**LIST OF AVAILABLE MATERIAL**

**JANUARY – DECEMBER 2014**

**ITEM NUMBERS – 2021-2068**

### Adult Attention Deficit Disorder and Lyme Disease

2033. The Appeals Council issued a fully favorable decision. The Appeals Council agreed with the ALJ that the claimant had "severe" impairments of severe Lyme disease and fibromyalgia, but the Council also found that she had "severe" ADD. The Council obtained two medical opinions. The first was from a psychologist who diagnosed severe ADD that limited the claimant to simple, repetitive work that did not require more detailed, complex tasks and a work environment with no strict production quotes. The second opinion was from a doctor who limited the claimant to a reduced range of light work. The claimant is 60 years old and in light of her other vocational factors, she was found disabled under Rule 202.06. Lawrence Wittenberg, Esq., Durham, NC, represented the claimant.

**Fully favorable Appeals Council decision on Adult Attention Deficit Disorder and Lyme Disease (May 7, 2014)**, Notice of Appeals Council Decision – Fully Favorable, Decision of the Appeals Council, Notice of Order of Appeals Council Fee Agreement Determination – 12 pages

### Closed period of disability

2038. The Appeals Council remanded the case. The ALJ awarded a closed period of disability for 13 months based on the claimant's peripheral vascular disease and denied continuing disability eligibility. He rejected forms completed by the treating doctor's nurse because she was not an "acceptable medical source." At the Appeals Council, the forms were co-signed by the doctor and were submitted. The Appeals Council affirmed the closed period but remanded as to the issue of disability after the closed period ended. First, the Council recognized that the date last insured (DLI) was one year later than found by the ALJ, so that the new evidence of neuropathy and carpal tunnel syndrome, which arose between the old and new DLI could be considered. It also ordered that the ALJ give further consideration to the forms co-signed by the treating doctor and nurse. Further, additional evaluation of the claimant's RFC may be necessary to include the additional medical evidence in the record. The claimant was represented by Constance R. Somers, Esq., San Antonio, TX.

**Appeals Council remand on closed period of disability (Mar. 20, 2014),** Cover letter from claimant's counsel, Affirmation and Order of Appeals Council Remanding Case to Administrative Law Judge, Claimant's letter brief to Appeals Council – 12 pages

### Court remand: Time limit

2036. The district court remanded and order the ALJ to conduct the remand hearing within 120 days. The U.S. Magistrate Judge recommended remand of the case, with the 120 day time limit to hold the hearing. The Commissioner objected, citing cases for the proposition that imposing a time limit exceeds the bounds of judicial authority. The court agreed with the plaintiff's attorney, Carol Avard, Esq., Cape Coral, FL, that the cases cited were distinguishable. One case was a class action and while the Supreme Court held that courts could not impose time limits in class actions, it specifically exempted its holding from individual cases. *Heckler v. Day*, 467 U.S. 104, 112-19 (1984). The other case involved reinstatement of benefits in a medical cessation case until the hearing. In this case, the court "finds that it is not precluded from compelling the ALJ to conduct a hearing on remand within 120 days." The court also affirmed the Magistrate Judge's holding that (1) the ALJ's finding that the plaintiff could perform her past relevant work was not supported by substantial evidence because the ALJ failed to consider her stooping limitations; and (2) the ALJ erred by failing to inquire into whether the plaintiff had any transferable skills. EAJA fees in the amount of that $6,388.38 are subsequently awarded.

***Bond v. Commissioner of Social Security*, Case No. 6:13-cv-175-CEH-DAB** (M.D.Fla. Jan. 28, 2014); *2014 U.S. Dist. LEXIS 9668* – 31 pages, including Judgment, Order, Plaintiff's Response to

Defendant's Objections to the Magistrate Judge's Response [sic] and Recommendation, Plaintiff's Memorandum in Opposition to the Commissioner's Decision

## Credibility

2065. Sixth Circuit remand with instructions to the ALJ to reconsider the evidence supporting the Appellant's complains of alleged disabling pain from the time that he stopped receiving unemployment compensation through his date last insured. The ALJ's findings on credibility were inconsistent with the factors in Rogers v. Comm'r of Soc. Sec. 486 F.3d 234, 247 (6th Cir. 2007). The ALJ mischaracterized the Appellant's testimony regarding his ability to perform daily activities. The ALJ failed to consider the "location, duration, frequency, and intensity of [the Appellant's symptoms." Finding the failure to "sit and squirm" during the hearing did not mean that the need to shift positions arose later. This does not demonstrate that this was merely a ruse for obtaining benefits." The ALJ also did not explain the discrepancies in the medical opinions and failed to adequately consider evidence relating the symptoms such as the length of time treatment was sought for pain, the nature and extent of medications prescribed and side effects, and frequency of ER visits. Medical evidence also supported the need for the use of a cane. While the opinion includes a thorough analysis of the Appellant's credibility it is important to note that the Sixth Circuit clearly stated that receipt of unemployment benefits and disability benefits are "inherently inconsistent." Chris Harrell, Esq., Louisville, KY represented the plaintiff.

***Cox v. Commissioner of Social Security***, Case No. 14-5588 (6th Cir. Nov. 24, 2014)– 26 pages, including Order and Appellant's Brief

2062. The district court remanded the case. The ALJ's credibility finding was flawed because the ALJ "(1) used meaningless boilerplate language; and (2) failed to discuss the side effects of claimant's medications." The ALJ used "the often frowned upon boilerplate language to support her credibility assessment" and "offered little more than a recitation of the medical evidence." The ALJ primarily implied that objective medical records do not support the claimant's testimony regarding minimal daily activities and debilitating pain. But an ALJ "may not discredit a claimant's complaints of pain and limitations solely because they are not substantiated by objective medical evidence." The ALJ also relied on the claimant's lack of significant mental health treatment. Before citing to that, the ALJ should have acknowledged evidence in the record, including testimony, that the claimant had problems finding a psychiatrist due to insurance problems. The ALJ also failed to address the claimant's testimony regarding the side effects of her medication. The court found that "the ALJ's credibility assessment lacks adequate explanation and leaves us unable to trace the path of her reasoning. As a result, remand is required." The plaintiff was represented by John E. Horn, Esq., Tinley Park, IL.

***Thomas v. Colvin*, Case No. 11 C 8956** (N.D.Ill. Sept. 5, 2014); *2014 U.S. Dist. LEXIS 123832*, Memorandum Opinion and Order – 26 pages

2051. The Seventh Circuit remanded for further proceedings. The Court held that the ALJ did not adequately explain her finding that the claimant was not credible and the finding was not supported by substantial evidence. The ALJ drew negative inferences from the facts without asking the claimant to explain them. The claimant, who had suffered a stroke, did not attend all of her physical therapy sessions and did not fully comply with her home exercise program. The ALJ did not ask why she did not attend the sessions or comply with home exercises. "There may be a reasonable explanation," such as the inability to afford treatment, further treatment may have been ineffective, or the treatment caused intolerable side effects. The ALJ also found the claimant less than credible because she went on two vacations, one shortly after the stroke. The record did not indicate any strenuous activity on the vacations. "[W]e cannot assess the validity of the ALJ's determination because the record is devoid of information that might support her assessment and the ALJ did not ask follow-up questions that might prove insightful." The Court also held that the ALJ's finding that the claimant could perform light work was not supported by the medical evidence or the testimony of the claimant. The ALJ also erred by relying on the grids to deny the claim because nonexertional limitations existed and the ALJ

did not include these limitations in her hypotheticals to the VE. John E. Horn, Esq., Tinley Park, IL, represented the claimant/Appellant.

***Murphy v. Colvin*,** No. 13-3154 (7th Cir. July 22, 2014); *2014 U.S. App. LEXIS 14035; published at 759 F.3d 811 (7th Cir. 2014)* Opinion – 17 pages

## Credibility

2030. The Seventh Circuit remanded for further proceedings. First, the ALJ erred by finding that the Appellant's "minimal" treatment for pain due to sciatic nerve pain meant that it could not be as severe as alleged. The record was "replete" with notes that the medication was not helping and sciatica is not always amendable to more severe treatments. The ALJ also appears to have ignored the medical evidence that supported the Appellant's complaints of pain. While the ALJ need not mention every piece of evidence, she "cannot ignore a line of evidence contrary to her conclusion." The ALJ also erred in finding no "medical necessity" for the Appellant to lie down during the day. "But a lack of medical evidence supporting the severity of a claimant's symptoms is insufficient, standing alone, to discredit her testimony." In addition, the ALJ's RFC was improper by failing to consider the combined effect of her ailments. Without considering all of the impairments "in concert, we cannot say that the ALJ built the required 'accurate and logical bridge' between the evidence and her conclusion." The Appellant was represented by John E. Horn, Esq., Tinley Park, IL.

***Thomas v. Colvin***, No. 13-2602 (7th Cir. Mar. 11, 2014); *2014 U.S. App. LEXIS 4530; published at 745 F.3d 802* – 9 pages

2041. The district court remanded for further proceedings. The court agreed with the plaintiff that substantial evidence does not support the ALJ's RFC finding. As part of that finding, the ALJ found the plaintiff was not credible. As an example, the ALJ noted the lack of objective medical tests and significant treatment. SSR 96-7p requires the adjudicator to consider any reasons offered for that failure, such as lack of insurance. Here, the plaintiff was in fact uninsured during those periods. Her treating doctor reflected that reason for lack of treatment. The ALJ failed to mention or consider the plaintiff's proffered justification. The ALJ misstated the plaintiff's testimony about her activities of daily living in finding her able to perform light work. Her husband did most household chores and she does a little bit of cleaning for a couple of minutes at a time. She reported the same to her treating doctor. The court stated that RFC is not determined by what a claimant might be able to unreliably or intermittently accomplish. "Here, there is no record evidence illustrating that Plaintiff performed the activities consistently and without substantial interference from pain." In addition, "[t]he ALJ's reliance upon Plaintiff's testimony to discount [the treating doctor's] opinion that Plaintiff would require unscheduled work breaks during the work day and that she can only sit for thirty minutes without interruption was also erroneous." The plaintiff was represented by Margolius, Margolius and Associates, Cleveland, OH.

***Pittman v. Commissioner of Social Security*, Civil Action 2:12-cv-980** (S.D.Ohio Mar. 4, 2014; *2014 U.S. Dist. LEXIS 27431; 200 SSRS 138* – 24 pages

## Date last insured

2043. The ALJ issued a favorable decision. The claimant, now age 63, has been receiving early Retirement Insurance benefits (RIB) since age 62. She filed an application for disability benefits in 2012, with a date last insured (DLI) of March 31, 2010. At the hearing, testimony was taken from a medical expert (ME) and a vocational expert (VE). The ME testified that severity could be inferred from the medical records subsequent to the DLI and that the claimant's pulmonary condition would have limited her to no more than sedentary work since she was last seen by her doctor four months prior to the DLI. The decision discusses how to apply SSR 83-20 when there is a remote alleged onset date and/or DLI. SSR 83-20 advises that it may be difficult to establish the precise date of onset with slowly progressive diseases. Testing in 2011 showed severe airflow obstruction but concurrent treatment notes reference "years" of chronic obstructive asthma. The ME testified that the 2011 test results would have been applicable in March 2010 due to the slowly progressive nature of the disease.

The ALJ found the claimant disabled as of March 31, 2010 and awarded benefits based on the February 2012 application. Barbara A. Lavender, Esq., Toledo, OH, represented the claimant.

**Favorable ALJ decision on remote onset date and date last insured (May 30, 2014)**, 7 pages

2023. The court remanded the case. The ALJ failed to consider the plaintiff's carpal tunnel syndrome (CTS), finding it "non-severe." The CTS was diagnosed after the date last insured (DLI), December 31, 2008. However, there was evidence during the hearing regarding numbness in the plaintiff's hands, contradicting the ALJ's finding that there was no objective medical evidence predating the DLI. The medical records suggest that the plaintiff suffered CTS symptoms for years before the 2009 diagnosis. "Therefore, even if the ALJ determined that Claimant's carpal tunnel syndrome was not severe, it still should have been considered in formulating Claimant's RFC." The ALJ also erred in "cherry picking" medical evidence from the treating physical therapist. She ignored evidence that supported the plaintiff's claim. "Picking one statement from the report while ignoring contracting [sic] evidence within the same report reflects the type of "cherry picking" that the ALJ is not allowed to do – and it undercuts the requirement that the ALJ's opinion be supported by substantial evidence." John E. Horn, Esq., Tinley Park, IL, represented the plaintiff.

***Tezak v. Colvin*, Case No. 12 C 2175** (N.D.Ill. Dec. 12, 2013), Memorandum Opinion and Order – 16 pages

### EAJA fees

2027. The district court awarded EAJA fees in the amount of $11,999.66. The court rejected the government's argument that a cap of 40 hours per Social Security appeal should be a guide. Plaintiff's counsel provided cases where the judges have approved three hours of time billed per page of briefing. The court noted: "This formula would start her off with 60 hours 'in the bank,' as it were, based solely on her 20 page brief …." The court acknowledged the attorney's experience, finding her frequent appearances before the court as "credible" and her ethics "unimpeachable." The court chastised the government for calling her integrity into question. The total hours – 34 hours – spent on the primary case, responding to the government, and preparing for oral argument was "entirely reasonable." In a footnote, the court was "constrained to observe that the Commissioner's own performance before this Court on the issue of legal fees charged by experienced practitioners has fallen well below par." Agnes WladykaEsq., Mountainside, NJ represented the plaintiff.

***Halley v. Commissioner of Social Security*, Civil No. 12-2754 (KSH)** (D.N.J. Jan. 29. 2014); *2014 U.S. Dist. LEXIS 10796*, Opinion – 4 pages

### EAJA fees

2034. The district court awarded EAJA attorney's fees in the amount of $7,607.78, the full amount requested by the plaintiff's attorney, Paul e. Radosevich, Esq., Denver, CO. The court had previously remanded the case, finding that the ALJ committed legal error in failing to account for the effect of all of plaintiff's mental impairments in assessing his RFC. The Commissioner failed to meet her burden of showing that her position was substantially justified during the entire civil action. "Rather, she has so narrowly construed the basis for my determination as to essentially mischaracterize the grounds on which remand was ordered." The court had concluded that the ALJ committed legal error in "purporting to afford substantial weight to certain medical source opinions of record, but then failing to adopt all limitations suggested by those sources" in his RFC assessment or explain why he did not. The court awarded fees at $181.57 per hour as a COLA. While higher than EAJA fee awards in other similar cases, the Commissioner presented no argument that the hourly rate was excessive or the total amount unreasonable.

***Apodaca v. Colvin*, Civil Action No. 12-cv-02508-REB** (D.Colo. Apr. 1, 2014); *2014 U.S. Dist. LEXIS 44385* – 5 pages

### EAJA fees

2050. The district court ordered EAJA fees in the amount of $7,328.00, for 38 hours spent on the case. The government argued that the amount of time was excessive, specifically pointing to the 31.5 hours spent preparing the plaintiff's 20-page brief. The court found this time to be reasonable. Although plaintiff's counsel, is very experienced, the transcript was over 1000 pages, and a review taking 8.4 hours is within reason. While the number of hours spent on preparing the brief might be longer than some other attorneys would spend, the number expended in this case were not unreasonable. "The Court determines that 31.5 hours to review the transcript, and draft the brief are reasonable, not excessive, redundant or otherwise unnecessary." The hourly rate awarded for 2013 was $187.50 and the rate for 2014 was $188.75. Carol Avard, Esq., Cape Coral, FL represented the plaintiff.

***Jipson v. Commissioner of Social Security***, Case No. 2:13-cv-450-FtM-38DNF (M.D.Fla. July 2, 2014), Amended Judgment in a Civil Case, Order, Report and Recommendation – 9 pages

### EAJA fees

2046. The district court awarded EAJA fees in the amount of $15,238.15, including time spent replying to the Government's reply to the EAJA petition. The court rejected the Commissioner's argument for substantial justification. The district court initially affirmed the ALJ's decision that the plaintiff was not disabled. The Seventh Circuit reversed and remanded the case. *Thomas v. Colvin*, 745 F.3d 802 (7th Cir. 2014) (LAM 2030). To support its substantial justification position, the Government restated the arguments made to the district court for affirming the ALJ's decision. However, under Seventh Circuit case law, "a district court must accept the appellate court's view of the merits as the premise for evaluating the government's position." (citation omitted). The Seventh Circuit "found several clear errors in the ALJ's determination that Plaintiff is capable of light work" including a flawed credibility determination and failing to consider the combined effect of impairments in the RFC finding. "The Seventh Circuit gave no indication that its decision to remand was at all a 'close case.'" Also, this case did not involve the ALJ making a "run-of-the-mill error in articulation." The court found that the ALJ's decision involved "numerous inadequacies," "ignoring or mischaracterizing a significant body of evidence." John E. Horn, Esq., Tinley Park, IL, represented the plaintiff.

***Thomas v. Colvin*, Case No. 12 C 4716** (N.D.Ill. July 23, 2014) – 16 pages, including Order, Plaintiff's Reply to Defendant's Response to Plaintiff's Motion for Attorney's Fees Under the Equal Access to Justice Act, Summary of Attorney Hours Expended on Defendant's EAJA Reply

### ALJ Duty - Failure to follow Appeals Council order

2053. The Appeals Council remanded the case to a different ALJ. In 2012, the Appeals Council remanded the case to an ALJ and ordered the ALJ to obtain evidence from a medical expert. The ALJ's decision on remand does not include evidence from a medical expert. The decision also does not address statements made by the claimant's former employer. "Evaluation of the third-party statement is required under Social Security Ruling 06-3p." Since the case was previously remanded to the same ALJ, the Appeals Council directed that for this second remand, the case is to be assigned to another ALJ. The claimant was represented by John A. Bowman, Esq., Davenport, IA.

**Appeals Council remand on failure to follow Appeals Council order (May 9, 2014)**, Notice of Order of Appeals Council Remanding Case to Administrative Law Judge, Order of Appeals Council – 3 pages

### Fibromyalgia

2057. The district court reversed and remanded for an award of benefits. The plaintiff filed her application in October 2006. It was denied at all levels and a civil action was filed in 2010. The court remanded for further proceedings in July 2011. In December 2012, the same ALJ held a remand hearing and again denied the claim. A second civil action was filed, i.e., the case considered here. The court found that the ALJ incorrectly interpreted the 2011 remand order and improperly rejected evidence from the plaintiff's treating physicians. The treating rheumatologist diagnosed fibromyalgia. The ALJ erroneously rejected the diagnosis by finding it "based solely on the claimant's subjective reports." "Rheumatologists are the relevant specialists for evaluating disability claims based on fibromyalgia. There is nothing in the record to indicate that [the treating rheumatologist] did not

reach his own conclusions based on his own observations and expertise." The primary care physician, who is a Doctor of Naturopathic Medicine and a Doctor of Chiropractic Medicine, initially diagnosed chronic fatigue syndrome. The ALJ referred to him as "Mr." and summarily rejected the diagnosis. However, in Oregon, naturopathic physicians can be licensed as primary care physicians with diagnostic and prescriptive rights. But even if he is not an "acceptable medical source," his opinion is to be considered to show the severity of the impairment. The court could not see "any useful purpose of ordering yet another remand" since the record is sufficiently developed to support a finding of disability. Arthur Stevens, III, Esq., Medford, OR, represented the plaintiff.

***Hansen v. Colvin*, Civ. No. 6:13-cv-00612-MC** (D.Ore. Sept. 8, 2014), Opinion and Order – 8 pages

### Hearing notice: Procedural due process

2021. The court remanded and reinstated benefits under a subsequently approved application. The court previously denied the government's motion to dismiss the complaint, finding that the requirements for waiving exhaustion of administrative remedies were met and that the hearing notice violated due process. [See Available Material No. 2010] The ALJ reconsidered and denied a 2011 application that had been allowed at the DDS level in the context of a 2007 claim that had been remanded by the Appeals Council. The hearing notice only mentioned the 2007 claim. The plaintiff's benefits had been suspended since June 2013, the month after the prior district court decision was issued, and she was notified of an overpayment based on the 2011 claim that was initially allowed. SSA filed an opposed motion to remand so that the Appeals Council could further develop the case and provide the plaintiff with proper notification of the issues. The plaintiff agreed but only if benefits were reinstated. The parties were unable to resolve the issues. The Appeals Council remanded the case to the hearing office for a supplemental hearing with proper notice. SSA failed to say what was being done regarding the "critical fact that prior to the un-noticed hearing, Plaintiff had been awarded benefits under the 2011 application. To put the Plaintiff back to where she was before the ALJ Hearing, and especially since the decision finding her not disabled was vacated, Plaintiff should be receiving benefits under her initially approved 2011 application, unless and until the SSA properly finds otherwise." Carol Avard, Esq., Cape Coral, FL represented the plaintiff.

***Dunnells v. Commissioner of Social Security*, Case No. 5:12-CV-484-Oc-18PRL** (M.D.Fla. Nov. 6, 2013); *2013 U.S. Dist. LEXIS 160299*– 6 pages

### Listing 1.04C

2035. The ALJ issued a fully favorable decision, finding that the claimant's impairments medically equaled Listing 1.04C – Disorders of the spine. The ALJ found that the claimant had the following "severe" impairments: asthma/bronchitis; history of lumbar spine compression fracture; status post spine surgery; neurogenic bladder; neuropathy of the lower extremities; and depression/anxiety. At the hearing, the medical expert (ME) testified that the combination of these impairments medically equaled listing 1.04C. First, the claimant's neurogenic bladder is based on a compression fracture which pushes into the bladder and requires him to self-catheterize. The ME also testified that the claimant continues to have bowel and bladder dysfunction and there is now a severe spasm in the paraspinal muscles. The ALJ gave great weight to the ME's opinion and to the opinion of the claimant's long-term treating specialist. He gave less weight to the state agency medical consultants because they did not adequately consider the combined effect of the claimant's impairments. He also gave less weight to the state agency's psychological consultant than to the opinion of the treating psychologist. John E. Horn, Esq., represented the claimant.

**Fully favorable ALJ decision on listing 1.04C (Mar. 26, 2014)**, Notice of Decision – Fully Favorable, Decision – 9 pages

### Listing 12.02

2056. The ALJ issued a fully favorable decision, finding the claimant eligible for disabled adult child benefits. The claimant had a full scale IQ of 69 and his counsel argued that he met or equaled listing 12.05C. The ALJ found that the combination of claimant's impairments (bipolar disorder, learning

disorder, and borderline intellectual functioning) met listing 12.02. The opinion of the medical expert was that the claimant's impairments, also including speech limitations, caused marked limitations in activities of daily living, social functioning, and concentration, persistence or pace, meeting listing 12.02. The claimant was represented by John E. Horn, Esq., Tinley Park, IL.

**Fully favorable ALJ decision on listing 12.02** (May 13, 2014), Notice of Decision – Fully Favorable, Order of Administrative Law Judge, Decision – 11 pages

### Listing 12.04

2058. The Appeals Council issued a fully favorable decision, finding the claimant disabled since November 2011. The Appeals Council found that the claimant's schizophrenia and depressive disorder met the criteria in listing 12.04A and B. A medical consultant to the Appeals Council reviewed the file and found that drug addiction and alcoholism were not material to the disability determination. "[E]ven without substance abuse the claimant has marked limitations in social functioning and in concentration, persistence or pace." The Appeals Council found the medical consultant's opinion consistent with the medical evidence of record, including the opinion of the claimant's non-physician therapist "who noted …that despite taking his medications as prescribed and attending treatment, the claimant was still hearing voices … Accordingly, the Appeals Council gives substantial weight to this opinion." Julia Deal, Esq., Mandeville, LA, represented the claimant.

**Fully favorable Appeals Council decision on listing 12.04** (Aug. 28, 2014), Notice of Appeals Council Decision Fully Favorable, Decision of the Appeals Council, Medical Consultant's Memorandum to the Appeals Council (July 18, 2014) – 7 pages

### Listing 12.04

2059. The district court remanded the case. The ALJ erred in failing to follow the treating physician rule and based her assessment on factual errors. The court found that the ALJ incorrectly determined that no treating source had indicated that the claimant's mental health impairment met a listing when, in fact, her treating psychiatrist indicated that her impairment did meet the criteria for listing 12.04. The ALJ erred in rejecting the treating psychiatrist's opinion because the plaintiff had not been hospitalized for mental health problems since 2007 – Hospitalization is not required by the listing or SSA's rules. By requiring evidence of inpatient hospitalization the ALJ "applied an improper legal standard, and substituted her judgment for that of the Social Security regulations." The ALJ also erred in rejecting the treating psychiatrist's opinion on the ground that the psychiatrist relied on the claimant's subjective complaints. The court noted that discounting "a psychiatric diagnosis for the sole reason that the analysis is based on subjective complaints would discount the entire field of psychiatry." The Court further found that the ALJ erred in determining that the claimant's activities of daily living were inconsistent with an inability to perform work because the ALJ failed to mention any of the claimant's statements that were inconsistent with the ALJ's finding. The plaintiff was represented by Meyer Silver, Esq., Ardmore, PA, and Angela Ross, Esq., Wilmington, DE.

***Collins v. Colvin*, Civil Action No. 12-1256-RGA** (D.Del. Feb. 25, 2014); *2014 U.S. Dist. LEXIS 23279*– 44 pages, including Order, Memorandum Opinion, Plaintiff's Brief

2037. Appeals Council favorable decision relying on a report from a psychological consultant to the Council who stated that the severity of the claimant's depression and anxiety disorder met the criteria of Listings 12.04A and B and 12.06A and B. "This Listing requires a residual disease process that has resulted in such marginal adjustment that even a minimal increase in mental demands or change in the environment would be predicted to cause the individual to decompensate." Under the B criteria, the consultant found marked limitations in social functional and in concentration. Additional medical records submitted with the request for review "indicate the severity of the claimant's anxiety and depression suggesting a person unable to effectively work with others … Sustained attention on a work task is unlikely …" In light of the evidence of record, including the new evidence, the consulting psychologist concluded "there is reasonable medical certainty that the claimant has been affected by

a severe and disabling condition." The claimant was represented by Lawrence Wittenberg, Esq., Durham, NC.

Appeals Council decision on Listing 12.04 (May 27, 2014) – 11 pages including Notice of Appeals Council Decision – Fully Favorable, Decision of the Appeals Council, Fee Agreement Determination

### Listing 12.05c

2064. Seventh Circuit remand where the ALJ should have requested an adult IQ test. The plaintiff had childhood IQ scores ranging from 62 to 75. He graduated from high school at age 20 and worked as a farmhand and laborer as an adult. He was under age 50 at the time of his alleged onset date in 2008. An adult IQ test could have demonstrated that his impairments met listing 12.05C. ". . . ALJs have a duty to develop a full and fair record and must order supplemental testing when the gap in the medical record is significant and prejudicial." The seventh circuit reasoned: "Because intellectual abilities re generally presumed to remain stable over time, the ALJ should have considered the likelihood that [the Appellant] would score at or below 70 today. The ALJ also erred in not accounting for the plaintiff's intellectual functioning in the hypothetical to the VE. The court further commented that the ALJ cannot reject the opinion of the examining orthopedic surgeon simply because it has been solicited by the Appellant's attorney. The plaintiff was represented by William E. Jenner, Esq. Madison, IN.

***Warren v. Colvin***, Case No. 13-2921 (7th Cir. July 15, 2014); *565 Fed. Appx. 540; 2014 U.S. App. LEXIS 13417* – 6 pages

### Listing 13.10C

2032. The Appeals Council issued a fully favorable decision. The claimant had breast cancer in one breast followed by metachronous cancer in the other breast. Her initial treatment ended 12 and ½ months after the initial diagnosis of breast cancer. Six months after the end of that treatment and while she was undergoing prophylactic removal of the other breast, she was diagnosed with metachronous cancer in that breast. She was still receiving radiation treatments for the second cancer diagnosis at the time of the hearing. The claimant's date last insured (DLI) expired one month after the surgery in which the second cancer was discovered, although treatment for that cancer did not start until three months after the DLI. The ALJ denied the claim, finding the first cancer did not meet the 12-month duration requirement and the second cancer was "not severe" prior to the DLI. He found the two cancers were separate and could not be "piggy-backed." The Appeals Council obtained a medical opinion and found that the first cancer limited the claimant to light work with restrictions and found her disabled under grid rule 202.09 for 19 months until the discovery of the second cancer at which time she met listing 13.10C. The decision was fully favorable, based on an April 2011 application. Constance R. Somers, Esq., San Antonio, TX, represented the claimant.

**Fully favorable Appeals Council decision on listing 13.10C (Mar. 28. 2014),** Decision of the Appeals Council, Claimant's Brief to the Appeals Council – 14 pages

### Lyme Disease and Adult Attention Deficit Disorder

2033. The Appeals Council issued a fully favorable decision. The Appeals Council agreed with the ALJ that the claimant had "severe" impairments of severe Lyme disease and fibromyalgia, but the Council also found that she had "severe" ADD. The Council obtained two medical opinions. The first was from a psychologist who diagnosed severe ADD that limited the claimant to simple, repetitive work that did not require more detailed, complex tasks and a work environment with no strict production quotes. The second opinion was from a doctor who limited the claimant to a reduced range of light work. The claimant is 60 years old and in light of her other vocational factors, she was found disabled under Rule 202.06. Lawrence Wittenberg, Esq., Durham, NC, represented the claimant.

**Fully favorable Appeals Council decision on Adult Attention Deficit Disorder and Lyme Disease (May 7, 2014)**, Notice of Appeals Council Decision – Fully Favorable, Decision of the Appeals Council, Notice of Order of Appeals Council Fee Agreement Determination – 12 pages

### Medical expert testimony

2026. The district court remanded the case for further proceedings. The court held that a testifying psychologist who does not read the "E" exhibits and hear testimony, and opines based on medical evidence alone, renders an incompetent opinion and the ALJ is not permitted to rely on it.
The ALJ erred in relying on the testimony of the medical expert (ME), a psychologist. The ME failed to consider evidence available to the ALJ, including disability and function reports, statements by the plaintiff and third parties related to his disabilities. 20 C.F.R. § 404.1520a requires the ME in a mental impairment case to consider this evidence, failing to do so prejudices the plaintiff, and is a basis for remand. The ALJ also failed to consider as "severe" all impairments alleged by the plaintiff. The potential "severe" impairments not considered included chronic pain syndrome, general anxiety disorder, and major depression, which were referenced frequently throughout the treating sources' medical records. The ALJ also erroneously relied on medical opinions that did not consider these alleged impairments and their impact on the plaintiff's functional limitations and discounted the treating source without providing good reasons. The plaintiff was represented by Catherine G. Ratliff, Esq., Hot Springs, S.D. EAJA fees and expenses in the amount of $12,012.72 are subsequently awarded.

***Colhoff v. Colvin*, CIV. 13-5002-JLV** (D.S.D. Mar. 20, 2014); *2014 U.S. Dist. LEXIS 36701*– 19 pages

## Medical improvement

2042. The district court held that the ALJ's finding of medical improvement in the context of a closed period decision regarding the plaintiff's severe mental impairment was not supported by substantial evidence and remanded for further proceedings. The plaintiff is represented by Elliott Andalman, Esq., Silver Spring, MD.

***Czerska v. Colvin*, Civil Action No. TMD 12-2238** (D.Md. Sept. 20, 2013); 2013 U.S. Dist. LEXIS 134935, Memorandum Opinion Granting Plaintiff's Motion for Remand, Plaintiff's Motion and Memorandum in Support Thereof, for Judgment on the Record or in the Alternative, for Remand, and Plaintiff's Reply Brief – 60 pages

## Mental impairments and employment

2022. The court reversed and awarded benefits. The ALJ erred in discrediting the plaintiff's subjective statements about the severity of her psychiatric symptoms because he believed her statements were contradicted by the longtime treating psychiatrist and the consultative psychologist. "This reasoning is not entirely convincing because the ALJ's interpretation of their findings is not supported by substantial evidence." The treating psychiatrist found while she could perform individual tasks, she had a decreased ability to focus on tasks, multitask, or tolerate multiple work environment stimuli. The ALJ also erred in rejecting the hearing testimony of the plaintiff's longtime case manager, finding it was inconsistent with the psychiatrist's and psychologist's findings. The case manager said that part-time work in a candy store was difficult because the plaintiff did not have the highly supportive environment of past jobs. The ALJ also gave little weight to several other statements from vocational professionals who worked with the plaintiff. The court found the statements consistent and corroborated, and convincing that the prior work was provided with "extraordinary support and accommodation that is not typical in competitive employment." The court concluded that she would be likely to decompensate and experience psychiatric symptoms if she worked full-time. The VE testified that an individual with these limitations would not be able to sustain competitive employment; thus, further administrative proceedings would serve no useful purpose. The plaintiff was represented by Arthur W. Stevens, III, Esq., Medford, OR.

***Jones v. Colvin*, Case No. 1:12-cv-01605-**JO (D.Ore. Dec. 11, 2013), Opinion and Order – 14 pages

## Migraines

2047. The district court remanded the case for further proceedings on the recommendation of the Magistrate Judge. The ALJ found that migraines were a medically determinable but nonsevere impairment. The ALJ must consider limitations imposed by all medically determinable impairments,

even those that are not severe. It was unclear the extent to which the ALJ attributed migraines in assessing the RFC. Remand was ordered because the ALJ's rejection of Plaintiff's testimony concerning migraines was not supported by the record. The ALJ also erred in failing to consider a GAF score of 57. Due to the lack of medical opinion evidence concerning physical limitations, the Magistrate Judge recommended that the ALJ expand the record on remand to include an RFC from a treating physician or consultative examiner. The plaintiff was represented by Meyer Silver, Esq., Ardmore, PA.

***Sims v. Colvin*, Civil Action No. 12-6441** (E.D. Pa. March 20, 2014), Report and Recommendation, Plaintiff's Brief and Statement of Issues in Support of Request for Review – 40 pages

### Musculoskeletal Impairments

2066. Favorable ALJ decision finding that the claimant's combination of degenerative disc disease of the spine, post-laminectomy syndrome, chronic bronchitis, degenerative joint disease, and obesity medically equaled Listing 1.02A, Major Dysfunction of a Joint, since 2010. After the hearing, the ALJ obtained interrogatory responses from a medical expert who opined that Listing 1.02A was medically equaled. The claimant also developed a cervical impairment in 2013, with an MRI showing a large herniated disc at C$-C5 and mild impingement in the left shoulder. The ALJ found the claimant's testimony that she could not stand for more than 15 minutes at a time to be credible. The claimant was represented by John E. Horn, Esq., Tinley Park, IL.

ALJ decision on Listing 1.02A (Aug. 18, 2014) – 9 pages

### Remand: Sentence six

2024. The court remanded the case under sentence six of § 405(g), finding that post-ALJ evidence was "new" and that the plaintiff had demonstrated "good cause" for failing to submit it to the ALJ. The ALJ decision denying the claim was issued in December 2011. In June 2011, she began seeing a specialist at the Cleveland Clinic for back pain, which was diagnosed initially as lumbar spondylosis and then lumbar disc herniation. Surgery was first scheduled for January 2012 but did not occur until April 2012. During surgery, it was discovered that the condition was worse than an October 2011 MRI found. The new evidence met the Sixth Circuit standard for a sentence six remand. First, "good cause" for not submitting earlier was met. The evidence was not available before the ALJ decision since the surgery occurred afterwards. Also, the surgery could not have occurred prior to the hearing since scheduling is subject to a doctor's order and outside the claimant's control. In this case, the surgery was postponed for medical reasons. Second, the evidence is "new" since it was not in existence before the hearing. Third, it is "material" since the ALJ noted the absence of objective medical evidence to support the claim and there is a reasonable probability that this evidence would have changed the ALJ's decision. The plaintiff was represented by Marcia W. Margolius, Esq., Cleveland, OH.

***Malec v. Colvin*, Case No. 1:13CV626** (N.D.Ohio Jan. 8, 2014), Memorandum Opinion a& Order – 18 pages

### Remote onset date

2049. The district court remanded the case. This case went to hearing twice, the second one after an Appeals Council remand. The case was then appealed to district court. The first hearing took place in August 2009 with an alleged onset of March 9, 1992, and a date last insured (DLI) of March 31, 1995. While the onset date and DLI are very remote, the case should be properly evaluated under SSR 83-20. The ALJ denied the claim at step 2, which was an obvious error as found by the district court. The court determined that the ALJ "selectively referred to only those portions of the record supporting his conclusions." This included the records of three treating physicians, including the treating psychiatrist. The court also disagreed with Defendants that the ALJ "was not required to discuss medical opinions 'from long after the relevant period." Medical opinions and reports of observations after the period of disability are relevant to assess the claimant's disability. The ALJ failed to even mention the reports from two treating rheumatologists. As treating physicians, "the ALJ was required to provide clear and convincing reasons for rejecting their uncontroverted opinions …." The court

discusses SSR 83-20 and orders that if the expanded record on remand warrants a determination of an onset date of disability, "such determination must be made in compliance with the requirements of SSR 83-20. The plaintiff was represented by Arthur W. Stevens, III, Esq., Medford, OR.

***Coryell v. Colvin*,** Civil No. 1:13-cv-00020-JE (D.Ore. June 30, 2014), Opinion and Order – 20 pages

2043. The ALJ issued a favorable decision. The claimant, now age 63, has been receiving early Retirement Insurance benefits (RIB) since age 62. She filed an application for disability benefits in 2012, with a date last insured (DLI) of March 31, 2010. At the hearing, testimony was taken from a medical expert (ME) and a vocational expert (VE). The ME testified that severity could be inferred from the medical records subsequent to the DLI and that the claimant's pulmonary condition would have limited her to no more than sedentary work since she was last seen by her doctor four months prior to the DLI. The decision discusses how to apply SSR 83-20 when there is a remote alleged onset date and/or DLI. SSR 83-20 advises that it may be difficult to establish the precise date of onset with slowly progressive diseases. Testing in 2011 showed severe airflow obstruction but concurrent treatment notes reference "years" of chronic obstructive asthma. The ME testified that the 2011 test results would have been applicable in March 2010 due to the slowly progressive nature of the disease. The ALJ found the claimant disabled as of March 31, 2010 and awarded benefits based on the February 2012 application. Barbara A. Lavender, Esq., Toledo, OH, represented the claimant.

**Favorable ALJ decision on remote onset date and date last insured (May 30, 2014)**, 7 pages

### Reopening

2055. The Appeals Council issued a fully favorable decision, finding that the ALJ erred by not reopening a prior application filed in June 2009, although he did find that the claimant's onset date was April 1, 2007. This was error of law. The 2009 application was denied on November 9, 2009, and on reconsideration in May 2010. The claimant did not appeal further. The claimant filed another application in March 2012, alleging an onset date of March 1, 2006. That application was appealed to the hearing level, where the ALJ found the claimant disabled as of April 1, 2007. The decision indicated no basis for reopening the prior unfavorable decision and did not include any rationale for that finding. The Appeals Council found it had the authority to reopen the November 2009 initial determination denial because the March 2012 application was filed less than four years later and there is "good cause" as set forth in 20 C.F.R. § 404.988. "New and material evidence" filed with the 2012 application shows a preponderance of evidence in the record that the claimant's impairments were disabling in the prior adjudicated period. The new evidence demonstrates that the claimant "has experienced intractable pain that was not relieved despite the use of multiple treatment modalities and increasingly aggressive treatment," and additional severe mental impairments. Barbara Lavender, Esq., Toledo, OH, represented the claimant.

**Fully favorable Appeals Council decision on reopening** (Aug. 14, 2014), Decision of the Appeals Council – 5 pages

### Respiratory Impairment

2068. Appeals Council remand to the ALJ who found that the claimant had a "severe" impairment of dyspnea with a history of pulmonary embolism, among other severe impairments. The ALJ found she had the RFC for a reduced range of light work, but the decision does not contain sufficient evaluation of the respiratory impairment and limitations imposed by it. The Appeals Council found that further consideration of her use of oxygen and how her respiratory condition affects her functional abilities was warranted. Thad J. Murphy, Esq., Davenport, IA represented the claimant.

Appeals Council remand (Nov. 21, 2013) – 3 pages

### Right to counsel

2054. The district court remanded the case for rehearing. The ALJ failed to obtain a knowing and voluntary waiver of the right to counsel due to the plaintiff's low level of intelligence In this case, the

ALJ had a colloquy with the *pro se* claimant at the hearing. However, testimony at the hearing regarding the plaintiff's mental capacity "should have called into question her ability to knowingly and intelligently waive her right to counsel." In the Third Circuit, [w]hen an ALJ fails to take account of a claimant's mental limitations, district courts in this circuit invalidate claimants' waivers of the right to counsel." The court observed that while "the ALJ's waiver facially complied with the minimum HALLEX standards [in HALLEX I-2-6-52(B)], the Court does not find this compliance dispositive on the question of the adequacy of Plaintiff's waiver." While remand is not automatic solely on the basis of the insufficiency of the waiver of the right to counsel, the court found that the *pro se* claimant may be prejudiced by the ALJ's failure to observe [the] heightened duty" to help develop the record. In this case, the ALJ failed to obtain a relevant psychological evaluation and the hearing was unfair due to VE testimony that was incomprehensible to the plaintiff. The plaintiff was represented by Agnes S. Wladyka, Esq., Mountainside, NJ.

***George v. Commissioner of Social Security,*** Civil Action No, 13-5179 (FLW)(D.N.J. Aug 13, 2014) – 14 pages

### Seizure disorder

2039. The ALJ issued a partially favorable decision for a closed period (due to the claimant's death), finding that the claimant's impairment met listing 11.02. The medical expert, who identified a severe seizure disorder, testified that the medical evidence of record supported the occurrence of three seizures per month. The records from the treating neurologist documented seizures every 10 days. Upon admission and monitoring at the hospital, a decrease in medication triggered recorded seizures that the claimant's husband testified also occurred at home. The ME stated that the seizures arose from the temporal lobe but became generalized, which are more severe. The claimant also experienced side effects from the high dosage of anti-epileptic medication. The ALJ also found the claimant's statements regarding her symptoms were generally credible. The opinions of the state agency physicians, who found no exertional limitations, were afforded "little weight." The claimant died two months before the hearing was held. The cause of death is unclear from the ALJ's decision. John E. Horn, Esq., Tinley Park, NJ.

**Partially favorable ALJ decision on seizure disorder (Mar. 27, 2014),** Notice of Decision – Partially Favorable, Decision – 11 pages

### Seizure disorders

2063. The district court remanded the case under sentences four and six of 42 U.S.C. § 405(g). The ALJ found the plaintiff less credible because her testimony regarding her seizure disorder was not consistent with the medical records, noting that her seizures were controlled "relatively well" when she took her medications and that she would not miss significant days of work. The court did not agree and concluded that the ALJ's credibility assessment was not supported by substantial evidence. The plaintiff has both tonic clonic and absence seizures. The ALJ lumped both types of seizures together. The ALJ noted that the plaintiff had only a few seizures since she began taking medication but her seizure calendar reflected numerous seizures while medically compliant. Also, she consistently reported frequent absence seizures to her treating physicians and continued to experience these seizures. The ALJ erred in discounting credibility because the plaintiff testified an event occurring on a certain date, when it occurred the same date but one year later. This is "unfair given that Plaintiff explicitly and repeatedly informed the ALJ that she could not be sure as to how many or the timing of her grand mal seizures without her calendar." Further, the ability to do housework or some seasonal work for two months does not undercut her testimony. The ability to perform "intermittent and interrupted daily functions" is not evidence of the ability to perform substantial gainful activity. Finally, the ALJ also rejected without explanation the treating neurologist's statement that the plaintiff experiences seizures multiple times daily and that her seizures have been "quite refractory to medical treatment." The court also found that new evidence submitted to the court was "material."

The new evidence reflected that the plaintiff continued to experience seizures despite medication. The plaintiff was represented by Marcia Margolius, Esq., Cleveland, OH.

***Swanagin v. Commissioner of Social Security*,** Civil Action 2:13-cv-434 (S.D.Ohio Aug. 21, 2014), Opinion and Order – 32 pages

### Transferable skills

2044. The district court reversed and remanded because the ALJ did not ascertain what exact skills the plaintiff learned on his job. As a result, the VE and the ALJ made assumptions based only on the job titles of the jobs held by the plaintiff. The ALJ failed to obtain testimony from the plaintiff about his job duties or the skills he actually acquired. Relying on Tenth Circuit case law, the court noted: "Job titles, in themselves, are not determinative of skill level." The court found: "Because the vocational expert's description of acquired skills relied on the occupational titles and was not based on Plaintiff's actual acquired skills, it does not constitute substantial evidence to support a finding that Plaintiff possessed these skills." The plaintiff was represented by Paul E. Radosevich, Esq., Denver, CO.

***Bethel v. Colvin*, Civil Action No. 13-cv-2044** (D.Colo. June 30, 2014), Order Vacating Administrative Law Judge's Decision and Remanding to the Commissioner for Rehearing, Plaintiff's Opening Brief – 24 pages

### Weight of Medical Evidence - Treating physician opinion

2067. District Court remand for further proceedings. The ALJ failed to provide "good reasons" for affording the treating psychiatrist's opinion less weight" The treating psychiatrist had diagnosed several mental impairments resulting in a "poor ability" to engage in several work-related limitations. "[T]he decision is 'marked by the absence of any reasoning at all' and the ALJ 'merely provided a recitation of the treating psychiatrist's findings' and stated that the doctor's conclusions were not supported by the evidence of record." The ALJ must give "good reasons" for the weight given to a treating doctor's opinion and must be "sufficiently specific" to make clear for subsequent reviewers the weight given to the opinions. Merely stating that the treating doctor's conclusions "are not supported by the evidence of record" is "insufficient to satisfy the good cause reasons requirement of the treating physician rule." The plaintiff was represented by Marcia Margolius, Esq., Cleveland, OH.

***Sovey v. Commissioner of Social Security***, Case Number 1:13cv1645 (N.D.Ohio Aug. 29, 2014) – 19 pages

2060. The Appeals Council remanded the case to the ALJ for further proceedings. The ALJ found the claimant disabled as of two days after the hearing, when the claimant was 50 years old. The treating doctor did not complete a medical source statement but did sign and endorse a functional capacity evaluation obtained by the claimant's attorney, Barbara A. Lavender, Esq., Toledo, OH. Ms. Lavender notes that this is the first time that the Appeals Council found that the ALJ erred in not treating the treating physician's endorsement of the FCE as the doctor's own medical source statement under the regulations and rulings. The Appeals Council found that the ALJ should have evaluated the FCE endorsed by the treating physician as a treating opinion under 20 C.F.R. § 404.1527.

**Appeals Council remand on treating physician opinion** (Oct. 30, 2014), Order of Appeals Council Remanding Case to Administrative Law Judge – 3 pages

### Unemployment Benefits

2065. Sixth Circuit remand with instructions to the ALJ to reconsider the evidence supporting the Appellant's complains of alleged disabling pain from the time that he stopped receiving unemployment compensation through his date last insured. The ALJ's findings on credibility were inconsistent with the factors in Rogers v. Comm'r of Soc. Sec. 486 F.3d 234, 247 (6th Cir. 2007). The ALJ mischaracterized the Appellant's testimony regarding his ability to perform daily activities. The ALJ failed to consider the "location, duration, frequency, and intensity of [the Appellant's symptoms." Finding the failure to

"sit and squirm" during the hearing did not mean that the need to shift positions arose later. This does not demonstrate that this was merely a ruse for obtaining benefits." The ALJ also did not explain the discrepancies in the medical opinions and failed to adequately consider evidence relating the symptoms such as the length of time treatment was sought for pain, the nature and extent of medications prescribed and side effects, and frequency of ER visits. Medical evidence also supported the need for the use of a cane. While the opinion includes a thorough analysis of the Appellant's credibility it is important to note that the Sixth Circuit clearly stated that receipt of unemployment benefits and disability benefits are "inherently inconsistent." Chris Harrell, Esq., Louisville, KY represented the plaintiff.

***Cox v. Commissioner of Social Security***, Case No. 14-5588 (6th Cir. Nov. 24, 2014), Order and Appellant's Brief – 26 pages

### VE telephone testimony

2045. The district court remanded the case for further proceedings. The hearing notice stated that a vocational expert (VE) would testify at the hearing. However, the VE testified by phone. The plaintiff's attorney, Carol Avard, Esq., Cape Coral, FL, objected to the VE testifying by phone because it was not in the hearing notice and was not authorized by the regulations then in effect [May 2012 – final regulations authorizing telephone testimony were issued in May 2013.] The court concluded that the regulations in effect at the time of the hearing did not permit the use of expert testimony by phone and that the ALJ erred by obtaining and relying on such testimony over the repeated objections of the plaintiff. The court found the error "presumptively prejudicial and/or not harmless."

While there has been a change now authorizing telephonic expert testimony, the court provides a useful statement regarding the new regulations: "Notably, even though the current regulations permit expert testimony via telephone, they still require the SSA to notify a claimant if a witness will be appearing by telephone. 20 C.F.R. §§ 404.928(b), 416.1438(b)."

***Hannah v. Colvin*, Case No. 8:13-cv-1082-SCB-TBM** (M.D.Fla. June 25, 2014), Judgment in a Civil Case, Order, Report and Recommendation, Plaintiff's Memorandum in Opposition to the Commissioner's Decision – 34 pages

### Vocational expert testimony

2031. The Appeals Council remanded the case to the ALJ. The VE relied on Occubrowse and specifically SOC category 51-9192, a conglomeration of a broad range of occupations within that general category including jobs at different exertional levels. The Appeals Council stated: "There is no indication that the number of jobs in the SOC category were reduced to reflect numbers consistent with the claimant's residual functional capacity, either by mathematical calculation or by personal knowledge. On remand, if the vocational expert again cites the job of washroom operator, the Administrative Law Judge should further question whether the number cited by the vocational expert includes sedentary jobs only." The Appeals Council also required the ALJ to define a sit-stand option with specificity, i.e., is it at will or at specific time intervals. The claimant was represented by Winona W. Zimberlin, Esq., Hartford, CT.

**Appeals Council remand on vocational expert testimony (Sept. 20, 2013)**, Notice of Order of Appeals Council Remanding Case to Administrative Law Judge, Order of Appeals Council – 4 pages

### Waiver of overpayment

2025. The ALJ waived the overpayment of SSDI benefits in the amount of $107,232 due to incorrect information from SSA about the beneficiary's housing allowance as a minister. The beneficiary began receiving benefits in December 1997. In January 2012, SSA informed him that his disability ceased as of April 2007 due to earnings and that he was overpaid $107,232 from January 2007 to January 2012. His reconsideration was denied and he filed for a hearing. The ALJ waived the overpayment. First, the beneficiary was not at fault. His testimony was credible. He made several trips to the local

SSA office to ask about the impact of the housing allowance on his SSDI benefits. He did his "due diligence" as to informing SSA. Based on what he was told, he had no reason to suspect a problem. He was justified in relying on the accuracy of what SSA told him. Second, recovery of the overpayment would be against equity and good conscience. He "understandably relied on the accuracy of what he was told" by SSA. For nearly ten years, he "detrimentally relied on the accuracy of the (incorrect) information" he received from SSA. Because he made reasonable efforts to determine how the housing allowance would affect his eligibility for SSDI and his detrimental reliance on inaccurate information, it would be against equity and good conscience to pursue recover of the overpayment. John A. Bowman, Esq., Davenport, IA, represented the claimant/beneficiary.

**Fully Favorable ALJ Decision on Waiver of Overpayment (Sept. 12, 2013)**, Notice of Decision – Fully Favorable, Decision – 11 pages

### Weight of medical evidence

2028.The court remanded for further proceedings. The court questioned the ALJ's RFC determination. First, the ALJ failed to properly evaluate the opinions of the treating and examining physicians. The ALJ found that the plaintiff, diagnosed with agoraphobia and PTSD, could perform light work with limited interpersonal contact, little judgment involved, and little complexity of tasks. The ALJ "cherry picked" the findings of the psychologist CE, which the ALJ gave great weight. The ALJ failed to mention a number of the CE's statements regarding the plaintiff's mental state. The ALJ also failed to mention statements by a treating physician. In addition, the evidence did not support the ALJ's conclusions regarding the plaintiff's activities of daily living. The ALJ found the plaintiff not fully credible but relied on only part of her statements, resulting in inaccurate findings. For example, she takes care of her grandson but she explained she makes herself do it because she has to. While she shops, she only does it "when I have to and it doesn't take long …" The ALJ used only part of her statements without context. The court awarded an EAJA fee of $12,220.20 for 65.7 hours at $186 per hour and costs of $86.90. The plaintiff was represented by Jim Carfagno, Jr., Esq., Russellville, AR.

***Hull v. Social Security Administration*, No. 4:13-cv-16-DPM** (E.D.Ark.), Proposed Findings and Recommendations, Brief of Plaintiff, Motion for Attorney's Fees and Expenses (EAJA), Order (EAJA) – 43 pages

### Weight of medical evidence

2029. The district court remanded the case under sentence four of § 405(g) for further proceedings. The ALJ's findings of fact must be based on the entire record. "[A] decision that focuses on one aspect of the evidence and disregards other contrary evidence is not based upon substantial evidence." Here, the ALJ failed to consider relevant portions of the medical evidence, "relying only on those portions of the record that supported a finding of no disability while ignoring other portions and referring to medical evidence that is not in the record, and even made erroneous statements concerning the record in her summary of the medical evidence." The ALJ repeatedly omitted references to treating doctors' treatment notes regarding lumbosacral pain and spasms, side effects from pain medication, and crying spells or "cherry-picked" parts of notes. The ALJ failed to discuss at all the notes of one treating physician, which were in fact consistent with other treating doctors. The lengthy decision covers a number of other situations where the ALJ failed to properly consider the evidence in its entirety. The ALJ's decision was "silent on a large amount of evidence provided by claimant" and mistakenly summarized some parts of the record. "A mere statement that the ALJ carefully considered all the testimony and exhibits is not sufficient to comply with her duty" to discuss the weight given to different medical evidence. The decision includes a number of citations and discussion of caselaw regarding the ALJ's duty to consider the entire record and discuss with some particularity the weight given to evidence. Michael J. Hofrichter, Esq., Fayetteville, GA, represented the plaintiff.

***Dellinger v. Colvin*, Civil Action No. 3:12-cv-00164-RGV** (N.D.Ga. Feb. 21, 2014), Final Order – 69 pages

### Weight of medical evidence

2040. The Appeals Council remanded the case after a district court remand. The ALJ discounted the medical opinion of the treating doctor and the nurse practitioner because the doctor merely countersigned the nurse practitioner's statement. "Discounting these opinions on that basis is not consistent with Social Security Ruling 06-3p." The ALJ seemed to discount the treating source's opinion because it indicates that DAA was not a material factor contributing to the inability to work. The ALJ was not clear how the claimant's continued use was inconsistent with that opinion. The ALJ decision also "seems to indicate that the claimant's credibility was adversely affected by her request for a Spanish interpreter …; however, it was inappropriate to evaluate the claimant's credibility based on this." The ALJ afforded "great weight" to the opinion of a medical expert who completed a "Testimony by Affirmation of Medical Advisor form sent by the ALJ. However, the administrative record does not indicate the ME's specialty, thus, clarification is necessary. The claimant was represented by Winona W. Zimberlin, Esq., Hartford, CT.

**Appeals Council remand on weight of medical evidence (Mar. 19, 2014),** Order of Appeals Council Remanding Case to Administrative Law Judge – 3 pages

### Weight of medical evidence

2048. The district court remanded the case for further proceedings. The ALJ's decision was not supported by substantial evidence because the ALJ rejected the opinions of the treating physician based on impermissible considerations. The ALJ erred by failing to defer to the treating physician's interpretation of an MRI. The ALJ improperly substituted his lay opinion regarding proper treatment for carpal tunnel syndrome. The ALJ's opinion included a factual error regarding the medical source statement. The evidence did not support the ALJ's determination that there were only moderate findings in treatment records and the ALJ improperly relied on lack of a cane. The ALJ also improperly based his credibility determination on testimony that took place outside the relevant time period. The plaintiff was represented by Meyer Silver, Esq., Ardmore, PA.

***Jones v. Colvin*,** Civil Action No. 2:12-cv-05205 (E.D. Pa. Feb. 12, 2014), Order, Report & Recommendation, Plaintiff's Brief and Statement in Support of Request for Review – 37 pages

### Weight of medical evidence

2061. The Seventh Circuit remanded for further proceedings. The ALJ erred in two respects: (1) The ALJ ignored a line of evidence demonstrating the progressive nature of the claimant's degenerative disc disease and arthritis, thus giving less weight to the treating physicians' opinions; and (2) The ALJ's RFC and credibility findings were flawed because she failed to fully consider the claimant/Appellant's daily activities, rehabilitation efforts, and physicians' evaluations. The ALJ erred in failing to give controlling weight to a treating physician's opinions by finding them inconsistent in using "faulty logic." Because of the progressive nature of the disease, there could be a legitimate difference between physical abilities in different years. The ALJ was "inappropriately selective" in evidence she chose to support her decision. This "sound bite approach" is an "impermissible methodology for evaluating the evidence." Also, while the ALJ could consider a claimant's application for unemployment benefits in assessing credibility, great care must be taken in the case of a progressive disease where the claimant may be unsure of the limits of his physical capabilities. Other credibility factors found by the Court included: rehabilitative efforts such as walking or swimming are "not necessarily transferable to the work setting …."; and a claimant's decision to undergo serious treatment such as surgery or taking heavy doses of strong drugs indicates that complaints of pain are likely credible. The claimant/Appellant was represented by William E. Jenner, Esq., Madison, IN.

***Scrogham v. Colvin*, No. 13-3601** (7th Cir. Aug/ 27, 2014), Opinion – 34 pages *[This decision is published at 765 F.3d 685 (7th Cir. 2014).]*

### Weight of medical opinions

2052. The district court remanded for further consideration of the opinion of the psychological consultative examiner (CE). The ALJ failed to mention the CE's report. The court rejected the government's argument that it was unnecessary for the ALJ to consider the CE's report because the CE did not "offer an opinion as to Plaintiff's mental limitations." The CE conducted the psychological examination and administered the "Beck Depression Inventory," which placed her in the range of severe depression. He assigned a GAF of 52 and diagnosed several serious mental impairments. He explained his diagnoses in the report and his opinions, including that the plaintiff "would likely have future interpersonal conflicts and misinterpretations due to her personality disorder." This and the other CE's statements qualify as "medical opinions"; however, "there is no indication whatsoever that the [ALJ] considered [the CE's] medical opinion." "[I]t must be apparent from a fair reading of the administrative decision that the medical opinions of nontreating sources were at least considered. This is not the case here." Remand is required. Marcia W. Margolius, Esq., Cleveland, OH, represented the plaintiff.

***Mayfield v. Commissioner of Social Security***, Civil Action 2:13-cv-764 (S.D.Ohio July 29, 2014), Opinion and Order, Judgment in a Civil Case

***George v. Commissioner of Social Security*, Civil Action No. 13-5179 (FLW)**(D.N.J. Aug. 13, 2014), Order, Opinion – 14 pages

**WEIGHT OF MEDICAL EVIDENCE – ATTORNEY HIRED**

2064. Seventh Circuit remand where the ALJ should have requested an adult IQ test. The plaintiff had childhood IQ scores ranging from 62 to 75. He graduated from high school at age 20 and worked as a farmhand and laborer as an adult. He was under age 50 at the time of his alleged onset date in 2008. An adult IQ test could have demonstrated that his impairments met listing 12.05C. ". . . ALJs have a duty to develop a full and fair record and must order supplemental testing when the gap in the medical record is significant and prejudicial." The seventh circuit reasoned: "Because intellectual abilities re generally presumed to remain stable over time, the ALJ should have considered the likelihood that [the Appellant] would score at or below 70 today. The ALJ also erred in not accounting for the plaintiff's intellectual functioning in the hypothetical to the VE. The court further commented that the ALJ cannot reject the opinion of the examining orthopedic surgeon simply because it has been solicited by the Appellant's attorney. The plaintiff was represented by William E. Jenner, Esq. Madison, IN.

***Warren v. Colvin***, Case No. 13-2921 (7th Cir. July 15, 2014) – 6 pages