."

Except for the purpose of determining whether the disability criteria of sections 404.1562 and 416.962 of the regulations are met, work performed 15 years or more prior to the time of adjudication of the claim (or 15 years or more prior to the date the title II disability insured status requirement was last met, if earlier) is ordinarily not considered relevant.

An individual who has worked only sporadically or for brief periods of time during the 15-year period, may be considered to have no relevant work experience.

Capacity to do past work may be indicative of the capacity to engage in SGA when that work experience constituted SGA and has current relevance considering duration and recency.

1. SGA
The adjudicative criteria for determining whether a person has done "substantial" and "gainful" work activity are explained in sections 404.1571-404.1575 and 416.971-416.975 of the regulations.
2. Duration
Duration refers to the length of time during which the person gained job experience. It should have been sufficient for the worker to have learned the techniques, acquired information, and developed the facility needed for average performance in the job situation. The length of time this would take depends on the nature and complexity of the work.
3. Recency
Recency refers to the time which has elapsed since the work was performed. A gradual change occurs in most jobs in our national economy so that after 15 years it is no long realistic to expect that skills (or proficiencies) and abilities acquired in these jobs continue to apply. The 15-year guide is intended to insure that remote work experience which could not reasonably be expected to be of current relevance is not applied.

While the regulations provide that a claimant/beneficiary's work experience is usually relevant when the work "was done within the last 15 years," in some cases worked performed prior to the 15-year period may be considered as relevant when a continuity of

skills, knowledge, and processes can be established between such work and the individual's more recent occupations.

The following subsections describe how the relevant 15-year period will be determined.

1. When deciding whether a claimant is disabled under title II or title XVI, the 15-year period is generally the 15 years prior to the time of adjudication at the initial, reconsideration or higher appellate level.
2. In those title II cases in which the claimant's disability insured status was last met prior to adjudication, the work performed for the 15-year period preceding the date the title II disability insured status requirement was last met would generally be considered relevant, since the claimant's capacity for SGA as of that date represents a critical disability issue.
3. When deciding whether a title II or a title XVI beneficiary continues to be disabled, relevant past work is work he or she performed in the 15- year period prior to adjudication of the issue of continuing disability.

What the Claimant Can Now Do Physically and Mentally -- RFC

Evaluation under sections 404.1520(e) and 416.920(e) of the regulations requires careful consideration of the interaction of the limiting effects of the person's impairment(s) and the physical and mental demands of his or her PRW to determine whether the individual can still do that work.

Since the severity of the impairment(s) must be the primary basis for a finding of disability, evaluation begins with a determination of the claimant's functional limitations and capacities to sit, stand, walk, lift, carry, etc. (See SSR 82-51 (PPS-85: Guidelines for Residual Functional Capacity Assessment in Musculoskeletal and Cardiovascular Impairments).)

Comparing RFC with the Physical and Mental Demands of Past Relevant Occupations

The RFC to meet the physical and mental demands of jobs a claimant has performed in the past (either the specific job a claimant performed or the same kind of work as it is customarily performed throughout the economy) is generally a sufficient basis for a finding of "not disabled." Past work experience must be considered carefully to assure that the available facts support a conclusion regarding the claimant's ability or inability to perform the functional activities required in this work. (See SSR 82-61 (PPS-72: Past Relevant Work -- The Particular Past Job or the Occupation as Generally Performed) and SSR 82-40: (PPS-69: The Vocational Relevance of Past Work Performed in a Foreign Country).)

The claimant is the primary source for vocational documentation, and statements by the claimant regarding past work are generally sufficient for determining the skill level, exertional demands and nonexertional demands of such work. Determination of the

claimant's ability to do PRW requires a careful appraisal of (1) the individual's statements as to which past work requirements can no longer be met and the reason(s) for his or her inability to meet those requirements; (2) medical evidence establishing how the impairment limits ability to meet the physical and mental requirements of the work; and (3) in some cases, supplementary or corroborative information from other sources such as employers, the *Dictionary of Occupational Titles,* etc., on the requirements of the work as generally performed in the economy.

The decision as to whether the claimant retains the functional capacity to perform past work which has current relevance has far-reaching implications and must be developed and explained fully in the disability decision. Since this is an important and, in some instances, a controlling issue, every effort must be made to secure evidence that resolves the issue as clearly and explicitly as circumstances permit.

Sufficient documentation will be obtained to support the decision. Any case requiring consideration of PRW will contain enough information on past work to permit a decision as to the individual's ability to return to such past work (or to do other work).

Adequate documentation of past work includes factual information about those work demands which have a bearing on the medically established limitations. Detailed information about strength, endurance, manipulative ability, mental demands and other job requirements must be obtained as appropriate. This information will be derived form a detailed description of the work obtained from the claimant, employer, or other informed source. Information concerning job titles, dates work was performed, rate of compensation, tools and machines used, knowledge required, the extent of supervision and independent judgment required, and a description of tasks and responsibilities will permit a judgment as to the skill level and the current relevance of the individual's work experience. In addition, for a claim involving a mental/emotional impairment, care must be taken to obtain a precise description of the particular job duties which are likely to produce tension and anxiety, e.g., speed, precision, complexity of tasks, independent judgments, working with other people, etc., in order to determine if the claimant's mental impairment is compatible with the performance of such work. Persons with physical impairments (e.g., cardiovascular or gastrointestinal disorders) may have performed stressful tasks. This may also require a decision as to whether the impairment is compatible with the performance of such work. If more than one job was performed during the 15-year period, separate descriptions of each job will be secured.

The Disability Determination or Decision Where a Claimant or Beneficiary Can Meet the Physical and Mental Demands of a Past Relevant Occupation

The rationale for a disability decision must be written so that a clear picture of the case can be obtained. The rationale must follow an orderly pattern and show clearly how specific evidence leads to a conclusion.

The file will contain all the pertinent information which respect to the medical aspects of the case as well as the nonmedical facts.

The explanation of the decision must describe the weight attributed the pertinent medical and nonmedical factors in the case and reconcile any significant inconsistencies. Reasonable inferences may be drawn, but presumptions, speculations and suppositions must not be used.

A decision that an individual is not disabled, if based on sections 404.1520(e) and 416.920(e) of the regulations, must contain adequate rationale and findings dealing with all of the first four steps in the sequential evaluation process.

In finding that an individual has the capacity to perform a past relevant job, the determination or decision must contain among the findings the following specific finds of fact:

1. A finding of fact as to the individual's RFC.
2. A finding of fact as to the physical and mental demands of the past job/occupation.
3. A finding of fact that the individual's RFC would permit a return to his or her past job or occupation.

EFFECTIVE DATE: The policy explained herein was effective on August 20, 1980, the date the regulations covering the basic policy in the subject area were effective (45 FR 55566).

CROSS-REFERENCES: Program Operations Manual System, Part 4 (Disability Insurance State Manual Procedures) sections DI 2041, 2382, 2383, 2383.1, 2387, 2389, and 3027.

(PPS-79)

SSR 82-63

SSR 82-63: TITLES II AND XVI: MEDICAL-VOCATIONAL PROFILES SHOWING AN INABILITY TO MAKE AN ADJUSTMENT TO OTHER WORK

PURPOSE: To clarify that there are two "medical-vocational profiles" which show an inability to make a vocational adjustment to other work (or any work) and which must be considered before a disability decision-maker refers to Appendix 2 of Subpart P of Regulations No. 4 to determine whether a claimant can do work which exists in significant numbers in the national economy, considering the interaction of the claimant's residual functional capacity (RFC), age, education, and work experience. The characteristics of these two profiles are: (1) marginal education and long work experience limited to arduous unskilled physical labor and (2) advanced age, limited education and no work experience.

CITATIONS (AUTHORITY): Sections 223(d)(2)(A) and 1614(a)(3)(B) of the Social Security Act, as amended; Regulations No. 4, Subpart P, sections 404.1505(a), 404.1520(f), 404.1521, 404.1545, 404.1560, 404.1561, 404.1562, 404.1563(d), 404.1564, 404.1565, and 404.1568; Appendix 2 of Subpart P, Regulations No. 4, sections 203.00(b) and (c); and Regulations No. 16, Subpart I, sections 416.905(a), 416.920(f), 416.921, 416.945, 416.960, 416.961, 416.962, 416.963(d), 416.964, 416.965 and 416.968.

INTRODUCTION: The law provides that, in order to be found disabled, an individual (except for a title II widow, widower, or surviving divorced spouse or a title XVI child younger than age 18 or a "statutorily blind" individual) must have a medically determinable physical or mental impairment(s) of such severity that he or she is not only unable to do previous work but cannot, considering his or her age, education, and work experience, engage in any other kind of substantial gainful work which exists in the national economy. Sections 404.1520/416.920 of the regulations provide a sequential evaluation process whereby current work activity, severity and duration of the impairment(s), ability to do past work, and vocational factors are considered in that order. In the fifth and last step of the sequential evaluation process, consideration is given to the impaired individual's capability to perform other work differing from that of his or her past relevant work experience (or, in the case of a person without work experience, his or her capability to begin to work). At this step, we consider what the person can do functionally and the vocational factors of his or her age, education, and work experience.

Work Experience Limited to Arduous Unskilled Physical Labor

Regulations issued in 1957 to implement the title II disability program provided for the consideration of vocational factors in addition to the primary consideration given to the severity of the worker's impairment.

In 1960, section 404.1502(c) was added to the regulations as the first specific directive for a finding of disability based on both medical and vocational factors. That section described an individual whose vocational limitations are so restrictive that the existence of an impairment which prevents the individual from doing his or her usual level of work would ordinarily justify a finding of disability. The provisions of former section 404.1502(c) are now reflected in sections 404.1562/416.962 of the regulations. These sections address the claimant who has only a marginal education and work experience limited to 35 years or more of arduous unskilled physical labor. Rule 203.01 in Table No. 3 of Appendix 2 somewhat approximates the criteria in those sections. However, should rule 203.01 be referred to before sections 404.1562/416.962, an individual younger than age 60 with a background of 35 years or more in unskilled arduous physical labor might be overlooked.

No Work Experience

Under title II, a person must have a significant and recent attachment to the work force to acquire disability insured status.

Disability benefits under title XVI were first payable in 1974. Under the title XVI program, financial need -- low income and resources -- is an eligibility criterion rather than disability insured status. However, the disability evaluation standards are essentially the same for both titles II and XVI. Since a large number of title XVI claimants have little or no work history, the question arose as to how much adjudicative weight should be given to the absence of work experience. The lack of work experience is a vocationally adverse factor in that a person who has not been in the labor market has not developed any basic knowledge of work products or services, the ability to relate and communicate to supervisors and coworkers, the work habits of scheduling time, etc. Recognizing that as a person grows older the ability to compensate for the lack of work experience diminishes, the Social Security Administration (SSA) established a policy in 1975 which provided that, up to a point, all other factors being equal, claimants without work experience and those who have performed only unskilled work would be treated the same. That point is advanced age. The policy decision, in effect, directs a finding of disability where a person has a severe impairment of any nature, is of advanced age, has only the limited educational competence required for unskilled work, and has no work experience at all or no recent and relevant work experience.

Rules 203.02 and 203.10 in Table No. 3 of Appendix 2 reflect the policy decision in July 1975 with respect to persons who have a severe exertional impairment which limits them to the medium level of work exertion. However, should only rules 203.02 and 203.10 be considered, a person with a severe nonexertional impairment who is of advanced age, has

a limited education, and has no recent and relevant work experience might not be found to be disabled.

POLICY STATEMENT: When an adjudicator has reached the last step of the sequential evaluation process -- sections 404.1520(f)/416.920(f) of the regulations -- he or she must consider two medical-vocational profiles which direct decisions of disability before considering the numbered rules in Appendix 2 of the regulations.

1. *Work Experience Limited to Arduous Unskilled Physical Labor*
Sections 404.1562/416.962 of the regulations describe a set of functional and vocational limitations which present such an unfavorable vocational profile that an inability to make a vocational adjustment to other work may be inferred if the person meets these requirements and is not engaging in substantial gainful activity. To meet the criteria of these sections, the person must have a marginal education and long work experience (i.e., 35 years or more) limited to the performance of arduous unskilled physical labor which can no longer be performed because of a severe impairment(s). Careful examination of the evidence, including a description of all jobs the individual has held (with sufficient details about job content to show any skills involved and the level of physical exertion required) is necessary to establish whether the individual meets each criterion.
The adjudicator must make a complete assessment of all the pertinent elements in the regulations. While there is room for judgment in determining whether the criteria of sections 404.1562/416.962 are met, judgment cannot be used to substitute for basic documentation, to broaden the intent of the regulations, or to disregard specified criteria. Rule 203.01 of Appendix 2 contains criteria which somewhat approximate those in sections 404.1562/416.962. When neither set of criteria is met, a substantive decision regarding disability requires an assessment of the person's capacity for other work on the basis of the principles and definitions in the regulations and rules other than 203.01 in Appendix 2.

Severity of Impairment

For the purpose of evaluation under sections 404.1562/416.962 of the regulations, an impairment must be severe and prevent the performance of arduous physical labor. It is necessary to assess the person's RFC and to relate it to the physical and mental demands of his or her arduous work background.

History of Arduous Unskilled Work

The individual's work history must have the following characteristics:

a. Duration of Work Experience 35 Years or More
This criterion assures that the person has a long-term commitment to work which is arduous and unskilled.

b. Arduous Work

Arduous work is primarily physical work requiring a high level of strength or endurance. No specific physical action or exertional level denotes arduous work. While arduous work will usually entail physical demands that are classified as heavy, the work need not be described as heavy to be considered arduous. For example, work involving lighter objects may be arduous if it demands a great deal of stamina or activity such as repetitive bending and lifting at a very fast pace. Thus, there is room for judgment in deciding whether this criterion is met.

c. Unskilled Work

Unskilled work consists of simple duties which require little or no judgment and may be learned in a short period of time (see sections 404.1568(a)/416.968(a) of the regulations for further discussion). The judgment that work is unskilled must be based on facts which describe fully the nature and extent of vocational competences necessary to the performance of the job duties.

Employment in semiskilled or skilled work generally would rule out the application of sections 404.1562/416.962 of the regulations. Isolated, brief, or remote periods of experience in semiskilled or skilled work, however, would not preclude the applicability of these regulations when such experience did not result in skills which enhance the person's present ability to do lighter work. Also, periods of semiskilled or skilled work may come within the provisions of these regulations if it is clear that the skill acquired is not readily transferable to lighter work and makes no meaningful contribution to the person's ability to do any work within his or her present functional capacity. (See examples in sections 404.1562/416.962.) When the transferability of the skill may be subject to question, the case should be evaluated under the provisions of sections 404.1568(d)/416.968(d).

Marginal education

Marginal education (sections 404.1564(b)(2)/416.964(b)(2) of the regulations) indicates that the person may not have attained a level of development in reasoning, arithmetic, and language which would suggest a vocational potential for more than unskilled work. Generally, an individual is considered to have a marginal education if he or she has no more than a sixth grade elementary school education. However, the level of formal education is not conclusive of a person's vocational competence. The responsibilities and tasks of past employment may demonstrate a higher level of competence than that indicated by his or her formal schooling. Conversely, a person may have attended school beyond the sixth grade, but other evidence may establish capability for reasoning, arithmetic, and language which does not, in fact, exceed the"marginal" criterion.

(Where an individual with this profile can perform arduous unskilled physical labor, see SSR 82-62 (PPS-80: A Disability Claimant's Capacity to Do Past Relevant Work, in General).)

2. *Special "No Work Experience" Cases*

An SSA policy decision of July 7, 1975, provided that, up to the point of advanced age, persons without work experience and those who have performed only unskilled work will be given the same consideration. Recognizing that advanced age (55 or older) is a critical point for a vocational adjustment in that a person would have much difficulty in learning and doing activities not previously performed, SSA decided that a special policy should apply to disability claimants and beneficiaries who are of advanced age and have no recent and relevant work experience.

Generally, individuals are considered as having no recent and relevant work experience when they have either performed no work activity within the 15-year period prior to the point at which the claim is being considered for adjudication, or the work activity performed within this 15-year period does not (on the basis of job content, recency, or duration) enhance present work capability.

All such cases requiring vocational consideration must be decided on the basis of whether the individual's RFC, age, education, and lack of work experience are compatible with an adjustment to competitive remunerative work. Although the absence of relevant work experience represents an adverse vocational consideration, the adjudicative weight to be ascribed to this factor must be viewed in the context of the substantial numbers of unskilled jobs in the national economy which involve only simple job duties that can be learned in a short period of time and require no previous qualifying work experience.

Therefore, the absence of work experience can be evaluated only in the context of the range of work the individual can do functionally and of the other vocational factors of age, education and training. The following adjudicative guidelines provide a perspective for evaluating the interaction of the functional and vocational variables in cases involving individuals without work experience:

Generally, the RFC to perform a wide range of light work represents sufficient capacity to engage in substantial work for the individual who is not of advanced age and can communicate, read, and write on a marginal educational level.

Generally, where an individual of advanced age with no relevant work experience has a limited education or less, a finding of an inability to make a vocational adjustment to substantial work will be made, provided his or her impairment(s) is severe, i.e., significantly limits his or her physical or mental capacity to perform basic work-related functions.

In the cases involving individuals of advanced age, the only medical issue is the existence of a severe medically determinable impairment. The only vocational issues are advanced age, limited education or less, and absence of relevant work experience. With affirmative findings of fact, the conclusion would generally follow that the claimant or beneficiary is under a disability. If all the criteria of this medical-vocational profile are not met, the case must be decided on the basis of the principles and definitions in the regulations, giving consideration to the rules for specific case situations in Appendix 2.

EFFECTIVE DATE: The policy explained herein was effective on August 20, 1980, the date the regulations covering the basic policy in the subject area were effective (45 FR 55566).

CROSS-REFERENCES: Program Operations Manual System, Part 4 (Disability Insurance State Manual Procedures) sections DI 2041C, 2381, and 2387B.6.

(PPS-101)

SSR 83-10

SSR 83-10: TITLES II AND XVI: DETERMINING CAPABILITY TO DO OTHER WORK -- THE MEDICAL-VOCATIONAL RULES OF APPENDIX 2

PURPOSE: To clarify the manner in which the medical-vocational rules in Appendix 2 of Subpart P, Regulations No. 4, address the issue of capability to do other work, and to provide definitions of terms and concepts frequently used in evaluating disability under the medical-vocational rules.

CITATIONS (AUTHORITY): Sections 223(d)(2)(A) and 1614(a)(3)(B) of the Social Security Act; Regulations No. 4, Subpart P, sections 404.1505(a), 404.1520(f)(1), 404.1545, 404.1560-404.1561, 404.1563-404.1569, and Appendix 2; and Regulations no. 16, Subpart I, sections 416.905(a), 416.920(f)(1), 416.945, 416..960-416.961, and 416.-963-416.969.

PERTINENT HISTORY: Under the sequential evaluation process for evaluating disability, if it is determined that an individual is not engaging in substantial gainful activity (SGA) and has one more severe medically determinable impairments which do not meet or equal the Listing of Impairments but prevent him or her from performing past relevant work, evaluation of the individual's capability to do other work becomes necessary (see SSR 82-56, PPS-81, The Sequential Evaluation Process). In this, the fifth and last step in the process, the individual's residual functional capacity (RFC) in conjunction with his or her age, education, and work experience, are considered to determine whether the individual can engage in any other substantial gainful work which exists in the national economy. (See the glossary at the end of the policy statement for definitions of terms and concepts commonly used in medical-vocational evaluation -- e.g., RFC.)

To increase the consistency and promote the uniformity with which disability determinations are made at this step at all levels of adjudication, the regulations for determining disability were expanded in February 1979. Appendix 2 was provided to establish specific numbered table rules for use in medical-vocational evaluation.

Each numbered rule in the appendix resolves the issue of capability to do other work by addressing specific combinations of the factors(i.e., RFC, age, education, and work experience) that determine capability to do work other than that previously performed. The criteria for each factor contained within a rule are defined in the regulations. Resolution of the issue of capability to do other work is indicated in the "Decision" column (i.e., "Disabled" or "Not disabled") for the particular rule.

In using the rules of Appendix 2, we compare an individual's circumstances, as indicated by the findings with respect to RFC, age, education, and work experience, to the pertinent rule(s). Where the findings regarding each factor coincide with the criteria for the corresponding factor in a rule, that rule applies and directs a decision of "Disabled" or "Not disabled." Where one or more of the criteria of a rule are not met, no decision is directed; instead, the rules are used, in conjunction with the definitions and discussions in the text of the regulations, as guidance for decisionmaking.

Specific questions have arisen as to how we determine that the criteria of a rule are met and, where the criteria are not met, how we use the rules as a framework for decisionmaking. This Program Policy Statement (PPS) reviews and clarifies considerations underlying the rules to provide the necessary foundation for other PPS's that address issues about using the rules to adjudicate claims. (See the cross-reference section at the end of the PPS).

POLICY STATEMENT: In making disability determinations and decisions at the last step of the sequential evaluation process, emphasis continues to be given to medical considerations. The rules of Appendix 2 assure that appropriate weight is afforded to the severity of the impairment within the context of medical-vocational evaluation to determine capability to do other work. For that purpose, RFC (i.e., what work-related activities an individual can do despite the impairment(s)) is used to determine the maximum sustained capability for work. RFC is considered a factor affecting ability to adjust to work other than that previously performed. Capability to do other work is determined by considering the interaction of RFC with the other factors affecting vocational adaptability, i.e., age, education, and work experience. Education and work experience may also reflect acquired skills that can be used in skilled or semiskilled work other than that previously performed.

Work Capability as Established by RFC Alone
-- the Occupational Base

In Appendix 2, work in the national economy is classified exertionally as sedentary, light, medium, heavy or very heavy. (Although the tables containing the specific numbered rules, i.e., Tables No. 1, 2, and 3, are limited to the sedentary, light, and medium levels of work, respectively, there is a specific rule pertaining to heavy and very heavy work, rule 204.00.) Each functional level is defined (in accordance with terms used by the United States Department of Labor) by the extent of its requirements in the primary strength activities of sitting, standing, walking, lifting, carrying, pushing, and pulling.

The rules of Appendix 2 use exertional capabilities (i.e., those required to perform the primary strength activities) to identify maximum sustained work capability. Under each rule, the capability considered is limited to that necessary to perform sustained work on a regular basis at the particular level of exertion.

The rules within a table are based on the same RFC. In each rule, the remaining exertional capabilities must be sufficient to allow performance of substantially all (nearly all) of the primary strength activities defining the particular level of exertion (i.e., sedentary, light, or medium). Also, the combined exertional capabilities do not allow performance of exertional levels beyond that in question.

Accordingly, the RFC determines a work capability that is exertionally sufficient to allow performance of at least substantially all of the activities of work at a particular level (e.g., sedentary, light, or medium), but is also insufficient to allow substantial performance of work at greater exertional levels. Sedentary exertional demands are less than light, which are, in turn, less than medium. In addition, RFC generally represents an exertional work capability for all work at any functional level(s) below that used in the table under consideration.

The exertional requirements of work at a particular functional level are the same regardless of whether the work is skilled, semi-skilled, or unskilled. Therefore, RFC alone never establishes the capability for skilled or semiskilled work. Ability to perform skilled or semiskilled work depends on the presence of acquired skills which may be transferred to such work from past job experience above the unskilled level or the presence of recently completed education which allows for direct entry into skilled or semiskilled work. However, as noted in SSR 82-41, PPS-67, Work Skills and Their Transferability as Intended by the Expanded Vocational Factors Regulations Effective February 26, 1979, a person's RFC may prevent the transferability of skills.

Unskilled work may be performed by individuals with no work skills or no work experience. However, as shown in the table rules, individuals may not be expected to make a vocational adjustment to unskilled work in certain circumstances. A final requirement in determining an occupational base under the rules within a table is that the RFC reflects no impairment-caused limitation affecting performance of other then exertional activities, i.e., no nonexertional limitation. Thus, the only impairment-caused limitations considered in each rule are exertional limitations. Accordingly, the RFC considered under each rule reflects the presence of nonexertional capabilities sufficient to perform unskilled work at the pertinent exertional levels.

The RFC addressed in a rule establishes the presence of an occupational base that is limited to and includes a full range (all or substantially all) of the unskilled occupations existing at the exertional level in question. The base established by the RFC also ordinarily includes all those occupations at any lower exertional level(s).

When the medical-vocational rules were promulgated, administrative notice was taken of the fact that it was possible to identify at the unskilled level, approximately 200 sedentary occupations; approximately 1,600 sedentary and light occupations; and approximately 2,500 sedentary, light and medium occupations, each representing numerous jobs in the national economy. (By "administration notice" we mean our recognition that various authoritative publications identify occupations which exist in the national economy; these sources are listed in sections 404.1566 and 416.966 of the regulations.) Thus, as related to RFC, the occupational base considered in each rule consists of those unskilled occupations identified at the exertional level in question. (The base may be enhanced by the addition of specific skilled or semiskilled occupations that an individual can perform by reason of his or her education or work experience.

The Issue of Work Adjustment

In the situations considered in the numbered table rules (those indicating decisions of "Disabled" as well as "Not disabled"), an individual has the RFC to perform a full range of the unskilled occupations relevant to the table. Each of these occupations represents numerous jobs in the national economy. However, the individual may not be able to adjust to those jobs because of adverse vocational factors.

The issue of whether a work adjustment is possible involves a determination as to whether the jobs whose requirements can be met provide an opportunity for adjusting to substantial and gainful work other than that previously performed. Accordingly, the issue of work adjustment is determined based on the interaction of the work capability represented by RFC (the remaining occupational base) with the other factors affecting capability for adjustment -- age, education, and work experience.

Each numbered rule in Appendix 2 includes an administrative evaluation which determines whether a work adjustment should be possible. In each instance, the issue is decided based on the interaction between the person's occupational base as determined by RFC with his or her age, education, and work experience.

The ultimate question in the medical-vocational evaluation of the capability to do other work is whether work that an individual can do functionally and vocationally exists in the national economy. Whether work exists in the national economy for any particular individual depends on whether there is a significant number of jobs (in one or more occupations) with requirements that the individual is able to meet, considering his or her remaining physical and mental abilities and vocational qualifications.

The occupational base that is determined to be available based on RFC alone consists of a full range of occupations, each of which represents numerous jobs in the national economy. Where a rule indicates that a work adjustment is expected, a reasonable opportunity exists for adjusting to work other than that previously performed. (Rules which include the transferability of a person's work skills to skilled or semiskilled occupations within his or her RFC (or use of recent education for direct entry into such work) impose specific skilled or semiskilled occupations upon the unskilled occupational

base.) Conversely, where the rules determine that a work adjustment is not expected, no reasonable opportunity exists for adjusting to substantial work. Thus, where the criteria of a rule are met, the issue as to the existence of work in the national economy for that individual is resolved. While there is no requirement to cite unskilled occupations where the criteria of a rule are met, specific examples of skilled or semiskilled occupations will be cited where a rule determines that a work adjustment above the unskilled level is expected.

GLOSSARY

The definitions of terms and related concepts provided in this glossary are to be used when an individual's capability to do other work is determined under the provisions of Appendix 2 of the regulations. The definitions are based on the regulations, the vocational reference material noted in section 200.00(b) of Appendix 2, and the adjudicative experience of the Social Security Administration.

Broad World of Work. Work which exists at all exertional levels. It may include skilled and semiskilled work as well as unskilled work.

Environmental Conditions. Extremes of temperature, humidity, noise, vibration, fumes, odors, toxic conditions, dust, poor ventilation, hazards, etc.

Exertional Activity. One of the primary strength activities (sitting, standing, walking, lifting, carrying, pushing, and pulling) defining a level of work.

Exertional Capability. A capability required to perform an exertional activity.

Exertional Limitation. An impairment-caused limitation which affects capability to perform an exertional activity.

Exertional Level (Level of Exertion) A work classification defining the functional requirements of work in terms of the range of the primary strength activities required. The primary strength activities specifically associated with the sedentary, light, and medium levels of exertion are set forth in sections 404.1567 and 416.967 of the regulations.

The following elaborations of the activities needed to carry out the requirements of sedentary, light, and medium work are based on the same resource materials noted in section 200.00(b) of Appendix 2. They may be used by decisionmakers to determine if an individual has the ability to perform the full range of sedentary, light, or medium work from an exertional standpoint.

1. Sedentary work. The regulations define sedentary work as involving lifting no more than 10 pounds at a time and occasionally lifting or carrying articles like docket files, ledgers, and small tools. Although sitting is involved, a certain amount of walking and standing is often necessary in carrying out job duties. Jobs

are sedentary if walking and standing are required occasionally and other sedentary criteria are met. By its very nature, work performed primarily in a seated position entails no significant stooping. Most unskilled sedentary jobs require good use of the hands and fingers for repetitive hand-finger actions.
"Occasionally" means occurring from very little up to one-third of the time. Since being on one's feet is required "occasionally" at the sedentary level of exertion, periods of standing or walking should generally total no more than about 2 hours of an 8-hour workday, and sitting should generally total approximately 6 hours of an 8-hour workday. Work processes in specific jobs will dictate how often and how long a person will need to be on his or her feet to obtain or return small articles.
2. *Light work.* The regulations define light work as lifting no more than 20 pounds at a time with frequent lifting or carrying of objects weighing up to 10 pounds. Even though the weight lifted in a particular light job may be very little, a job is in this category when it requires a good deal of walking or standing -- the primary difference between sedentary and most light jobs. A job is also in this category when it involves sitting most of the time but with some pushing and pulling of arm-hand or leg-foot controls, which require greater exertion than in sedentary work; e.g., mattress sewing machine operator, motor-grader operator, and road-roller operator (skilled and semiskilled jobs in these particular instances). Relatively few unskilled light jobs are performed in a seated position.
"Frequent" means occurring from one-third to two-thirds of the time. Since frequent lifting or carrying requires being on one's feet up to two-thirds of a workday, the full range of light work requires standing or walking, off and on, for a total of approximately 6 hours of an 8-hour workday. Sitting may occur intermittently during the remaining time. The lifting requirement for the majority of light jobs can be accomplished with occasional, rather than frequent, stooping. Many unskilled light jobs are performed primarily in one location, with the ability to stand being more critical than the ability to walk. They require use of arms and hands to grasp and to hold and turn objects, and they generally do not require use of the fingers for fine activities to the extent required in much sedentary work.
3. *Medium work.* The regulations define medium work as lifting no more than 50 pounds at a time with frequent lifting or carrying of objects weighing up to 25 pounds. A full range of medium work requires standing or walking, off and on, for a total of approximately 6 hours in an 8-hour workday in order to meet the requirements of frequent lifting or carrying objects weighing up to 25 pounds. As in light work, sitting may occur intermittently during the remaining time. Use of the arms and hands is necessary to grasp, hold, and turn objects, as opposed to the finer activities in much sedentary work, which require precision use of the fingers as well as use of the hands and arms.
The considerable lifting required for the full range of medium work usually requires frequent bending-stooping. (Stooping is a type of bending in which a person bends his or her body downward and forward by bending the spine at the waist.) Flexibility of the knees as well as the torso is important for this activity. (Crouching is bending both the legs and spine in order to bend the body downward and forward.) However, there are relatively few occupations in the

national economy which require exertion in terms of weights that must be lifted at time (or involve equivalent exertion in pushing and pulling), but are performed primarily in a sitting position, e.g., taxi driver, bus driver, and tank-truck driver (semi-skilled jobs). In most medium jobs, being on one's feet for most of the workday is critical. Being able to do frequent lifting or carrying of objects weighing up to 25 pounds is often more critical than being able to lift up to 50 pounds at a time.

Full Range of Work. All or substantially all occupations existing at an exertional level.

> Limited to. Does not exceed.

Maximum Sustained Work Capability. The highest functional level a person can perform on a regular work basis -- sedentary, light, medium, heavy, or very heavy work.

Nonexertional Impairment. Any impairment which does not directly affect the ability to sit, stand, walk, lift, carry, push, or pull. This includes impairments which affect the mind, vision, hearing, speech, and use of the body to climb, balance, stoop, kneel, crouch, crawl, reach, handle, and use of the fingers for fine activities.

Nonexertional Limitation. An impairment-caused limitation of function which directly affects capability to perform work activities other than the primary strength activities.

Nonexertional Restriction (Environmental Restriction). An impairment-caused need to avoid one or more environmental conditions in a workplace.

Occupational Base. The number of occupations as represented by RFC, that an individual is capable of performing. These "base" occupations are unskilled in terms of complexity. The regulations take notice of approximately 2,500 medium. light, and sedentary occupations; 1,600 light and sedentary occupations; and 200 sedentary occupations. Each occupation represents numerous jobs in the national economy. (In individual situations, specific skilled or semi-skilled occupations may be added to the base.)

Range of Work. Occupations existing at an exertional level.

Residual Functional Capacity. A medical assessment of what an individual can do in a work setting in spite of the functional limitations and environmental restrictions imposed by all of his or her medically determinable impairment(s). RFC is the maximum degree to which the individual retains the capacity for sustained performance of the physical-mental requirements of jobs.

Skilled Level. A work classification whereby work is defined according to skill requirements. The requirements of the different skill levels are set forth in section 404.1568 and 416.968 of the regulations as follows:

1. *Unskilled work.* Unskilled work is work which needs little or no judgment to do simple duties that can be learned on the job in a short period of time. The job may or may not require considerable strength. For example, we consider jobs unskilled if the primary work duties are handling, feeding, and offbearing (that is, placing or removing materials from machines which are automatic or operated by others), or machine tending, and a person can usually learn to do the job in 30 days, and little specific vocational preparation and judgment are needed. A person does not gain work skills by doing unskilled work.
2. *Semiskilled work.* Semiskilled work is work which needs some skills but does not require doing the more complex work duties. Semiskilled jobs may require alertness and close attention to watching machine processes; or inspecting, testing or otherwise looking for irregularities; or tending or guarding equipment, property, material, or persons against loss, damage or injury; or other types of activities which are similarly less complex than skilled work, but more complex than unskilled work. A job may be classified as semiskilled where coordination and dexterity are necessary, as when hands or feet must be moved quickly to do repetitive tasks.
3. *Skilled work.* Skilled work requires qualifications in which a person uses judgment to determine the machine and manual operations to be performed in order to obtain the proper form, quality, or quantity of material to be produced. Skilled work may require laying out work, estimating qualify, determining the suitability and needed quantities, of materials, making precise measurements, reading blueprints or other specifications, or making necessary computations or mechanical adjustments to control or regulate the work. Other skilled jobs may require dealing with people, facts, or figures or abstract ideas at a high level of complexity.
For a further discussion of skills see SSR 82-41, PPS-67, Work Skills and Their Transferability as Intended by the Expanded Vocational Factors Regulations Effective February 26, 1979.

Substantially All Activities. Nearly all (essentially all) of the activities required in an exertional range of work.

Vocational Factors: An Individual's Age, Education, and Work Experience

1. *Age*. The regulations provide the older age is an increasingly adverse vocational factor for persons with severe impairments. The chronological ages, 45, 50, 55, and 60 may be critical to a decision. However, the regulations also provide that age categories are not applied mechanically in borderline situations. For example, a rule for an individual of advanced age (55 or older) could be found applicable, in some circumstances, to an individual whose chronological age is 54 years and 11 months (closely approaching advanced age). No fixed guidelines as to when a borderline situation exists are provided since such guidelines would themselves reflect a mechanical approach.
Under Title II, a period of disability cannot begin after a worker's disability insured status has expired. When the person last met the insured status

requirement before the date of adjudication, the oldest age to be considered is the person's age at the date last insured. In these situations, the person's age at the time of decisionmaking is immaterial.

2. *Education.* Unless there is evidence to contradict a persons's statement as to the numerical grade level completed in school, the statement will be used to determine the persons's educational abilities. The person's present level of reasoning, communication, and arithmetical ability may be higher or lower than the level of formal education. Evidence of this includes the kinds of responsibilities the person had when working, any acquired work skills, daily activities, and hobbies, as well as the results of testing. Therefore, a person will meet the criteria for the different education levels specified in the regulations, not solely on the basis of his or her statements, but based upon all evidence pertinent to evaluating that person's educational capacities.

The criterion of "high school graduate or more -- provides for direct entry into skilled work" is met when there is little time lapse between the completion of formal education and the date of adjudication, and where the content of the education would enable individuals, with a minimal degree of job orientation, to begin performing the skilled job duties of certain identifiable occupations within their RFC.

3. *Previous Work Experience.* A person's work experience may be none, not vocationally relevant, unskilled, semiskilled, or skilled. To meet the criterion of "skilled or semiskilled -- skills transferable," a person must have performed work which is above the unskilled level of complexity, must have identifiable skills, and must be able to use these skills in specific skilled or semiskilled occupations within his or her RFC. (For additional guidance related to work experience, see SSR 82-41, PPS-67, Work Skills and Their Transferability as Intended by the Expanded Vocational Factors Regulations Effective February 26, 1979; SSR 82-61, PPS-72, Past Relevant Work: The Particular Job or the Occupation as Generally Performed; SSR 82-62, PPS-80, A Disability Claimant's Capacity to Do Past Relevant Work, in General; and SSR 82-63, PPS-79, Medical-Vocational Profiles Showing an Incapability to Make an Adjustment to Other Work.

EFFECTIVE DATE: Final regulations providing the Medical-Vocational Guidelines were published in the *Federal Register* on November 28, 1978, at 43 FR 55349, effective February 26, 1979. They were rewritten to make them easier to understand and were published on August 20, 1980, at 45 FR 55566. The policies in this PPS are also effective as of February 26, 1979.

CROSS-REFERENCES: Program Operations Manual System, Part 4 (Disability Insurance State Manual Procedures), sections DI 2380E, 2382.1, 2382.2, 2384, and 2388A through E; SSR 83-11, PPS-102, Capability to Do Other Work -- The Exertionally Based Medical-Vocational Rules Met; SSR 83-12, PPS-103, Capability to Do Other Work -- The Medical-Vocational Rules as a Framework for Evaluating Exertional Limitation Within a Range of Work or Between Ranges of Work; SSR 83-13, PPS-104, Capability to Do Other Work -- The Medical-Vocational Rules as a Framework for Evaluating Solely Nonexertional Impairments; and SSR 83-14, PPS-105, Capability to

Do Other Work -- The Medical-Vocational Rules as Framework for Evaluating a Combination of Exertional and Nonexertional Impairments.

(PPS-103)

SSR 83-12

SSR 83-12: TITLES II AND XVI: CAPABILITY TO DO OTHER WORK -- THE MEDICAL-VOCATIONAL RULES AS A FRAMEWORK FOR EVALUATING EXERTIONAL LIMITATIONS WITHIN A RANGE OF WORK OR BETWEEN RANGES OF WORK

PURPOSE: To clarify policies applicable in using the numbered table rules in Appendix 2 of Subpart P of the regulations as a framework for adjudicating claims in which an individual has only exertional limitations, and no specific rule applies because the individual's residual functional capacity (RFC) does not coincide with any one of the defined exertional ranges of work.

CITATIONS (AUTHORITY): Sections 223(d)(2)(A) and 1614(a)(3)(B) of the Social Security Act; Regulations No, 4, Subpart P, sections 404.1520(f), 404.1545, 404.1561, 404.1566, 404.1567, 404.1569; Appendix 2 of Subpart P, section 200.00(d); Regulations No. 16, Subpart I, sections 416.920(f), 416.945, 416.961, 416.966, 416.967, and 416.969.

PERTINENT HISTORY: If a person has a severe medically determinable impairment which, though not meeting or equaling the criteria in the Listing of Impairments (Regulations No. 4, Subpart P, Appendix 1), prevents the person from performing past relevant work, we must decide whether he or she can do other work. The Medical-Vocational Guidelines which follow Appendix 1 as Appendix 2 contain numbered table rules which direct conclusions of "Disabled" or "Not disabled" where all of the individual findings coincide with those of a numbered rule. The table rules do not direct such conclusions when an individual's exertional RFC does not coincide with the exertional criteria of any one of the external ranges, i.e., sedentary, light, medium, as defined in sections 404.1567 and 416.967 of the regulations (See SSR 83-10, PPS-101, Determining Capability to Do Other Work -- The Medical-Vocational Rules of Appendix 2, for a discussion of exertion and ranges of work.) In some instances, an individual can do a

little more or less than the exertion specified for a particular range of work; e.g., the person is considered to be physically capable of meeting the exertional demands of light work except that he or she can lift no more than 15 pounds at a time rather than 20 pounds, or he or she can fully meet the exertional demands of light work and can also perform part of the greater lifting requirement of medium work (such as up to 30 pounds at a time rather than 50 pounds at a time).

This Program Policy Statement (PPS) sets out the process of using the numbered rules in adjudicating those claims in which the exertional components of the RFC are less or greater than those of a specifically defined exertional range of work.

POLICY STATEMENT: Each numbered rule directs a conclusion as to whether an individual in a specific case situation is able to make an adjustment to work other than that previously performed. The decision is based on the person's remaining occupational base, as determined by RFC, in conjunction with his or her age, education, and work experience. (See the text and work experience. (See the text and glossary of SSR 83-10, PPS-101, Determining Capability to Do Other Work -- The Medical-Vocational Rules of Appendix 2.)

Where an individual exertional RFC does not coincide with the definitions of any one of the ranges of work as defined in sections 404.1567 and 416.967 of the regulations, the occupational base is affected and may or may not represent a significant number of jobs in terms of the rules directing a conclusion as to disability. The adjudicator will consider the extent of any erosion of the occupational base and access its significance. In some instances, the restriction will be so slight that it would clearly have little effect on the occupational base. In cases of considerably greater restriction(s), the occupational base will obviously be affected, In still other instances, the restrictions of the occupational base will be less obvious.

Where the extent of erosion of the occupational base is not clear, the adjudicator will need to consult a vocational resource. The publications listed in sections 404.1566 and 416.966 of the regulations will be sufficient for relatively simple issues. In more complex cases, a person or persons with specialized knowledge would be helpful. State agencies may use personnel termed vocational consultants or specialists, or they may purchase the services of vocational evaluation workshops. Vocational experts may testify for this purpose at the hearing and appeals levels. In this PPS, the term vocational specialist (VS) describes all vocational resource personnel.

Adjudicative Guidance

The rules provide a basis for equitable consideration of the remaining occupational base, as follows:

1. If the individual's exertional capacity falls between two rules which direct the same conclusion, a finding of "Disabled" or "Not disabled," as appropriate, will follow.

a. As an example, where an exertional RFC is between the sedentary and light exertional levels and a finding of "Disabled" is indicated under both relevant rules, a finding of "Disabled" will follow. Even the complete occupational base (light) would not represent significant work for the individual.
b. As a second example, where an exertional RFC is between medium and light work, and both relevant rules, direct a conclusion of "Not disabled," the occupational base is clearly more than what is required as representing significant numbers of jobs because even the rule for less exertion directs a decision of "Not disabled."
2. 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 finding of "Disabled."
c. In situations where the rules would direct different conclusions, and the individual's exertional limitations are somewhere "in the middle" in terms of the regulatory criteria for exertional ranges of work, more difficult judgments are involved as to the sufficiency of the remaining occupational base to support a conclusion as to disability. Accordingly, VS assistance is advisable for these types of cases.
3. Another situation where VS assistance is advisable is where an individual's exertional RFC does not coincide with the full range of sedentary work. In such cases, equally difficult judgments are involved. Rather than having two rules which direct either the same or opposite conclusions, the decisionmaker would have only one relevant rule and would have to decide whether the full range of sedentary work is significantly compromised.
A VS can assess the effect of any limitation on the range of work at issue (e.g., the potential occupational base); advise whether the impaired person's RFC permits him or her to perform substantial numbers of occupations within the range of work at issue; identify jobs which are within the RFC, if they exist; and provide a statement of the incidence of such jobs in the region in which the person lives or in several regions of the country.
a. Where an individual's impairment has not met or equal the criteria of the Listing of Impairments at an earlier step in the sequence of adjudication, but the full range of sedentary work is significantly compromised, section 201.00(h) of Appendix 2 provides that a finding of "Disabled" is not precluded for even younger individuals. (The example in that section are of significantly restricted occupational bases.)
b. Where a person can perform all of the requirements of sedentary work except, for example, a restriction to avoid frequent contact with petroleum based solvents, there is an insignificant compromise of the full range of sedentary work. Technically, because of the restriction, this person cannot perform the full range

of sedentary work. However, this slight compromise within the full range of sedentary work (i.e., eliminating only the very few sedentary jobs in which frequent exposure to petroleum based solvents would be required) leaves the sedentary occupational base substantially intact. Using the rules as a framework, a finding of "Not disabled" would be appropriate.

Consideration of restrictions less clear in their effect than in the examples cited will require a more detailed review of the impact of the particular limitations on the performance of the full range of sedentary work. The assistance of a VS will usually be required in assessing the extent of the reduced work capabilities caused by the limitations. The particular examples set out above illustrate cases in which nonexertional impairments impinge upon the full range of sedentary work. Using the rules as a framework, the same principals may be applied to determine whether there has been a significant compromise in those instances where additional exertional limitations impinge on the full range of sedentary work.

SPECIAL SITUATIONS

1. *Alternate Sitting and Standing*

In some disability claims, the medical facts lead to an assessment of RFC which compatible with the performance of either sedentary or light work except that the person must alternate periods of sitting and standing. The individual may be able to sit for time, but must then get up and stand or walk for awhile before returning to sitting. Such an individual is not functionally capable of doing either the prolonged sitting contemplated in the definition of sedentary work (and for the relatively few light jobs which are performed primarily in a seated position) or the prolonged standing or walking contemplated for most light work. (Persons who can adjust to any need to vary sitting and standing by doing so at breaks, lunch periods, etc., would still be able to perform a defined range of work.)

There are some jobs in the national economy -- typically professional and managerial ones -- in which a person can sit or stand with a degree of choice. If an individual had such a job and is still capable of performing it, or is capable of transferring work skills to such jobs, he or she would not be found disabled. However, must jobs have ongoing work processes which demand that a worker be in a certain place or posture for at least a certain length of time to accomplish a certain task. Unskilled types of jobs are particularly structured so that a person cannot ordinarily sit or stand at will. In cases of unusual limitation of ability to sit or stand, a VS should be consulted to clarify the implications for the occupational base.

2. *Loss of Use of an Upper Extremity*

A person who has lost the use of an arm or hand because of amputation, paralysis, etc., obviously cannot perform jobs which require use of both arms or both hands. Loss of major use of an upper extremity is rather definitive in that there is a considerable absence of functional ability. As stated in SSR 82-51, PPS-85, Guidelines for Residual Functional Capacity Assessment in Musculoskeletal and Cardiovascular Impairments, an amputation above the elbow would limit a person to light work activity with additional limitations because of loss of bimanual

manipulation and difficulty or inability to handle bulky objects; effective use of the remaining hand may also be affected. An amputation below the elbow -- or partial loss of use of the extremity -- will require a more detailed evaluation of functional ability, including the condition of the remaining stump and the person's ability to use a prosthesis -- or the person's remaining ability for fine and gross manipulating.

Experience with persons who have lost the use of an upper extremity has shown that their potential occupational base is between the occupational bases for Table No. (sedentary work) and Table No.2 (light work). While individuals with this impairment have been known to perform selected occupations at nearly all exertional levels, the total number of occupations within their RFC's is less than the number represented by a full or wide range of light work. These individuals would generally not be expected to perform sedentary work because most unskilled sedentary jobs require good use of both hands. Persons who have the least remaining function would have only the lower occupational base, while those who have the most remaining function would have some of the higher occupational base added in terms of numbers of jobs which can be performed with this type of impairment. Given an individual's particular RFC, a VS will be able to determine the size of the remaining occupational base, cite specific jobs within the individual's RFC, and provide a statement of the incidence of those jobs in the region of the individual's residence or in several regions of the country.

The Disability Determination or Decision Where a Claimant or Beneficiary Has Exertional Limitations Within A Range of Work or Between Ranges of Work

The usual requirements apply for a clear, persuasive, orderly rationale, reflecting the sequential evaluation process, with recitations of the evidence and specific findings of fact. (See SSR 82-56, PPS-81, The Sequential Evaluation Process.) Whenever vocational resources are used, and an individual is found to be not disabled, the determination or decision will include (1) citations of examples of occupation/jobs the person can do functionally and vocationally and (2) a statement of the incidence of such work in the region in which the individual resides or in several regions of the country.

EFFECTIVE DATE: Final regulations providing the Medical-Vocational Guidelines were published in the *Federal Register* November 28, 1978, at 43 FR 55349, effective February 26, 1979. They were rewritten to make them easier to understand and were published on August 20, 1980, at 45 FR 55566. The policies in this PPS are effective as of February 26, 1979.

CROSS-REFERENCE: Program Operations Manual System, Part 4 (Disability Insurance State Manual Procedure), sections DI 2380E, 2382.2, 2384, and 2388A-E; SSR 83-10, PPS-101, Determining Capability to Do Other Work -- The Medical-Vocational Rules of Appendix 2; SSR 83-11, PPS-102, Capability to Do Other Work -- The Exertionally Based Medical-Vocational Rules Met; SSR 83-13, PPS-104, Capability to Do Other Work -- The Medical-Vocational Rules as a Framework for Evaluating Solely

Nonexertional Impairments; and SSR 83-14, PPS-105, Capability to Do Other Work -- The Medical-Vocational Rules as a Framework for Evaluating a Combination of Exertional and Nonexertional Impairments.

(PPS-105)

SSR 83-14

SSR 83-14: TITLES II AND XVI: CAPABILITY TO DO OTHER WORK -- THE MEDICAL-VOCATIONAL RULES AS A FRAMEWORK FOR EVALUATING A COMBINATION OF EXERTIONAL AND NONEXERTIONAL IMPAIRMENTS

PURPOSE: To clarify how the table rules in Appendix 2, Subpart P, Regulations No. 4, provide a framework for decisions concerning persons who have both a severe exertional impairment and a nonexertional limitation or restriction.

CITATIONS (AUTHORITY): Sections 223(d)(2)(A) and 1614(a)(3)(B) of the Social Security Act; Regulations No. 4, Subpart P, sections 404.1505(a), 404.1520(f)(1), 404.1545, 404.1560-404.1569; Appendix 2 of Subpart P, section 200.00(e)(2); and Regulations No. 16, Subpart I, sections 416.905(a), 416.920(f)(1), 416.945, 416.960-416.969.

PERTINENT HISTORY: No table rule applies to direct a conclusion of "Disabled" or "Not disabled" where an individual has a nonexertional limitation or restriction imposed by a medically determinable impairment. In these situations, the table rules are used, in conjunction with the definitions and discussions provided in the text of the regulations, as a framework for decisionmaking.

This Program Policy Statement (PPS) clarifies the distinction between exertional and nonexertional limitations and explains how the latter affect performance of work activities. The PPS also explains how to evaluate the vocational effects of nonexertional impairments within the context of the exertionally based table rules where claimants or beneficiaries also have severe exertional impairments that limit them to sedentary, light, or medium work.

See the cross-reference section at the end of this PPS for related PPS's, the first one of which contains a glossary of terms used.

POLICY STATEMENT: The term "exertional" has the same meaning in the regulations as it has in the United States Department of Labor's publication, the *Dictionary of Occupational Titles* (DOT). In the DOT supplement, *Selected Characteristics of Occupations Defined in the Dictionary of Occupational Titles* (SCO), occupations are classified as sedentary, light, medium, heavy, and very heavy according to the degree of primary strength requirements of the occupations. These consist of three work positions (standing, walking, and sitting) and four worker movements of objects (lifting, carrying, pushing, and pulling).

Any functional or environmental job requirement which is not exertional is "nonexertional." In the disability programs, a nonexertional impairment is one which is medically determinable and causes a nonexertional limitation of function or an environmental restriction. Nonexertional impairments may or may not significantly narrow the range of work a person can do. In the SCO, where specific occupations have critical demands for certain physical activities, they are rated for climbing or balancing; stooping, kneeling, crouching or crawling; reaching, handling, fingering, or feeling; talking or hearing; and seeing. Occupations are also rated for certain environmental conditions (e.g., high humidity or excessive dust). With respect to job complexity, occupations are rated by the training time required for average performance. Further, the occupational code numbers assigned to jobs reflect different levels of complexity in dealing with data, people, and objects. Narrative occupational descriptions in the DOT explain what is generally done in the job.

Effects of Nonexertional Impairments

Maintaining body equilibrium; using the fingers and finger tips to work with small objects; using the eyes and ears to see and hear; and using the vocal apparatus to speak are considered nonexertional activities. Limitations of these functions can affect the capacity to perform certain jobs at all levels of physical exertion. An entire range of jobs can be severely compromised. For example, section 201.00(h) of Appendix 2 calls attention to the fact that bilateral manual dexterity is necessary for the performance of substantially all unskilled sedentary occupations.

Mental activities are also nonexertional. Jobs at various levels of complexity require mental functions such as intellectual competence and ability to function in terms of behavior, affect, thought, memory, orientation and contact with reality. Exposure to particular work stresses may not be medically sustainable for some persons with mental impairments, as would be the case with some persons who have physical impairments (e.g., certain cardiovascular or gastrointestinal disorders). Depending on the nature and extent of a person's mental impairment which does not meet or equal the criteria in the Listing of Impairments, relatively broad or narrow types of work may be precluded (e.g., dealing with a variety of abstract and concrete variables with nonverbal symbolism -- a highly skilled level of work -- or dealing frequently with members of the public -- a particular type of work at any level of complexity). Although mental impairments as such are considered to be nonexertional, some conditions (e.g., depression or a conversion reaction) may also affect a person's exertional capacity.

Working conditions (environmental demands) which a person may not be able to tolerate as a result of an impairment include exposure to extremes of heat or cold, humidity, noise, vibration, hazards, fumes, dust, and toxic conditions. Physical limitation of function may be linked with an environmental restriction (e.g., a respiratory impairment may diminish exertional capacity as well as restrict a person to types of work not requiring exposure to excessive dust or fumes). In other cases, functional ability may not be impaired by an environmental restriction (e.g., a person may be able to do anything so long as he or she is not near dangerous moving machinery, on unprotected elevations, or in contact with certain substances to which he or she is allergic).

After it has been decided that an impaired person can meet the primary strength requirements of sedentary, light, or medium work -- sitting, standing, walking, lifting, carrying, pushing, and pulling -- a further decision may be required as to how much of this potential occupational base remains, considering certain nonexertional limitations which the person may also have. For example, at all exertional levels, a person must have certain use of the arms and hands to grasp, hold, turn, raise, and lower objects. Most sedentary jobs require good use of the hands and fingers. In jobs performed in a seated position which require the operation of pedals or treadles, a person must have the use of his or her legs and feet. Relatively few jobs in the national economy require ascending or descending ladders and scaffolding. Two types of bending must be done frequently (from one-third to two-thirds of the time) in most medium, heavy, and very heavy jobs because of the positions of objects to be lifted, the amounts of weights to be moved, and the required repetitions. They are stooping (bending the body downward and forward by bending the spine at the waist) and crouching (bending the body downward and forward by bending both the legs and spine). However, to perform substantially all of the exertional requirements of most sedentary and light jobs, a person would not need to crouch and would need to stoop only occasionally (from very little up to one-third of the time, depending on the particular job).

For additional discussions of nonexertional impairments, see SSR 83-13, PPS-104, Capability to Do Other Work -- The Medical-Vocational Rules as a Framework for Evaluating Solely Nonexertional Impairments.

Evaluating the Claim

Section 200.00(e)(2) of Appendix 2 provides that, "where an individual has an impairment or combination of impairments resulting in both strength limitations and nonexertional limitations, the rules in this subpart are considered in determining first whether a finding of disabled may be possible based on the strength limitations alone and, if not, the rule(s) reflecting the individual's maximum residual strength capabilities, age, education, and work experience provide a framework for consideration of how much the individual's work capability is further diminished in terms of any types of jobs that would be contraindicated by the nonexertional limitations. Also, in these combinations of nonexertional and exertional limitations which cannot be wholly determined under the rules in this Appendix 2, full consideration must be given to all of the relevant facts in the case in accordance with the definitions and discussions of each factor in the appropriate

sections of the regulations, which will provide insight into the adjudicative weight to be accorded each factor."

Disabled Based on Strength Limitations Alone

Where a person's residual functional capacity (RFC), age, education, and work experience coincide with the criteria of an exertionally based rule in Table No. 1, 2, or 3 -- and that rule directs a conclusion of "Disabled" -- there is no need to consider the additional effects of a nonexertional impairment since consideration of it would add nothing to the fact of disability. A written determination or decision supporting a conclusion must specify the rule in Appendix 2 which directs such conclusion. It must also reflect consideration of the individual steps of the sequential evaluation process specified in sections 404.1520 and 416.920 of the regulations. There must also be findings of fact based on the evidence in the individual claim which leads to the conclusion that the individual is not exertionally capable of doing work different from past work, considering the medical and vocational factors (See SSR 83-11, PPS-102, Capability to Do Other Work -- The Exertionally Based Medical-Vocational Rules Met.)

The Exertionally Based Rules as A Framework for Evaluating Additional Impairments of a Nonexertional Nature

Where a person cannot be found disabled based on strength limitations alone, the rule(s) which corresponds to the person's vocational profile and maximum sustained exertional work capability (Table No. 1, 2, or 3) will be the starting point to evaluate what the person can still do functionally. The rules will also be used to determine how the totality of limitations or restrictions reduces the occupational base of administratively noticed unskilled sedentary, light, or medium jobs.

A particular additional exertional or nonexertional limitation may have very little effect on the range of work remaining that an individual can perform. The person, therefore, comes very close to meeting a table rule which directs a conclusion of "Not disabled." On the other hand, an additional exertional or nonexertional limitation may substantially reduce a range of work to the extent that an individual is very close to meeting a table rule which directs a conclusion of "Disabled."

Use of a vocational resource may be helpful in the evaluation of what appear to be "obvious" types of cases. In more complex situations, the assistance of a vocational resource may be necessary. The publications listed in sections 404.1566 and 416.966 of the regulations will be sufficient for relatively simple issues. In more complex cases, a person or persons with specialized knowledge would be helpful. State agencies may use personnel termed vocational consultants or specialists, or they may purchase the services of vocational evaluation workshops. Vocational experts may testify for this purpose at the hearing and Appeals Council levels. In this PPS, the term vocational specialist (VS) describes all vocational resource personnel.

Examples of Evaluation Involving Combinations of Exertional and Nonexertional Limitations

1. *Sedentary exertion combined with a nonexertional impairment.* Example 1 of section 201.00(h) in Appendix 2 illustrates a limitation to unskilled sedentary work with an additional loss of bilateral manual dexterity that is significant and, thus, warrants a conclusion of "Disabled." (The bulk of unskilled sedentary jobs requires bilateral manual dexterity.) An example of nonexertional impairment which ordinarily has an insignificant effect on a per son's ability to work is an allergy to ragweed pollen. Many individuals who have this allergy experience no more discomfort during the ragweed season than someone who has a common cold. However, others are more affected by the condition. Assuming that an individual has a severe impairment of the low back which limits that person to sedentary work, and that the assessment of RFC also restricts him or her from workplaces which involve exposure to ragweed pollen, the implications for adjustment to sedentary work are relatively clear. Ragweed grows outdoors and its pollen is carried in the air, but the overwhelming majority of sedentary jobs are performed indoors. Therefore, with the possible exclusion of some outdoor sedentary occupations which would require exposure to ragweed pollen, the unskilled sedentary occupational base is not significantly compromised. The decisionmaker may need the assistance of a VS in determining the significance of the remaining occupational base of unskilled sedentary work in more difficult cases.

2. *Light exertion combined with a nonexertional impairment.* The major difference between sedentary and light work is that most light jobs -- particularly those at the unskilled level of complexity -- require a person to be standing or walking most of the workday. Another important difference is that the frequent lifting or carrying of objects weighing up to 10 pounds (which is required for the full range of light work) implies that the worker is able to do occasional bending of the stooping type, i.e., for no more than one-third of the workday to bend the body downward and forward by bending the spine at the waist. Unlike unskilled sedentary work, many unskilled light jobs do not entail fine use of the fingers. Rather, they require gross use of the hands to grasp, hold, and turn objects. Any limitation of these functional abilities must be considered very carefully to determine its impact on the size of the remaining occupational base of a person who is otherwise found functionally capable of light work.

Where a person has a visual impairment which is not of Listing severity but causes the person to be a hazard to self and others -- usually a constriction of visual fields rather than a loss of acuity -- the manifestations of tripping over boxes while walking, inability to detect approaching persons or objects, difficulty in walking up and down stairs, etc., will indicate to the decisionmaker that the remaining occupational base is significantly diminished for light work (and medium work as well).

On the other hand, there are nonexertional limitations or restrictions which have very little or no effect on the unskilled light occupational base. Examples are inability to ascend or descend scaffolding, poles, and ropes; inability to crawl on

hands and knees; and inability to use the finger tips to sense the temperature or texture of an object. Environmental restrictions, such as the need to avoid exposure to feathers, would also not significantly affect the potential unskilled light occupational base.

Where nonexertional limitations or restrictions within the light work category are between the examples above, a decisionmaker will often require the assistance of a VS.

3. *Medium exertion combined with a nonexertional impairment.* Most medium jobs, like most light jobs, require the worker to stand or walk most of the time. Also, as in light work, most unskilled medium jobs require gross use of the hands to grasp, hold, and turn objects rather than use of the fingers for fine movements of small objects. Medium work is distinct from the less strenuous levels in the activities needed to accomplish the considerable lifting and carrying involved for the full range of medium work. A maximum of 50 pounds may be lifted at a time, with frequent lifting or carrying of objects weighing up to 25 pounds. (Frequent in this context means from one-third to two-thirds of the workday.) Consequently, to perform the full range of medium work as defined, a person must be able to do both frequent stooping and frequent crouching -- bending both the back and the legs -- in order to move objects from one level to another or to move the objects near foot level. While individual occupations classified as medium work vary in exertional demands from just above the light work requirements to the full range of medium work, any limitation of these functional abilities must be considered very carefully to determine its impact on the size of the remaining occupational base of a person who is otherwise found capable of medium work.

In jobs at the medium level of exertion, there is more likelihood than in light work that such factors as the ability to ascend or descend ladders and scaffolding, kneel, and crawl will be a part of the work requirement. However, limitations of these activities would not significantly affect the occupational base.

As in light work, inability to use the finger tips to sense the temperature or texture of an object is an example of a nonexertional limitation which would have very little effect on the potential unskilled medium occupational base. The need to avoid environments which contain objects or substances commonly known not to exist in most workplaces would be an obvious example of a restriction which does not significantly affect the medium occupational base.

Where nonexertional limitations or restrictions within the medium work category are between the examples above, a decisionmaker will often require the assistance of a VS.

The Disability Determination or Decision Based on a Combination of Exertional and Nonexertional Impairments

The usual requirements apply for a clear, persuasive, orderly rationale, reflecting the sequential evaluation process. There must be findings of fact and recitation of the evidence which supports each finding (see SSR 82-56, PPS-81, The Sequential Evaluation Process). Whenever a vocational resource is used and an individual is found to be not disabled, the determination or decision will include (1) citations of examples of occupations/jobs the person can do functionally and vocationally and (2) a statement of

the incidence of such work in the region in which the individual resides or in several regions of the country.

In reaching judgments as to the sufficiency of the remaining exertional job base (approximately 2,500 unskilled medium, light, and sedentary occupations, approximately 1,600 unskilled light and sedentary occupations, and approximately 200 unskilled sedentary occupations), there are three possible situations to consider:

1. Where it is clear that the additional limitation or restriction has very little effect on the exertional occupational base, the conclusion directed by the appropriate rule in Tables No. 1, 2, or 3 would not be affected.
2. Where it is clear that additional limitations or restrictions have significantly eroded the exertional job base set by the exertional limitations alone, the remaining portion of the job base will guide the decision.
3. Where the adjudicator does not have a clear understanding of the effects of additional limitations on the job base, the services of a VS will be necessary.

EFFECTIVE DATE: Final regulations providing the Medical-Vocational Guidelines were published in the *Federal Register* on November 28, 1978, at 43 FR 55349, effective February 26, 1979. They were rewritten to make them easier to understand and were published on August 20, 1980, at 45 FR 55566. The policies in this PPS also became effective as of February 26, 1979.

CROSS-REFERENCES: Program Operations Manual System, Part 4 (Disability Insurance State Manual Procedures), section DI 2388. A.5.b., SSR 83-10, PPS-101, Determining Capability to Do Other Work -- The Medical-Vocational Rules of Appendix 2 (with a glossary); SSR 83-11, PPS-102, Capability to Do Other Work -- The Exertionally Based Medical-Vocational Rules Met; SSR 83-12, PPS-103, Capability to Do Other Work -- The Medical-Vocational Rules as a Framework for Evaluating Exertional Limitations Within a Range of Work or Between Ranges of Work; and SSR 83-13, PPS-104, Capability to Do Other Work -- The Medical-Vocational Rules as a Framework for Evaluating Solely Nonexertional Impairments.

(PPS-113)

SSR 84-25

SSR 84-25: TITLES II AND XVI: DETERMINATION OF SUBSTANTIAL GAINFUL ACTIVITY IF SUBSTANTIAL WORK ACTIVITY IS DISCONTINUED OR REDUCED -- UNSUCCESSFUL WORK ATTEMPT

PURPOSE: To state the policy for determining whether substantial work activity that is discontinued or reduced below a specified level may be considered an unsuccessful work attempt (UWA) under the disability provisions of the law.

CITATIONS (AUTHORITY): Sections 216(i), 223(d), and 1614(a) of the Social Security Act, as amended; Regulations No. 4, Subpart P, sections 404.1571-404.1576; Regulations No. 16, Subpart I, sections 416.971-416.976.

PERTINENT HISTORY: Under the disability provisions of the law, except within the trial work period (TWP) provisions, a person who is engaging in substantial gainful activity (SGA) is not eligible for payment of disability benefits. (There was a temporary provision of the Act, section 1619(a), in effect until December 31, 1983, that authorized continued disability payments to title XVI recipients engaging in SGA, provided their income was within specified limits. These payments are being continued for the year 1984 under a demonstration project (49 Federal Register 9774, March 15, 1984).) (See Social Security Ruling (SSR) 83-33, Program Policy Statement (PPS)-107, Determining Whether Work Is Substantial Gainful Activity -- Employees, regarding evaluation of work activity of employees. See SSR 83-34, PPS-108, Determining Whether Work Is Substantial Gainful Activity -- Self-Employed Persons, regarding evaluation of work activity of self-employed persons.) The UWA concept was designed as an equitable means of disregarding relatively brief work attempts that do not demonstrate sustained SGA.

The concept is embodied in the disability regulations. Concerning employees, sections 404.1574(a)(1) and 416.974(a)(1) of the regulations state: "We will generally consider work that you are forced to stop after a short time because of your impairment as an unsuccessful work attempt and your earnings from that work will not show that you are able to do substantial gainful activity." With respect to the self-employed, sections

404.1575(a) and 416.975(a) state: "We will generally consider work that you are forced to stop after a short time because of your impairment as an unsuccessful work attempt and your income from that work will not show that you are able to do substantial gainful activity."

Specific criteria evolved for evaluating work activity lasting up to 6 months. Concerning a work effort of over 6 months, operating instructions stated that ordinarily we would consider it as successful regardless of why it ended or was reduced below the SGA earnings level. Instructions added, however, that in "unusual circumstances," a finding of UWA could be made, with such cases referred for postadjudicative study. Review of the cases referred has not shown that a UWA of over 6 months is warranted. The circumstances that existed in these cases (e.g., frequent absences, special conditions) and the reasons for work stoppage were not unusual and were generally no different from those that existed in cases where the work effort lasted no more than 6 months. Also, in some of these referred cases the period of work actually lasted longer than the 9 months allowed by law for TWP purposes. The provision for permitting the dismissal of work activity of over 6 months' duration as a UWA is accordingly being deleted from the UWA policy and will no longer be applicable. The UWA criteria currently being followed for work of 6 months or less remain unchanged and are described in this PPS.

POLICY STATEMENT: For SGA determination purposes, substantial work may, under certain conditions, be disregarded if it is discontinued or reduced to the non-SGA level after a short time because of the person's impairment or the removal of special conditions related to the impairment that are essential to the further performance of work. The UWA criteria differ depending on whether the work effort was for "3 months or less" or for "between 3 and 6 months." If a work attempt was "unsuccessful," a finding of disability during the time that such work was performed would not be precluded.

When the UWA is Applicable

The UWA policy explained in this PPS is to be used in initial disability cases. It is also to be used in continuing disability cases in determining whether, because of work activity, disability continues or ceases. However, the UWA criteria do not apply in determining whether payments should be made for a particular month during the reentitlement period *after* disability has been ceased because of SGA.

Event That Must Precede a UWA

There must be a significant break in the continuity of a person's work before he or she can be considered to have begun a work attempt that later proved unsuccessful. Such an interruption would occur when, because of the impairment or the removal of special conditions related to the impairment that are essential to the further performance of work, the work was discontinued or was reduced (or limited) to the non-SGA level. Work is considered to be "discontinued" if the person (1) was out of work for at least 30 consecutive days or (2) was forced to change to another type of work or another employer. (On rare occasions a break lasting a few days less than 30 may satisfy this

requirement if the subsequent work episode was brief and clearly not successful because of the impairment.)

Event That Must Follow a UWA

After the first significant break in continuity of a person's work, the ensuing period of work is regarded as continuous until another such change occurs -- that is, until the impairment or the removal of special conditions related to the impairment that are essential to the further performance of work causes the work to be "discontinued" as defined above or to be reduced to the non-SGA level. Each continuous period, separated by significant breaks as described, may be a UWA so long as criteria as to duration and conditions of work are met, as set out below.

UWA Criteria -- Duration and Conditions of Work

1. *Work Effort of 3 Months or Less*
The work must have ended or have been reduced to the non-SGA level within 3 months due to the impairment or to the removal of special conditions related to the impairment that are essential to the further performance of work. (Examples of "special conditions" are given below.)
2. *Work Effort of Between 3 and 6 Months*
If work lasted more than 3 months, it must have ended or have been reduced to the non-SGA level within 6 months due to the impairment or to the removal of special conditions (see below) related to the impairment that are essential to the further performance of work and:
a. There must have been frequent absences due to the impairment; or
b. The work must have been unsatisfactory due to the impairment; or
c. The work must have been done during a period of temporary remission of the impairment; or
d. The work must have been done under special conditions.
(To illustrate how UWA time periods are figured, work from November 5, 1982, through a date no later than February 4, 1983, is for "3 months or less." Work from November 5, 1982, through at least February 5, 1983, but through a date no later than May 4, 1983, is for "between 3 and 6 months.")
3. *Work Effort of Over 6 Months*
SGA-level work lasting more than 6 months cannot be a UWA regardless of why it ended or was reduced to the non-SGA level.
4. *Performance of Work Under Special Conditions*
One situation under which SGA-level work may have ended, or may have been reduced to the non-SGA level, as set out above, is "the removal of special conditions related to the impairment that are essential to the further performance of work." That is, a severely impaired person may have worked under conditions especially arranged to accommodate his or her impairment or may have worked through an unusual job opportunity, such as in a sheltered workshop. Special or unusual conditions may be evidenced in many ways. For example, the person:

a. Required and received special assistance from other employees in performing the job; or
b. Was allowed to work irregular hours or take frequent rest periods; or
c. Was provided with special equipment or was assigned work especially suited to the impairment; or
d. Was able to work only within a framework of especially arranged circumstances, such as where other persons helped him or her prepare for or get to and from work; or
e. Was permitted to perform at a lower standard of productivity or efficiency than other employees; or
f. Was granted the opportunity to work, despite his or her handicap, because of family relationship, past association with the firm, or other altruistic reason.

5. *Development of Reasons for Work Discontinuance or Reduction*

In considering why a work effort ended or was reduced to the non-SGA level, we do not rely solely on information from the worker. Therefore, if impartial supporting evidence is not already a part of the claims file, confirmation with the employer is required. If the information from the employer is inconclusive or if none is available, the reason for work discontinuance or reduction may be confirmed with the person's physician or other medical source. After being apprised of the circumstances, the physician or other medical source could state whether, in his or her opinion or according to the records, the work discontinuance or reduction was due to the impairment.

Answers to questions such as the following will help to verify the nature and duration of work and the reason it ended or was reduced:

a. When and why was the SGA-level work interrupted, reduced or stopped?
b. If special working conditions (as described in the preceding section) were removed, what were those conditions or concessions? When, how and why were they changed?
c. Were there frequent absences from work? Were days and hours of work irregular and, if so, why?
d. Was job performance unsatisfactory because of the impairment?
e. Did the employer reduce the person's duties, responsibilities or earnings because of the impairment?
f. When the employee's work effort ended, was the continuity of employment broken? Did the employer grant sick leave or hold the position open for the person's return?
g. In the case of a self-employed person, what has happened to the business since the discontinuance or reduction of work? If the business continued in operation, who managed and worked in it and what income will the disabled person derive from it?

EFFECTIVE DATE: The policy explained herein is effective as of the date of publication of this PPS.

CROSS-REFERENCES: Program Operations Manual System, Part 4, sections DI 00503.500-00503.515; SSR 82-67, PPS-77, Extension of Eligibility for Benefits Based

on Disability; SSR 83-33, PPS-107, Determining Whether Work is Substantial Gainful Activity -- Employees; SSR 83-34, PPS-108, Determining Whether Work is Substantial Gainful Activity -- Self-Employed Persons.

(PPS-119)

SSR 85-15

SSR 85-15: TITLES II AND XVI: CAPABILITY TO DO OTHER WORK — THE MEDICAL-VOCATIONAL RULES AS A FRAMEWORK FOR EVALUATING SOLELY NONEXERTIONAL IMPAIRMENTS

This supersedes Program Policy Statement No. 116 (SSR 85-7) with the same title (which superseded Program Policy Statement No. 104 (SSR 83-13) and is in accord with an order of the U.S. District Court for the District of Minnesota.

PURPOSE: The original purpose of SSR 83-13 was to clarify how the regulations and the exertionally based numbered decisional rules in Appendix 2, Subpart P, Regulations No. 4, provide a framework for decisions concerning persons who have only a nonexertional limitation(s) of function or an environmental restriction(s). The purpose of this revision to SSR 83-13 and SSR 85-7 is to emphasize, in the sections relating to mental impairments: (1) that the potential job base for mentally ill claimants without adverse vocational factors is not necessarily large even for individuals who have no other impairments, unless their remaining mental capacities are sufficient to meet the intellectual and emotional demands of at least unskilled, competitive, remunerative work on a sustained basis; and (2) that a finding of disability can be appropriate for an individual who has a severe mental impairment which does not meet or equal the Listing of Impairments, even where he or she does not have adversities in age, education, or work experience.

CITATIONS (AUTHORITY): Sections 223(d)(2)(A) and 1614(a)(3)(E) of the Social Security Act; Regulations No. 4, Subpart P, sections 404.1505(a), 404.1520(f)(1), 404.1521(b), 404.1545. and 404.1560 through 404.1569; Appendix 2 of Subpart P, sections 200.00(c), 200.00(e)(1), and 204.00; and Regulations No. 16, Subpart 1, sections 416.905(a), 416.920(f)(1), 416,921(b), 416.945, and 416.960 through 416.969.

PERTINENT HISTORY: If a person has a severe medically determinable impairment which, though not meeting or equaling the criteria in the Listing of Impairments, prevents the person from doing past relevant work, it must be determined whether the person can

do other work. This involves consideration of the person's RFC and the vocational factors of age, education, and work experience.

The Medical-Vocational Guidelines (Regulations No. 4, Subpart P, Appendix 2) discuss the relative adjudicative weights which are assigned to a person's age, education, and work experience. Three tables in Appendix 2 illustrate the interaction of these vocational factors with his or her RFC. RFC is expressed in terms of sedentary, light, and medium work exertion. The tables rules reflect the potential occupational base of unskilled jobs for individuals who have severe impairments which limit their exertional capacities: approximately 2,500 medium, light, and sedentary occupations; 1,600 light and sedentary occupations; and 200 sedentary occupations — each occupation representing numerous jobs in the national economy. (See the text and glossary in SSR 83-10, PPS-101, Determining Capability to Do Other Work — the Medical-Vocational Rules of Appendix 2.) Where individuals also have nonexertional limitations of function or environmental restrictions, the table rules provide a framework for consideration of how much the individual's work capability is further diminished in terms of any types of jobs within these exertional ranges with would be contraindicated by the additional limitations or restrictions. However, where a person has solely a nonexertional impairment(s), the tables rules do not direct conclusions of disabled or not disabled. Conclusions must, instead, be based on the principles in the appropriate sections of the regulations, giving consideration to the rules for specific case situations in Appendix 2.

This PPS clarifies policies applicable in cases involving the evaluation of solely nonexertional impairments.

POLICY STATEMENT: Given that no medically determinable impairment limits exertion, the RFC reflecting the severity of the particular nonexertional impairment(s) with its limiting effects on the broad world of work is the first issue. The individual's relative advantages or adversities in terms of age, education, and work experience is the second. Section 204.00 of Appendix 2 provides an example of one type of nonexertional impairment — environmental restrictions — and states that environmental restrictions ordinarily would not significantly affect the range of work existing in the national economy for individuals with the physical capability for heavy work (or very heavy work); i.e., with no medically determinable impairment which limits exertion. However, numerous environmental restrictions might lead to a different conclusion, as might one or more severe losses of nonexertional functional capacities. The medical and vocational factors of the individual case determine whether exclusion of particular occupation or kinds of work so reduces the person's vocational opportunity that a work adjustment could not be made.

Nonexertional Impairments Contrasted with Exertional Impairments

The term "exertional" has the same meaning in the regulations as it has in the U.S. Department of Labor's classifications of occupations by strength levels. (See SSR 83-10, PPS-101, Determining Capability to Do Other Work — The Medical-Vocational Rules of Appendix 2.) Any job requirement which is not exertional is considered to be

nonexertional. A nonexertional impairment is one which is medically determinable and causes a nonexertional limitation of function or an environmental restriction. Nonexertional impairments may or may not affect a person's capacity to carry out the primary strength requirements of jobs, and they may or may not significantly narrow the range of work a person can do.

Nonexertional limitations can affect the abilities to reach; to seize, hold, grasp, or turn an object (handle); to bend the legs alone (kneel); to bend the spine alone (stoop) or bend both the spine and legs (crouch). Fine movements of small objects, such as done in much sedentary work and in certain types of more demanding work (e.g., surgery), require use of the fingers to pick, pinch, etc. Impairments of vision, speech, and hearing are nonexertional. Mental impairments are generally considered to be nonexertional, but depressions and conversion disorders may limit exertion. Although some impairments may cause both exertional limitations and environmental restriction (e.g., a respiratory impairment may limit a person to light work exertion as well as contraindicate exposure to excessive dust or fumes), other impairments may result in only environmental restrictions (e.g., skin allergies may only contraindicate contact with certain liquids). What is a nonexertional and extremely rare factor in one range of work (e.g., crawling in sedentary work) may become an important element in arduous work like coal mining.

Where a person's exertional capacity is compromised by a nonexertional impairment(s), see SSR 83-14, PPS-105, Capability to Do Other Work — The Medical-Vocational Rules as a Framework for Evaluating a Combination of Exertional and Nonexertional Impairments.

Jobs which can possibly be performed by persons with solely nonexertional impairments are not limited to the approximately 2,500 unskilled sedentary, light and medium occupations which pertain to the table rules in Appendix 2. The occupational base cuts across exertional categories through heavy (and very heavy) work and will include occupations above the unskilled level if a person has skills transferable to skilled and semiskilled occupations within his or her RFC. (Note the examples in item 4.b of SSR 82-41, PPS-67, Work Skills and Their Transferability as Intended by the Expanded Vocational Factors Regulations effective February 26, 1979, where medical factors prevent not only the performance of past work but also the transferability of skills.)

Given no medically determinable impairment which limits exertion, the first issue is how much the person's occupational base — the entire exertional span from sedentary work through heavy (or very heavy) work — is reduced by the effects of the nonexertional impairment(s). This may range from very little to very much, depending on the nature and extent of the impairment(s). In many cases, a decisionmaker will need to consult a vocational resource.

The publications listed in sections 404.1566 and 416.966 of the regulations will be sufficient vocational resources for relatively simple issues. In more complex cases, a person or persons with specialized knowledge would be helpful. State agencies may use personnel termed vocational consultants or specialist, or they may purchase the services

of vocational evaluation workshops. Vocational experts may testify for this purpose at the hearing and appeals levels. In this PPS, the term vocational specialist (VS) describes all vocational resource personnel.

The second issue is whether the person can be expected to make a vocational adjustment considering the interaction of his or her remaining occupational base with his or her age, education, and work experience. A decisionmaker must consider sections 404.1562-404.1568 and 416.962-416.968 of the regulations, section 204.00 of Appendix 2, and the table rules for specific case situations in Appendix 2. If, despite the nonexertional impairment(s), an individual has a large potential occupational base, he or she would ordinarily not be found disabled in the absence of extreme adversities in age, education, and work experience. (This principle is illustrated in rule 203.01, 203.02, and 203.10 and is set out in SSR 82-63, PPS-79, Medical-Vocational Profiles Showing an Inability to Make an Adjustment to Other Work.) The assistance of a vocational resource may be helpful. Whenever vocational resources are used and in the decision is adverse to the claimant, the determination or decision will include: (1) citations of examples of occupation/jobs the person can do functionally and vocationally, and (2) a statement of the incidence of such work in the region in which the individual resides or in several regions of the country.

Examples of Nonexertional Impairments
and Their Effects on the Occupational Base

1. *Mental Impairments*

There has been some misunderstanding in the evaluation of mental impairments. Unless the claimant or beneficiary is a widow, widower, surviving divorced spouse or a disabled child under the Supplemental Security Income program, the sequential evaluation process mandated by the regulations does not end with the finding that the impairment, though severe, does not meet or equal an impairment listed in Appendix 1 of the regulations. The process must go on to consider whether the individual can meet the mental demands of past relevant work in spite of the limiting effects of his or her impairment and, if not, whether the person can do other work, consideration his or her remaining mental capacities reflected in terms of the occupational base, age, education, and work experience. The decisionmaker must not assume that failure to meet or equal a listed mental impairment equates with capacity to do at least unskilled work. The decision requires careful consideration of the assessment of RFC.

In the world of work, losses of intellectual and emotional capacities are generally more serious when the job is complex. Mental impairments may or may not prevent the performance of a person's past jobs. They may or may not prevent an individual from transferring work skills. (See SSR 82-41, PPS-67, Work Skills and Their Transferability as Intended by the Expanded Vocational Factors Regulations effective February 26, 1979.)

Where a person's only impairment is mental, is not of listing severity, but does prevent the person from meeting the mental demands of past relevant work and prevents the transferability of acquired work skills, the final consideration is whether the person can be expected to perform unskilled work. The basic mental demands of competitive, remunerative, unskilled work include the abilities (on a sustained basis) to understand, carry out, and remember simple instructions; to respond appropriately to supervision, coworkers, and usual work situations; and to deal with changes in a routine work setting. A substantial loss of ability to meet any of these basic work-related activities would severely limit the potential occupational base. This, in turn, would justify a finding of disability because even favorable age, education, or work experience will not offset such a severely limited occupational base.

> Example 1: A person whose vocational factors of age, education, and work experience would ordinarily be considered favorable (i.e., very young age, university education, and highly skilled work experience) would have severely limited occupational base if he or she has a mental impairment which causes a substantial loss of ability to respond appropriately to supervision, coworkers, and usual work situations. A finding of disability would be appropriate.

Where there is no exertional impairment, unskilled jobs at all levels of exertion constitute the potential occupational base for persons who can meet the mental demands of unskilled work. These jobs ordinarily involve dealing primarily with objects, rather than with data or people, and they generally provide substantial vocational opportunity for person with solely mental impairments who retain the capacity to meet the intellectual and emotional demands of such jobs on a sustained basis. However, persons with this large job base may be found disabled because of adversities in age, education, and work experience. (This is illustrated in examples 2 and 3 immediately following.)

> Example 2: Someone who is of advanced age, has a limited education, has no relevant work experience, and has more than a non severe mental impairment will generally be found disabled. (See SSR 82-63, PPS-79, Medical-Vocational Profiles Showing an Inability to Make an Adjustment to Other Work.)
> Example 3: Someone who is closely approaching retirement age, has a limited education or less, worked for 30 years in a cafeteria doing an unskilled job as a "server," almost constantly dealing with the public, and now cannot, because of a severe mental impairment, frequently deal with the public. In light of the narrowed vocational opportunity in conjunction with the person's age, education, lack of skills, and long commitment to the particular type of work, a finding of disabled would be appropriate; but the decision would not necessarily be the same for a younger, better-educated, or skilled person. (Compare sections 404.1562 and 416.962 of the regulations and rule 203.01 of Appendix 2.)

Where a person has only a mental impairment but does not have extreme adversities in age, education, and work experience, and does not lack the capacity to do basic work-related activities, the potential occupational base would be reduced by his or her inability

to perform certain complexities or particular kinds of work. These limitations would affect the occupational base in various ways.

> Example 4: Someone who is of advance age, has a high school education, and did skilled work as manager of a housing project can no longer, because of a severe mental impairment, develop and implement plans and procedures, prepare budget requests, schedule repairs or otherwise deal with complexities of this level and nature. Assuming that, in this case, all types of related skilled jobs are precluded but the individual can do work which is not detailed and does not require lengthy planning, the remaining related semiskilled jobs to which skills can be transferred and varied unskilled jobs, at all levels of exertion, constitute a significant vocational opportunity. A conclusion of "not disabled" would be appropriate. (Compare rules 201.07, 202.07, and 203.13 of Appendix 2.)
> Example 5: Someone who is of advanced age, has a limited education, and did semiskilled work as a first-aid attendant no longer has the mental capacity to work with people who are in emergency situations and require immediate attention to cuts, burns, suffocation, etc. Although there may be very few related semiskilled occupations to which this person could transfer work skills, the large occupational base of unskilled work at all levels of exertion generally would justify a finding of not under a disability. (This is consistent with rules 203.11-203.17 of Appendix 2.)

Stress and Mental Illness — Since mental illness is defined and characterized by maladaptive behavior, it is not unusual that the mentally impaired have difficulty accommodating to the demands of work and work-like settings. Determining whether these individuals will be able to adapt to the demands or "stress" of the workplace is often extremely difficult. This section is not intended to set out any presumptive limitations for disorders, but to emphasize the importance of thoroughness in evaluation on an individualized basis.

Individuals with mental disorders often adopt a highly restricted and/or inflexible lifestyle within which they appear to function will. Good mental health services and care may enable chronic patients to function adequately in the community by lowering psychological pressures, by medication, and by support from services such as outpatient facilities, day care programs, social work programs and similar assistance.

The reaction to the demands of work (stress) is highly individualized, and mental illness is characterized by adverse responses to seemingly trivial circumstances. The mentally impaired may cease to function effectively when facing such demands as getting to work regularly, having their performance supervised, and remaining in the workplace for a full day. A person may become panicked and develop palpitations, shortness of breath, or feel faint while riding in an elevator; another may experience terror and begin to hallucinate when approached by a stranger asking a question. Thus, the mentally impaired may have difficulty meeting the requirement of even so-called "low stress" jobs.

Because response to the demands of work is highly individualized, the skill level of a position is not necessarily related to the difficulty an individual will have in meeting the demands of the job. A claimant's condition may make performance of an unskilled job as difficult as an objectively more demanding job, for example, a busboy need only clear dishes from tables. But an individual with a severe mental disorder may find unmanageable the demand of making sure that he removes all the dishes, does not drop them, and gets the table cleared promptly for the waiter or waitress. Similarly, an individual who cannot tolerate being supervised may be not able to work even in the absence of close supervision; the *knowledge* that one's work is being judged and evaluated, even when the supervision is remote or indirect, can be intolerated for some mentally impaired persons. Any impairment-related limitations created by an individual's response to demands of work, however, must be reflected in the RFC assessment.

2. *Postural-Manipulative Impairments*

a. Limitations in *climbing and balancing* can have varying effects on the occupational base, depending on the degree of limitation and the type of job. Usual everyday activities, both at home and at work, include ascending or descending ramps or a few stairs and maintaining body equilibrium while doing so. These activities are required more in some jobs that in others, and they may be critical in some occupations. Where a person has some limitation in climbing and balancing and it is the only limitation, it would not ordinarily have a significant impact on the broad world of work. Certain occupations, however, may be ruled out; e.g., the light occupation of construction painter, which requires climbing ladders and scaffolding, and the very heavy occupation of fire-fighter, which sometimes requires the individual to climb poles and ropes. Where the effects of a person's actual limitations of climbing and balancing on the occupational base are difficult to determine, the services of a VS may be necessary.

b. *Stooping, kneeling, crouching, and crawling* are progressively more strenuous forms of bending parts of the body, with crawling as a form of locomotion involving bending. Some stooping (bending the body downward and forward by bending the spine at the waist) is required to do almost any kind of work,, particularly when objects below the waist are involved. If a person can stoop occasionally (from very little up to one-third of the time) in order to lift objects, the sedentary and light occupational base is virtually intact. However, because of the lifting require for most medium, heavy, and very heavy jobs, a person must be able to stoop frequently (from one-third to two-thirds of the time); inability to do so would substantially affect the more strenuous portion of the occupational base. This is also true for crouching (bending the body downward and forward by bending both the legs and spine). However, crawling on hands and knees and feet is a relatively rare activity even in arduous work, and limitations on the ability to crawl would be of little significance in the broad world or work. This is also true of kneeling (bending the legs at the knees to come to rest on one or both knees).

c. *Reaching, handling, fingering, and feeling* require progressively finer usage of the upper extremities to perform work-related activities. Reaching (extending the hands and arms in any direction) and handling (seizing, holding, grasping, turning

or otherwise working primarily with the whole hand or hands) are activities required in almost all jobs. Significant limitations of reaching or handling, therefore, may eliminate a large number of occupations a person could otherwise do. Varying degrees of limitations would have different effects, and the assistance of a VS may be needed to determine the effects of the limitations. "Fingering" involves picking, pinching, or otherwise working primarily with the fingers. It is needed to perform most unskilled sedentary jobs and to perform certain skilled and semiskilled jobs at all levels of exertion. As a general rule, limitations of fine manual dexterity have greater adjudicative significance — in terms of relative number of jobs in which the function is required — as the person's exertional RFC decreases. Thus, loss of fine manual dexterity narrows the sedentary and light ranges of work much more than it does the medium, heavy, and very heavy ranges of work. The varying degrees of loss which can occur may require a decisionmaker to have the assistance of a VS. However, a VS would not ordinarily be required where a person has a loss of ability to feel the size, shape temperature, or texture of an object by the fingertips, since this is a function required in very few jobs.

3. *Hearing Impairments*

Communication is an important factor in work. The inability to hear, because it vitally affects communication, is thus of great importance. However, hearing impairments do not necessarily prevent communication, and differences in types of work may be compatible with various degrees of hearing loss. Occupations involving loud noise, such as in printing, have traditionally attracted persons with hearing impairments, whereas individuals with normal hearing have to wear ear protectors to be able to tolerate the working conditions. On the other hand, occupations such as bus driver require good hearing. There are so many possible medical variables of hearing loss that consultation of vocational reference materials or the assistance of a VS is often necessary to decide the effect on the broad world of work.

4. *Visual Impairment*

As a general rule, even if a person's visual impairment(s) were to eliminate all jobs that involve very good vision (such as working with small objects or reading small print), as long as he or she retains sufficient visual acuity to be able to handle and work with rather large objects (and has the visual fields to avoid ordinary hazards in a workplace), there would be a substantial number of jobs remaining across all exertional levels. However, a finding of disability could be appropriate in the relatively few instances in which the claimant's vocational profile is extremely adverse, e.g., closely approaching retirement age, limited education or less, unskilled or no transferable skills, and essentially a lifetime commitment to a field of work in which good vision is essential.

5. *Environmental Restriction*

A person may have the physical and mental capacity to perform certain functions in certain places, but to do so may aggravate his or her impairment(s) or subject the individual or others to the risk of bodily injury. Surroundings which an individual may need to avoid because of impairment include those involving extremes of temperature, noise, and vibration; recognized hazards such as unprotected elevations and dangerous moving machinery; and fumes, dust, and poor ventilation. A person with a seizure disorder who is restricted only from being on unprotected elevations and near dangerous moving machinery is an example of someone who environmental restriction does not have a significant effect on work that exist at all exertional levels.

Where a person has a medical restriction to avoid excessive amounts of noise, dust, etc., the impact on the broad world of work would be minimal because most job environments do not involve great noise, amounts of dust, etc.

Where an individual can tolerate very little noise, dust, etc., the impact on the ability to work would be considerable because very few job environments are entirely free of irritants, pollutants, and other potentially damaging conditions.

Where the environmental restriction falls between very little and excessive, resolution of the issue will generally require consultation of occupational reference materials or the services of a VS.

EFFECTIVE DATE: Final regulations providing the Medical-Vocational Guidelines were published in the *Federal Register* on November 28, 1978, at FR 55349, effective February 26, 1979. They were rewritten to make them easier to understand and were published on August 20, 1980, at 45 FR 55566. The policies in this PPS also became effective as of February 26, 1979.

CROSS-REFERENCES: Program Operations Manual System, Part 4 (Disability Insurance State Manual Procedures) sections DI 00401.691 and 00401.694; SSR 83-10, PPS-101, Determining Capability to Do Other Work — The Medical-Vocational Rules of Appendix 2 (with a glossary); SSR 83-11, PPS-102, Capability to Do Other Work — The Exertionally Based Medical-Vocational Rules Met; SSR 83-12, PPS-103, Capability to Do Other Work — The Medical-Vocational Rules as a Framework for Evaluating Exertional Limitations Within a Range of Work or Between Ranges of Work or Between Ranges of Work; and SSR 83-14, PPS-105, Capability to Do Other Work — The Medical-Vocational Rules as a Framework for Evaluating a Combination of Exertional and Nonexertional Impairments.

(PPS-120)

SSR 85-16

SSR 85-16: TITLES II AND XVI: RESIDUAL FUNCTIONAL CAPACITY FOR MENTAL IMPAIRMENTS

This supersedes Program Policy Statement (PPS) No. 117 (Social Security Ruling (SSR) 85-8), Titles II and XVI: Residual Functional Capacity (RFC) for Mental Impairments (which superseded PPS No. 97 (SSR 83-16) with the same title).

PURPOSE: To state the policy and describe the issues to be considered when an individual with a mental impairment requires an assessment of the residual functional capacity (RFC) in order to determine the individual's capacity to engage in basic work-related activities.

CITATIONS (AUTHORITY): Sections 223(d), 216(i) and 1614(a) of the Social Security Act, as amended; Regulations No. 4, Subpart P, sections 404.1545, 404.1546, and Appendix 1, Part A, section 12.00, and Regulations No. 16, Subpart I, sections 416.945, 416.946.

INTRODUCTION: An individual whose impairment(s) meets, or is medically equivalent to, the requirements of an impairment(s) contained in the Listing of Impairments is considered unable to function adequately in work-related activities. On the other hand, an individual whose impairment is found to be not severe is considered not to be significantly restricted in the ability to engage in basic work-related activities. An individual whose impairment(s) falls between these two levels has a significant restriction in the ability to engage in some basic work-related activities. It is, therefore, necessary to determine the RFC for these individuals. This policy statement provides guides for the determination of RFC for individuals whose mental impairment(s) does not meet or equal the listing, but is more than not severe.

POLICY STATEMENT:

Importance of RFC Assessments in Mental Disorders

Medically determinable mental disorders present a variable continuum of symptoms and effects, from minor emotional problems to bizarre and dangerous behavior. However, in determining the impact of a mental disorder on an individual's capacities, essentially the same impairment-related medical and nonmedical information is considered to determine

whether the mental disorder meets listing severity as is considered to determine whether the mental impairment is of lesser severity, yet diminishes the individual's RFC. For impairments of listing severity, inability to perform substantial gainful activity (SGA) is presumed from prescribed findings. However, with mental impairments of lesser severity, such inability must be demonstrated through a detailed assessment of the individual's capacity to perform and sustain mental activities which are critical to work performance. Conclusions of ability to engage in SGA are not to be inferred merely from the fact that the mental disorder is not of listing severity.

Regulations No. 4, section 404.1545(c)/416.945(c), presents the broad issues to be considered in the evaluation of RFC in mental disorders. It states that this evaluation includes consideration of the ability to understand, to carry out and remember instructions and to respond appropriately to supervision, coworkers, and customary work pressures in a work setting. Consideration of these factors, which are contained in section 12.00 of the Listing of Impairments in Appendix 1, is required for the proper evaluation of the severity of mental impairments.

The determination of mental RFC involves the consideration of evidence, such as:

- History, findings, and observations from medical sources (including psychological test results), regarding the presence, frequency, and intensity of hallucinations, delusions or paranoid tendencies; depression or elation; confusion or disorientation; conversion symptoms or phobias; psychophysiological symptoms, withdrawn or bizarre behavior; anxiety or tension.
- Reports of the individual's activities of daily living and work activity, as well as testimony of third parties about the individual's performance and behavior.
- Reports from workshops, group homes, or similar assistive entities.

In analyzing the evidence, it is necessary to draw meaningful inferences and allow reasonable conclusions about the individual's strengths and weaknesses. Consideration should be given to factors such as:

- Quality of daily activities, both in occupational and social spheres (see Listing 12.00, Introduction), as well as of the individual's actions with respect to a medical examination.
- Ability to sustain activities, interests, and relate to others *over a period of time*. The frequency, appropriateness, and independence of the activities must also be considered (see PPS No. 96, SSR 83-15, Titles II and XVI: Evaluation of Chronic Mental Impairments).
- Level of intellectual functioning.
- Ability to function in a work-like situation.

When a case involves an individual (except disabled widow(ers) and title XVI children under 18) who has a severe impairment(s), which does not meet or equal the criteria in

the Listing of Impairments, the individual's RFC must be considered in conjunction with the individual's age, education, and work experience. While some individuals will have a significant restriction of the ability to perform some work-related activities, not all such activities will be precluded by the mental impairment. However, all limits on work-related activities resulting from the mental impairment must be described in the mental RFC assessment.

It is the responsibility of the program physician or psychologist, the disability hearing officer (DHO), the administrative law judge (ALJ), or the Appeals Council (AC) member to identify the pertinent evidence from medical and nonmedical reports and to make findings as to the individual's ability to perform work-related activities (RFC). The determination of impairment severity and the resulting RFC constitute the medical evaluation of the mental disorder. The determination of "disability," however, depends upon the extent to which the individual has the vocational qualifications to perform work, in light of the restrictions described in the RFC assessment.

Evaluation of Medical and Other Evidence

Medical evidence is critical to determinations of disability. It provides medical history, test results, examination findings, and observations, as well as conclusions of medical sources trained and knowledgeable in the diagnosis and treatment of diseases and disorders.

Reports from psychiatrists and other physicians, psychologists, and other professionals working in the field of mental health should contain the individual's medical history, mental status evaluation, psychological testing, diagnosis, treatment prescribed and response, prognosis, a description of the individual's daily activities, and a medical assessment describing ability to do work-related activities. These reports may also contain other observations and opinions or conclusions on such matters as the individual's ability to cope with stress, the ability to relate to other people, and the ability to function in a group or work situation.

Medical documentation can often give clues as to functional limitation. For example, evidence that an individual is markedly withdrawn or seclusive suggests a greatly reduced capacity for close contact and interaction with other people. The conclusion of reduced RFC in this area can then be applied to all steps of vocational assessment. For example, when the vocational assessment establishes that the claimant's past work has been limited to work requiring close contact and interaction with other people, the preceding assessment would indicate that the claimant would be unable to fulfill the requirements of his or her past work. Therefore, the determination of disability in this instance would depend on the individual's vocational capacity for other work.

Similarly, individuals with paranoid tendencies may be expected to experience moderate to moderately severe difficulties in relating to coworkers or supervisors, or in tolerating normal work pressures. The ability to respond appropriately to supervision and to

coworkers under customary work pressure is a function of a number of different factors, some of which may be unique to a specific work situation.

The evaluation of intellectual functioning by a program physician, psychologist, ALJ, or AC member provides information necessary to determine the individual's ability to understand, to remember instructions, and to carry out instructions. Thus, an individual, in whom the only finding in intellectual testing is an IQ between 60 and 69, is ordinarily expected to be able to understand simple oral instructions and to be able to carry out these instructions under somewhat closer supervision than required of an individual with a higher IQ. Similarly, an individual who has an IQ between 70 and 79 should ordinarily be able to carry out these instructions under somewhat less close supervision.

Since treating medical sources often have considerable information about the development and progress of an individual's impairment, as well as information about the individual's response to treatment, evidence from treating sources should be given appropriate consideration. On occasion, the report of a current treating source may disclose other sources of medical evidence not previously report. If so, these sources should be contacted, since it is essential that the medical documentation reflect all available sources, particularly in instances of questionable severity of impairment or inconclusive RFC. When medical source notes appear to be incomplete, recontact with the source should be made to attempt to obtain more detailed information. Every reasonable effort should be made to obtain all medical evidence from the treating source necessary to make a determination of impairment severity and RFC before obtaining evidence from any other source on a consultative basis. However, when treating medical sources cannot provide essential information, consultative examination by a treating or nontreating source may resolve the impairment or RFC issue. Similarly, when the reports from these sources appear to be incomplete, the source should be recontacted to clarify the issues.

Other evidence also may play a vital role in the determination of the effects of impairment. To arrive at an overall assessment of the effects of mental impairment, relevant, reliable information, obtained from third party sources such as social workers, previous employers, family members, and staff members of halfway houses, mental health centers, and community centers, may be valuable in assessing an individual's level of activities of daily living. Information concerning an individual's performance in any work setting (including sheltered work and volunteer or competitive work), as well as the circumstances surrounding the termination of the work effort, may be pertinent in assessing the individual's ability to function in a competitive work environment.

Reports of workshop evaluation may also be of value in assessing the individual's ability to understand, to carry out and remember instructions, and to respond appropriately to supervisors, coworkers, and customary work pressures in a work setting. Consequently, wherever the record shows that a workshop evaluation has been performed, the report should be requested from the source. If no workshop evaluation has been done, but, after complete and comprehensive documentation, genuine doubt remains as to the individual's functional capacity, consideration should be given to obtaining one. Information derived

from workshop evaluations must be used in conjunction with the clinical evidence of impairment, but all conflicts between workshop evaluation and evidence and the conclusions based on objective medical findings must be resolved.

Descriptions and observations of the individual's restrictions by medical and other sources (including Social Security Administration representatives, such as district office representatives and ALJ's), in addition to those made during formal medical examinations, must also be considered in the determination of RFC. However, care must be taken not to give duplicate weight to certain findings. For example, a competent psychometric assessment of intellectual functioning provides a sample, referenced to established norms, of the individual capabilities in various areas, including those germane to a workshop situation. such a psychometric assessment, therefore, usually provides the same impairment-related information about functional capacity that might also be disclosed in the course of a workshop evaluation. Since the effects of the same underlying impairment(s) may be revealed in both assessment approaches, it would be incorrect to consider this duplicate representation of the same impairment to reflect separate and independent impairments. Such an approach would give the same impairment(s) double weight.

Observations and findings from a workshop evaluation may supplement the psychometric assessment or may raise some question concerning the accuracy of the psychometric assessment. Whenever a significant discrepancy in conclusions between the two arises, an explanation must be given by the program physician, psychologist, ALJ, or AC member for rejecting or modifying the conclusions of the psychometric assessment or the workshop evaluation.

EFFECTIVE DATE: On publication.

CROSS-REFERENCES: Program Operations Manual System, section DI 00401.592.

SSR 96-1p

EFFECTIVE/PUBLICATION DATE: 07/02/96

SSR 96-1p: POLICY INTERPRETATION RULING APPLICATION BY THE SOCIAL SECURITY ADMINISTRATION (SSA) OF FEDERAL CIRCUIT COURT AND DISTRICT COURT DECISIONS

PURPOSE: To clarify longstanding policy that, unless and until a Social Security Acquiescence Ruling (AR) is issued determining that a final circuit court holding conflicts with the Agency's interpretation of the Social Security Act or regulations and explaining how SSA will apply such a holding, SSA decisionmakers continue to be bound by SSA's nationwide policy, rather than the court's holding, in adjudicating other claims within that circuit court's jurisdiction. This Ruling does not in any way modify SSA's acquiescence policy to which the Agency continues to remain firmly committed, but instead serves to emphasize consistent adjudication in the programs SSA administers. This Ruling is also issued to clarify longstanding Agency policy that, despite a district court decision which may conflict with SSA's interpretation of the Social Security Act or regulations, SSA adjudicators will continue to apply SSA's nationwide policy when adjudicating other claims within that district court's jurisdiction unless the court directs otherwise.

CITATIONS (AUTHORITY): Sections 205(a), 702(a)(5) and 1631(d) of the Social Security Act; Sections 413(b), 426(a) and 508 of the Black Lung Benefits Act; Regulations No. 4, section 404.985; Regulations No. 10, section 410.670c; Regulations No. 16, section 416.1485; Regulations No. 22, section 422.406.

BACKGROUND: Final regulations on the application of circuit court law in the Social Security, Supplemental Security Income, and Black Lung programs were published in the Federal Register on January 11, 1990 (55 FR 1012). SSA first adopted the acquiescence policy set forth in these rules in 1985, with the details evolving over the next 5 years. These rules explain how SSA acquiesces in circuit court law which conflicts with Agency policy; it does so by issuing an AR for a final circuit court decision which SSA determines is in conflict with the Agency's interpretation of the Social Security Act or regulations. 20 CFR 404.985(b), 410.670c(b) and 416.1485(b). The AR, which is issued through publication in the Federal Register, describes the administrative case and the

court decision, identifies the issue(s), explains how the court decision differs from SSA policy, and explains how SSA will apply the court holding, instead of its nationwide policy, when deciding claims within the applicable circuit. ARs apply at all steps in the administrative process within the applicable circuit unless the court decision, by its nature, applies only at certain steps in this process. In the latter case, the AR may be so limited.

As of the effective date of this Ruling, SSA had issued a total of 62 ARs, averaging about 3-4 ARs per year in recent years; 42 of those ARs are still in effect. The majority of the ARs issued by SSA to date have dealt with nondisability issues, although a significant portion have dealt directly with the disability determination process. Decisions for which ARs are issued often involve complex and difficult issues. The court's holding may be unclear in its scope and susceptible to differing interpretations. Despite these difficulties, no AR has been found to be inadequate by the circuit court which issued the underlying decision.

POLICY INTERPRETATION: Unless and until an AR for a circuit court holding has been issued, SSA adjudicates other claims within that circuit by applying its nationwide policy. The preamble to the final acquiescence regulations published on January 11, 1990, explained the basis for this approach in responding to a public comment suggesting that administrative law judges (ALJs) and the Appeals Council should be allowed to apply circuit court holdings without the benefit of an Acquiescence Ruling:

> [W]e have not adopted this comment. First, under this final acquiescence policy, Acquiescence Rulings apply to all levels of adjudication, not only to the ALJ and Appeals Council levels, unless a holding by its nature applies only to certain levels of adjudication. Thus, the approach suggested in this comment would create different standards of adjudication at the different levels of administrative review. Second, interpreting and applying a circuit court holding is not always a simple matter, as we noted previously.[1] Finally, by statute, establishing policy is the Secretary's[2] responsibility; adjudicators are responsible for applying that policy to the facts in any given case. Therefore, we believe that to ensure the uniform and consistent adjudication necessary in the administration of a national program, the agency must analyze court decisions and provide adjudicators as specific a statement as possible explaining the agency's interpretation of a court of appeals holding, as well as providing direction on how to apply the holding in the course of adjudication.

55 FR 1013 (1990).

As explained in SSA's regulations at 20 CFR 404.985(b), 410.670c(b), and 416.1485(b), if SSA makes an administrative determination or decision on a claim between the date of a circuit court decision and the date of issuance of an AR for that decision, the claimant, upon request, is permitted to have the claim readjudicated by demonstrating that application of the AR could change the result. Thus, as explained in the preamble to the acquiescence regulations, a readjudication procedure is provided which allows a

claimant, whose application was adjudicated during the interim period between a circuit court decision and the issuance of an AR for that decision, to seek immediate application of the AR once it is issued, without the necessity of appeal. 55 FR 1013 (1990).

Finally, in accordance with its regulations, SSA acquiesces only in decisions of the Federal circuit courts, and not in decisions of Federal district courts within a circuit. Thus, despite a district court decision which may conflict with SSA's interpretation of the Social Security Act or regulations, SSA adjudicators will continue to apply SSA's nationwide policy when adjudicating other claims within that district court's jurisdiction unless the court directs otherwise such as may occur in a class action.

EFFECTIVE DATE: This Ruling, which reflects longstanding procedures which SSA continues to believe represent the most effective and fair way to implement its acquiescence policy, is effective upon publication in the Federal Register. This Ruling does not apply to the claims of New York disability claimants who are covered by the court-approved settlement in Stieberger v. Sullivan.

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[1] The preamble previously noted that, "Whether or not the holding of a particular circuit court decision `conflicts' with our policy is not always clear . . ." 55 FR 1012 (1990).

[2] As a result of Pub. L. 103-296, the Social Security Independence and Program Improvements Act of 1994, which made SSA an independent agency separate from the Department of Health and Human Services effective March 31, 1995, the responsibility for establishing policy now resides with the Commissioner of Social Security, rather than the Secretary of Health and Human Services.

EFFECTIVE/PUBLICATION DATE: 07/02/96

SSR 96-2p: POLICY INTERPRETATION RULING TITLES II AND XVI: GIVING CONTROLLING WEIGHT TO TREATING SOURCE MEDICAL OPINIONS

PURPOSE: To explain terms used in our regulations on evaluating medical opinions concerning when treating source medical opinions are entitled to controlling weight, and to clarify how the policy is applied. In particular, to emphasize that:

1. A case cannot be decided in reliance on a medical opinion without some reasonable support for the opinion.
2. Controlling weight may be given only in appropriate circumstances to medical opinions, i.e., opinions on the issue(s) of the nature and severity of an individual's impairment(s), from treating sources.
3. Controlling weight may not be given to a treating source's medical opinion unless the opinion is well- supported by medically acceptable clinical and laboratory diagnostic techniques.
4. Even if a treating source's medical opinion is well- supported, controlling weight may not be given to the opinion unless it also is "not inconsistent" with the other substantial evidence in the case record.
5. The judgment whether a treating source's medical opinion is well-supported and not inconsistent with the other substantial evidence in the case record requires an understanding of the clinical signs and laboratory findings and what they signify.
6. If a treating source's medical opinion is well- supported and not inconsistent with the other substantial evidence in the case record, it must be given controlling weight; i.e., it must be adopted.
7. A finding that a treating source's medical opinion is not entitled to controlling weight does not mean that the opinion is rejected. It may still be entitled to deference and be adopted by the adjudicator.

CITATIONS (AUTHORITY): Sections 205(a), 216(i), 223(d), 1614(a)(3), and 1631(d) of the Social Security Act, as amended; Regulations No. 4, sections 404.1502 and 404.1527, and Regulations No. 16, sections 416.902 and 416.927.

PERTINENT HISTORY: Our regulations at 20 CFR 404.1502, 404.1527, 416.902, and 416.927 were revised on August 1, 1991, to define who we consider to be a "treating source" and to set out detailed rules for evaluating treating source medical opinions and other opinions. Among the provisions of these rules is a special provision in 20 CFR 404.1527(d)(2) and 416.927(d)(2) that requires adjudicators to adopt treating source medical opinions (i.e., opinions on the issue(s) of the nature and severity of an individual's impairment(s)) in one narrowly defined circumstance. As we stated in the preamble to the publication of the final rules:

> The provision recognizes the deference to which a treating source's medical opinion should be entitled. It does not permit us to substitute our own judgment for the opinion of a treating source on the issue(s) of the nature and severity of an impairment when the treating source has offered a medical opinion that is well-supported by medically acceptable clinical and laboratory diagnostic techniques and is not inconsistent with other substantial evidence.

56 FR 36932, 36936 (1991).

POLICY INTERPRETATION:

Explanation of Terms

Controlling weight. This is the term used in 20 CFR 404.1527(d)(2) and 416.927(d)(2) to describe the weight we give to a medical opinion from a treating source that must be adopted. The rule on controlling weight applies when all of the following are present:

1. The opinion must come from a "treating source," as defined in 20 CFR 404.1502 and 416.902. Although opinions from other acceptable medical sources may be entitled to great weight, and may even be entitled to more weight than a treating source's opinion in appropriate circumstances, opinions from sources other than treating sources can never be entitled to "controlling weight."
2. The opinion must be a "medical opinion." Under 20 CFR 404.1527(a) and 416.927(a), "medical opinions" are opinions about the nature and severity of an individual's impairment(s) and are the only opinions that may be entitled to controlling weight. (See SSR 96-5p, "Titles II and XVI: Medical Source Opinions on Issues Reserved to the Commissioner.")
3. The adjudicator must find that the treating source's medical opinion is "well-supported" by "medically acceptable" clinical and laboratory diagnostic techniques. The adjudicator cannot decide a case in reliance on a medical opinion without some reasonable support for the opinion.
4. Even if well-supported by medically acceptable clinical and laboratory diagnostic techniques, the treating source's medical opinion also must be "not inconsistent" with the other "substantial evidence" in the individual's case record.

If any of the above factors is not satisfied, a treating source's opinion cannot be entitled to controlling weight. It is an error to give an opinion controlling weight simply because it is

the opinion of a treating source if it is not well-supported by medically acceptable clinical and laboratory diagnostic techniques or if it is inconsistent with the other substantial evidence in the case record. However, when all of the factors are satisfied, the adjudicator must adopt a treating source's medical opinion irrespective of any finding he or she would have made in the absence of the medical opinion.

For a medical opinion to be well-supported by medically acceptable clinical and laboratory diagnostic techniques, it is not necessary that the opinion be fully supported by such evidence. Whether a medical opinion is well-supported will depend on the facts of each case. It is a judgment that adjudicators must make based on the extent to which the opinion is supported by medically acceptable clinical and laboratory diagnostic techniques and requires an understanding of the clinical signs and laboratory findings in the case record and what they signify.

It is not unusual for a single treating source to provide medical opinions about several issues; for example, at least one diagnosis, a prognosis, and an opinion about what the individual can still do. Although it is not necessary in every case to evaluate each treating source medical opinion separately, adjudicators must always be aware that one or more of the opinions may be controlling while others may not. Adjudicators must use judgment based on the facts of each case in determining whether, and the extent to which, it is necessary to address separately each medical opinion from a single source.

Medically acceptable. This term means that the clinical and laboratory diagnostic techniques that the medical source uses are in accordance with the medical standards that are generally accepted within the medical community as the appropriate techniques to establish the existence and severity of an impairment. The requirement that controlling weight can be given to a treating source medical opinion only if it is well-supported by medically acceptable clinical and laboratory diagnostic techniques helps to ensure that there is a sound medical basis for the opinion.

Not inconsistent. This is a term used to indicate that a well-supported treating source medical opinion need not be supported directly by all of the other evidence (i.e., it does not have to be consistent with all the other evidence) as long as there is no other substantial evidence in the case record that contradicts or conflicts with the opinion.

Whether a medical opinion is "not inconsistent" with the other substantial evidence is a judgment that adjudicators must make in each case. Sometimes, there will be an obvious inconsistency between the opinion and the other substantial evidence; for example, when a treating source's report contains an opinion that the individual is significantly limited in the ability to do work-related activities, but the opinion is inconsistent with the statements of the individual's spouse about the individual's actual activities, or when two medical sources provide inconsistent medical opinions about the same issue. At other times, the inconsistency will be less obvious and require knowledge about, or insight into, what the evidence means. In this regard, it is especially important to have an understanding of the clinical signs and laboratory findings and any treatment provided to determine whether there is an inconsistency between this evidence and medical opinions about such issues as

diagnosis, prognosis (for example, when deciding whether an impairment is expected to last for 12 months), or functional effects. Because the evidence is in medical, not lay, terms and information about these issues may be implied rather than stated, such an inconsistency may not be evident without an understanding of what the clinical signs and laboratory findings signify.

Substantial evidence. This term describes a quality of evidence. Substantial evidence is "...more than a mere scintilla. It means such relevant evidence as a reasonable mind might accept as adequate to support a conclusion." (Richardson v. Perales, 402 U.S. 389 (1971), SSR 71-53c, C.E. 1971-1975, p. 418.) The term is intended to have this same meaning in 20 CFR 404.1527(d)(2) and 416.927(d)(2). It is intended to indicate that the evidence that is inconsistent with the opinion need not prove by a preponderance that the opinion is wrong. It need only be such relevant evidence as a reasonable mind would accept as adequate to support a conclusion that is contrary to the conclusion expressed in the medical opinion.

Depending upon the facts of a given case, any kind of medical or nonmedical evidence can potentially satisfy the substantial evidence test. For example, a treating source's medical opinion on what an individual can still do despite his or her impairment(s) will not be entitled to controlling weight if substantial, nonmedical evidence shows that the individual's actual activities are greater than those provided in the treating source's opinion. The converse is also true: Substantial evidence may demonstrate that an individual's ability to function may be less than what is indicated in a treating source's opinion, in which case the opinion will also not be entitled to controlling weight.

When a Treating Source's Medical Opinion is not Entitled to Controlling Weight

Adjudicators must remember that a finding that a treating source medical opinion is not well-supported by medically acceptable clinical and laboratory diagnostic techniques or is inconsistent with the other substantial evidence in the case record means only that the opinion is not entitled to "controlling weight," not that the opinion should be rejected. Treating source medical opinions are still entitled to deference and must be weighed using all of the factors provided in 20 CFR 404.1527 and 416.927. In many cases, a treating source's medical opinion will be entitled to the greatest weight and should be adopted, even if it does not meet the test for controlling weight.

Also, in some instances, additional development required by a case--for example, to obtain more evidence or to clarify reported clinical signs or laboratory findings--may provide the requisite support for a treating source's medical opinion that at first appeared to be lacking or may reconcile what at first appeared to be an inconsistency between a treating source's medical opinion and the other substantial evidence in the case record. In such instances, the treating source's medical opinion will become controlling if, after such development, the opinion meets the test for controlling weight. Conversely, the additional development may show that the treating source's medical opinion is not well-supported by medically acceptable clinical and laboratory diagnostic techniques or may create an inconsistency between the medical opinion and the other substantial evidence in

the case record, even though the medical opinion at first appeared to meet the test for controlling weight. Ordinarily, development should not be undertaken for the purpose of determining whether a treating source's medical opinion should receive controlling weight if the case record is otherwise adequately developed. However, in cases at the administrative law judge (ALJ) or Appeals Council (AC) level, the ALJ or the AC may need to consult a medical expert to gain more insight into what the clinical signs and laboratory findings signify in order to decide whether a medical opinion is well-supported or whether it is not inconsistent with other substantial evidence in the case record.

Explanation of the Weight Given to a Treating Source's Medical Opinion

Paragraph (d)(2) of 20 CFR 404.1527 and 416.927 requires that the adjudicator will always give good reasons in the notice of the determination or decision for the weight given to a treating source's medical opinion(s), i.e., an opinion(s) on the nature and severity of an individual's impairment(s). Therefore:

When the determination or decision:

- is not fully favorable, e.g., is a denial; or
- is fully favorable based in part on a treating source's medical opinion, e.g., when the adjudicator adopts a treating source's opinion about the individual's remaining ability to function;

the notice of the determination or decision must contain specific reasons for the weight given to the treating source's medical opinion, supported by the evidence in the case record, and must be sufficiently specific to make clear to any subsequent reviewers the weight the adjudicator gave to the treating source's medical opinion and the reasons for that weight.

When the determination or decision is fully favorable and would be even without consideration of a treating source's medical opinion, the notice of the determination or decision must contain an explanation of the weight given to the treating source's medical opinion. This explanation may be brief.

EFFECTIVE DATE: This Ruling is effective on the date of its publication in the *Federal Register*.

CROSS-REFERENCES: SSR 96-5p, "Titles II and XVI: Medical Source Opinions on Issues Reserved to the Commissioner;" Program Operations Manual System, sections DI 22505.001, and DI 24515.001-24515.003; Hearings, Appeals, and Litigation Law manual, sections I-2-530, I-2-532, I-2-534, I-2-539, I- 2-540, I-2-825, I-3-111, I-3-712, I-3-812, and Temporary Instruction 5-310.

EFFECTIVE/PUBLICATION DATE: 07/02/96

SSR 96-3p: POLICY INTERPRETATION RULING TITLES II AND XVI: CONSIDERING ALLEGATIONS OF PAIN AND OTHER SYMPTOMS IN DETERMINING WHETHER A MEDICALLY DETERMINABLE IMPAIRMENT IS SEVERE

PURPOSE: To restate and clarify the longstanding policies of the Social Security Administration for considering allegations of pain or other symptoms in determining whether individuals claiming disability benefits under title II and title XVI of the Social Security Act (the Act) have a "severe" medically determinable physical or mental impairment(s). In particular, the purpose of this Ruling is to restate and clarify the policy that:

1. The evaluation of whether an impairment(s) is "severe" that is done at step 2 of the applicable sequential evaluation process set out in 20 CFR 404.1520, 416.920, or 416.924 requires an assessment of the functionally limiting effects of an impairment(s) on an individual's ability to do basic work activities or, for an individual under age 18 claiming disability benefits under title XVI, to do age-appropriate activities; and
2. An individual's symptoms may cause limitations and restrictions in functioning which, when considered at step 2, may require a finding that there is a "severe" impairment(s) and a decision to proceed to the next step of sequential evaluation.

CITATIONS (AUTHORITY): Sections 216(i), 223(d), and 1614(a)(3) of the Social Security Act, as amended; Regulations No. 4, sections 404.1508, 404.1520(a) and (c), 404.1521, 404.1523, 404.1528, and 404.1529; and Regulations No. 16, sections 416.908, 416.920(a) and (c), 416.921, 416.923, 416.924(b) and (d), 416.924d, 416.928, and 416.929.

INTRODUCTION: NOTE: For clarity, the following discussions refer only to claims of individuals claiming disability benefits under title II and individuals age 18 or older claiming disability benefits under title XVI. However, the same principles regarding the evaluation of symptoms and their effects apply in determining whether the impairment(s) of an individual who is under age 18 and claiming title XVI disability benefits is severe under 20 CFR 416.924(d). For such an individual, an impairment(s) is considered "not severe" if it is a slight abnormality(ies) that causes no more than minimal limitation in the individual's ability to function independently, appropriately, and effectively in an age-appropriate manner.

To be found disabled, an individual must have a medically determinable "severe" physical or mental impairment or combination of impairments that meets the duration requirement. At step 2 of the sequential evaluation process, an impairment or combination of impairments is considered "severe" if it significantly limits an individual's physical or mental abilities to do basic work activities; an impairment(s) that is "not severe" must be a slight abnormality (or a combination of slight abnormalities) that has no more than a minimal effect on the ability to do basic work activities. (See SSR 85-28, "Titles II and XVI: Medical Impairments That Are Not Severe," C.E. 1981-1985, p. 394.)

Symptoms, such as pain, fatigue, shortness of breath, weakness, or nervousness, will not be found to affect an individual's ability to do basic work activities unless the individual first establishes by objective medical evidence (i.e., signs and laboratory findings) that he or she has a medically determinable physical or mental impairment(s) and that the impairment(s) could reasonably be expected to produce the alleged symptom(s). (See SSR 96-4p, "Titles II and XVI: Symptoms, Medically Determinable Physical and Mental Impairments, and Exertional and Nonexertional Limitations.") The finding that an individual's impairment(s) could reasonably be expected to produce the alleged symptom(s) does not involve a determination as to the intensity, persistence, or functionally limiting effects of the symptom(s). However, once the requisite relationship between the medically determinable impairment(s) and the alleged symptom(s) is established, the intensity, persistence, and limiting effects of the symptom(s) must be considered along with the objective medical and other evidence in determining whether the impairment or combination of impairments is severe.

POLICY INTERPRETATION: In determining the severity of an impairment(s) at step 2 of the sequential evaluation process set out in 20 CFR 404.1520 and 416.920, evidence about the functionally limiting effects of an individual's impairment(s) must be evaluated in order to assess the effect of the impairment(s) on the individual's ability to do basic work activities. The vocational factors of age, education, and work experience are not considered at this step of the process. A determination that an individual's impairment(s) is not severe requires a careful evaluation of the medical findings that describe the impairment(s) (i.e., the objective medical evidence and any impairment-related symptoms), and an informed judgment about the limitations and restrictions the impairment(s) and related symptom(s) impose on the individual's physical and mental ability to do basic work activities. (See SSR 96-7p, "Titles II and XVI: Evaluation of

Symptoms in Disability Claims: Assessing the Credibility of an Individual's Statements.")

Because a determination whether an impairment(s) is severe requires an assessment of the functionally limiting effects of an impairment(s), symptom-related limitations and restrictions must be considered at this step of the sequential evaluation process, provided that the individual has a medically determinable impairment(s) that could reasonably be expected to produce the symptoms. If the adjudicator finds that such symptoms cause a limitation or restriction having more than a minimal effect on an individual's ability to do basic work activities, the adjudicator must find that the impairment(s) is severe and proceed to the next step in the process even if the objective medical evidence would not in itself establish that the impairment(s) is severe. In addition, if, after completing development and considering all of the evidence, the adjudicator is unable to determine clearly the effect of an impairment(s) on the individual's ability to do basic work activities, the adjudicator must continue to follow the sequential evaluation process until a determination or decision about disability can be reached.

EFFECTIVE DATE: This Ruling is effective on the date of its publication in the Federal Register.

CROSS-REFERENCES: SSR 85-28, "Titles II and XVI: Medical Impairments That are Not Severe," SSR 96-4p, "Titles II and XVI: Symptoms, Medically Determinable Physical and Mental Impairments, and Exertional and Nonexertional Limitations," and SSR 96-7p, "Titles II and XVI: Evaluation of Symptoms in Disability Claims: Assessing the Credibility of an Individual's Statements;" and Program Operations Manual System, sections DI 24505.001, DI 24505.005, DI 24515.061, DI 25215.005, DI 25225.001, DI 26515.005, DI 26515.015, and DI 26516.010.

SSR 96-4p

EFFECTIVE/PUBLICATION DATE: 07/02/96

SSR 96-4p: POLICY INTERPRETATION RULING TITLES II AND XVI: SYMPTOMS, MEDICALLY DETERMINABLE PHYSICAL AND MENTAL IMPAIRMENTS, AND EXERTIONAL AND NONEXERTIONAL LIMITATIONS

PURPOSE: The purpose of this Ruling is to clarify longstanding policy of the Social Security Administration on the evaluation of symptoms in the adjudication of claims for disability benefits under title II and title XVI of the Social Security Act (the Act). In particular, this Ruling emphasizes that:

1. A "symptom" is not a "medically determinable physical or mental impairment" and no symptom by itself can establish the existence of such an impairment.
2. In the absence of a showing that there is a "medically determinable physical or mental impairment," an individual must be found not disabled at step 2 of the sequential evaluation process. No symptom or combination of symptoms can be the basis for a finding of disability, no matter how genuine the individual's complaints may appear to be, unless there are medical signs and laboratory findings demonstrating the existence of a medically determinable physical or mental impairment.
3. The terms "exertional" and "nonexertional" in the regulations describe types of functional limitations or restrictions resulting from a medically determinable physical or mental impairment; i.e., exertional limitations affect an individual's ability to meet the strength demands of jobs, and nonexertional limitations or restrictions affect an individual's ability to meet the nonstrength demands of jobs. Therefore, a symptom in itself is neither exertional nor nonexertional. Rather, it is the nature of the functional limitations or restrictions caused by an impairment-related symptom that determines whether the impact of the symptom is exertional, nonexertional, or both.

4. The application of the medical-vocational rules in appendix 2 of subpart P of Regulations No. 4 depends on the nature of the limitations and restrictions imposed by an individual's medically determinable physical or mental impairment(s), and any related symptoms.

CITATIONS (AUTHORITY): Sections 216(i), 223(d) and 1614(a)(3) of the Social Security Act, as amended; Regulations No. 4, sections 404.1505, 404.1508, 404.1520, 404.1528(a), 404.1529, 404.1569a and subpart P, appendix 2; and Regulations No. 16, sections 416.905, 416.908, 416.920, 416.924, 416.928(a), 416.929 and 416.969a.

POLICY INTERPRETATION:

Need to Establish the Existence of a Medically Determinable Physical or Mental Impairment

The Act defines disability as the inability to do any substantial gainful activity by reason of any medically determinable physical or mental impairment that can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months.[1] An "impairment" must result from anatomical, physiological, or psychological abnormalities that can be shown by medically acceptable clinical and laboratory diagnostic techniques. Although the regulations provide that the existence of a medically determinable physical or mental impairment must be established by medical evidence consisting of signs, symptoms,[2] and laboratory findings, the regulations further provide that under no circumstances may the existence of an impairment be established on the basis of symptoms alone. Thus, regardless of how many symptoms an individual alleges, or how genuine the individual's complaints may appear to be, the existence of a medically determinable physical or mental impairment cannot be established in the absence of objective medical abnormalities; i.e., medical signs and laboratory findings.

No symptom or combination of symptoms by itself can constitute a medically determinable impairment. In claims in which there are no medical signs or laboratory findings to substantiate the existence of a medically determinable physical or mental impairment, the individual must be found not disabled at step 2 of the sequential evaluation process set out in 20 CFR 404.1520 and 416.920 (or, for an individual under age 18 claiming disability benefits under title XVI, 20 CFR 416.924).

In addition, 20 CFR 404.1529 and 416.929 provide that an individual's symptoms, such as pain, fatigue, shortness of breath, weakness, or nervousness, will not be found to affect the individual's ability to do basic work activities (or, for an individual under age 18 claiming disability benefits under title XVI, to function independently, appropriately, and effectively in an age-appropriate manner) unless medical signs and laboratory findings show that there is a medically determinable physical or mental impairment(s) that could reasonably be expected to produce the symptom(s) alleged.

Exertional and Nonexertional Limitations

Once the existence of a medically determinable physical or mental impairment(s) that could reasonably be expected to produce the pain or other symptoms alleged has been established on the basis of medical signs and laboratory findings, allegations about the intensity and persistence of the symptoms must be considered with the objective medical abnormalities, and all other evidence in the case record, in evaluating the functionally limiting effects of the impairment(s). In addition, for determinations or decisions at step 5 of the sequential evaluation process for individuals claiming disability benefits under title II and individuals age 18 or older claiming disability benefits under title XVI, 20 CFR 404.1569a and 416.969a explain that an individual's impairment(s) and related symptoms, such as pain, may cause limitations of function or restrictions that limit an individual's ability to meet certain demands of jobs. These sections divide limitations or restrictions into three classifications: Exertional, nonexertional, and combined exertional and nonexertional. Exertional limitations or restrictions affect an individual's ability to meet the seven strength demands of jobs (sitting, standing, walking, lifting, carrying, pushing, and pulling), while nonexertional limitations or restrictions affect an individual's ability to meet the nonstrength demands of jobs (all physical limitations and restrictions that are not reflected in the seven strength demands, and mental limitations and restrictions). The nature of the limitations or restrictions affects whether the rules in appendix 2 to subpart P of Regulations No. 4 may be used to direct a decision or must be used as a framework for decisionmaking.

Likewise, under the regulations, symptoms in themselves are neither exertional nor nonexertional. An individual's symptoms, however, can cause limitations or restrictions that are classified as exertional, nonexertional, or a combination of both. For example, pain can result in an exertional limitation if it limits the ability to perform one of the strength activities (e.g., lifting), or a nonexertional limitation if it limits the ability to perform a nonstrength activity (e.g., fingering or concentrating). It is the nature of the limitations or restrictions resulting from the symptom (i.e., exertional, nonexertional, or both) that will determine whether the medical-vocational rules in appendix 2 may be used to direct a decision or must be used as a framework for decisionmaking. For additional discussion of this longstanding policy, see SSR 96-8p, "Titles II and XVI: Assessing Residual Functional Capacity in Initial Claims."

EFFECTIVE DATE: This Ruling is effective on the date of its publication in the Federal Register.

CROSS-REFERENCES: SSR 96-3p, "Titles II and XVI: Considering Allegations of Pain and Other Symptoms in Determining Whether a Medically Determinable Impairment is Severe," SSR 96-7p, "Titles II and XVI: Evaluation of Symptoms in Disability Claims: Assessing the Credibility of an Individual's Statements," and SSR 96-8p, "Titles II and XVI: Assessing Residual Functional Capacity in Initial Claims;" and Program Operations Manual System, sections DI 24501.020, DI 24515.061, and DI 24515.063.

[1] This definition of disability applies to individuals claiming disability benefits under title II and individuals age 18 or older claiming disability benefits under title XVI. For title XVI, an individual under age 18 will be considered disabled if he or she is suffering from a medically determinable physical or mental impairment of comparable severity to an impairment that would disable an adult.

[2] 20 CFR 404.1528, 404.1529, 416.928, and 416.929 provide that symptoms, such as pain, fatigue, shortness of breath, weakness or nervousness, are an individual's own perception or description of the impact of his or her physical or mental impairment(s). (20 CFR 416.928 further provides that, for an individual under age 18 who is unable to adequately describe his or her symptom(s), the adjudicator will accept as a statement of this symptom(s) the description given by the person most familiar with the individual, such as a parent, other relative, or guardian.) However, when any of these manifestations is an anatomical, physiological, or psychological abnormality that can be shown by medically acceptable clinical diagnostic techniques, it represents a medical "sign" rather than a "symptom."

SSR 96-5p

EFFECTIVE/PUBLICATION DATE: 07/02/96

SSR96-5p: POLICY INTERPRETATION RULING TITLES II AND XVI: MEDICAL SOURCE OPINIONS ON ISSUES RESERVED TO THE COMMISSIONER

PURPOSE: To clarify Social Security Administration (SSA) policy on how we consider medical source opinions on issues reserved to the Commissioner, including whether an individual's impairment(s) meets or is equivalent in severity to the requirements of any impairment(s) in the Listing of Impairments in appendix 1, subpart P of 20 CFR part 404 (the listings); what an individual's residual functional capacity (RFC) is; whether an individual's RFC prevents him or her from doing past relevant work; how the vocational factors of age, education, and work experience apply; and whether an individual is "disabled" under the Social Security Act (the Act). In particular, to emphasize:

1. The difference between issues reserved to the Commissioner and medical opinions.
2. That treating source opinions on issues reserved to the Commissioner are never entitled to controlling weight or special significance.
3. That opinions from any medical source about issues reserved to the Commissioner must never be ignored, and that the notice of the determination or decision must explain the consideration given to the treating source's opinion(s).
4. The difference between the opinion called a "medical source statement" and the administrative finding called a "residual functional capacity assessment."

CITATIONS (AUTHORITY): Sections 205(a) and (b)(1), 216(i), 221(a)(1) and (g), 223(d), 1614(a), 1631(c)(1) and (d)(1), and 1633 of the Social Security Act, as amended; Regulations No. 4, sections 404.1503, 404.1504, 404.1512, 404.1513, 404.1520, 404.1526, 404.1527, and 404.1546; Regulations No. 16, sections 416.903, 416.904, 416.912, 416.913, 416.920, 416.924, 416.924d, 416.926, 416.926a, 416.927, and 416.946.

INTRODUCTION:[1] On August 1, 1991, SSA published regulations at 20 CFR 404.1527 and 416.927 that set out rules for evaluating medical opinions. The regulations provide general guidance for evaluating all evidence in a case record and provide detailed rules for evaluating medical opinion evidence. They explain the significance given to

medical opinions from treating sources on the nature and severity of an individual's impairment(s). They also set out factors used to weigh opinions from all types of medical sources, including treating sources, other examining sources, and nonexamining physicians, psychologists, and other medical sources. In addition, the regulations provide that the final responsibility for deciding certain issues, such as whether an individual is disabled under the Act, is reserved to the Secretary of Health and Human Services (the Secretary).

On March 31, 1995, SSA became an independent agency under P.L. 103- 296. As a result of this legislative change, the Commissioner of Social Security (the Commissioner) replaced the Secretary as the official responsible for making determinations of disability under titles II and XVI of the Act.

POLICY INTERPRETATION: The regulations at 20 CFR 404.1527(a) and 416.927(a) define medical opinions as "statements from physicians and psychologists or other acceptable medical sources that reflect judgments about the nature and severity of your impairment(s), including your symptoms, diagnosis and prognosis, what you can still do despite impairment(s), and your physical or mental restrictions." The regulations recognize that treating sources are important sources of medical evidence and expert testimony, and that their opinions about the nature and severity of an individual's impairment(s) are entitled to special significance; sometimes the medical opinions of treating sources are entitled to controlling weight. Paragraphs (b), (c), (d), and (f) of 20 CFR 404,1527 and 416.927 explain how we weigh treating source and other medical source opinions. (See, also, 96-2p, "Titles II and XVI: Giving Controlling Weight to Treating Source Medical Opinions," and SSR 96-6p, "Titles II and XVI: Consideration of Administrative Findings of Fact by State Agency Medical and Psychological Consultants and Other Program Physicians and Psychologists at the Administrative Law Judge and Appeals Council Levels of Administrative Review; Medical Equivalence.")

Under 20 CFR 404.1527(e) and 416.927(e), some issues are not medical issues regarding the nature and severity of an individual's impairment(s) but are administrative findings that are dispositive of a case; i.e., that would direct the determination or decision of disability. The following are examples of such issues:

1. Whether an individual's impairment(s) meets or is equivalent in severity to the requirements of any impairment(s) in the listings;
2. What an individual's RFC is;
3. Whether an individual's RFC prevents him or her from doing past relevant work;
4. How the vocational factors of age, education, and work experience apply; and
5. Whether an individual is "disabled" under the Act.

The regulations provide that the final responsibility for deciding issues such as these is reserved to the Commissioner.

Nevertheless, our rules provide that adjudicators must always carefully consider medical source opinions about any issue, including opinions about issues that are reserved to the

Commissioner. For treating sources, the rules also require that we make every reasonable effort to recontact such sources for clarification when they provide opinions on issues reserved to the Commissioner and the bases for such opinions are not clear to us.

However, treating source opinions on issues that are reserved to the Commissioner are never entitled to controlling weight or special significance. Giving controlling weight to such opinions would, in effect, confer upon the treating source the authority to make the determination or decision about whether an individual is under a disability, and thus would be an abdication of the Commissioner's statutory responsibility to determine whether an individual is disabled.

However, opinions from any medical source on issues reserved to the Commissioner must never be ignored. The adjudicator is required to evaluate all evidence in the case record that may have a bearing on the determination or decision of disability, including opinions from medical sources about issues reserved to the Commissioner. If the case record contains an opinion from a medical source on an issue reserved to the Commissioner, the adjudicator must evaluate all the evidence in the case record to determine the extent to which the opinion is supported by the record.

In evaluating the opinions of medical sources on issues reserved to the Commissioner, the adjudicator must apply the applicable factors in 20 CFR 404.1527(d) and 416.927(d). For example, it would be appropriate to consider the supportability of the opinion and its consistency with the record as a whole at the administrative law judge and Appeals Council levels in evaluating an opinion about the claimant's ability to function which is from a State agency medical or psychological consultant who has based the opinion on the entire record (see Findings of State Agency Medical and Psychological Consultants, below). However, pursuant to paragraph (e)(2) of 20 CFR 404.1527 and 416.927, the adjudicator is precluded from giving any special significance to the source; e.g., giving a treating source's opinion controlling weight, when weighing these opinions on issues reserved to the Commissioner.

The following discussions provide additional policy interpretations and procedures for evaluating opinions on issues reserved to the Commissioner.

Opinions About Whether an Individual's Impairment Meets the Requirements of a Listed Impairment

Whether the findings for an individual's impairment meet the requirements of an impairment in the listings is usually more a question of medical fact than a question of medical opinion. Many of the criteria in the listings relate to the nature and severity of impairments; e.g., diagnosis, prognosis and, for those listings that include such criteria, symptoms and functional limitations. In most instances, the requirements of listed impairments are objective, and whether an individual's impairment manifests these requirements is simply a matter of documentation. To the extent that a treating source is usually the best source of this documentation, the adjudicator looks to the treating source for medical evidence with which he or she can determine whether an individual's

impairment meets a listing. When a treating source provides medical evidence that demonstrates that an individual has an impairment that meets a listing, and the treating source offers an opinion that is consistent with this evidence, the adjudicator's administrative finding about whether the individual's impairment(s) meets the requirements of a listing will generally agree with the treating source's opinion. Nevertheless, the issue of meeting the requirements of a listing is still an issue ultimately reserved to the Commissioner.

Opinions on Whether an Individual's Impairment(s) Is Equivalent in Severity to the Requirements of a Listed Impairment

In 20 CFR 404.1526 and 416.926, equivalence is addressed as a "decision * * * on medical evidence only" because this finding does not consider the vocational factors of age, education, and work experience. A finding of equivalence involves more than findings about the nature and severity of medical impairments. It also requires a judgment that the medical findings equal a level of severity set forth in 20 CFR 404.1525(a) and 416.925(a); i.e., that the impairment(s) is "* * * severe enough to prevent a person from doing any gainful activity." This finding requires familiarity with the regulations and the legal standard of severity set forth in 20 CFR 404.1525(a), 404.1526, 416.925(a), and 416.926. Therefore, it is an issue reserved to the Commissioner.[2]

Residual Functional Capacity Assessments and Medical Source Statements

The regulations describe two distinct kinds of assessments of what an individual can do despite the presence of a severe impairment(s). The first is described in 20 CFR 404.1513(b) and (c) and 416.913(b) and (c) as a "statement about what you can still do despite your impairment(s)" made by an individual's medical source and based on that source's own medical findings. This "medical source statement" is an opinion submitted by a medical source as part of a medical report. The second category of assessments is the RFC assessment described in 20 CFR 404.1545, 404.1546, 416.945, and 416.946 which is the adjudicator's ultimate finding of "what you can still do despite your limitations." Even though the adjudicator's RFC assessment may adopt the opinions in a medical source statement, they are not the same thing: A medical source statement is evidence that is submitted to SSA by an individual's medical source reflecting the source's opinion based on his or her own knowledge, while an RFC assessment is the adjudicator's ultimate finding based on a consideration of this opinion and all the other evidence in the case record about what an individual can do despite his or her impairment(s).

Medical Source Statement

Medical source statements are medical opinions submitted by acceptable medical sources,[3] including treating sources and consultative examiners, about what an individual can still do despite a severe impairment(s), in particular about an individual's physical or mental abilities to perform work-related activities on a sustained basis. Adjudicators are generally required to request that acceptable medical sources provide

these statements with their medical reports. Medical source statements are to be based on the medical sources' records and examination of the individual; i.e., their personal knowledge of the individual. Therefore, because there will frequently be medical and other evidence in the case record that will not be known to a particular medical source, a medical source statement may provide an incomplete picture of the individual's abilities.

Medical source statements submitted by treating sources provide medical opinions which are entitled to special significance and may be entitled to controlling weight on issues concerning the nature and severity of an individual's impairment(s). Adjudicators must remember, however, that medical source statements may actually comprise separate medical opinions regarding diverse physical and mental functions, such as walking, lifting, seeing, and remembering instructions, and that it may be necessary to decide whether to adopt or not adopt each one.

RFC Assessment

The term "*residual functional capacity assessment*" describes an adjudicator's finding about the ability of an individual to perform work-related activities. The assessment is based upon consideration of all relevant evidence in the case record, including medical evidence and relevant nonmedical evidence, such as observations of lay witnesses of an individual's apparent symptomatology, an individual's own statement of what he or she is able or unable to do, and many other factors that could help the adjudicator determine the most reasonable findings in light of all the evidence.

Medical Source Statement vs. RFC Assessment

A medical source's statement about what an individual can still do is medical opinion evidence that an adjudicator must consider together with all of the other relevant evidence (including other medical source statements that may be in the case record) when assessing an individual's RFC. Although an adjudicator may decide to adopt all of the opinions expressed in a medical source statement, a medical source statement must not be equated with the administrative finding known as the RFC assessment. Adjudicators must weigh medical source statements under the rules set out in 20 CFR 404.1527 and 416.927, providing appropriate explanations for accepting or rejecting such opinions.

From time-to-time, medical sources may provide opinions that an individual is limited to "sedentary work," "sedentary activity," "light work," or similar statements that appear to use the terms set out in our regulations and Rulings to describe exertional levels of maximum sustained work capability. Adjudicators must not assume that a medical source using terms such as "sedentary" and "light" is aware of our definitions of these terms. The judgment regarding the extent to which an individual is able to perform exertional ranges of work goes beyond medical judgment regarding what an individual can still do and is a finding that may be dispositive of the issue of disability.

At steps 4 and 5 of the sequential evaluation process in 20 CFR 404.1520 and 416.920, the adjudicator's assessment of an individual's RFC may be the most critical finding

contributing to the final determination or decision about disability. Although the overall RFC assessment is an administrative finding on an issue reserved to the Commissioner, the adjudicator must nevertheless adopt in that assessment any treating source medical opinion (i.e., opinion on the nature and severity of the individual's impairment(s)) to which the adjudicator has given controlling weight under the rules in 20 CFR 404.1527(d)(2) and 416.927(d)(2).

Opinions on Whether an Individual Is Disabled

Medical sources often offer opinions about whether an individual who has applied for title II or title XVI disability benefits is "disabled" or "unable to work," or make similar statements of opinions. In addition, they sometimes offer opinions in other work-related terms; for example, about an individual's ability to do past relevant work or any other type of work. Because these are administrative findings that may determine whether an individual is disabled, they are reserved to the Commissioner. Such opinions on these issues must not be disregarded. However, even when offered by a treating source, they can never be entitled to controlling weight or given special significance.

Findings of State Agency Medical and Psychological Consultants

Medical and psychological consultants in the State agencies are adjudicators at the initial and reconsideration determination levels (except in disability hearings--see 20 CFR 404.914 ff. and 416.1414 ff.). As such, they do not express opinions; they make findings of fact that become part of the determination. However, 20 CFR 404.1527(f) and 416.927(f) provide that, at the administrative law judge and Appeals Council levels of the administrative review process, medical and psychological consultant findings about the nature and severity of an individual's impairment(s), including any RFC assessments, become opinion evidence. Adjudicators at these levels, including administrative law judges and the Appeals Council, must consider these opinions as expert opinion evidence of nonexamining physicians and psychologists and must address the opinions in their decisions. In addition, under 20 CFR 404.1526 and 416.926, adjudicators at the administrative law judge and Appeals Council levels must consider and address State agency medical or psychological consultant findings regarding equivalence to a listed impairment.

At the administrative law judge and Appeals Council levels, adjudicators must evaluate opinion evidence from medical or psychological consultants using all of the applicable rules in 20 CFR 404.1527 and 416.927 to determine the weight to be given to the opinion. For additional detail regarding these policies and policy interpretations, see SSR 96-6p, "Titles II and XVI: Consideration of Administrative Findings of Fact by State Agency Medical and Psychological Consultants and Other Program Physicians and Psychologists at the Administrative Law Judge and Appeals Council Levels of Administrative Review; Medical Equivalence."

Requirements for Recontacting Treating Sources

Because treating source evidence (including opinion evidence) is important, if the evidence does not support a treating source's opinion on any issue reserved to the Commissioner and the adjudicator cannot ascertain the basis of the opinion from the case record, the adjudicator must make "every reasonable effort" to recontact the source for clarification of the reasons for the opinion.

Explanation of the Consideration Given to a Treating Source's Opinion

Treating source opinions on issues reserved to the Commissioner will never be given controlling weight. However, the notice of the determination or decision must explain the consideration given to the treating source's opinion(s).

EFFECTIVE DATE: This Ruling is effective on the date of its publication in the *Federal Register.*

CROSS-REFERENCES: SSR 96-6p, "Titles II and XVI: Consideration of Administrative Findings of Fact by State Agency Medical and Psychological Consultants and Other Program Physicians and Psychologists at the Administrative Law Judge and Appeals Council Levels of Administrative Review; Medical Equivalence," SSR 96-2p, "Titles II and XVI: Giving Controlling Weight to Treating Source Medical Opinions;" and Program Operations Manual System, section DI 24515.010.

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[1] NOTE: For clarity, the following discussions refer only to claims of individuals claiming disability benefits under title II and individuals age 18 or older claiming disability benefits under title XVI. However, the same principles regarding medical source opinions apply in determining disability for individuals under age 18 claiming disability benefits under title XVI. Therefore, it should be understood that references in this Ruling to the ability to do gainful activity, RFC, and other terms and rules that are applicable only to title II disability claims and title XVI disability claims of individuals age 18 or older, are also intended to refer to appropriate terms and rules applicable in determining disability for individuals under age 18 under title XVI.

[2] See the section below entitled "Findings of State Agency Medical and Psychological Consultants" for an explanation of how administrative law judges and the Appeals Council must evaluate State agency medical and psychological consultant findings about equivalence. See also SSR 96-6p, "Titles II and XVI: Consideration of Administrative Findings of Fact by State Agency Medical and Psychological Consultants and Other Program Physicians and Psychologists at the Administrative Law Judge and Appeals Council Levels of Administrative Review; Medical Equivalence."

[3] The term "acceptable medical sources" is defined in 20 CFR 404.1513(a) and 416.913(a).

SSR 96-6p

EFFECTIVE/PUBLICATION DATE: 07/02/96

SSR 96-6p: POLICY INTERPRETATION RULING TITLES II AND XVI: CONSIDERATION OF ADMINISTRATIVE FINDINGS OF FACT BY STATE AGENCY MEDICAL AND PSYCHOLOGICAL CONSULTANTS AND OTHER PROGRAM PHYSICIANS AND PSYCHOLOGISTS AT THE ADMINISTRATIVE LAW JUDGE AND APPEALS COUNCIL LEVELS OF ADMINISTRATIVE REVIEW; MEDICAL EQUIVALENCE

PURPOSE: To clarify Social Security Administration policy regarding the consideration of findings of fact by State agency medical and psychological consultants and other program physicians and psychologists by adjudicators at the administrative law judge and Appeals Council levels. Also, to restore to the Rulings and clarify policy interpretations regarding administrative law judge and Appeals Council responsibility for obtaining opinions of physicians or psychologists designated by the Commissioner regarding equivalence to listings in the Listing of Impairments (appendix 1, subpart P of 20 CFR part 404) formerly in SSR 83-19. In particular, to emphasize the following longstanding policies and policy interpretations:

1. Findings of fact made by State agency medical and psychological consultants and other program physicians and psychologists regarding the nature and severity of an individual's impairment(s) must be treated as expert opinion evidence of

nonexamining sources at the administrative law judge and Appeals Council levels of administrative review.
2. Administrative law judges and the Appeals Council may not ignore these opinions and must explain the weight given to these opinions in their decisions.
3. An updated medical expert opinion must be obtained by the administrative law judge or the Appeals Council before a decision of disability based on medical equivalence can be made.

CITATIONS (AUTHORITY): Sections 216(i), 223(d) and 1614(a) of the Social Security Act (the Act), as amended; Regulations No. 4, sections 404.1502, 404.1512(b)(6), 404.1526, 404.1527, and 404.1546; and Regulations No. 16, sections 416.902, 416.912(b)(6), 416.926, 416.927, and 416.946.

INTRODUCTION: Regulations 20 CFR 404.1527 and 416.927 set forth detailed rules for evaluating medical opinions about an individual's impairment(s) offered by medical sources[1] and the medical opinions of State agency medical and psychological consultants and other nonexamining sources. Paragraph (a) of these regulations provides that "medical opinions" are statements from physicians and psychologists or other acceptable medical sources that reflect judgments about the nature and severity of an individual's impairment(s), including symptoms, diagnosis and prognosis, what the individual can still do despite his or her impairment(s), and the individual's physical or mental restrictions. Paragraph (b) provides that, in deciding whether an individual is disabled, the adjudicator will always consider the medical opinions in the case record together with the rest of the relevant evidence. Paragraphs (c), (d), and (e) then provide general rules for evaluating the record, with particular attention to medical and other opinions from acceptable medical sources.

Paragraph (f) provides that findings of fact made by State agency medical and psychological consultants and other program physicians and psychologists become opinions at the administrative law judge and Appeals Council levels of administrative review and requires administrative law judges and the Appeals Council to consider and evaluate these opinions when making a decision in a particular case.

State agency medical and psychological consultants are highly qualified physicians and psychologists who are experts in the evaluation of the medical issues in disability claims under the Act. As members of the teams that make determinations of disability at the initial and reconsideration levels of the administrative review process (except in disability hearings), they consider the medical evidence in disability cases and make findings of fact on the medical issues, including, but not limited to, the existence and severity of an individual's impairment(s), the existence and severity of an individual's symptoms, whether the individual's impairment(s) meets or is equivalent in severity to the requirements for any impairment listed in 20 CFR part 404, subpart P, appendix 1 (the Listing of Impairments), and the individual's residual functional capacity (RFC).

POLICY INTERPRETATION: Because State agency medical and psychological consultants and other program physicians and psychologists are experts in the Social Security disability programs, the rules in 20 CFR 404.1527(f) and 416.927(f) require administrative law judges and the Appeals Council to consider their findings of fact about the nature and severity of an individual's impairment(s) as opinions of nonexamining physicians and psychologists. Administrative law judges and the Appeals Council are not bound by findings made by State agency or other program physicians and psychologists, but they may not ignore these opinions and must explain the weight given to the opinions in their decisions.

Paragraphs 404.1527(f) and 416.927(f) provide that the rules for considering medical and other opinions of treating sources and other sources in paragraphs (a) through (e) also apply when we consider the medical opinions of nonexamining sources, including State agency medical and psychological consultants and other program physicians and psychologists. The regulations provide progressively more rigorous tests for weighing opinions as the ties between the source of the opinion and the individual become weaker. For example, the opinions of physicians or psychologists who do not have a treatment relationship with the individual are weighed by stricter standards, based to a greater degree on medical evidence, qualifications, and explanations for the opinions, than are required of treating sources.

For this reason, the opinions of State agency medical and psychological consultants and other program physicians and psychologists can be given weight only insofar as they are supported by evidence in the case record, considering such factors as the supportability of the opinion in the evidence including any evidence received at the administrative law judge and Appeals Council levels that was not before the State agency, the consistency of the opinion with the record as a whole, including other medical opinions, and any explanation for the opinion provided by the State agency medical or psychological consultant or other program physician or psychologist. The adjudicator must also consider all other factors that could have a bearing on the weight to which an opinion is entitled, including any specialization of the State agency medical or psychological consultant.

In appropriate circumstances, opinions from State agency medical and psychological consultants and other program physicians and psychologists may be entitled to greater weight than the opinions of treating or examining sources. For example, the opinion of a State agency medical or psychological consultant or other program physician or psychologist may be entitled to greater weight than a treating source's medical opinion if the State agency medical or phychological consultant's opinion is based on a review of a complete case record that includes a medical report from a specialist in the individual's particular impairment which provides more detailed and comprehensive information than what was available to the individual's treating source.

The following additional guidelines apply at the administrative law judge and Appeals Council levels to opinions about equivalence to a listing in the Listing of Impairments and RFC assessments, issues that are reserved to the Commissioner in 20 CFR

404.1527(e) and 416.927(e). (See also SSR 96-5p, "Titles II and XVI: Medical Source Opinions on Issues Reserved to the Commissioner.")

Medical Equivalence to an Impairment in the Listing of Impairments.

The administrative law judge or Appeals Council is responsible for deciding the ultimate legal question whether a listing is met or equaled. As trier of the facts, an administrative law judge or the Appeals Council is not bound by a finding by a State agency medical or psychological consultant or other program physician or psychologist as to whether an individual's impairment(s) is equivalent in severity to any impairment in the Listing of Impairments. However, longstanding policy requires that the judgment of a physician (or psychologist) designated by the Commissioner on the issue of equivalence on the evidence before the administrative law judge or the Appeals Council must be received into the record as expert opinion evidence and given appropriate weight.

The signature of a State agency medical or psychological consultant on an SSA-831-U5 (Disability Determination and Transmittal Form) or SSA-832-U5 or SSA-833-U5 (Cessation or Continuance of Disability or Blindness) ensures that consideration by a physician (or psychologist) designated by the Commissioner has been given to the question of medical equivalence at the initial and reconsideration levels of administrative review. Other documents, including the Psychiatric Review Technique Form and various other documents on which medical and psychological consultants may record their findings, may also ensure that this opinion has been obtained at the first two levels of administrative review.

When an administrative law judge or the Appeals Council finds that an individual s impairment(s) is not equivalent in severity to any listing, the requirement to receive expert opinion evidence into the record may be satisfied by any of the foregoing documents signed by a State agency medical or psychological consultant. However, an administrative law judge and the Appeals Council must obtain an updated medical opinion from a medical expert[2] in the following circumstances:

- When no additional medical evidence is received, but in the opinion of the administrative law judge or the Appeals Council the symptoms, signs, and laboratory findings reported in the case record suggest that a judgment of equivalence may be reasonable; or
- When additional medical evidence is received that in the opinion of the administrative law judge or the Appeals Council may change the State agency medical or psychological consultant's finding that the impairment(s) is not equivalent in severity to any impairment in the Listing of Impairments.

When an updated medical judgment as to medical equivalence is required at the administrative law judge level in either of the circumstances above, the administrative law judge must call on a medical expert. When an updated medical judgment as to medical equivalence is required at the Appeals Council level in either of the

circumstances above, the Appeals Council must call on the services of its medical support staff.

Assessment of RFC.

Although the administrative law judge and the Appeals Council are responsible for assessing an individual's RFC at their respective levels of administrative review, the administrative law judge or Appeals Council must consider and evaluate any assessment of the individual's RFC by a State agency medical or psychological consultant and by other program physicians or psychologists. At the administrative law judge and Appeals Council levels, RFC assessments by State agency medical or psychological consultants or other program physicians or psychologists are to be considered and addressed in the decision as medical opinions from nonexamining sources about what the individual can still do despite his or her impairment(s). Again, they are to be evaluated considering all of the factors set out in the regulations for considering opinion evidence.

EFFECTIVE DATE: This Ruling is effective on the date of its publication in the *Federal Register.*

CROSS-REFERENCES: Source Opinions on Issues Reserved to the Commissioner;" Program Operations Manual System, section DI 24515.007; and Hearings, Appeals, and Litigation Law Manual, section I-5-310.

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[1] "Medical sources" are defined in 20 CFR 404.1502 and 416.902 as "treating sources," "sources of record" (i.e., medical sources that have provided an individual with medical treatment or evaluation, but do not have or did not have an ongoing treatment relationship with the individual), and "consultative examiners" for the Social Security Administration.

[2] The term "medical expert" is being used to refer to the source of expert medical opinion designated as a "medical advisor" in 20 CFR 404.1512(b)(6), 404.1527(f), 416.912(b)(6), and 416.927(f). This term is being used because it describes the role of the "medical expert" as an expert witness rather than an advisor in the course of an administrative law judge hearing.

SSR 96-7p

EFFECTIVE/PUBLICATION DATE: 07/02/96

SSR 96-7p: POLICY INTERPRETATION RULING TITLES II AND XVI: EVALUATION OF SYMPTOMS IN DISABILITY CLAIMS: ASSESSING THE CREDIBILITY OF AN INDIVIDUAL'S STATEMENTS

This Ruling supersedes Social Security Ruling (SSR) 95-5p, "Titles II and XVI: Considering Allegations of Pain and Other Symptoms in Residual Functional Capacity and Individualized Functional Assessments and Explaining Conclusions Reached."

PURPOSE: The purpose of this Ruling is to clarify when the evaluation of symptoms, including pain, under 20 CFR 404.1529 and 416.929 requires a finding about the credibility of an individual's statements about pain or other symptom(s) and its functional effects; to explain the factors to be considered in assessing the credibility of the individual's statements about symptoms; and to state the importance of explaining the reasons for the finding about the credibility of the individual's statements in the disability determination or decision.[1] In particular, this Ruling emphasizes that:

1. No symptom or combination of symptoms can be the basis for a finding of disability, no matter how genuine the individual's complaints may appear to be, unless there are medical signs and laboratory findings demonstrating the existence of a medically determinable physical or mental impairment(s) that could reasonably be expected to produce the symptoms.
2. When the existence of a medically determinable physical or mental impairment(s) that could reasonably be expected to produce the symptoms has been established, the intensity, persistence, and functionally limiting effects of the symptoms must be evaluated to determine the extent to which the symptoms affect the individual's ability to do basic work activities. This requires the adjudicator to make a finding about the credibility of the individual's statements about the symptom(s) and its functional effects.
3. Because symptoms, such as pain, sometimes suggest a greater severity of impairment than can be shown by objective medical evidence alone, the adjudicator must carefully consider the individual's statements about symptoms with the rest of the relevant evidence in the case record in reaching a conclusion

about the credibility of the individual's statements if a disability determination or decision that is fully favorable to the individual cannot be made solely on the basis of objective medical evidence.

4. In determining the credibility of the individual's statements, the adjudicator must consider the entire case record, including the objective medical evidence, the individual's own statements about symptoms, statements and other information provided by treating or examining physicians or psychologists and other persons about the symptoms and how they affect the individual, and any other relevant evidence in the case record. An individual's statements about the intensity and persistence of pain or other symptoms or about the effect the symptoms have on his or her ability to work may not be disregarded solely because they are not substantiated by objective medical evidence.
5. It is not sufficient for the adjudicator to make a single, conclusory statement that "the individual's allegations have been considered" or that "the allegations are (or are not) credible." It is also not enough for the adjudicator simply to recite the factors that are described in the regulations for evaluating symptoms. The determination or decision must contain specific reasons for the finding on credibility, supported by the evidence in the case record, and must be sufficiently specific to make clear to the individual and to any subsequent reviewers the weight the adjudicator gave to the individual's statements and the reasons for that weight.

CITATIONS (AUTHORITY): Sections 216(i), 223(d), and 1614(a)(3) of the Social Security Act, as amended; Regulations No. 4, sections 404.1528(a), 404.1529, and 404.1569a; and Regulations No. 16, sections 416.928(a), 416.929, and 416.969a.

INTRODUCTION: A symptom is an individual's own description of his or her physical or mental impairment(s).[2] Under the regulations, an individual's statement(s) about his or her symptoms is not enough in itself to establish the existence of a physical or mental impairment or that the individual is disabled.

The regulations describe a two-step process for evaluating symptoms, such as pain, fatigue, shortness of breath, weakness, or nervousness:

- First, the adjudicator must consider whether there is an underlying medically determinable physical or mental impairment(s)--i.e., an impairment(s) that can be shown by medically acceptable clinical and laboratory diagnostic techniques--that could reasonably be expected to produce the individual's pain or other symptoms.[3] The finding that an individual's impairment(s) could reasonably be expected to produce the individual's pain or other symptoms does not involve a determination as to the intensity, persistence, or functionally limiting effects of the individual's symptoms. If there is no medically determinable physical or mental impairment(s), or if there is a medically determinable physical or mental impairment(s) but the impairment(s) could not reasonably be expected to produce the individual's pain or other symptoms, the symptoms cannot be found to affect the individual's ability to do basic work activities.

- Second, once an underlying physical or mental impairment(s) that could reasonably be expected to produce the individual's pain or other symptoms has been shown, the adjudicator must evaluate the intensity, persistence, and limiting effects of the individual's symptoms to determine the extent to which the symptoms limit the individual's ability to do basic work activities. For this purpose, whenever the individual's statements about the intensity, persistence, or functionally limiting effects of pain or other symptoms are not substantiated by objective medical evidence, the adjudicator must make a finding on the credibility of the individual's statements based on a consideration of the entire case record. This includes the medical signs and laboratory findings, the individual's own statements about the symptoms, any statements and other information provided by treating or examining physicians or psychologists and other persons about the symptoms and how they affect the individual, and any other relevant evidence in the case record. This requirement for a finding on the credibility of the individual's statements about symptoms and their effects is reflected in 20 CFR 404.1529(c)(4) and 416.929(c)(4). These provisions of the regulations provide that an individual's symptoms, including pain, will be determined to diminish the individual's capacity for basic work activities to the extent that the individual's alleged functional limitations and restrictions due to symptoms can reasonably be accepted as consistent with the objective medical evidence and other evidence in the case record.

When additional information is needed to assess the credibility of the individual's statements about symptoms and their effects, the adjudicator must make every reasonable effort to obtain available information that could shed light on the credibility of the individual's statements. In recognition of the fact that an individual's symptoms can sometimes suggest a greater level of severity of impairment than can be shown by the objective medical evidence alone, 20 CFR 404.1529(c) and 416.929(c) describe the kinds of evidence, including the factors below, that the adjudicator must consider in addition to the objective medical evidence when assessing the credibility of an individual's statements:

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

Once the adjudicator has determined the extent to which the individual's symptoms limit the individual's ability to do basic work activities by making a finding on the credibility of the individual's statements, the impact of the symptoms on the individual's ability to function must be considered along with the objective medical and other evidence, first in determining whether the individual's impairment or combination of impairments is "severe" at step 2 of the sequential evaluation process for determining disability and, as necessary, at each subsequent step of the process.[4] (See SSR 96-3p, "Titles II and XVI: Considering Allegations of Pain and Other Symptoms in Determining Whether a Medically Determinable Impairment is Severe," and SSR 96-8p, "Titles II and XVI: Assessing Residual Functional Capacity in Initial Claims.")

POLICY INTERPRETATION: A symptom is an individual's own description of his or her physical or mental impairment(s). Once the existence of a medically determinable physical or mental impairment(s) that could reasonably be expected to produce pain or other symptoms has been established, adjudicators must recognize that individuals may experience their symptoms differently and may be limited by their symptoms to a greater or lesser extent than other individuals with the same medical impairments and the same medical signs and laboratory findings. Because symptoms, such as pain, sometimes suggest a greater severity of impairment than can be shown by objective medical evidence alone, any statements of the individual concerning his or her symptoms must be carefully considered if a fully favorable determination or decision cannot be made solely on the basis of objective medical evidence.

If an individual's statements about pain or other symptoms are not substantiated by the objective medical evidence, the adjudicator must consider all of the evidence in the case record, including any statements by the individual and other persons concerning the individual's symptoms. The adjudicator must then make a finding on the credibility of the individual's statements about symptoms and their functional effects.

Credibility

In general, the extent to which an individual's statements about symptoms can be relied upon as probative evidence in determining whether the individual is disabled depends on the credibility of the statements. In basic terms, the credibility of an individual's statements about pain or other symptoms and their functional effects is the degree to which the statements can be believed and accepted as true. When evaluating the credibility of an individual's statements, the adjudicator must consider the entire case record and give specific reasons for the weight given to the individual's statements.

The finding on the credibility of the individual's statements cannot be based on an intangible or intuitive notion about an individual's credibility. The reasons for the credibility finding must be grounded in the evidence and articulated in the determination or decision. It is not sufficient to make a conclusory statement that "the individual's allegations have been considered" or that "the allegations are (or are not) credible." It is also not enough for the adjudicator simply to recite the factors that are described in the regulations for evaluating symptoms. The determination or decision must contain specific

reasons for the finding on credibility, supported by the evidence in the case record, and must be sufficiently specific to make clear to the individual and to any subsequent reviewers the weight the adjudicator gave to the individual's statements and the reasons for that weight. This documentation is necessary in order to give the individual a full and fair review of his or her claim, and in order to ensure a well- reasoned determination or decision.

In making a finding about the credibility of an individual's statements, the adjudicator need not totally accept or totally reject the individual's statements. Based on a consideration of all of the evidence in the case record, the adjudicator may find all, only some, or none of an individual's allegations to be credible. The adjudicator may also find an individual's statements, such as statements about the extent of functional limitations or restrictions due to pain or other symptoms, to be credible to a certain degree. For example, an adjudicator may find credible an individual's statement that the abilities to lift and carry are affected by symptoms, but find only partially credible the individual's statements as to the extent of the functional limitations or restrictions due to symptoms; i.e., that the individual's abilities to lift and carry are compromised, but not to the degree alleged. Conversely, an adjudicator may find credible an individual's statement that symptoms limit his or her ability to concentrate, but find that the limitation is greater than that stated by the individual.

Moreover, a finding that an individual's statements are not credible, or not wholly credible, is not in itself sufficient to establish that the individual is not disabled. All of the evidence in the case record, including the individual's statements, must be considered before a conclusion can be made about disability.

Factors in Evaluating Credibility

Assessment of the credibility of an individual's statements about pain or other symptoms and about the effect the symptoms have on his or her ability to function must be based on a consideration of all of the evidence in the case record. This includes, but is not limited to:

- The medical signs and laboratory findings;
- Diagnosis, prognosis, and other medical opinions provided by treating or examining physicians or psychologists and other medical sources; and
- Statements and reports from the individual and from treating or examining physicians or psychologists and other persons about the individual's medical history, treatment and response, prior work record and efforts to work, daily activities, and other information concerning the individual's symptoms and how the symptoms affect the individual's ability to work.

The adjudicator must also consider any observations about the individual recorded by Social Security Administration (SSA) employees during interviews, whether in person or by telephone. In instances where the individual attends an administrative proceeding conducted by the adjudicator, the adjudicator may also consider his or her own recorded

observations of the individual as part of the overall evaluation of the credibility of the individual's statements.

Consideration of the individual's statements and the statements and reports of medical sources and other persons with regard to the seven factors listed in the regulations,[5] along with any other relevant information in the case record, including the information described above, will provide the adjudicator with an overview of the individual's subjective complaints. The adjudicator must then evaluate all of this information and draw appropriate inferences and conclusions about the credibility of the individual's statements.

The following sections provide additional guidelines for the adjudicator to consider when evaluating the credibility of an individual's statements.

Consistency

One strong indication of the credibility of an individual's statements is their consistency, both internally and with other information in the case record. The adjudicator must consider such factors as:

- The degree to which the individual's statements are consistent with the medical signs and laboratory findings and other information provided by medical sources, including information about medical history and treatment.
- The consistency of the individual's own statements. The adjudicator must compare statements made by the individual in connection with his or her claim for disability benefits with statements he or she made under other circumstances, when such information is in the case record. Especially important are statements made to treating or examining medical sources and to the "other sources" defined in 20 CFR 404.1513(e) and 416.913(e). The adjudicator must also look at statements the individual made to SSA at each prior step of the administrative review process and in connection with any concurrent claim or, when available, prior claims for disability benefits under titles II and XVI. Likewise, the case record may contain statements the individual made in connection with claims for other types of disability benefits, such as workers' compensation, benefits under programs of the Department of Veterans Affairs, or private insurance benefits. However, the lack of consistency between an individual's statements and other statements that he or she has made at other times does not necessarily mean that the individual's statements are not credible. Symptoms may vary in their intensity, persistence, and functional effects, or may worsen or improve with time, and this may explain why the individual does not always allege the same intensity, persistence, or functional effects of his or her symptoms. Therefore, the adjudicator will need to review the case record to determine whether there are any explanations for any variations in the individual's statements about symptoms and their effects.
- The consistency of the individual's statements with other information in the case record, including reports and observations by other persons concerning the

individual's daily activities, behavior, and efforts to work. This includes any observations recorded by SSA employees in interviews and observations recorded by the adjudicator in administrative proceedings.

Medical Evidence

Symptoms cannot be measured objectively through clinical or laboratory diagnostic techniques; however, their effects can often be clinically observed. The regulations at 20 CFR 404.1529(c)(2) and 416.929(c)(2) provide that objective medical evidence "is a useful indicator to assist us in making reasonable conclusions about the intensity and persistence of" an individual's symptoms and the effects those symptoms may have on the individual's ability to function. The examples in the regulations (reduced joint motion, muscle spasm, sensory deficit, and motor disruption) illustrate findings that may result from, or be associated with, the symptom of pain. When present, these findings tend to lend credibility to an individual's allegations about pain or other symptoms and their functional effects.

When there are medical signs and laboratory findings demonstrating the existence of a medically determinable physical or mental impairment(s) that could reasonably be expected to produce the pain or other symptoms, the adjudicator must always attempt to obtain any available objective medical evidence concerning the intensity and persistence of the pain or other symptoms, and, when such evidence is obtained, must consider it in evaluating the individual's statements. *However, allegations concerning the intensity and persistence of pain or other symptoms may not be disregarded solely because they are not substantiated by objective medical evidence.* A report of negative findings from the application of medically acceptable clinical and laboratory diagnostic techniques is one of the many factors that appropriately are to be considered in the overall assessment of credibility. However, the absence of objective medical evidence supporting an individual's statements about the intensity and persistence of pain or other symptoms is only one factor that the adjudicator must consider in assessing an individual's credibility and must be considered in the context of all the evidence.

Over time, there may also be medical signs and laboratory findings that, though not directly supporting or refuting statements about the intensity or persistence of pain or other symptoms, demonstrate worsening or improvement of the underlying medical condition. Such signs and findings may also help an adjudicator to draw appropriate inferences about the credibility of an individual's statements.

Apart from the medical signs and laboratory findings, the medical evidence, especially a longitudinal medical record, can be extremely valuable in the adjudicator's evaluation of an individual's statements about pain or other symptoms. Important information about symptoms recorded by medical sources and reported in the medical evidence may include:

- Onset, description of the character and location of the symptoms, precipitating and aggravating factors, frequency and duration, course over time (e.g., whether worsening, improving, or static), and daily activities. Very often, this information will have been obtained by the medical source from the individual and may be compared with the individual's other statements in the case record. However, the evidence provided by a medical source may also contain medical opinions of the source about the individual's symptoms and their effects, and such opinions must be weighed applying the factors in 20 CFR 404.1527 and 416.927.
- A longitudinal record of any treatment and its success or failure, including any side effects of medication.
- Indications of other impairments, such as potential mental impairments, that could account for the allegations.

Although longitudinal records showing regular contact with a treating source are the most desirable, longitudinal medical records can be valuable even when they are not treating source records. For example, an individual may receive treatment at a clinic and see different physicians, but the clinic records may still show a longitudinal history of complaints and attempts at relief.

Medical Treatment History

In general, a longitudinal medical record demonstrating an individual's attempts to seek medical treatment for pain or other symptoms and to follow that treatment once it is prescribed lends support to an individual's allegations of intense and persistent pain or other symptoms for the purposes of judging the credibility of the individual's statements. Persistent attempts by the individual to obtain relief of pain or other symptoms, such as by increasing medications, trials of a variety of treatment modalities in an attempt to find one that works or that does not have side effects, referrals to specialists, or changing treatment sources may be a strong indication that the symptoms are a source of distress to the individual and generally lend support to an individual's allegations of intense and persistent symptoms.[6]

On the other hand, the individual's statements may be less credible if the level or frequency of treatment is inconsistent with the level of complaints, or if the medical reports or records show that the individual is not following the treatment as prescribed and there are no good reasons for this failure. However, the adjudicator must not draw any inferences about an individual's symptoms and their functional effects from a failure to seek or pursue regular medical treatment without first considering any explanations that the individual may provide, or other information in the case record, that may explain infrequent or irregular medical visits or failure to seek medical treatment. The adjudicator may need to recontact the individual or question the individual at the administrative proceeding in order to determine whether there are good reasons the individual does not seek medical treatment or does not pursue treatment in a consistent manner. The explanations provided by the individual may provide insight into the individual's credibility. For example:

- The individual's daily activities may be structured so as to minimize symptoms to a tolerable level or eliminate them entirely, avoiding physical or mental stressors that would exacerbate the symptoms. The individual may be living with the symptoms, seeing a medical source only as needed for periodic evaluation and renewal of medications.
- The individual's symptoms may not be severe enough to prompt the individual to seek ongoing medical attention or may be relieved with over-the-counter medications.
- The individual may not take prescription medication because the side effects are less tolerable than the symptoms.
- The individual may be unable to afford treatment and may not have access to free or low-cost medical services.
- The individual may have been advised by a medical source that there is no further, effective treatment that can be prescribed and undertaken that would benefit the individual.
- Medical treatment may be contrary to the teaching and tenets of the individual's religion.

Other Sources of Information

Other sources may provide information from which inferences and conclusions may be drawn about the credibility of the individual's statements. Such sources may provide information about the seven factors listed in the regulations and may be especially helpful in establishing a longitudinal record. Examples of such sources include public and private agencies, other practitioners, and nonmedical sources such as family and friends.

Observations of the Individual

In instances in which the adjudicator has observed the individual, the adjudicator is not free to accept or reject the individual's complaints solely on the basis of such personal observations, but should consider any personal observations in the overall evaluation of the credibility of the individual's statements.

In evaluating the credibility of the individual's statements, the adjudicator must also consider any observations recorded by SSA personnel who previously interviewed the individual, whether in person or by telephone.

Consideration of Findings by State Agency and Other Program Physicians and Psychologists at the Administrative Law Judge and Appeals Council Levels of Administrative Review

Under 20 CFR 404.1527(f) and 416.927(f), administrative law judges and the Appeals Council are required to consider findings of fact by State agency medical and psychological consultants and other program physicians and psychologists about the existence and severity of an individual's impairment(s), including the existence and

severity of any symptoms, as opinions of nonexamining physicians and psychologists. Administrative law judges and the Appeals Council are not bound by any State agency findings, but they may not ignore these opinions and must explain the weight given to the opinions in their decisions. Therefore, if the case record includes a finding by a State agency medical or psychological consultant or other program physician or psychologist on the credibility of the individual's statements about limitations or restrictions due to symptoms, the adjudicator at the administrative law judge or Appeals Council level of administrative review must consider and weigh this opinion of a nonexamining source under the applicable rules in 20 CFR 404.1527 and 416.927 and must explain the weight given to the opinion in the decision. (See SSR 96-6p, "Titles II and XVI: Consideration of Administrative Findings of Fact by State Agency Medical and Psychological Consultants and Other Program Physicians and Psychologists at the Administrative Law Judge and Appeals Council Levels of Administrative Review; Medical Equivalence.")

EFFECTIVE DATE: This Ruling is effective on the date of its publication in the *Federal Register.*

CROSS-REFERENCES: SSR 96-3p, "Titles II and XVI: Considering Allegations of Pain and Other Symptoms in Determining Whether a Medically Determinable Impairment is Severe," SSR 96-8p, "Titles II and XVI: Assessing Residual Functional Capacity in Initial Claims," SSR 96-6p, "Titles II and XVI: Consideration of Administrative Findings of Fact by State Agency Medical and Psychological Consultants and Other Program Physicians and Psychologists at the Administrative Law Judge and Appeals Council Levels of Administrative Review; Medical Equivalence;" and Program Operations Manual System, sections DI 24515.061 and DI 24515.064.B.3.

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[1] For clarity, the discussions in this Ruling refer only to claims of individuals claiming disability benefits under title II and individuals age 18 or older claiming disability benefits under title XVI. However, the same basic principles with regard to determining whether statements about symptoms are credible also apply to claims of individuals under age 18 claiming disability benefits under title XVI.

[2] For an individual under age 18 claiming disability benefits under title XVI who is unable to adequately describe his or her symptom(s), the adjudicator will accept as a statement of this symptom(s) the description given by the person most familiar with the individual, such as a parent, other relative, or guardian. 20 CFR 416.928(a).

[3] The adjudicator must develop evidence regarding the possibility of a medically determinable mental impairment when the record contains information to suggest that such an impairment exists, and the individual alleges pain or other symptoms, but the medical signs and laboratory findings do not substantiate any physical impairment(s) capable of producing the pain or other symptoms.

[4] In determining whether the impairment(s) of an individual claiming disability benefits under title II or an individual age 18 or older claiming disability benefits under title XVI is medically equivalent to a listed impairment in appendix 1 of subpart P of 20 CFR Part 404, the adjudicator will not substitute allegations of pain or other symptoms for a missing or deficient sign or laboratory finding to raise the severity of the individual's impairment(s) to that of a listed impairment. 20 CFR 404.1529(d)(3) and 416.929(d)(3). In determining whether the impairment(s) of an individual under age 18 claiming disability benefits under title XVI is equivalent to a listed impairment, if the adjudicator cannot find equivalence based on medical evidence only, the adjudicator will consider pain or another symptom(s) under 20 CFR 416.926a(b)(3) in determining whether the individual has an impairment(s) that results in overall functional limitations that are the same as the disabling functional consequences of a listed impairment. 20 CFR 416.929(d)(3).

[5] The seven factors are also set out in the "Introduction," above.

[6] The adjudicator must also remember that medical treatment need not always be specifically for the relief of a symptom. Often, treatment will be aimed at ameliorating the underlying medical condition which, in turn, may result in improvement in symptoms. The treatment may also cause symptoms as a side effect.

SSR 96-8p

EFFECTIVE/PUBLICATION DATE: 07/02/96

SSR 96-8p: POLICY INTERPRETATION RULING TITLES II AND XVI: ASSESSING RESIDUAL FUNCTIONAL CAPACITY IN INITIAL CLAIMS

PURPOSE: To state the Social Security Administration's policies and policy interpretations regarding the assessment of residual functional capacity (RFC) in initial claims for disability benefits under titles II and XVI of the Social Security Act (the Act). In particular, to emphasize that:

1. Ordinarily, RFC is an assessment of an individual's ability to do sustained work-related physical and mental activities in a work setting on a regular and continuing basis. A "regular and continuing basis" means 8 hours a day, for 5 days a week, or an equivalent work schedule.
2. The RFC assessment considers only functional limitations and restrictions that result from an individual's medically determinable impairment or combination of impairments, including the impact of any related symptoms. Age and body habitus are not factors in assessing RFC. It is incorrect to find that an individual has limitations beyond those caused by his or her medically determinable impairment(s) and any related symptoms, due to such factors as age and natural body build, and the activities the individual was accustomed to doing in his or her previous work.
3. When there is no allegation of a physical or mental limitation or restriction of a specific functional capacity, and no information in the case record that there is such a limitation or restriction, the adjudicator must consider the individual to have no limitation or restriction with respect to that functional capacity.
4. The RFC assessment must first identify the individual's functional limitations or restrictions and assess his or her work-related abilities on a function-by-function basis, including the functions in paragraphs (b), (c), and (d) of 20 CFR 404.1545 and 416.945. Only after that may RFC be expressed in terms of the exertional levels of work, sedentary, light, medium, heavy, and very heavy.
5. RFC is not the *least* an individual can do despite his or her limitations or restrictions, but the *most.*

6. Medical impairments and symptoms, including pain, are not intrinsically exertional or nonexertional. It is the functional limitations or restrictions caused by medical impairments and their related symptoms that are categorized as exertional or nonexertional.

CITATIONS (AUTHORITY): Sections 223(d) and 1614(a) of the Social Security Act, as amended; Regulations No. 4, subpart P, sections 404.1513, 404.1520, 404.1520a, 404.1545, 404.1546, 404.1560, 404.1561, 404.1569a, and appendix 2; and Regulations No. 16, subpart I, sections 416.913, 416.920, 416.920a, 416.945, 416.946, 416.960, 416.961, and 416.969a.

INTRODUCTION: In disability determinations and decisions made at steps 4 and 5 of the sequential evaluation process in 20 CFR 404.1520 and 416.920, in which the individual's ability to do past relevant work and other work must be considered, the adjudicator must assess RFC. This Ruling clarifies the term "RFC" and discusses the elements considered in the assessment. It describes concepts for both physical and mental RFC assessments.

This Ruling applies to the assessment of RFC in claims for initial entitlement to disability benefits under titles II and XVI. Although most rules and procedures regarding RFC assessment in deciding whether an individual's disability continues are the same, there are some differences.

POLICY INTERPRETATION:

GENERAL

When an individual is not engaging in substantial gainful activity and a determination or decision cannot be made on the basis of medical factors alone (i.e., when the impairment is severe because it has more than a minimal effect on the ability to do basic work activities yet does not meet or equal in severity the requirements of any impairment in the Listing of Impairments), the sequential evaluation process generally must continue with an identification of the individual's functional limitations and restrictions and an assessment of his or her remaining capacities for work-related activities.[1] This assessment of RFC is used at step 4 of the sequential evaluation process to determine whether an individual is able to do past relevant work, and at step 5 to determine whether an individual is able to do other work, considering his or her age, education, and work experience.

Definition of RFC. RFC is what an individual can still do despite his or her limitations. RFC is an administrative assessment of the extent to which an individual's medically determinable impairment(s), including any related symptoms, such as pain, may cause physical or mental limitations or restrictions that may affect his or her capacity to do work- related physical and mental activities. (See SSR 96-4p, "Titles II and XVI: Symptoms, Medically Determinable Physical and Mental Impairments, and Exertional and Nonexertional Limitations.") Ordinarily, RFC is the individual's *maximum* remaining

ability to do sustained work activities in an ordinary work setting on a **regular and continuing** basis, and the RFC assessment must include a discussion of the individual's abilities on that basis. A "regular and continuing basis" means 8 hours a day, for 5 days a week, or an equivalent work schedule.[2] RFC does not represent the *least* an individual can do despite his or her limitations or restrictions, but the *most.*[3] RFC is assessed by adjudicators at each level of the administrative review process based on all of the relevant evidence in the case record, including information about the individual's symptoms and any "medical source statements" -- i.e., opinions about what the individual can still do despite his or her impairment(s)-- submitted by an individual's treating source or other acceptable medical sources.[4]

The RFC Assessment Must be Based Solely on the Individual's Impairment(s). The Act requires that an individual's inability to work must result from the individual's physical or mental impairment(s). Therefore, in assessing RFC, the adjudicator must consider only limitations and restrictions attributable to medically determinable impairments. **It is incorrect to find that an individual has limitations or restrictions beyond those caused by his or her medical impairment(s) including any related symptoms, such as pain, due to factors such as age or height, or whether the individual had ever engaged in certain activities in his or her past relevant work (e.g., lifting heavy weights.)** Age and body habitus (i.e., natural body build, physique, constitution, size, and weight, insofar as they are unrelated to the individual's medically determinable impairment(s) and related symptoms) are not factors in assessing RFC in initial claims.[5]

Likewise, when there is no allegation of a physical or mental limitation or restriction of a specific functional capacity, and no information in the case record that there is such a limitation or restriction, the adjudicator must consider the individual to have no limitation or restriction with respect to that functional capacity.

RFC AND SEQUENTIAL EVALUATION

RFC is an issue only at steps 4 and 5 of the sequential evaluation process. The following are issues regarding the RFC assessment and its use at each of these steps.

RFC and exertional levels of work. The RFC assessment is a function-by-function assessment based upon all of the relevant evidence of an individual's ability to do work-related activities. At step 4 of the sequential evaluation process, the RFC must not be expressed initially in terms of the exertional categories of "sedentary," "light," "medium," "heavy," and "very heavy" work because the first consideration at this step is whether the individual can do past relevant work as he or she actually performed it.

RFC may be expressed in terms of an exertional category, such as light, if it becomes necessary to assess whether an individual is able to do his or her past relevant work as it is generally performed in the national economy. However, without the initial function-by-function assessment of the individual's physical and mental capacities, it may not be possible to determine whether the individual is able to do past relevant work as it is generally performed in the national economy because particular occupations may not

require all of the exertional and nonexertional demands necessary to do the full range of work at a given exertional level.

At step 5 of the sequential evaluation process, RFC must be expressed in terms of, or related to, the exertional categories when the adjudicator determines whether there is other work the individual can do. However, in order for an individual to do a full range of work at a given exertional level, such as sedentary, the individual must be able to perform substantially all of the exertional and nonexertional functions required in work at that level. Therefore, it is necessary to assess the individual s capacity to perform each of these functions in order to decide which exertional level is appropriate and whether the individual is capable of doing the full range of work contemplated by the exertional level.

Initial failure to consider an individual's ability to perform the specific work-related functions could be critical to the outcome of a case. For example:

1. At step 4 of the sequential evaluation process, it is especially important to determine whether an individual who is at least "closely approaching advanced age" is able to do past relevant work because failure to address this issue at step 4 can result in an erroneous finding that the individual is disabled at step 5. It is very important to consider first whether the individual can still do past relevant work as he or she *actually* performed it because individual jobs within an occupational category as performed for particular employers may not entail all of the requirements of the exertional level indicated for that category in the *Dictionary of Occupational Titles* and its related volumes.
2. The opposite result may also occur at step 4 of the sequential evaluation process. When it is found that an individual cannot do past relevant work as he or she actually performed it, the adjudicator must consider whether the individual can do the work as it is generally performed in the national economy. Again, however, a failure to first make a function-by-function assessment of the individual's limitations or restrictions could result in the adjudicator overlooking some of an individual's limitations or restrictions. This could lead to an incorrect use of an exertional category to find that the individual is able to do past relevant work as it is generally performed and an erroneous finding that the individual is not disabled.
3. At step 5 of the sequential evaluation process, the same failures could result in an improper application of the rules in appendix 2 to subpart P of the Regulations No. 4 (the "Medical-Vocational Guidelines) and could make the difference between a finding of "disabled" and "not disabled." Without a careful consideration of an individual's functional capacities to support an RFC assessment based on an exertional category, the adjudicator may either overlook limitations or restrictions that would narrow the ranges and types of work an individual may be able to do, or find that the individual has limitations or restrictions that he or she does not actually have.
4.

RFC represents the most that an individual can do despite his or her limitations or restrictions. At step 5 of the sequential evaluation process, RFC must not be expressed in terms of the lowest exertional level (e.g., "sedentary" or "light" when the individual can perform "medium" work) at which the medical-vocational rules would still direct a finding of "not disabled." This would concede lesser functional abilities than the individual actually possesses and would not reflect the *most* he or she can do based on the evidence in the case record, as directed by the regulations.[6]

The psychiatric review technique. The psychiatric review technique described in 20 CFR 404.1520a and 416.920a and summarized on the Psychiatric Review Technique Form (PRTF) requires adjudicators to assess an individual's limitations and restrictions from a mental impairment(s) in categories identified in the "paragraph B" and "paragraph C" criteria of the adult mental disorders listings. The adjudicator must remember that the limitations identified in the "paragraph B" and "paragraph C" criteria are not an RFC assessment but are used to rate the severity of mental impairment(s) at steps 2 and 3 of the sequential evaluation process. The mental RFC assessment used at steps 4 and 5 of the sequential evaluation process requires a more detailed assessment by itemizing various functions contained in the broad categories found in paragraphs B and C of the adult mental disorders listings in 12.00 of the Listing of Impairments, and summarized on the PRTF.

EVIDENCE CONSIDERED

The RFC assessment must be based on *all* of the relevant evidence in the case record, such as:

- Medical history,
- Medical signs and laboratory findings,
- The effects of treatment, including limitations or restrictions imposed by the mechanics of treatment (e.g., frequency of treatment, duration, disruption to routine, side effects of medication),
- Reports of daily activities,
- Lay evidence,
- Recorded observations,
- Medical source statements,
- Effects of symptoms, including pain, that are reasonably attributed to a medically determinable impairment,
- Evidence from attempts to work,
- Need for a structured living environment, and
- Work evaluations, if available.

The adjudicator must consider all allegations of physical and mental limitations or restrictions and make every reasonable effort to ensure that the file contains sufficient evidence to assess RFC. Careful consideration must be given to any available information about symptoms because subjective descriptions may indicate more severe limitations or restrictions than can be shown by objective medical evidence alone.

In assessing RFC, the adjudicator must consider limitations and restrictions imposed by all of an individual's impairments, even those that are not "severe." While a "not severe" impairment(s) standing alone may not significantly limit an individual's ability to do basic work activities, it may--when considered with limitations or restrictions due to other impairments--be critical to the outcome of a claim. For example, in combination with limitations imposed by an individual's other impairments, the limitations due to such a "not severe" impairment may prevent an individual from performing past relevant work or may narrow the range of other work that the individual may still be able to do.

EXERTIONAL AND NONEXERTIONAL FUNCTIONS

The RFC assessment must address both the remaining exertional and nonexertional capacities of the individual.

Exertional capacity

Exertional capacity addresses an individual's limitations and restrictions of physical strength and defines the individual's remaining abilities to perform each of seven strength demands: Sitting, standing, walking, lifting, carrying, pushing, and pulling. Each function must be considered separately (e.g., "the individual can walk for 5 out of 8 hours and stand for 6 out of 8 hours"), even if the final RFC assessment will combine activities (e.g., "walk/stand, lift/carry, push/pull"). Although the regulations describing the exertional levels of work and the *Dictionary of Occupational Titles* and its related volumes pair some functions, it is not invariably the case that treating the activities together will result in the same decisional outcome as treating them separately.

It is especially important that adjudicators consider the capacities separately when deciding whether an individual can do past relevant work. However, separate consideration may also influence decisionmaking at step 5 of the sequential evaluation process, for reasons already given in the section on "RFC and Sequential Evaluation."

Nonexertional capacity

Nonexertional capacity considers all work-related limitations and restrictions that do not depend on an individual's physical strength; i.e., all physical limitations and restrictions that are not reflected in the seven strength demands, and mental limitations and restrictions. It assesses an individual's abilities to perform physical activities such as postural (e.g., stooping, climbing), manipulative (e.g., reaching, handling), visual (seeing), communicative (hearing, speaking), and mental (e.g., understanding and remembering instructions and responding appropriately to supervision). In addition to these activities, it also considers the ability to tolerate various environmental factors (e.g., tolerance of temperature extremes).

As with exertional capacity, nonexertional capacity must be expressed in terms of work-related functions. For example, in assessing RFC for an individual with a visual impairment, the adjudicator must consider the individual's residual capacity to perform such work-related functions as working with large or small objects, following instructions, or avoiding ordinary hazards in the workplace. In assessing RFC with impairments affecting hearing or speech, the adjudicator must explain how the individual's limitations would affect his or her ability to communicate in the workplace. Work-related mental activities generally required by competitive, remunerative work include the abilities to: understand, carry out, and remember instructions; use judgment in making work-related decisions; respond appropriately to supervision, co-workers and work situations; and deal with changes in a routine work setting.

Consider the nature of the activity affected

It is the nature of an individual's limitations or restrictions that determines whether the individual will have only exertional limitations or restrictions, only nonexertional limitations or restrictions, or a combination of exertional and nonexertional limitations or restrictions. For example, symptoms, including pain, are not intrinsically exertional or nonexertional. Symptoms often affect the capacity to perform one of the seven strength demands and may or may not have effects on the demands of occupations other than the strength demands. If the only limitations or restrictions caused by symptoms, such as pain, are in one or more of the seven strength demands (e.g., lifting) the limitations or restrictions will be exertional. On the other hand, if an individual's symptoms cause a limitation or restriction that affects the individual's ability to meet the demands of occupations other than their strength demands (e.g., manipulation or concentration), the limitation or restriction will be classified as nonexertional. Symptoms may also cause both exertional and nonexertional limitations.

Likewise, even though mental impairments usually affect nonexertional functions, they may also limit exertional capacity by affecting one or more of the seven strength demands. For example, a mental impairment may cause fatigue or hysterical paralysis.

NARRATIVE DISCUSSION REQUIREMENTS

The RFC assessment must include a narrative discussion describing how the evidence supports each conclusion, citing specific medical facts (e.g., laboratory findings) and nonmedical evidence (e.g., daily activities, observations). In assessing RFC, the adjudicator must discuss the individual's ability to perform sustained work activities in an ordinary work setting on a regular and continuing basis (i.e., 8 hours a day, for 5 days a week, or an equivalent work schedule)[7], and describe the maximum amount of each work-related activity the individual can perform based on the evidence available in the case record. The adjudicator must also explain how any material inconsistencies or ambiguities in the evidence in the case record were considered and resolved.

Symptoms. In all cases in which symptoms, such as pain, are alleged, the RFC assessment must:

- Contain a thorough discussion and analysis of the objective medical and other evidence, including the individual's complaints of pain and other symptoms and the adjudicator's personal observations, if appropriate;
- Include a resolution of any inconsistencies in the evidence as a whole; and
- Set forth a logical explanation of the effects of the symptoms, including pain, on the individual's ability to work.

The RFC assessment must include a discussion of why reported symptom-related functional limitations and restrictions can or cannot reasonably be accepted as consistent with the medical and other evidence. In instances in which the adjudicator has observed the individual, he or she is not free to accept or reject that individual's complaints *solely* on the basis of such personal observations. (For further information about RFC assessment and the evaluation of symptoms, see SSR 96-7p, "Titles II and XVI: Evaluation of Symptoms in Disability Claims: Assessing the Credibility of an Individual's Statements.")

Medical opinions. The RFC assessment must always consider and address medical source opinions. If the RFC assessment conflicts with an opinion from a medical source, the adjudicator must explain why the opinion was not adopted.

Medical opinions from treating sources about the nature and severity of an individual's impairment(s) are entitled to special significance and may be entitled to controlling weight. If a treating source's medical opinion on an issue of the nature and severity of an individual's impairment(s) is well-supported by medically acceptable clinical and laboratory diagnostic techniques and is not inconsistent with the other substantial evidence in the case record, the adjudicator must give it controlling weight. (See SSR 96-2p, "Titles II and XVI: Giving Controlling Weight to Treating Source Medical Opinions," and SSR 96-5p, "Titles II and XVI: Medical Source Opinions on Issues Reserved to the Commissioner.")[8]

EFFECTIVE DATE: This ruling is effective on the date of its publication in the *Federal Register*.

CROSS-REFERENCES: SSR 82-52, "Titles II and XVI: Duration of the Impairment" (C.E. 1981-1985, p. 328), SSR 82-61, "Titles II and XVI: Past Relevant Work--The Particular Job Or the Occupation As Generally Performed" (C.E. 1981-1985, p. 427), SSR 82-62, "Titles II and XVI: A Disability Claimant's Capacity To Do Past Relevant Work, In General" (C.E. 1981-1985, p. 400), SSR 83-20, "Titles II and XVI: Onset of Disability" (C.E. 1981-1985, p. 375), SSR 85-16, "Titles II and XVI: Residual Functional Capacity for Mental Impairments" (C.E. 1981-1985, p. 390), SSR 86-8, "Titles II and XVI: The Sequential Evaluation Process" (C.E. 1986, p. 78), SSR 96-6p, "Titles II and XVI: Consideration of Administrative Findings of Fact by State Agency Medical and Psychological Consultants and Other Program Physicians and Psychologists at the

Administrative Law Judge and Appeals Council Levels of Administrative Review; Medical Equivalence," SSR 96-2p, "Titles II and XVI: Giving Controlling Weight to Treating Source Medical Opinions," SSR 96-4p, "Titles II and XVI: Symptoms, Medically Determinable Physical and Mental Impairments, and Exertional and Nonexertional Limitations," SSR 96-5p "Titles II and XVI: Medical Source Opinions on Issues Reserved to the Commissioner," SSR 96-9p "Titles II and XVI: Determining Capability to Do Other Work--Implications of a Residual Functional Capacity for Less Than a Full Range of Sedentary Work," SSR 96-7p, "Titles II and XVI: Evaluation of Symptoms in Disability Claims: Assessing the Credibility of an Individual's Statements;" and Program Operations Manual System, sections DI 22515.010, DI 24510.000 ff., DI 24515.002- DI 24515.007, DI 24515.061-DI 24515.062, DI 24515.064, DI 25501.000 ff., DI 25505.000 ff., and DI 28015.000 ff.

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[1] However, a finding of "disabled" will be made for an individual who: a) has a severe impairment(s), b) has no past relevant work, c) is age 55 or older, and d) has no more than a limited education. (See SSR 82-63 "Titles II and XVI: Medical- Vocational Profiles Showing an Inability to Make an Adjustment to Other Work" (C.E. 1981-1985, p. 447.) In such a case, it is not necessary to assess the individual's RFC to determine if he or she meets this special profile and is, therefore, disabled.

[2] The ability to work 8 hours a day for 5 days a week is not always required when evaluating an individual's ability to do past relevant work at step 4 of the sequential evaluation process. Part-time work that was substantial gainful activity, performed within the past 15 years, and lasted long enough for the person to learn to do it constitutes past relevant work, and an individual who retains the RFC to perform such work must be found not disabled.

[3] See SSR 83-10, "Titles II and XVI: Determining Capability to Do Other Work--The Medical Vocational Rules of Appendix 2" (C.E. 1981-1985, p. 516). SSR 83-10 states that "(T)he RFC determines a work capability that is exertionally sufficient to allow performance of at least substantially all of the activities of work at a particular level (e.g., sedentary, light, or medium), but is also insufficient to allow substantial performance of work at greater exertional levels."

[4] For a detailed discussion of the difference between the RFC assessment, which is an administrative finding of fact, and the opinion evidence called the "medical source statement" or "MSS," see SSR 96-5p, "Titles II and XVI: Medical Source Opinions on Issues Reserved to the Commissioner."

[5] The definition of disability in the Act requires that an individual's inability to work must be due to a medically determinable physical or mental impairment(s). The assessment of RFC must therefore be concerned with the impact of a disease process or injury on the individual. In determining a person's maximum RFC for sustained activity, factors of age or body habitus must not be allowed to influence the assessment.

[6] In the Fourth Circuit, adjudicators are required to adopt a finding, absent new and material evidence, regarding the individual's RFC made in a final decision by an administrative law judge or the Appeals Council on a prior disability claim arising under the same title of the Act. In this jurisdiction, an unfavorable determination or decision using the lowest exertional level at which the rules would direct a finding of not disabled could result in an unwarranted favorable determination or decision on an individual's subsequent application; for example, if the individual's age changes to a higher age category following the final decision on the earlier application. See Acquiescence Ruling (AR) 94-2(4), "Lively v. Secretary of Health and Human Services, 820 F.2d 1391 (4th Cir. 1987)--Effect of Prior Disability Findings on Adjudication of a Subsequent Disability Claim Arising Under the Same Title of the Social Security Act--Titles II and XVI of the Social Security Act." AR 94-2(4) applies to disability findings in cases involving claimants who reside in the Fourth Circuit at the time of the determination or decision on the subsequent claim.

[7] See Footnote 2.

[8] A medical source opinion that an individual is "disabled" or "unable to work," has an impairment(s) that meets or is equivalent in severity to the requirements of a listing, has a particular RFC, or that concerns the application of vocational factors, is an opinion on an issue reserved to the Commissioner. Every such opinion must still be considered in adjudicating a disability claim; however, the adjudicator will not give any special significance to the opinion because of its source. See SSR 96-5p, "Titles II and XVI: Medical Source Opinions on Issues Reserved to the Commissioner." For further information about the evaluation of medical source opinions, SSR 96-6p, "Titles II and XVI: Consideration of Administrative Findings of Fact by State Agency Medical and Psychological Consultants and Other Program Physicians and Psychologists at the Administrative Law Judge and Appeals Council Levels of Administrative Review; Medical Equivalence."

SSR 96-9p

EFFECTIVE/PUBLICATION DATE: 07/02/96

SSR 96-9p: POLICY INTERPRETATION RULING TITLES II AND XVI: DETERMINING CAPABILITY TO DO OTHER WORK--IMPLICATIONS OF A RESIDUAL FUNCTIONAL CAPACITY FOR LESS THAN A FULL RANGE OF SEDENTARY WORK

PURPOSE: To explain the Social Security Administration's policies regarding the impact of a residual functional capacity (RFC) assessment for less than a full range of sedentary work on an individual's ability to do other work. In particular, to emphasize that:

1. An RFC for less than a full range of sedentary work reflects very serious limitations resulting from an individual's medical impairment(s) and is expected to be relatively rare.
2. However, a finding that an individual has the ability to do less than a full range of sedentary work does not necessarily equate with a decision of "disabled." If the performance of past relevant work is precluded by an RFC for less than the full range of sedentary work, consideration must still be given to whether there is other work in the national economy that the individual is able to do, considering age, education, and work experience.

CITATIONS (AUTHORITY): Sections 223(d) and 1614(a) of the Social Security Act (the Act), as amended; Regulations No. 4, sections 404.1513(c), 404.1520, 404.1520a, 404.1545, 404.1546, 404.1560, 404.1561, 404.1562, 404.1563 through 404.1567, 404.1569, 404.1569a; appendix 1 of subpart P, section 12.00; appendix 2 of subpart P, sections 200.00 and 201.00; Regulations No. 16, sections 416.913(c), 416.920, 416.920a, 416.945, 416.946, 416.960, 416.961, 416.962, 416.963 through 416.967, 416.969 and 416.969a.

INTRODUCTION: Under the sequential evaluation process, once it has been determined that an individual is not engaging in substantial gainful activity and has a "severe" medically determinable impairment(s) which, though not meeting or equaling the criteria of any listing, prevents the individual from performing past relevant work (PRW), it must be determined whether the individual can do any other work, considering the individual's RFC, age, education, and work experience.

RFC is what an individual can still do despite his or her functional limitations and restrictions caused by his or her medically determinable physical or mental impairments. It is an administrative assessment of the extent to which an individual's medically determinable impairment(s), including any related symptoms, such as pain, may cause physical or mental limitations or restrictions that may affect his or her capacity to perform work-related physical and mental activities. RFC is assessed by adjudicators at each level of the administrative review process based on all of the relevant evidence in the case record, including information about the individual's symptoms and any "medical source statements"--i.e., opinions about what the individual can still do despite a severe impairment(s)--submitted by an individual's treating source(s) or other acceptable medical source.[1]

RFC is the individual's maximum remaining ability to perform sustained work on a regular and continuing basis; i.e., 8 hours a day, for 5 days a week, or an equivalent work schedule. It is not the least an individual can do, but the most, based on all of the information in the case record. The RFC assessment considers only those limitations and restrictions that are caused by an individual's physical or mental impairments. It does not consider limitations or restrictions due to age or body habitus, since the Act requires that an individual's inability to work must result from the individual's physical or mental impairment(s). (See SSR 96-8p, "Titles II and XVI: Assessing Residual Functional Capacity in Initial Claims.")

Initially, the RFC assessment is a function-by-function assessment based upon all of the relevant evidence of an individual's ability to perform work-related activities. This RFC assessment is first used for a function-by-function comparison with the functional demands of an individual's PRW as he or she actually performed it and then, if necessary, as the work is generally performed in the national economy.[2]

However, at the last step of the sequential evaluation process, the RFC assessment is used to determine an individual's "maximum sustained work capability" and, where solely non-exertional impairments are not involved, must be expressed in terms of the exertional classifications of work: sedentary, light, medium, heavy, and very heavy work. The rules of appendix 2 of subpart P of Regulations No. 4 take administrative notice of the existence of numerous unskilled occupations within each of these exertional levels. The rules are then used to direct decisions about whether an individual is disabled or, when the individual is unable to perform the full range of work contemplated by an exertional level(s), as a framework for decisionmaking considering the individual's RFC, age, education, and work experience.

The impact of an RFC for less than a full range of sedentary work is especially critical for individuals who have not yet attained age 50. Since age, education, and work experience are not usually significant factors in limiting the ability of individuals under age 50 to make an adjustment to other work,[3] the conclusion whether such individuals who are limited to less than the full range of sedentary work are disabled will depend primarily on the nature and extent of their functional limitations or restrictions. On the other hand, since the rules in Table No. 1 of appendix 2, "Residual Functional Capacity: Maximum Sustained Work Capability Limited to Sedentary Work as a Result of Severe Medically Determinable Impairment(s)," direct a decision of "disabled" for individuals age 50 and over who are limited to a full range of sedentary work, unless the individual has transferable skills or education that provides for direct entry into skilled sedentary work, the impact of an RFC for less than the full range of sedentary work in such individuals is less critical.

POLICY INTERPRETATION: Under the regulations, "sedentary work" represents a significantly restricted range of work. Individuals who are limited to no more than sedentary work by their medical impairments have very serious functional limitations. For the majority of individuals who are age 50 or older and who are limited to the full range of sedentary work by their medical impairments, the rules and guidelines in appendix 2 require a conclusion of "disabled."

Nevertheless, the rules in Table No. 1 in appendix 2 take administrative notice that there are approximately 200 separate unskilled sedentary occupations, each representing numerous jobs, in the national economy.[4] Therefore, even though "sedentary work" represents a significantly restricted range of work, this range in itself is not so prohibitively restricted as to negate work capability for substantial gainful activity in all individuals.

Moreover, since each occupation administratively noticed by Table No. 1 represents numerous jobs, the ability to do even a *limited* range of sedentary work does not in itself establish disability in all individuals, although a finding of "disabled" usually applies when the full range of sedentary work is significantly eroded (see *Using the Rules in Table No. 1 as a Framework: "Erosion" of the Occupational Base* below). In deciding whether an individual who is limited to a partial range of sedentary work is able to make an adjustment to work other than any PRW, the adjudicator is required to make an individualized determination, considering age, education, and work experience, including any skills the individual may have that are transferable to other work, or education that provides for direct entry into skilled work, under the rules and guidelines in the regulations.

Sedentary Work

The ability to perform the full range of sedentary work requires the ability to lift no more than 10 pounds at a time and occasionally to lift or carry articles like docket files, ledgers, and small tools. Although a sedentary job is defined as one that involves sitting, a certain amount of walking and standing is often necessary in carrying out job duties. Jobs are

sedentary if walking and standing are required occasionally and other sedentary criteria are met. "Occasionally" means occurring from very little up to one- third of the time, and would generally total no more than about 2 hours of an 8-hour workday. Sitting would generally total about 6 hours of an 8-hour workday. Unskilled sedentary work also involves other activities, classified as "nonexertional," such as capacities for seeing, manipulation, and understanding, remembering, and carrying out simple instructions.

The Occupational Base for Sedentary Work

The term "occupational base" means the approximate number of occupations that an individual has the RFC to perform considering all exertional and nonexertional limitations and restrictions. (See SSR 83-10, "Titles II and XVI: Determining Capability to Do Other Work--The Medical- Vocational Rules of Appendix 2" (C.E. 1981-1985, p. 516).) A full range of sedentary work includes all or substantially all of the approximately 200[5] unskilled sedentary occupations administratively noticed in Table No. 1.

Thus, the RFC addressed by a particular rule in Table No. 1 establishes an occupational base that at a minimum includes the full range of unskilled sedentary occupations administratively noticed. The base may be broadened by the addition of specific skilled or semiskilled occupations that an individual with an RFC limited to sedentary work can perform by reason of his or her education or work experience. However, if the individual has no transferable skills or no education or training that provides for direct entry into skilled work, the occupational base represented by the rules in Table No. 1 comprises only the sedentary unskilled occupations in the national economy that such an individual can perform.

The rules in Table No. 1 direct conclusions as to disability where the findings of fact coincide with all of the criteria of a particular rule; i.e., RFC (a maximum sustained work capability for sedentary work) and the vocational factors of age, education, and work experience. In order for a rule in Table No. 1 to direct a conclusion of "not disabled," the individual must be able to perform the full range of work administratively noticed by a rule. This means that the individual must be able to perform substantially all of the strength demands defining the sedentary level of exertion, as well as the physical and mental nonexertional demands that are also required for the performance of substantially all of the unskilled work considered at the sedentary level. Therefore, in order for a rule to direct a conclusion of "not disabled," an individual must also have no impairment that restricts the nonexertional capabilities to a level below those needed to perform unskilled work, in this case, at the sedentary level.

Using the Rules in Table No. 1 as a Framework: "Erosion" of the Occupational Base

Where any one of the findings of fact does not coincide with the corresponding criterion of a rule in Table No. 1 (except in those cases where the concept of borderline age applies)[6], the rule does not direct a decision. In cases such as the following, the medical-

vocational rules must be used as a framework for considering the extent of any erosion of the sedentary occupational base:

- Any one of an individual's exertional capacities is determined to be less than that required to perform a full range of sedentary work; or
- Based on an individual's exertional capacities, a rule in Table No. 1 would direct a decision of "not disabled," but the individual also has a nonexertional limitation(s) that narrows the potential range of sedentary work to which he or she might be able to adjust (i.e., the individual has the exertional capacity to do the full range of sedentary work, but the sedentary occupational base is reduced because of at least one nonexertional limitation).

When there is a reduction in an individual's exertional or nonexertional capacity so that he or she is unable to perform substantially all of the occupations administratively noticed in Table No. 1, the individual will be unable to perform the full range of sedentary work: the occupational base will be "eroded" by the additional limitations or restrictions. However, the mere inability to perform substantially all sedentary unskilled occupations does not equate with a finding of disability. There may be a number of occupations from the approximately 200 occupations administratively noticed, and jobs that exist in significant numbers, that an individual may still be able to perform even with a sedentary occupational base that has been eroded.

Whether the individual will be able to make an adjustment to other work requires adjudicative judgment regarding factors such as the type and extent of the individual's limitations or restrictions and the extent of the erosion of the occupational base; i.e., the impact of the limitations or restrictions on the number of sedentary unskilled occupations or the total number of jobs to which the individual may be able to adjust, considering his or her age, education, and work experience, including any transferable skills or education providing for direct entry into skilled work. Where there is more than a slight impact on the individual's ability to perform the full range of sedentary work, if the adjudicator finds that the individual is able to do other work, the adjudicator must cite examples of occupations or jobs the individual can do and provide a statement of the incidence of such work in the region where the individual resides or in several regions of the country.

Exertional and Nonexertional Limitations and Restrictions

Exertional capacity addresses an individual's limitations and restrictions of physical strength and defines the individual's remaining ability to perform each of seven strength demands: Sitting, standing, walking, lifting, carrying, pushing, and pulling. An exertional limitation is an *impairment-caused* limitation of any one of these activities.

Nonexertional capacity considers any work-related limitations and restrictions that are not exertional. Therefore, a nonexertional limitation is an *impairment- caused* limitation affecting such capacities as mental abilities, vision, hearing, speech, climbing, balancing, stooping, kneeling, crouching, crawling, reaching, handling, fingering, and feeling. Environmental restrictions are also considered to be nonexertional.

Thus, it is the *nature of an individual's limitations and restrictions*, not certain impairments or symptoms, that determines whether the individual will be found to have only exertional limitations or restrictions, only nonexertional limitations or restrictions, or a combination of exertional and nonexertional limitations or restrictions. For example, even though mental impairments often affect nonexertional functions, they may also limit exertional capacity affecting one of the seven strength demands; e.g., from fatigue or hysterical paralysis. Likewise, symptoms, including pain, are not intrinsically exertional or nonexertional; when a symptom causes a limitation in one of the seven strength demands, the limitation must be considered exertional. (See SSR 96-8p, "Titles II and XVI: Assessing Residual Functional Capacity in Initial Claims.")

Guidelines for Evaluating the Ability to Do Less Than a Full Range of Sedentary Work

The following sections provide adjudicative guidance as to the impact of various RFC limitations and restrictions on the unskilled sedentary occupational base. The RFC assessment must include a narrative that shows the presence and degree of any specific limitations and restrictions, as well as an explanation of how the evidence in file was considered in the assessment. The individual's maximum remaining capacities to perform sustained work on a regular and continuing basis (what he or she can still do 8 hours a day, for 5 days a week, or an equivalent work schedule) must be stated.

An accurate accounting of an individual's abilities, limitations, and restrictions is necessary to determine the extent of erosion of the occupational base, the types of sedentary occupations an individual might still be able to do, and whether it will be necessary to make use of a vocational resource. The RFC assessment must be sufficiently complete to allow an adjudicator to make an informed judgment regarding these issues.

Exertional Limitations and Restrictions

Lifting/carrying and pushing/pulling: If an individual is unable to lift 10 pounds or occasionally lift and carry items like docket files, ledgers, and small tools throughout the workday, the unskilled sedentary occupational base will be eroded. The extent of erosion will depend on the extent of the limitations. For example, if it can be determined that the individual has an ability to lift or carry slightly less than 10 pounds, with no other limitations or restrictions in the ability to perform the requirements of sedentary work, the unskilled sedentary occupational base would not be significantly eroded; however, an inability to lift or carry more than 1 or 2 pounds would erode the unskilled sedentary occupational base significantly. For individuals with limitations in lifting or carrying weights between these amounts, consultation with a vocational resource may be appropriate.

Limitations or restrictions on the ability to push or pull will generally have little effect on the unskilled sedentary occupational base.

Standing and walking: The full range of sedentary work requires that an individual be able to stand and walk for a total of approximately 2 hours during an 8-hour workday. If an individual can stand and walk for a total of slightly less than 2 hours per 8-hour workday, this, by itself, would not cause the occupational base to be significantly eroded. Conversely, a limitation to standing and walking for a total of only a few minutes during the workday would erode the unskilled sedentary occupational base significantly. For individuals able to stand and walk in between the slightly less than 2 hours and only a few minutes, it may be appropriate to consult a vocational resource.

Sitting: In order to perform a full range of sedentary work, an individual must be able to remain in a seated position for approximately 6 hours of an 8-hour workday, with a morning break, a lunch period, and an afternoon break at approximately 2-hour intervals. If an individual is unable to sit for a total of 6 hours in an 8-hour work day, the unskilled sedentary occupational base will be eroded. The extent of the limitation should be considered in determining whether the individual has the ability to make an adjustment to other work. See *Alternate sitting and standing* below.

The fact that an individual cannot do the sitting required to perform the full range of sedentary work does not necessarily mean that he or she cannot perform other work at a higher exertional level. In unusual cases, some individuals will be able to stand and walk longer than they are able to sit. If an individual is able to stand and walk for approximately 6 hours in an 8-hour workday (and meets the other requirements for light work), there may be a significant number of light jobs in the national economy that he or she can do even if there are not a significant number of sedentary jobs.

Alternate sitting and standing: An individual may need to alternate the required sitting of sedentary work by standing (and, possibly, walking) periodically. Where this need cannot be accommodated by scheduled breaks and a lunch period, the occupational base for a full range of unskilled sedentary work will be eroded. The extent of the erosion will depend on the facts in the case record, such as the frequency of the need to alternate sitting and standing and the length of time needed to stand. The RFC assessment must be specific as to the frequency of the individual's need to alternate sitting and standing. It may be especially useful in these situations to consult a vocational resource in order to determine whether the individual is able to make an adjustment to other work.

Medically required hand-held assistive device: To find that a hand-held assistive device is medically required, there must be medical documentation establishing the need for a hand-held assistive device to aid in walking or standing, and describing the circumstances for which it is needed (i.e., whether all the time, periodically, or only in certain situations; distance and terrain; and any other relevant information). The adjudicator must always consider the particular facts of a case. For example, if a medically required hand-held assistive device is needed only for prolonged ambulation, walking on uneven terrain, or ascending or descending slopes, the unskilled sedentary occupational base will not ordinarily be significantly eroded.

Since most unskilled sedentary work requires only occasional lifting and carrying of light objects such as ledgers and files and a maximum lifting capacity for only 10 pounds, an individual who uses a medically required hand-held assistive device in one hand may still have the ability to perform the minimal lifting and carrying requirements of many sedentary unskilled occupations with the other hand.[7] For example, an individual who must use a hand-held assistive device to aid in walking or standing because of an impairment that affects one lower extremity (e.g., an unstable knee), or to reduce pain when walking, who is limited to sedentary work because of the impairment affecting the lower extremity, and who has no other functional limitations or restrictions may still have the ability to make an adjustment to sedentary work that exists in significant numbers. On the other hand, the occupational base for an individual who must use such a device for balance because of significant involvement of both lower extremities (e.g., because of a neurological impairment) may be significantly eroded.

In these situations, too, it may be especially useful to consult a vocational resource in order to make a judgment regarding the individual's ability to make an adjustment to other work.

Nonexertional Limitations and Restrictions

Postural limitations: Postural limitations or restrictions related to such activities as climbing ladders, ropes, or scaffolds, balancing, kneeling, crouching, or crawling would not usually erode the occupational base for a full range of unskilled sedentary work significantly because those activities are not usually required in sedentary work. In the SCO, "balancing" means maintaining body equilibrium to prevent falling when walking, standing, crouching, or running on narrow, slippery, or erratically moving surfaces. If an individual is limited in balancing only on narrow, slippery, or erratically moving surfaces, this would not, by itself, result in a significant erosion of the unskilled sedentary occupational base. However, if an individual is limited in balancing even when standing or walking on level terrain, there may be a significant erosion of the unskilled sedentary occupational base. It is important to state in the RFC assessment what is meant by limited balancing in order to determine the remaining occupational base. Consultation with a vocational resource may be appropriate in some cases.

An ability to stoop occasionally; i.e., from very little up to one-third of the time, is required in most unskilled sedentary occupations. A *complete* inability to stoop would significantly erode the unskilled sedentary occupational base and a finding that the individual is disabled would usually apply, but restriction to occasional stooping should, by itself, only minimally erode the unskilled occupational base of sedentary work. Consultation with a vocational resource may be particularly useful for cases where the individual is limited to less than occasional stooping.

Manipulative limitations: Most unskilled sedentary jobs require good use of both hands and the fingers; i.e., bilateral manual dexterity. Fine movements of small objects require use of the fingers; e.g., to pick or pinch. Most unskilled sedentary jobs require good use of the hands and fingers for repetitive hand-finger actions.

Any *significant* manipulative limitation of an individual's ability to handle and work with small objects with both hands will result in a significant erosion of the unskilled sedentary occupational base. For example, example 1 in section 201.00(h) of appendix 2, describes an individual who has an impairment that prevents the performance of any sedentary occupations that require bilateral manual dexterity (i.e., "limits the individual to sedentary jobs which do not require bilateral manual dexterity"). When the limitation is less significant, especially if the limitation is in the non-dominant hand, it may be useful to consult a vocational resource.

The ability to feel the size, shape, temperature, or texture of an object by the fingertips is a function required in very few jobs and impairment of this ability would not, by itself, significantly erode the unskilled sedentary occupational base.

Visual limitations or restrictions: Most sedentary unskilled occupations require working with small objects. If a visual limitation prevents an individual from seeing the small objects involved in most sedentary unskilled work, or if an individual is not able to avoid ordinary hazards in the workplace, such as boxes on the floor, doors ajar, or approaching people or vehicles, there will be a significant erosion of the sedentary occupational base. These cases may require the use of vocational resources.

Communicative limitations: Basic communication is all that is needed to do unskilled work. The ability to hear and understand simple oral instructions or to communicate simple information is sufficient. If the individual retains these basic communication abilities, the unskilled sedentary occupational base would not be significantly eroded in these areas.

Environmental restrictions: An "environmental restriction" is an impairment-caused need to avoid an environmental condition in a workplace. Definitions for various workplace environmental conditions are found in the SCO; e.g., "extreme cold" is exposure to nonweather-related cold temperatures.

In general, few occupations in the unskilled sedentary occupational base require work in environments with extreme cold, extreme heat, wetness, humidity, vibration, or unusual hazards. The "hazards" defined in the SCO are considered unusual in unskilled sedentary work. They include: moving mechanical parts of equipment, tools, or machinery; electrical shock; working in high, exposed places; exposure to radiation; working with explosives; and exposure to toxic, caustic chemicals. Even a need to avoid all exposure to these conditions would not, by itself, result in a significant erosion of the occupational base.

Since all work environments entail some level of noise, restrictions on the ability to work in a noisy workplace must be evaluated on an individual basis. The unskilled sedentary occupational base may or may not be significantly eroded depending on the facts in the case record. In such cases, it may be especially useful to consult a vocational resource.

Restrictions to avoid exposure to odors or dust must also be evaluated on an individual basis. The RFC assessment must specify which environments are restricted and state the extent of the restriction; e.g., whether only excessive or even small amounts of dust must be avoided.

Mental limitations or restrictions: A substantial loss of ability to meet any one of several basic work-related activities on a sustained basis (i.e., 8 hours a day, 5 days a week, or an equivalent work schedule), will substantially erode the unskilled sedentary occupational base and would justify a finding of disability. These mental activities are generally required by competitive, remunerative, unskilled work:

- Understanding, remembering, and carrying out simple instructions.
- Making judgments that are commensurate with the functions of unskilled work--i.e., simple work- related decisions.
- Responding appropriately to supervision, co- workers and usual work situations.
- Dealing with changes in a routine work setting.

A less than substantial loss of ability to perform any of the above basic work activities may or may not significantly erode the unskilled sedentary occupational base. The individual's remaining capacities must be assessed and a judgment made as to their effects on the unskilled occupational base considering the other vocational factors of age, education, and work experience. When an individual has been found to have a limited ability in one or more of these basic work activities, it may be useful to consult a vocational resource.

Use of Vocational Resources

When the extent of erosion of the unskilled sedentary occupational base is not clear, the adjudicator may consult various authoritative written resources, such as the DOT, the SCO, the **Occupational Outlook Handbook,** or **County Business Patterns.**

In more complex cases, the adjudicator may use the resources of a vocational specialist or vocational expert.[8] The vocational resource may be asked to provide any or all of the following: An analysis of the impact of the RFC upon the full range of sedentary work, which the adjudicator may consider in determining the extent of the erosion of the occupational base, examples of occupations the individual may be able to perform, and citations of the existence and number of jobs in such occupations in the national economy.

EFFECTIVE DATE: This Ruling is effective on the date of its publication in the *Federal Register.*

CROSS-REFERENCES: SSR 86-8 "Titles II and XVI: The Sequential Evaluation Process" (C.E. 1986, p. 78), SSR 83-10, "Titles II and XVI: Determining Capability to Do Other Work--The Medical-Vocational Rules of Appendix 2" (C.E. 1981-1985, p. 516), SSR 83-12, "Titles II and XVI: Capability to Do Other Work--The Medical-

Vocational Rules as a Framework for Evaluating Exertional Limitations Within a Range of Work or Between Ranges of Work" (C.E. 1981-1985, p. 529), SSR 83-14, "Titles II and XVI: Capability to Do Other Work--The Medical-Vocational Rules as a Framework for Evaluating a Combination of Exertional and Nonexertional Impairments" (C.E. 1981-1985, p. 535), SSR 85-15, "Titles II and XVI: Capability to Do Other Work--The Medical- Vocational Rules as a Framework for Evaluating Solely Nonexertional Impairments" (C.E. 1981-1985, p. 543), SSR 96- 8p, "Titles II and XVI: Assessing Residual Functional Capacity in Initial Claims;" Program Operations Manual System, sections DI 24510.001, DI 24510.005, DI 24510.010, DI 24510.050, DI 24515.061, DI 25001.001, DI 25010.001, DI 25020.005, DI 25020.010, DI 25020.015, DI 25025.001 and DI 28005.015; and Hearings, Appeals, and Litigation Law Manual, sections I-2-548 and I-2-550.

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[1] For a detailed discussion of the difference between the RFC assessment, which is an administrative finding of fact, and the opinion evidence called the "medical source statement" or "MSS," see SSR 96-5p, "Titles II and XVI: Medical Source Opinions on Issues Reserved to the Commissioner."

[2] RFC may be expressed in terms of an exertional category, such as "light," if it becomes necessary to assess whether an individual is able to perform past relevant work as it is generally performed in the national economy. However, without the initial function-by-function accounting of the individual's capacities, it may not be possible to determine whether the individual is able to perform past relevant work as it is generally performed in the national economy because particular occupations may not require all of the exertional and nonexertional demands necessary to perform the full range of work at a given exertional level. See SSR 96-8p, "Titles II and XVI: Assessing Residual Functional Capacity in Initial Claims."

[3] However, "younger individuals" age 45-49 who are unable to communicate in English or who are illiterate in English and who are limited to even a *full* range of sedentary work must be found disabled under rule 201.17 in Table No. 1.

[4] An "occupation" refers to a grouping of numerous individual "jobs" with similar duties. Within occupations (e.g., "carpenter") there may be variations among jobs performed for different employers (e.g., "rough carpenter").

[5] The regulations specify that this is an approximation. The revised fourth edition of the **Dictionary of Occupational Titles** and its companion volumes (the DOT, 1991) lists 137 separate occupations. However, the introduction to Volume I explains that the fourth edition of the DOT (1977) "substantially modified or combined with related definitions" several thousand definitions from the third edition. In 1992, we published a notice in the *Federal Register* explaining that an analysis of the revised fourth edition of the DOT and available data for the then upcoming volume of the **Selected Characteristics of Occupations Defined in the Revised Dictionary of Occupational Titles** (SCO) showed

"that the range of work of which the medical- vocational rules take administrative notice continues to represent more occupations than would be required to represent significant numbers," and that "we have received no significant data or other evidence to indicate that * * * the unskilled occupational base * * * has changed substantially." (See 57 FR 43005, September 17, 1992.) In February 1996, contact with the North Carolina Occupational Analysis Field Center, the organization that compiles the data the Department of Labor uses in the SCO, confirmed that there are no precise updated data but that the regulatory estimate of approximately 200 sedentary unskilled occupations is still valid, because some of the 137 occupations in the current edition of the DOT comprise more than one of the separate occupations of which we take administrative notice.

[6] See 20 CFR 404.1563(a) and 416.963(a) and SSR 83-10.

[7] Bilateral manual dexterity is needed when sitting but is not generally necessary when performing the standing and walking requirements of sedentary work.

[8] At the hearings and appeals levels, vocational experts (VEs) are vocational professionals who provide impartial expert opinion during the hearings and appeals process either by testifying or by providing written responses to interrogatories. A VE may be used before, during, or after a hearing. Whenever a VE is used, the individual has the right to review and respond to the VE evidence prior to the issuance of a decision. The VE's opinion is not binding on an adjudicator, but must be weighed along with all other evidence.

Effective/Publication Date: 12/4/00

POLICY INTERPRETATION RULING

SSR 00-4p: TITLES II AND XVI: USE OF VOCATIONAL EXPERT AND VOCATIONAL SPECIALIST EVIDENCE, AND OTHER RELIABLE OCCUPATIONAL INFORMATION IN DISABILITY DECISIONS

PURPOSE:

This Ruling clarifies our standards for the use of vocational experts (VEs) who provide evidence at hearings before administrative law judges (ALJs), vocational specialists (VSs) who provide evidence to disability determination services (DDS) adjudicators, and other reliable sources of occupational information in the evaluation of disability claims. In particular, this ruling emphasizes that before relying on VE or VS evidence to support a disability determination or decision, our adjudicators must:

- Identify and obtain a reasonable explanation for any conflicts between occupational evidence provided by VEs or VSs and information in the *Dictionary of Occupational Titles* (DOT), including its companion publication, the *Selected Characteristics of Occupations Defined in the Revised Dictionary of Occupational Titles* (SCO), published by the Department of Labor, and
- Explain in the determination or decision how any conflict that has been identified was resolved.

CITATIONS (AUTHORITY):

Sections 216(i), 223(d)(2)(A), and 1614(a)(3)(B) of the Social Security Act, as amended; 20 CFR Part 404, sections 404.1566-404.1569, 20 CFR Part 404, subpart P, appendix 2, § 200.00(b), and 20 CFR Part 416, sections 416.966-416.969.

PERTINENT HISTORY:

To determine whether an individual applying for disability benefits (except for a child applying for Supplement Security Income) is disabled, we follow a 5-step sequential evaluation process as follows:

1. Is the individual engaging in substantial gainful activity? If the individual is working and the work is substantial gainful activity, we find that he or she is not disabled.
2. Does the individual have an impairment or combination of impairments that is severe? If the individual does not have an impairment or combination of impairments that is severe, we will find that he or she is not disabled. If the individual has an impairment or combination of impairments that is severe, we proceed to step 3 of the sequence.
3. Does the individual's impairment(s) meet or equal the severity of an impairment listed in appendix 1 of subpart P of part 404 of our regulations? If so, we find that he or she is disabled. If not, we proceed to step 4 of the sequence.
4. Does the individual's impairment(s) prevent him or her from doing his or her past relevant work (PRW), considering his or her residual functional capacity (RFC)? If not, we find that he or she is not disabled. If so, we proceed to step 5 of the sequence.
5. Does the individual's impairment(s) prevent him or her from performing other work that exists in the national economy, considering his or her RFC together with the "vocational factors" of age, education, and work experience? If so, we find that the individual is disabled. If not, we find that he or she is not disabled.

The regulations at 20 CFR 404.1566(d) and 416.966(d) provide that we will take administrative notice of "reliable job information" available from various publications, including the DOT. In addition, as provided in 20 CFR 404.1566(e) and 416.966(e), we use VEs and VSs as sources of occupational evidence in certain cases. Questions have arisen about how we ensure that conflicts between occupational evidence provided by a VE or a VS and information in the DOT (including its companion publication, the SCO) are resolved. Therefore, we are issuing this ruling to clarify our standards for identifying and resolving such conflicts.

POLICY INTERPRETATION:

Using Occupational Information at Steps 4 and 5

In making disability determinations, we rely primarily on the DOT (including its companion publication, the SCO) for information about the requirements of work in the national economy. We use these publications at steps 4 and 5 of the sequential evaluation process. We may also use VEs and VSs at these steps to resolve complex vocational issues.[1] We most often use VEs to provide evidence at a hearing before an ALJ. At the initial and reconsideration steps of the administrative review process, adjudicators in the DDSs may rely on VSs for additional guidance. See, for example, SSRs 82-41, 83-12, 83-14, and 85-15.

Resolving Conflicts in Occupational Information

Occupational evidence provided by a VE or VS generally should be consistent with the occupational information supplied by the DOT. When there is an apparent unresolved

conflict between VE or VS evidence and the DOT, the adjudicator must elicit a reasonable explanation for the conflict before relying on the VE or VS evidence to support a determination or decision about whether the claimant is disabled. At the hearings level, as part of the adjudicator's duty to fully develop the record, the adjudicator will inquire, on the record, as to whether or not there is such consistency.

Neither the DOT nor the VE or VS evidence automatically "trumps" when there is a conflict. The adjudicator must resolve the conflict by determining if the explanation given by the VE or VS is reasonable and provides a basis for relying on the VE or VS testimony rather than on the DOT information.

Reasonable Explanations for Conflicts (or Apparent Conflicts) in Occupational Information

Reasonable explanations for such conflicts, which may provide a basis for relying on the evidence from the VE or VS, rather than the DOT information, include, but are not limited to the following:

- Evidence from VEs or VSs can include information not listed in the DOT. The DOT contains information about most, but not all, occupations. The DOT's occupational definitions are the result of comprehensive studies of how similar jobs are performed in different workplaces. The term "occupation," as used in the DOT, refers to the collective description of those jobs. Each occupation represents numerous jobs. Information about a particular job's requirements or about occupations not listed in the DOT may be available in other reliable publications, information obtained directly from employers, or from a VE's or VS's experience in job placement or career counseling.
- The DOT lists maximum requirements of occupations as generally performed, not the range of requirements of a particular job as it is performed in specific settings. A VE, VS, or other reliable source of occupational information may be able to provide more specific information about jobs or occupations than the DOT.

Evidence That Conflicts With SSA Policy

SSA adjudicators may not rely on evidence provided by a VE, VS, or other reliable source of occupational information if that evidence is based on underlying assumptions or definitions that are inconsistent with our regulatory policies or definitions. For example:

- Exertional Level

  We classify jobs as sedentary, light, medium, heavy and very heavy (20 CFR 404.1567 and 416.967). These terms have the same meaning as they have in the exertional classifications noted in the DOT.

  Although there may be a reason for classifying the exertional demands of an occupation (as generally performed) differently than the DOT (e.g., based on

other reliable occupational information), the regulatory definitions of exertional levels are controlling. For example, if all available evidence (including VE testimony) establishes that the exertional demands of an occupation meet the regulatory definition of "medium" work (20 CFR 404.1567 and 416.967), the adjudicator may not rely on VE testimony that the occupation is "light" work.

- Skill Level

  A skill is knowledge of a work activity that requires the exercise of significant judgment that goes beyond the carrying out of simple job duties and is acquired through performance of an occupation that is above the unskilled level (requires more than 30 days to learn). (See SSR 82-41.) Skills are acquired in PRW and may also be learned in recent education that provides for direct entry into skilled work.

  The DOT lists a specific vocational preparation (SVP) time for each described occupation. Using the skill level definitions in 20 CFR 404.1568 and 416.968, unskilled work corresponds to an SVP of 1-2; semi-skilled work corresponds to an SVP of 3-4; and skilled work corresponds to an SVP of 5-9 in the DOT.

  Although there may be a reason for classifying an occupation's skill level differently than in the DOT, the regulatory definitions of skill levels are controlling. For example, VE or VS evidence may not be relied upon to establish that unskilled work involves complex duties that take many months to learn, because that is inconsistent with the regulatory definition of unskilled work. See 20 CFR 404.1568 and 416.968.

- Transferability of Skills

  Evidence from a VE, VS, or other reliable source of occupational information cannot be inconsistent with SSA policy on transferability of skills. For example, an individual does not gain skills that could potentially transfer to other work by performing unskilled work. Likewise, an individual cannot transfer skills to unskilled work or to work involving a greater level of skill than the work from which the individual acquired those skills. See SSR 82-41.

The Responsibility To Ask About Conflicts

When a VE or VS provides evidence about the requirements of a job or occupation, the adjudicator has an affirmative responsibility to ask about any possible conflict between that VE or VS evidence and information provided in the DOT. In these situations, the adjudicator will:

- Ask the VE or VS if the evidence he or she has provided conflicts with information provided in the DOT; and
- If the VE's or VS's evidence appears to conflict with the DOT, the adjudicator will obtain a reasonable explanation for the apparent conflict.

Explaining the Resolution

When vocational evidence provided by a VE or VS is not consistent with information in the DOT, the adjudicator must resolve this conflict before relying on the VE or VS evidence to support a determination or decision that the individual is or is not disabled. The adjudicator will explain in the determination or decision how he or she resolved the conflict. The adjudicator must explain the resolution of the conflict irrespective of how the conflict was identified.

EFFECTIVE DATE:

This Ruling is effective on the date of its publication in the *Federal Register*. The clarified standard stated in this ruling with respect to inquiring about possible conflicts applies on the effective date of the ruling to all claims for disability benefits in which a hearing before an ALJ has not yet been held, or that is pending a hearing before an ALJ on remand. The clarified standard on resolving identified conflicts applies to all claims for disability or blindness benefits on the effective date of the ruling.

CROSS-REFERENCES:

SSR 82-41, "Titles II and XVI: Work Skills and Their Transferability as Intended by the Expanded Vocational Factors Regulations Effective February 26, 1979," SSR 82-61, "Titles II and XVI: Past Relevant Work--The Particular Job or the Occupation as Generally Performed," SSR 82-62, "Titles II and XVI: A Disability Claimant's Capacity to Do Past Relevant Work, In General," SSR 83-10, "Titles II and XVI: Determining Capability to Do Other Work--The Medical-Vocational Rules of Appendix 2," SSR 83-12, "Titles II and XVI: Capability to Do Other Work--The Medical-Vocational Rules as a Framework for Evaluating Exertional Limitations Within a Range of Work or Between Ranges of Work," SSR 83-14, "Titles II and XVI: Capability to do Other Work--The Medical-Vocational Rules as a Framework for Evaluating a Combination of Exertional and Nonexertional Impairments," and SSR 85-15, "Titles II and XVI: Capability to Do Other Work--The Medical-Vocational Rules as a Framework for Evaluating Solely Nonexertional Impairments";
AR 90-3(4), 837 F.2d 635 (4th Cir. 1987)-Use of Vocational Experts or Other Vocational Specialist in Determining Whether a Claimant Can Perform Past Relevant Work-Titles II and XVI of the Social Security Act;
Program Operations Manual System, Part 04, sections DI 25001.001, DI 25005.001, DI 25020.001-DI 25020.015, and DI 25025.001- DI 25025.005.

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[1] In accordance with Acquiescence Ruling 90-3(4), we do not use VEs at step 4 of the sequential evaluation process in the Fourth Circuit.

SSR 91-5p

EFFECTIVE/PUBLICATION DATE: 07/01/91

SSR 91-5p: POLICY INTERPRETATION RULING Titles II and XVI: Mental Incapacity and Good Cause for Missing the Deadline to Request Review

PURPOSE: The purpose of this interpretative ruling is to clarify our policy on establishing good cause for missing the deadline to request review. It is being issued to avoid the improper application of res judicata or administrative finality when the evidence establishes that a claimant lacked the mental capacity to understand the procedures for requesting review.

CITATIONS (AUTHORITY): Sections 205(b) and 1631(c) of the Social Security Act, as amended; Regulations No. 4, sections 404.903(j), 404.909(b), 404.911, 404.925(c), 404.933(c), 404.957(c)(3), 404.968(b), 404.982; and Regulations No. 16, sections 416.1403(a)(8), 416.1409(b), 416.1411, 416.1425(c), 416.1433(c), 416.1457(c)(3), 416.1468(b), and 416.1482.

PERTINENT HISTORY: Our rules in 20 CFR, sections 404.909(a), 404.933(b), 404.968(a), 404.982, 416.1409(a), 416.1433(b), 416.1468(a), and 416.1482, respectively, provide that a request for reconsideration, hearing before an administrative law judge (ALJ), review by the Appeals Council, or review by a Federal district court must be filed within 60 days after the date of receipt by the claimant of the notice of the determination or decision being appealed. However, the regulations also provide that a claimant can request that the 60-day time period for filing a request for review be extended if the claimant can show good cause for missing the deadline. The request for an extension of time must be in writing and must give the reasons why the request for review was not filed timely.

When the claimant fails to timely request reconsideration, an ALJ hearing, Appeals Council review, or review by a Federal district court, the Appeals Council review, or review by a Federal district court, the Agency applies the criteria in section 404.911 or section 416.1411, as appropriate, in determining whether good cause for missing the deadline exists.

Section 404.911(a) states:

In determining whether you have shown that you had good cause for missing a deadline to request review we consider

> (1) what circumstances kept you from making the request on time;
> (2) whether our action misled you;
> (3) whether you did not understand the requirements of the Act resulting from amendments to the Act, other legislation, or court decisions.

Section 416.1411(a) sets out essentially the same language.

If the claimant establishes good cause for missing the deadline to request review, we process the request for review in accordance with established procedures and the prior administrative action is not final or binding for purposes of applying the rules on either res judicata or administrative finality.

The rules on administrative finality (20 CFR, sections 404.987, 404.988, 404.989, 416.1487, 416.1488, 416.1489) provide that a final determination or decision cannot be reopened more than 4 years (2 years for supplemental security income cases) from the date of the notice of the initial determination on the claim unless one of the specified conditions in section 404.988(c) or section 416.1488(c) applies.

Similarly, the rules in 20 CFR, sections 404.957(c)(1) and 416.1457(c)(1) indicate that an ALJ may apply res judicata to dismiss a hearing request in cases where a previous determination or decision on a claim, involving the same facts and the same issues, has become final. A determination or decision becomes final for purposes of the application of res judicata, when the claimant fails to file a request for reconsideration, or a hearing before an ALJ, or review by the Appeals Council, or judicial review, whichever is appropriate, within the time periods provided by the regulations. If the claimant establishes good cause for missing the deadline to seek judicial review of an Appeals Council's decision or denial of review or expedited appeals process agreement, the time period will be extended.

POLICY INTERPRETATION: It has always been SSA policy that failure to meet the time limits for requesting review is not automatic grounds for dismissing the appeal and that proper consideration will be given to a claimant who presents evidence that mental incapacity may have prevented him or her from understanding the review process.

When a claimant presents evidence that mental incapacity prevented him or her from timely requesting review of an adverse determination, decision, dismissal, or review by a Federal district court, and the claimant had no one legally responsible for prosecuting the claim (e.g., a parent of a claimant who is a minor, legal guardian, attorney, or other legal representative) at the time of the prior administrative action, SSA will determine whether or not good cause exists for extending the time to request review. If the claimant satisfies the substantive criteria, the time limits in the reopening regulations do not apply; so that,

regardless of how much time has passed since the prior administrative action, the claimant can establish good cause for extending the deadline to request review of that action.

The claimant will have established mental incapacity for the purpose of establishing good cause when the evidence establishes that he or she lacked the mental capacity to understand the procedures for requesting review.

In determining whether a claimant lacked the mental capacity to understand the procedures for requesting review, the adjudicator must consider the following factors as they existed at the time of the prior administrative action:

-- inability to read or write;
-- lack of facility with the English language;
-- limited education;
-- any mental or physical condition which limits the claimant's ability to do things for him/herself.

If the claimant is unrepresented and has one of the factors listed above, the adjudicator will assist the claimant in obtaining any relevant evidence. The decision as to what constitutes mental incapacity must be based on all the pertinent facts in a particular case. The adjudicator will resolve any reasonable doubt in favor of the claimant.

If the adjudicator determines good cause exists, he or she will extend the time for requesting review and take the action which would have been appropriate had the claimant filed a timely request for review. A finding of good cause will result either in a determination or decision that is subject to further administrative or judicial review of the claim, or a dismissal (for a reason other than late filing) of the request for review, as appropriate.

If the adjudicator determines good cause does not exist to extend the time, the adjudicator will consider the claimant to have filed an untimely request for review, deny the request to extend the time for filing, and dismiss the request. The dismissal of the request for review will state the adjudicator's rationale for not finding good cause and advise the claimant that he or she can file a new application and use the written request for review as a protective filing date.

EFFECTIVE DATE: The right to establish good cause for missing the deadline to request review is a longstanding SSA policy. SSA will apply this policy to any case brought to its attention.

EXCEPTION: In addition to this Ruling, Acquiescence Ruling AR 90-4(4), which implements the *Culbertson* and *Young* cases, must be followed when adjudicating such cases arising in the Fourth Circuit.

CROSS-REFERENCE: Program Operations Manual System, Part 2, Chapter 031, Subchapter 01; Acquiescence Ruling AR 90-4(4).

SSR 95-1p

EFFECTIVE/PUBLICATION DATE: 04/26/95

SSR 95-1p: POLICY INTERPRETATION RULING TITLE II and TITLE XVI: FINDING GOOD CAUSE FOR MISSING THE DEADLINE TO REQUEST ADMINISTRATIVE REVIEW DUE TO STATEMENTS IN THE NOTICE OF INITIAL OR RECONSIDERATION DETERMINATION CONCERNING THE RIGHT TO REQUEST ADMINISTRATIVE REVIEW AND THE OPTION TO FILE A NEW APPLICATION

PURPOSE: To reflect the Social Security Administration's (SSA) policy on establishing good cause for late filing of a request for administrative review as it applies to a claimant who received an initial or reconsideration determination notice dated prior to July 1, 1991, which did not state that filing a new application instead of a request for administrative review could result in the loss of benefits.

CITATIONS (AUTHORITY): Sections 205(b) and 1631(c)(1) of the Social Security Act (the Act); Regulations No. 4, sections 404.903(j), 404.909, 404.911, 404.933, 404.957(c)(3); and Regulations No. 16, sections 416.1403(a)(8), 416.1409, 416.1411, 416.1433, 416.1457(c)(3).

PERTINENT HISTORY: Our rules in 20 CFR sections 404.909(a), 404.933(b), 416.1409(a), and 416.1433(b) provide that a request for reconsideration and a request for hearing before an administrative law judge (ALJ) must be filed within 60 days after the

date of receipt by the claimant of the notice of the determination being appealed. However, the regulations also provide that a claimant can request that the 60-day time period for filing a request for review be extended if the claimant can show good cause for missing the deadline. The request for an extension of time must be in writing and must give the reason why the request for review was not filed timely.

When the claimant fails to timely request reconsideration or an ALJ hearing, the Agency applies the criteria in section 404.911 or section 416.1411, as appropriate, in determining whether good cause for missing the deadline exists.

Section 404.911(a) states:

> In determining whether you have shown that you had good cause for missing a deadline to request review we consider --
> (1) What circumstances kept you from making the request on time;
> (2) Whether our action misled you;
> (3) Whether you did not understand the requirements of the Act resulting from amendments to the Act, other legislation, or court decisions; and
> (4) Whether you had any physical, mental, educational, or linguistic limitations (including any lack of facility with the English language) which prevented you from filing a timely request or from understanding or knowing about the need to file a timely request for review.

Section 416.1411(a) sets out essentially the same criteria.

If the Agency determines that good cause for the claimant missing the deadline to request review exists, we process the request for review in accordance with established procedures and the prior administrative action is not final or binding for purposes of applying the rules on either *res judicata* or administrative finality.

Many SSA initial and reconsideration determination notices denying claims for Social Security benefits based on disability issued from September 1, 1977, through February 28, 1990, stated that, if the claimant did not seek administrative review within the 60-day time period, he or she still had the right to file another application at any time. The notices did not further state that filing a new application instead of a request for administrative review could result in the loss of benefits. Some claimants have alleged that they have failed to file a timely request for administrative review as a result of these notices.

In 1984, SSA began making revisions to its notices to explain more clearly the difference between seeking administrative review and filing a new application. Language was added to the initial determination notice stating that a new application is not the same as an appeal of the determination. In 1989 SSA began adding this language to the reconsideration determination notice along with an explanation on both notices to specifically advise the claimant that failing to seek administrative review could result in a

loss of benefits. SSA completed implementation of this revision to the notices in February 1990.

SSA has further revised its notices as a result of section 5107 of the Omnibus Budget Reconciliation Act of 1990, Pub. L. 101- 508. This section amended the Act to provide that a failure to timely request administrative review of an initial or reconsideration determination made on or after July 1, 1991, may not be used to deny or dismiss a subsequent claim for benefits on the basis of *res judicata* if the claimant demonstrates that he or she failed to request administrative review of the determination acting in good faith reliance upon incorrect, incomplete or misleading information, relating to the consequences of reapplying for benefits in lieu of seeking review of the determination and the information was provided by an officer or employee of SSA or a State agency making disability determinations under section 221 of the Act.

POLICY INTERPRETATION: SSA will make a finding of good cause for late filing of a request for administrative review for a title II, title XVI, or concurrent title II/title XVI claim if a claimant received a notice covered by this Ruling and demonstrates that, as a result of the notice, he or she did not timely request such review. The mere receipt of a notice covered by this Ruling will not, by itself, establish good cause.

A. ***Notices Covered By This Ruling***

A notice is covered by this Ruling if it advised the claimant that if he or she did not request administrative review, he or she still had the right to file a new application at any time without further explaining that filing a new application instead of a request for administrative review could result in the loss of benefits. The following are notices covered by this Ruling, if the notice did not state that filing a new application instead of a request for review could result in the loss of benefits.

1. *Initial Determination Notice Containing The Following Sentence:*
"If you do not request reconsideration of your case within the prescribed time period, you still have the right to file another application at any time."
2. *Reconsideration Determination Notice Containing The Following Sentence:*
"If you do not request a hearing of your case within the prescribed time period, you still have the right to file another application at any time."
A notice described above is not excluded from the Ruling simply because it contained the following additional sentence:
"A new application is not the same as an appeal of this determination."
However, the fact that a notice contained this additional statement is a factor to be considered along with all of the pertinent facts in each case in determining whether good cause for failure to file a timely request for administrative review exists. The presence of this additional statement will make it more difficult for a claimant to show that he or she did not make a timely request for administrative review as a result of the notice. In making the good cause determination when the notice contained this additional statement, the adjudicator may consider whether

the claimant should reasonably have been expected to make additional inquiries, whether such inquiries were made, and the results thereof.

B. ***Proof of Receipt of a Notice Covered By This Ruling***

Absent evidence to the contrary, SSA will presume that any notice of an initial or reconsideration determination denying a claim for title II disability benefits is covered by this Ruling if it was dated after August 31, 1977, and prior to March 1, 1990.

In all other situations (e.g., notices in title II nondisability claims, title XVI disability notices and any notice dated prior to September 1, 1977, or after February 28, 1990), the claimant must furnish a copy of the notice covered by this Ruling, or SSA's records must show that a notice covered by this Ruling was issued to the claimant.

C. ***Failure to Request Administrative Review as a Result of a Notice Covered By This Ruling***

Under this Ruling, the Agency will find that a claimant has demonstrated that the failure to file a timely request for administrative review was the result of a notice covered by this Ruling if he or she provides an acceptable explanation, based on all the pertinent facts in a particular case, linking his or her failure to file a timely request for administrative review to the absence in the notice of a statement that filing a new application instead of a request for administrative review could result in the loss of benefits.

In making this determination, factors which an adjudicator may consider include, but are not limited to, the following:

- the claimant's explanation of what he or she thought the notice meant and how that understanding influenced his or her actions;
- the claimant's mental condition [1];
- the claimant's educational level;
- the claimant's ability to speak and understand the English language;
- how much time elapsed before the claimant filed a subsequent claim or sought administrative review of the prior determination; and
- whether the claimant was represented by a non-attorney. Normally, representation by an attorney at the time of receipt of the notice bars a claimant from relief under this Ruling.

D. ***Good Cause Found***

If the adjudicator determines that good cause exists, he or she will extend the time for requesting administrative review and take the action which would have been appropriate had the claimant filed a timely request for administrative review. A finding of good cause will result either in a new determination or decision that is subject to further administrative or judicial review of the claim, or a dismissal (for a reason other than late filing) of the request for review, as appropriate.

If the adjudicator determines that good cause does not exist, he or she will deny the request to extend the time for filing and dismiss the request. The dismissal will state the adjudicator's rationale for not finding good cause and advise the claimant that he or she can file a new application.

FURTHER INFORMATION: This Ruling does not supersede or modify any instructions issued in connection with Acquiescence Ruling (AR) 92-7(9). Claimants in the Ninth Circuit are eligible for relief under the conditions set forth in this Ruling and/or under the AR as applicable. SSA will not apply this Ruling where the administrative determination at issue has been reopened previously or where a decision finding good cause to extend the time for review of that determination has been made previously under SSA policies and procedures or under court order.

EFFECTIVE DATE: This Ruling is effective upon publication in the **Federal Register**.

CROSS-REFERENCES: Program Operations Manual System, Part 2, Chapter 031, Subchapters 01 and 09; Part 4, Chapter 275, Subchapter 16; Acquiescence Ruling 92-7(9); Social Security Ruling 91-5p.

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[1] In cases in which the claimant's capacity to understand the administrative appeal process is questionable, Social Security Ruling 91-5p and for Fourth Circuit residents, Acquiescence Ruling 90-4(4) should be applied prior to consideration under this Ruling.
