

NOTE

The Lack of Deference to Medical Opinions in Adjudicating Social Security Disability Claims

AMRITA MAHARAJ†

INTRODUCTION

Becoming a doctor is not easy. It typically requires four years of undergraduate school, four years of medical school, and three to seven years of professional training in a residency program.¹ For those who want to become highly specialized in a certain field, e.g. gastroenterology, add on another one to three years for a fellowship.² The American Medical Association must therefore believe that extensive training is required to enable one to diagnose and treat people.

Interestingly enough, Administrative Law Judges (“ALJs”) for the Social Security Administration (“SSA”) do

† J.D. Candidate, Class of 2015, SUNY Buffalo Law School; B.A. in Economics, 2008, Cornell University. Thank you to Gary Pernice, Esq., for hiring me as a paralegal in the field of Social Security disability law and cultivating my passion for the law. Thank you also to Thomas Katsiotas, my fiancé, my very best friend, and my law school classmate—I cannot imagine taking this law school journey without him. Thank you to my editor, Jaclyn Silver, and all of the other members of the *Buffalo Law Review* for their hard work in preparing my Note for publication. Last but certainly not least, I am deeply grateful for the endless love and support of my parents and my brother.

1. *Requirements for Becoming a Physician*, AM. MED. ASS’N, <http://www.ama-assn.org/ama/pub/education-careers/becoming-physician.page> (last visited Nov. 10, 2014).

2. *Id.*

work very similar to that of doctors, but without any comparable training. In evaluating a claim for Social Security disability benefits³, an ALJ evaluates the claimant's medical records and the "intensity, persistence, and functionally limiting effects"⁴ of the claimant's symptoms to determine if the claimant is disabled and unable to work.⁵ In fact, one may argue that an ALJ is better qualified than a doctor to evaluate an individual's medical condition and degree of disability because, according to SSA, an ALJ is free to discredit a doctor's diagnosis or medical opinion if the ALJ feels that the doctor's opinion is not, in the ALJ's opinion, "well-supported" by "medically acceptable clinical and laboratory diagnostic techniques."⁶

How can this make any sense? This system does actually make some sense if you consider the safeguard that SSA had built into the disability determination process. I use the past tense "had" because, effective March 26, 2012, SSA amended the Code of Federal Regulations ("Regulations") to reflect new rules governing the collection and consideration of evidence of disability.⁷ With the amendment came removal of the safeguard, a safeguard that actually needed strengthening rather than total removal. To understand the safeguard, consider the following hypothetical.

Charlie, a forty-nine-year-old man who has been working as a carpenter for thirty years, injures his back badly on the job. Charlie undergoes surgery, but even after surgery, he is unable to work. He files for Social Security disability benefits, and after appearing at a hearing before an ALJ, the ALJ

3. For the purposes of this Note, I will use the phrase "Social Security disability benefits" to encompass both disability benefits provided under the Social Security Disability Insurance ("SSDI") program as well as benefits provided under Supplemental Security Insurance ("SSI"). The programs differ in that eligibility for SSDI is contingent on having worked for a certain duration and having paid Social Security taxes. SSI eligibility is based on financial need and does not require that an individual paid any Social Security taxes. *See Benefits for People with Disabilities*, SOC. SEC. ADMIN., <http://www.ssa.gov/disability> (last visited Nov. 10, 2014).

4. SSR 96-7p, 61 Fed. Reg. 34483, 34484 (July 2, 1996).

5. 20 C.F.R. § 404.1529(c) (2014).

6. SSR 96-2p, 61 Fed. Reg. 34489, 34490 (July 2, 1996).

7. *See How We Collect and Consider Evidence of Disability*, 77 Fed. Reg. 10651 (Feb. 23, 2012).

denies his claim. Even though the medical evidence included a medical opinion from his orthopedic surgeon that Charlie was unable to perform the minimum sitting, standing, and walking needed to perform full-time, competitive work on a sustained basis, the ALJ rejected the doctor's opinion. In his decision, the ALJ reasoned that the opinion was not well enough supported by objective clinical findings such as a positive straight-leg raising test, limitation of motion of the spine, and sensory or reflex loss. The ALJ further reasoned that the doctor's opinion was entitled to little weight because it was inconsistent with the doctor's treatment records wherein the doctor noted that Charlie was recovering well from surgery.

Prior to March 26, 2012, the ALJ would have had to first recontact Charlie's doctor to offer him the opportunity to provide additional evidence or clarification of his medical opinion *before* the ALJ was lawfully permitted to reject the opinion.⁸ Such protocol reflected the non-adversarial nature of Social Security proceedings and the affirmative duty that all ALJs have to develop a full and fair case record.⁹ It also reflected SSA's proclaimed respect for the superiority of evidence from a claimant's own medical source over other evidence. SSA's Regulations detail how a claimant's treating sources' opinions are generally entitled to more weight than other opinion evidence because

these sources are likely to be the medical professionals most able to provide a detailed, longitudinal picture of [a claimant's] medical impairment(s) and may bring a unique perspective to the medical evidence that cannot be obtained from the objective medical

8. 20 C.F.R. § 404.1512(e)(1) (1996), *amended by* 20 C.F.R. § 404.1520(b) (2014) ("We will seek additional evidence or clarification from your medical source when the report from your medical source contains a conflict or ambiguity that must be resolved, the report does not contain all the necessary information, or does not appear to be based on medically acceptable clinical and laboratory diagnostic techniques.").

9. *Sims v. Apfel*, 530 U.S. 103, 110-11 (2000) ("Social Security proceedings are inquisitorial rather than adversarial. . . . The regulations make this nature of SSA proceedings quite clear. They expressly provide that the SSA 'conducts the administrative review process in an informal, nonadversary manner.'") (quoting 20 C.F.R. § 404.900(b) (1999)).

findings alone or from reports of individual examinations, such as consultative examinations or brief hospitalizations.¹⁰

Thus, developing the evidence by recontacting a claimant's medical source before taking any other actions to develop the evidence was mandated whenever the record contained an insufficiency or inconsistency that prevented the ALJ from making a decision on disability.¹¹ As a result of the amendment though, Charlie's ALJ would now be free to use his discretion in determining when, or if, to give Charlie's orthopedic surgeon the opportunity to clarify his opinion before rejecting it.¹²

The amendment destroys the fundamental safeguard against an ALJ playing doctor. No longer do ALJs have any obligation to defer first and foremost to professional medical opinions in evaluating disability claims.¹³ An ALJ can interpret medical evidence as he so chooses and can decide how to resolve insufficiencies or inconsistencies in any number of ways, including ordering that the claimant undergo a consultative examination that would be performed by a doctor hired and paid by SSA¹⁴. Giving ALJs this freedom sends a clear message to them: SSA is de-emphasizing the importance of a claimant's medical sources. Further, SSA is empowering ALJs with a false sense of competence; ALJs are not licensed medical professionals though and they should not be acting as such. The fact that ALJs continue to adjudicate disability claims incorrectly, thus resulting in a high volume of remands, shows us that ALJs need more, not less, guidance. *Selian v. Astrue* is a recent example of the United States Court of Appeals for the Second Circuit reiterating once again that ALJs need to stop substituting

10. 20 C.F.R. § 404.1527(c)(2) (2013).

11. 20 C.F.R. § 404.1512(e)(1) (1996), amended by 20 C.F.R. § 404.1520(b) (2014).

12. See 77 Fed. Reg. 10651.

13. *Id.*

14. See Frank S. Bloch, *Medical Proof, Social Policy, and Social Security's Medically Centered Definition of Disability*, 92 CORNELL L. REV. 189, 222-23 (2007).

their lay opinions into their analyses.¹⁵ Further, while some ALJs' failures in properly developing records of evidence can be attributed to their misunderstanding of the situations requiring recontact, other ALJs' failures can be attributed to anti-claimant bias and/or a false sense of competency, as evidenced by SSA's recent settlement in *Padro v. Astrue*.¹⁶ For these reasons, SSA erred in amending the recontact Regulation to provide ALJs with even more discretion.

In Part I of my Note, I will provide an overview of the Social Security disability adjudication process. I will explain each of the regimented steps that an ALJ must follow to determine whether a claimant is disabled and deserving of Social Security disability benefits. Part II will be a case study of the Second Circuit's decision in *Selian v. Astrue*. I will walk you through the plaintiff's journey of trying to secure disability benefits, outlining the various decisions made on his case and paying special attention to the Second Circuit's rationale in vacating the district court's decision, which had affirmed the ALJ's decision. In Part III, I will analyze *Selian v. Astrue* through the lens of its unintended consequences: (1) it showcases why aspects of SSA's rationale for changing the recontact Regulation from a mandatory provision to a permissive one are both illogical and unreasonable; and (2) it encourages ALJs to play doctor even more than they already have been. I will also describe why, apart from *Selian v. Astrue*, every aspect of SSA's rationale does not hold water. A discussion of SSA's recent settlement in connection with *Padro v. Astrue* will additionally serve to support my contentions. Finally, I will document my proposals for reform and the expected advantages the system will gain should it institute my proposals.

I. THE SOCIAL SECURITY DISABILITY ADJUDICATION PROCESS: HOW DO THEY DO IT?

A total of 14,249,000 people are receiving Social Security disability benefits, according to January 2014 statistics from

15. *Selian v. Astrue*, 708 F.3d 409, 419-20 (2d Cir. 2013).

16. No. 11-CV-1788 (CBA) (RLM), 2013 U.S. Dist. LEXIS 150494, at *3-4 (E.D.N.Y. Oct. 18, 2013).

SSA.¹⁷ SSA also paid out a total of over fourteen billion dollars to those individuals in January 2014.¹⁸ If you want a piece of that multi-million dollar pie, you must prove to SSA that you are disabled.

Before I dive into the five-step sequential evaluation, which is the method that SSA employs to determine disability, I should define “disability” as per the Regulations. “[D]isability [is] the inability to do 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.”¹⁹ Substantial gainful activity is work that involves “significant physical or mental activities” and that is done for pay or profit.²⁰

The five-step sequential evaluation begins with a determination of whether the claimant is engaging in substantial gainful activity.²¹ Technically, a claimant may be working and may still not be performing substantial gainful activity.²² This is so as long as the claimant is earning less than a specified amount.²³ SSA has provided earnings guidelines to determine whether a claimant’s work is substantial: for example, for calendar year 2014, monthly earnings of more than \$1,070 counted as substantial.²⁴ If a claimant is found to be engaging in substantial gainful activity, the sequential evaluation ceases at this first step,

17. Quick Facts regarding Social Security Benefits Payouts, SOC. SEC. ADMIN., http://www.ssa.gov/policy/docs/quickfacts/stat_snapshot/2014-01.pdf (last visited Nov. 10, 2014).

18. *Id.* at Table 2 & 3.

19. 20 C.F.R. § 404.1505(a) (2014).

20. 20 C.F.R. § 404.1572(a) (2014).

21. 20 C.F.R. § 404.1520(a)(4)(i) (2014).

22. *SSR 83-33: Titles II & XVI: Determining Whether Work is Substantial Gainful Activity—Employees*, SOC. SEC. ADMIN. (1983), http://www.socialsecurity.gov/OP_Home/rulings/di/03/SSR83-33-di-03.html.

23. *Id.*

24. Program Operations Manual System (“POMS”), *DI 10501.015 Tables of SGA Earnings Guidelines and Effective Dates Based on Year of Work Activity*, SOC. SECURITY ADMIN., <https://secure.ssa.gov/poms.nsf/lnx/0410501015> (last updated Nov. 1, 2013).

and the claimant is deemed not disabled.²⁵ Otherwise, the evaluation proceeds to the second step.²⁶

At the second step, SSA evaluates the severity of the claimant's medically determinable physical or mental impairment(s).²⁷ Medically determinable impairments result from "anatomical, physiological, or psychological abnormalities" and can be established by "medically acceptable clinical and laboratory diagnostic techniques."²⁸ Some examples of diagnostic techniques include chemical tests, electrophysiological studies such as electrocardiograms and electroencephalograms, roentgenological studies such as x-rays, and psychological tests.²⁹ After SSA concludes that the claimant has at least one medically determinable impairment, the impairment is analyzed to determine its severity.³⁰ The claimant must have an impairment or a combination of impairments that is severe.³¹ An impairment is "severe" if it has more than a "minimal effect on an individual's physical or mental ability(ies) to do basic work activities."³² Basic work activities include, but are not limited to: walking; standing; sitting; lifting; pushing; pulling; reaching; carrying; understanding, carrying out, and remembering simple instructions; and responding appropriately to supervision, co-workers and usual work situations.³³ The impairment must also satisfy a durational requirement—"unless [the] impairment is expected to result in death, it must have lasted or must be expected to

25. 20 C.F.R. § 404.1520(a)(4)(i).

26. *Id.* § 404.1520(a)(4)(ii).

27. *Id.*

28. 20 C.F.R. § 404.1508 (2014).

29. POMS, *DI 24501.020 Symptoms, Signs, and Laboratory Findings*, SOC. SEC. ADMIN., <https://secure.ssa.gov/poms.nsf/lnx/0424501020> (last updated Aug. 9, 2012).

30. 20 C.F.R. § 404.1520(a)(4)(ii).

31. *Id.*

32. *SSR 85-28: Title II & XVI: Medical Impairments that are not Severe*, SOC. SEC. ADMIN. (1985), http://www.socialsecurity.gov/OP_Home/rulings/di/01/SSR85-28-di-01.html.

33. 20 C.F.R. § 404.1521(b) (2014).

last for a continuous period of at least 12 months.”³⁴ A claimant who successfully establishes that he suffers from a severe impairment or combination of impairments proceeds to the third step of the sequential evaluation.³⁵

While the first and second steps of the sequential evaluation are essentially “minimum requirements” for a finding of disability, the third step is the first step where a claimant may win his case outright. If a claimant succeeds at this step, he is disabled and entitled to benefits; the sequential evaluation would thus cease here.³⁶ If the claimant cannot succeed at this step, he may proceed to the fourth step.

To succeed at the third step of the sequential evaluation, the claimant must establish that his impairment meets or equals³⁷ one of SSA’s Listings of Impairments (“Listings”).³⁸ The Listings include a wide range of impairments that SSA “consider[s] severe enough to prevent an individual from doing any gainful activity.”³⁹ The Listings cover impairments from categories including the musculoskeletal system, special senses and speech, respiratory system, cardiovascular system, digestive system, genitourinary impairments, hematological disorders, skin disorders, endocrine disorders, congenital disorders that affect multiple body systems, neurological conditions, mental disorders, malignant neoplastic diseases, and immune system

34. 20 C.F.R. § 404.1509 (2014).

35. 20 C.F.R. § 404.1520(a)(4)(ii)-(iii).

36. Disability Evaluation Under Social Security, *Listing of Impairments*, SOC. SEC. ADMIN., <http://www.ssa.gov/disability/professionals/bluebook/listing-impairments.htm> (last visited Nov. 10, 2014).

37. 20 C.F.R. § 404.1526(a) (2014) (indicating that an impairment “is medically equivalent to a listed impairment in appendix 1 if it is at least equal in severity and duration to the criteria of any listed impairment”).

38. 20 C.F.R. § 404.1520(a)(4)(iii).

39. *Disability Evaluation under Social Security, Listing of Impairments*, SOC. SEC. ADMIN., <http://www.ssa.gov/disability/professionals/bluebook/listing-impairments.htm> (last visited Nov. 10, 2014).

disorders.⁴⁰ If SSA finds that a claimant's impairment does not meet or equal one of the Listings, the evaluation proceeds to step four of the sequential evaluation, which requires consideration of the claimant's ability to perform his past relevant work.⁴¹

To perform the evaluation at step four, SSA must first assess the claimant's residual functional capacity ("RFC").⁴² A claimant's RFC is the most that he can still do despite his physical or mental limitations.⁴³ The RFC assessment is then used to determine if the claimant can perform his past relevant work,⁴⁴ which is work that the claimant did within the past fifteen years that was substantial gainful activity and that lasted long enough for the claimant to learn to do it.⁴⁵ If SSA determines that the claimant can perform his past relevant work, the claimant is found not disabled.⁴⁶ To make such a determination, sometimes SSA utilizes the services of a vocational expert who "may offer relevant evidence within his or her expertise or knowledge concerning the physical and mental demands of a claimant's past relevant work."⁴⁷ If the claimant is deemed unable to perform his past relevant work, the analysis proceeds to the fifth and final step of the sequential evaluation.⁴⁸

At the fifth step of the sequential evaluation, SSA determines whether the claimant, even despite all of his limitations, can adjust to other work in the national

40. *Disability Evaluation under Social Security, Adult Listings*, SOC. SECURITY ADMIN., <http://www.ssa.gov/disability/professionals/bluebook/AdultListings.htm> (last visited Nov. 10, 2014).

41. 20 C.F.R. § 404.1520(a)(4)(iv).

42. *SSR 96-8p: Policy Interpretation Ruling Titles II & XVI: Assessing Residual Functional Capacity in Initial Claims*, SOC. SEC. ADMIN. (1996), http://www.socialsecurity.gov/OP_Home/rulings/di/01/SSR96-08-di-01.html.

43. 20 C.F.R. § 404.1545(a)(1) (2014).

44. 20 C.F.R. § 404.1560(b) (2014).

45. *Id.* § 404.1560(b)(1).

46. *Id.* § 404.1560(b)(3).

47. *Id.* § 404.1560(b)(2).

48. *Id.* § 404.1520(a)(4)(v).

economy.⁴⁹ SSA considers the claimant's RFC, age, education, and work experience.⁵⁰ The proposed work must exist in "significant numbers in the national economy."⁵¹ A claimant who prevails at the fifth step of the sequential evaluation is disabled and entitled to benefits.

II. *SELIAN V. ASTRUE*: THE ROAD TO SECURING A REMAND

Robert Selian ("Selian") worked from 1980 until 2000 doing a range of unskilled and physically taxing jobs.⁵² Take, for example, his job as a delivery driver.⁵³ That job had a minimum lifting requirement of seventy-five pounds.⁵⁴ Selian also worked as a road painter, which required him to lift a spray painter weighing about one hundred pounds onto a truck.⁵⁵ After twenty years and with only a GED, Selian began searching for less physically demanding work because his physical strength was declining, particularly his lifting ability.⁵⁶ From 2001 to 2006, Selian worked various part-time, unskilled jobs, but Selian's diminishing physical capacity forced him to discontinue each of those jobs. For example, Selian worked as a gas station attendant until he could no longer lift car hoods or squeeze gas pump handles.⁵⁷

Selian filed his claim for Social Security disability benefits on February 8, 2007, alleging disability as of June 30, 2001.⁵⁸ While I cannot be sure, I am fairly certain that

49. *Id.*

50. *Id.*

51. *Id.* § 404.1560(c)(1).

52. *Selian v. Astrue*, 708 F.3d 409, 415 (2d Cir. 2013).

53. *Id.*

54. *Id.*

55. *Id.*

56. *Id.*

57. *Id.*

58. *Selian v. Astrue*, No. 3:10-cv-1400 (GLS), 2012 U.S. Dist. LEXIS 7447, at *1 (N.D.N.Y. Jan. 23, 2012). Note that even though Selian continued to work part-time until 2006, Selian alleged in his application for benefits that he was disabled since 2001. *Id.* As explained in Part I, an individual can be found disabled for a period of time during which he worked as long as the individual's work does not

Selian did not expect to be litigating his case—over six years after he filed it—before United States Court of Appeals for the Second Circuit.⁵⁹ Moreover, I am even more certain that Selian did not imagine that the Second Circuit would simply remand his case back to an ALJ for a do-over.⁶⁰ Selian may have expected though to have his case denied at the initial level of review, which it was on April 20, 2007.⁶¹ For disabled-worker applicants who filed claims between 2002 and 2010, approximately 74% of them were denied at the initial level of review.⁶² Luckily for Selian, New York is one of the few states where the first level of appeal is requesting a hearing before an ALJ.⁶³ In most states, the first level of appeal is to request reconsideration.⁶⁴ Notably, at the reconsideration level, about 97% of claims were denied between 2002 and 2010.⁶⁵

Skipping the reconsideration level, Selian appealed his initial denial to the hearing level and appeared at a disability hearing before an ALJ on April 29, 2009.⁶⁶ Before I discuss the ALJ's findings and conclusions, it is important that I recount Selian's treatment history and the evidence in the record before the ALJ at the time he decided to deny Selian's claim.

Selian began seeing Dr. Mark Corey in January 2007. Selian explained to Dr. Corey that he was experiencing "chronic pain in both shoulders, shortness of breath, and

constitute substantial gainful activity, for which there is a threshold earnings requirement. *See SSR 83-33, supra* note 22.

59. *Selian v. Astrue*, 708 F.3d 409 (2d Cir. 2013).

60. *Id.* at 422.

61. *Id.* at 416.

62. SOC. SEC. ADMIN., ANNUAL STATISTICAL REPORT ON THE SOCIAL SECURITY DISABILITY INSURANCE PROGRAM, 2012, SSA PUB. NO. 13-11826, 143 (2013), *available at* http://www.ssa.gov/policy/docs/statcomps/di_asr/2012/di_asr12.pdf. [hereinafter SOC. SEC. ADMIN.].

63. Michael J. Astrue, Comm'r, Soc. Sec. Admin., Statement Before the Committee on Ways and Means Subcommittee on Social Security (June 27, 2012), *available at* http://www.ssa.gov/legislation/testimony_062712.html.

64. *Id.*

65. SOC. SEC. ADMIN., *supra* note 62.

66. *Selian v. Astrue*, No. 3:10-cv-1400 (GLS), 2012 U.S. Dist. LEXIS 7447, at *1 (N.D.N.Y. Jan. 23, 2012).

'severe' fatigue."⁶⁷ Based on his examination, Dr. Corey diagnosed Selian with bilateral rotator cuff tendinitis and probable epicondylitis.⁶⁸ At that time, Dr. Corey administered injections of Lidocaine and Depo-Medrol.⁶⁹ The following month, Dr. Corey prescribed Celebrex for Selian's continued shoulder pain and recommended that Selian see an orthopedist.⁷⁰

A couple months after Selian filed his application for disability benefits, SSA requested that Selian attend two consultative examinations. These examinations were performed by doctors that are paid by SSA to perform one-time examinations.⁷¹ Upon examination, Dr. Naughten, the physical consultative examiner, noted that Selian "walked with a stiff gait and was 'unbalanced' when walking on his heels and toes."⁷² Significant clinical findings also included limited range of motion of the shoulders, reduced sensitivity to touch and pain in both shoulders at the acromioclavicular ("AC") joints, and reduced grip strength.⁷³ Diagnostic findings included an x-ray of the left shoulder that suggested the "possibility of rotator cuff impingement syndrome."⁷⁴ Regarding Selian's RFC, Dr. Naughten opined that "Selian would have no limitations in his ability to see, hear, talk, sit, or stand, but would have moderate limitations in walking, climbing stairs, pushing, pulling, and reaching."⁷⁵ Dr. Naughten further opined that Selian "could lift and carry 'a mild degree of weight on an intermittent basis.'"⁷⁶ A

67. *Selian v. Astrue*, 708 F.3d 409, 412 (2d Cir. 2013).

68. *Id.*

69. *Id.*

70. *Id.*

71. *See id.* at 412-13.

72. *Id.* at 412.

73. *Id.* at 413.

74. *Id.*

75. *Id.*

76. *Id.*

psychological consultative examiner also examined Selian and diagnosed him with a depressive disorder.⁷⁷

Selian continued to treat with Dr. Corey. By Selian's May 30, 2007 appointment, Selian had developed upper back spasms.⁷⁸ Physical examination was significant for "marked muscular tenderness posteriorly."⁷⁹ Dr. Corey diagnosed "[f]ibromyalgia-type pain."⁸⁰ On September 4, 2007, Dr. Corey affirmed a diagnosis of fibromyalgia.⁸¹ Dr. Corey provided a detailed RFC assessment on July 24, 2008.⁸² The Second Circuit summarized his opinion as follows:

[Dr. Corey] indicated a diagnosis of fibromyalgia and possible rotator-cuff tendinitis, noting that Selian's "condition is largely subjective in nature." Corey opined that Selian would need to take rest breaks of more than one 10 minutes rest period per hour while working. He also stated that Selian could not sit for six or more hours a day and could stand for at least two hours in an eight-hour workday. He explained that Selian's medication would affect his concentration and ability to sustain a work pace "at least moderately."⁸³

Finally, it should be noted that after Selian's hearing, but before the ALJ's decision, the ALJ ordered that Selian attend a rheumatological consultative examination by Dr. Dura.⁸⁴ Upon examination, Dr. Dura noted that Selian exhibited "numerous soft tissue tender points" and "appear[ed] to have fibromyalgia syndrome" and "perhaps early degenerative arthritis."⁸⁵

77. *Id.*

78. *Id.*

79. *Id.*

80. *Id.*

81. *Id.* at 414.

82. *Id.* at 415.

83. *Id.*

84. *Id.*

85. *Id.*

A. *The Lower Courts' Analyses*

The ALJ issued a decision dated July 23, 2009 denying Selian's claim.⁸⁶ Selian successfully made it past the first step of the sequential evaluation.⁸⁷ At step two though, the ALJ bifurcated the period for which Selian alleged disability. The ALJ found that prior to January 26, 2007, the date upon which Selian began treating with Dr. Corey, Selian had no medically determinable impairments.⁸⁸ But, since January 26, 2007, the ALJ found that Selian had been suffering from two severe impairments: degenerative joint disease of the shoulders and a mood disorder.⁸⁹ Notably, the ALJ failed to find fibromyalgia a severe impairment despite the diagnosis from Selian's treating physician, Dr. Corey, and from the rheumatological consultative examiner, Dr. Dura.⁹⁰

After finding that neither of Selian's severe impairments met or equaled a Listing, the ALJ assessed Selian's RFC. The Second Circuit summarized the ALJ's RFC assessment as follows:

[The ALJ] found that [Selian] could lift and carry up to 20 pounds occasionally and 10 pounds frequently, and that, during an eight-hour workday, Selian had no limitations on standing or sitting and could walk for a total of two hours. The ALJ further found that Selian could only occasionally push, pull, and reach in all directions. With respect to Selian's mental limitations, the ALJ found that Selian could understand, carry out, and remember simple instructions; respond appropriately to supervision, coworkers, and usual work situations; and deal with changes in his routine work setting. The ALJ therefore concluded that Selian could perform "light work" as defined in the Social Security regulations.⁹¹

In evaluating Selian's RFC, the ALJ accorded the "greatest weight" to the opinions of the consultative

86. *Selian v. Astrue*, No. 3:10-cv-1400 (GLS), 2012 U.S. Dist. LEXIS 7447, at *1 (N.D.N.Y. Jan. 23, 2012).

87. *See Selian*, 708 F.3d at 416.

88. *Id.* at 416.

89. *Id.*

90. *Id.*

91. *Id.*

examiners because the ALJ deemed those opinions consistent with the record's clinical and diagnostic evidence.⁹² Regarding the opinion of Selian's treating physician, Dr. Corey, the ALJ discredited it on the grounds that she found it was "inconsistent with diagnostic studies, clinical findings and the reports of other physicians participating in [Selian's] health care."⁹³

Based on the ALJ's RFC assessment, the ALJ denied Selian's claim at step five of the sequential evaluation, finding that there were "jobs existing in significant numbers in the national economy" that Selian could perform.⁹⁴ Selian requested review of the ALJ's decision by the Appeals Council, but the Appeals Council denied the request.⁹⁵ As the Appeals Council denied Selian's request, the ALJ's decision became "the final decision of the [Social Security] Commissioner."⁹⁶ Selian appealed the Commissioner's decision to the United States District Court for the Northern District of New York, contending that the ALJ failed to properly assess the medical evidence and failed to properly determine his RFC.⁹⁷ The District Court, however, was unconvinced.⁹⁸ In his opinion affirming the ALJ's decision, Chief United States District Court Judge Gary Sharpe reminded us that "the Social Security Administration considers the data that physicians provide but draws its own conclusions as to whether those data indicate disability."⁹⁹ Selian appealed the District Court's decision to the Second Circuit Court of Appeals.¹⁰⁰

92. *Selian v. Astrue*, No. 3:10-cv-1400 (GLS), 2012 U.S. Dist. LEXIS 7447, at *8 (N.D.N.Y. Jan. 23, 2012).

93. *Id.* at *7.

94. *Selian*, 708 F.3d at 417.

95. *Id.*

96. *Id.*

97. *Selian*, 2012 U.S. Dist. LEXIS 7447, at *2.

98. *Id.* at *9.

99. *Id.* at *6 (quoting *Snell v. Apfel*, 177 F.3d 128, 133 (2d Cir. 1999)).

100. *Selian*, 708 F.3d at 411.

B. *The Second Circuit's Analysis: Selian v. Astrue*

Selian had a number of grounds for appealing the District Court's decision.¹⁰¹ For the purposes of this Note, I will focus on two of his arguments. Those arguments are: (1) the ALJ erred in finding Selian's fibromyalgia was not a severe impairment; and (2) the ALJ's RFC assessment was not supported by substantial evidence.¹⁰² The Second Circuit agreed with Selian on both of those points and ordered that the District Court's judgment be vacated and that the case be remanded to the Commissioner for further proceedings consistent with the Second Circuit's opinion.¹⁰³ The Second Circuit's analysis demonstrates the failure of the lower courts to give proper deference to the opinions of licensed medical professionals and especially those who had a treating relationship with Selian.

1. "[T]he ALJ improperly disregarded the diagnosis of Selian's treating physician, . . . improperly substituted her own medical judgments[,] and confused and misstated the medical evidence."¹⁰⁴ The opinion of a claimant's treating physician is a critical piece of evidence in any Social Security disability claim. As stated earlier, the Regulations instruct that treating physician opinions are generally entitled to more weight than other opinion evidence because

these sources are likely to be the medical professionals most able to provide a detailed, longitudinal picture of [a claimant's] medical impairment(s) and may bring a unique perspective to the medical evidence that cannot be obtained from the objective medical findings alone or from reports of individual examinations, such as consultative examinations or brief hospitalizations.¹⁰⁵

Moreover, a treating physician's opinion is entitled to *controlling weight* in evaluating a disability claim where that opinion is "well-supported and not inconsistent with the other substantial evidence in the case record;" under those

101. *Id.* at 412.

102. *Id.*

103. *Id.* at 422.

104. *Id.* at 418.

105. 20 C.F.R. § 404.1527(c)(2) (2013).

circumstances, SSA mandates that the opinion “must be adopted.”¹⁰⁶

The Second Circuit has cautioned ALJs that they cannot summarily dismiss a treating physician’s opinion; they must consider specific factors¹⁰⁷ in evaluating the opinion, and they must “comprehensively set forth [their] reasons for the weight assigned to a treating physician’s opinion.”¹⁰⁸ The Second Circuit has also warned ALJs about playing doctor:

[T]he ALJ cannot arbitrarily substitute his own judgment for competent medical opinion. . . . [W]hile an [ALJ] is free to resolve issues of credibility as to lay testimony or to choose between properly submitted medical opinions, he is not free to set his own expertise against that of a physician who [submitted an opinion to or] testified before him.¹⁰⁹

Here, the Second Circuit found the ALJ’s rationale for discrediting Dr. Corey’s opinion that Selian suffered from fibromyalgia thin.¹¹⁰ The ALJ reasoned that Dr. Corey’s diagnosis was inconsistent with the record because Dr. Corey’s notes stated that Selian’s “response to prednisone is curious and not suggestive of fibromyalgia although [he] clinically appears to have [it]—advised strongly to see

106. *SSR 96-2p, Policy Interpretation Ruling Titles II and XVI: Giving Controlling Weight to Treating Source Medical Opinions*, SOC. SEC. ADMIN. (July 2, 1996), http://www.socialsecurity.gov/OP_Home/rulings/di/01/SSR96-02-di-01.html.

107. *Burgess v. Astrue*, 537 F.3d 117, 129 (2d Cir. 2008) (“The ALJ must consider, *inter alia*, the ‘[l]ength of the treatment relationship and the frequency of examination’; the ‘[n]ature and extent of the treatment relationship’; the ‘relevant evidence . . . particularly medical signs and laboratory findings,’ supporting the opinion; the consistency of the opinion with the record as a whole; and whether the physician is a specialist in the area covering the particular medical issues.” (alteration in original) (quoting 20 C.F.R. § 404.1527(d)(2)(i)-(ii), (3) (2008))).

108. *Id.* at 129 (quoting *Halloran v. Barnhart*, 362 F.3d 28, 33 (2d Cir. 2004)); *see also* 20 C.F.R. § 404.1527(c)(2) (“We will always give good reasons in our notice of determination for the weight we give your treating source’s opinion.”).

109. *Balsamo v. Chater*, 142 F.3d 75, 81 (2d Cir. 1998) (alteration in original) (quoting *McBrayer v. Sec’y of Health & Human Servs.*, 712 F.2d 795, 799 (2d Cir. 1983)).

110. *Selian v. Astrue*, 708 F.3d 409, 418-19 (2d Cir. 2013).

rheumatology.”¹¹¹ The ALJ also concluded that Dr. Corey’s diagnosis of “fibromyalgia” differed from Dr. Dura’s diagnosis of “fibromyalgia syndrome.”¹¹² Regarding Dr. Corey’s comment about Selian’s response to prednisone, the Second Circuit zeroed in on the fact that the ALJ “made no effort to reconcile this apparent inconsistency.”¹¹³ Further, the Second Circuit faulted the ALJ for her failure to explain why she concluded that a “fibromyalgia” diagnosis and a “fibromyalgia syndrome” diagnosis were different, noting “this failure was especially problematic considering that Dr. Dura’s letter appears to concur with Dr. Corey’s diagnosis.”¹¹⁴

The Second Circuit also found fault in the ALJ’s reliance on the opinion of consultative examiner Dr. Naughten, who did not diagnose fibromyalgia.¹¹⁵ “We have previously cautioned that ALJs should not rely heavily on the findings of consultative physicians after a single examination.”¹¹⁶ Again, the Second Circuit took issue with the ALJ’s failure to “reconcile the contradiction or grapple with Dr. Corey’s diagnosis.”¹¹⁷

Finally, the Second Circuit found that “the ALJ improperly substituted her own criteria as to what is necessary to establish a fibromyalgia diagnosis without support from medical testimony.”¹¹⁸ The ALJ contended that the record lacked evidence of the requisite symptoms

111. *Id.* at 419 (alteration in original) (emphasis added).

112. *Id.*

113. *Id.*

114. *Id.*

115. *Id.*

116. *Id.*; see also *Cruz v. Sullivan*, 912 F.2d 8, 13 (2d Cir. 1990) (“[I]n evaluating a claimant’s disability, a consulting physician’s opinions or report should be given limited weight. . . . This is justified because ‘consultative exams are often brief, are generally performed without benefit or review of claimant’s medical history and, at best, only give a glimpse of the claimant on a single day. Often, consultative reports ignore or give only passing consideration to subjective symptoms without stated reasons.’” (quoting *Torres v. Bowen*, 700 F. Supp. 1306, 1312 (S.D.N.Y. 1988))).

117. *Selian*, 708 F.3d at 419.

118. *Id.*

associated with fibromyalgia.¹¹⁹ But the Second Circuit refuted this claim and found that the ALJ's conclusion "overlooked the facts in the record and, more egregiously, constituted an improper substitution by the ALJ of her own lay opinion in place of medical testimony."¹²⁰ Specifically, the Second Circuit pointed to various clinical findings in the record from both Dr. Corey and Dr. Dura that supported a fibromyalgia diagnosis such as the presence of "tender points."¹²¹ The Second Circuit ordered that, on remand, the proper weight to give to Dr. Corey's opinion must be determined, and it reminded that the ALJ has "an affirmative duty to 'fill any clear gaps in the administrative record' before rejecting a treating physician's diagnosis."¹²²

2. *"Dr. Naughten's opinion is remarkably vague. . . . At a minimum, the ALJ likely should have contacted [him] and sought clarification of his report."*¹²³ As evidenced above, the Second Circuit took issue with the ALJ's failure to make any effort to develop the record of evidence by simply recontacting Selian's treating physician, Dr. Corey, to resolve the ALJ's perceived inconsistencies. It should be noted, though, that an ALJ has an affirmative duty to develop the record as it pertains to treating physician opinions and other opinions such as those from one-time examiners.¹²⁴ This affirmative duty serves to discourage ALJs from relying on their own lay assumptions.

When medical opinions are vague or susceptible to more than one meaning, the Second Circuit has especially stressed the importance of recontacting the author of the opinion. Otherwise, an ALJ may fall into the all too easy trap of overreaching her bounds and superimposing her own opinion on that of the author. In *Curry v. Apfel*, the Second Circuit found that an opinion that a claimant's lifting ability was "moderate" and his sitting ability was "mild" was "so vague

119. *Id.*

120. *Id.*

121. *Id.* at 419-20.

122. *Id.* at 420 (quoting *Burgess v. Astrue*, 537 F.3d 117, 129 (2d Cir. 2008)).

123. *Id.* at 421.

124. See *Melville v. Apfel*, 198 F.3d 45, 51 (2d Cir. 1999).

as to render it useless in evaluating whether [the claimant] can perform sedentary work.”¹²⁵ In that case, the ALJ used that opinion as a basis for finding the claimant able to perform sedentary work.¹²⁶ The Second Circuit rejected the ALJ’s reliance on the opinion, holding that “[the doctor’s] use of the terms ‘moderate’ and ‘mild,’ without additional information, does not permit the ALJ, a layperson notwithstanding her considerable and constant exposure to medical evidence, to make the necessary inference that [the claimant] can perform the exertional requirements of sedentary work.”¹²⁷

Here, in *Selian*, the Second Circuit found that the ALJ’s reliance on Dr. Naughten’s opinion that Selian “should be able to lift . . . objects of a mild degree of weight on an intermittent basis” was improper.¹²⁸ The Second Circuit explained that the ALJ had no way of actually knowing what Dr. Naughten meant by “mild degree” and “intermittent”; in other words, the ALJ’s interpretation was “sheer speculation.”¹²⁹ Based on the ALJ’s failure to recontact Dr. Naughten and obtain clarification of his report, the Second Circuit ruled that the ALJ’s RFC assessment was not supported by substantial evidence.¹³⁰

The Second Circuit’s holding in *Selian* speaks to the importance of recontacting medical sources when their opinions appear inconsistent or vague. But how can we reconcile this with SSA’s amendment to the Regulations, which speaks to the unimportance of such recontacting?

III. THE UNINTENDED CONSEQUENCES OF *SELIAN V. ASTRUE*

The unintended consequences of the Second Circuit’s holding in *Selian* cannot be understated. As a result of the decision, SSA’s rationale for amending the recontact requirement is directly contradicted. Further, *Selian*

125. 209 F.3d 117, 123 (2d Cir. 1999).

126. *Id.*

127. *Id.*

128. *Selian*, 708 F.3d at 421.

129. *Id.*

130. *Id.*

demonstrates why the recontact amendment encourages ALJs to play doctor even more than they already have been.

A. *Recontact Requirements Before and After the Amendment and Why SSA Claims They Had To Do What They Did*

Before SSA's amendment to the recontact Regulation, ALJs were required to recontact a claimant's medical source when the source provided evidence that contained a conflict or ambiguity.¹³¹ Notably, this requirement was in effect at the time the ALJ denied Selian's claim.¹³² Despite the requirement, Selian's ALJ and many others throughout the country failed to comply with it in the adjudication of disability claims, as noted by the Second Circuit.¹³³ Time and time again, ALJs have rejected the opinions of claimants' medical sources when the ALJs perceived some sort of inconsistency or ambiguity without abiding by their affirmative duties to recontact the sources for further information and/or clarification.¹³⁴

SSA responded to the flood of remands based on failures to recontact medical sources by changing the mandatory

131. 20 C.F.R. § 404.1512(e) (2011) (*amended by* 20 C.F.R. § 404.1520(b) (2012)) ("When the evidence we receive from your treating physician or psychologist or other medical source is inadequate for us to determine whether you are disabled, we will need additional information to reach a determination or a decision. . . . We will first recontact your treating physician or psychologist or other medical source to determine whether the additional information we need is readily available. We will seek additional evidence or clarification from your medical source when the report from your medical source contains a conflict or ambiguity that must be resolved, the report does not contain all the necessary information, or does not appear to be based on medically acceptable clinical and laboratory diagnostic techniques. We may do this by requesting copies of your medical source's records, a new report, or a more detailed report from your medical source, including your treating source, or by telephoning your medical source. . . . We may not seek additional evidence or clarification from a medical source when we know from past experience that the source either cannot or will not provide necessary findings.").

132. *See generally* Selian v. Astrue, 708 F.3d 409 (2d Cir. 2013).

133. *See generally id.*

134. *See* SARAH H. BOHR ET AL., BOHR'S SOCIAL SECURITY ISSUES ANNOTATED § 202.6 (rev. vol. 2012).

recontact provision to a permissive one. Beginning March 26, 2012, ALJs became free to use their discretion in determining when or if to give claimants' doctors any opportunities to clarify their opinions before they were simply rejected.¹³⁵ The Regulations pertaining to recontacting now read as follows:

(c) If the evidence is consistent but we have insufficient evidence to determine whether you are disabled, or if after weighing the evidence we determine we cannot reach a conclusion about whether you are disabled, we will determine the best way to resolve the inconsistency or insufficiency. The action(s) we take will depend on the nature of the inconsistency or insufficiency. We will try to resolve the inconsistency or insufficiency by taking any one or more of the actions listed in paragraphs (c)(1) through (c)(4) of this section. We might not take all of the actions listed below. We will consider any additional evidence we receive together with the evidence we already have.

(1) We may recontact your treating physician, psychologist, or other medical source. We may choose not to seek additional evidence or clarification from a medical source if we know from experience that the source either cannot or will not provide the necessary evidence. . . .;

(2) We may request additional existing records;

(3) We may ask you to undergo a consultative examination at our expense; or

(4) We may ask you or others for more information.¹³⁶

In its Notice of Proposed Rulemaking ("Notice"), SSA claimed that the amendment to the recontact Regulation would be beneficial to the adjudicatory process.¹³⁷ Specifically, SSA contended, "[b]y giving adjudicators more flexibility in determining how best to obtain [the information needed to resolve an inconsistency or insufficiency in the medical source's evidence], we will be able to make a determination or decision on disability claims more quickly

135. 77 Fed. Reg. 10651, 10655 (Feb. 23, 2012).

136. 20 C.F.R. § 404.1520(c) (2013).

137. How We Collect and Consider Evidence of Disability, 76 Fed. Reg. 20,282, 20,282 (proposed Apr. 12, 2011) (to be codified at 20 C.F.R. pts. 404 & 416).

and efficiently in certain situations.”¹³⁸ SSA further contended that “there may be other, more appropriate sources from whom we could obtain the information we need.”¹³⁹

Interestingly, despite the fact that ALJs were regularly failing to comply with the recontact provision when it was mandatory, SSA reasoned in its Notice:

Although we propose to eliminate the requirement that we recontact your medical source(s) first when we need to resolve an inconsistency or insufficiency he or she provided, *we expect that our adjudicators would continue to recontact your medical source(s)* when we believe such recontact is the most effective and efficient way to resolve an inconsistency or insufficiency. For example, if we have a report from one of your medical sources that contains a functional assessment of your physical capacity for work, but no clinical or objective findings in support, *we expect that the adjudicator would first contact that source* to find out the reasons for his or her assessment. Similarly, when the medical evidence we receive from one of your medical sources contains an internal inconsistency about an issue relevant to our disability determination, *we would also expect that our adjudicator would contact that source* to resolve the inconsistency.¹⁴⁰

Therefore, SSA still “expects” its adjudicators to recontact sources first and foremost at times when those sources’ opinions or records are insufficient or inconsistent even though the adjudicators are no longer required to do so by the Regulations.¹⁴¹ If SSA still “expects” its adjudicators to recontact medical sources first in these circumstances, why did SSA not amend the Regulation to reflect a mandatory recontact requirement in this regard? Moreover, if SSA still “expects” its adjudicators to recontact medical sources in these circumstances, when would SSA expect adjudicators to not recontact medical sources first?

In its Notice, SSA provided only two examples to clarify the circumstances where the discretion newly granted to the

138. *Id.*

139. *Id.*

140. *Id.* at 20,283 (emphasis added).

141. *Id.*

adjudicators by the amendment would come in handy.¹⁴² First, SSA explained that when a claimant's medical source does not specialize in the area of the impairment alleged and when SSA needs more evidence about the impairment's current severity, "[SSA] may supplement the evidence in [the] case record by obtaining a CE¹⁴³ with a specialist (such as a pulmonologist) who can perform the type of examination [needed] in order to determine whether [the claimant] is disabled under [SSA's] rules."¹⁴⁴ Second, SSA argued that if medical records contain a reference to a claimant returning to work, it would be more appropriate to contact the claimant himself for verification instead of the author of the medical records and, further, the claimant could directly provide information such as schedules, earning, and job duties.¹⁴⁵ SSA argued that in a case like the former, contacting the medical source first for clarification could cause undue delay in the adjudication of the case.¹⁴⁶

B. *The Fallacies in SSA's Rationale and the Repercussions of the Amendment*

The Social Security trust fund is a hot topic¹⁴⁷ these days, and it will continue to be one as we near the predicted depletion date. The Social Security Disability Insurance ("DI") program's trust fund is in the most dire straits.¹⁴⁸ "DI

142. *Id.*

143. "CE" stands for "consultative examination." See 20 C.F.R. § 404.1519(a)-(t) (2013).

144. How We Collect and Consider Evidence of Disability, 76 Fed. Reg. 20,282, 20,283 (proposed Apr. 12, 2011) (to be codified at 20 C.F.R. pts. 404 & 416).

145. *Id.*

146. *Id.*

147. See, e.g., Jagadeesh Gokhale, *Social Security Reform: Does Privatization Still Make Sense?*, 50 HARV. J. ON LEGIS. 169, 173-74 (2013); David Kamin, *Risky Returns: Accounting for Risk in the Federal Budget*, 88 IND. L.J. 723, 765 (2013); Daniel Shaviro, *Should Social Security and Medicare Be More Market-Based?*, 21 ELDER L.J. 87, 113 (2013); Benjamin A. Templin, *Social Security Reform: The Politics of the Payroll Tax*, 32 QUINNIPIAC L. REV. 1, 4 (2013).

148. See *Status of the Social Security and Medicare Programs: A Summary of the 2013 Annual Reports*, SOC. SEC. ADMIN., <http://www.ssa.gov/oact/trsum/tr13summary.pdf> (last visited Nov. 10, 2014).

Trust Fund reserves expressed as a percent of annual cost (the trust fund ratio) declined to eighty-five percent at the beginning of 2013, and the Trustees project trust fund depletion in 2016.”¹⁴⁹ Perhaps it is the stress of the ever-emptying reserves that has caused SSA to amend the recontact Regulations. Maybe SSA thinks that by allowing more discretion regarding recontacting medical sources, they can shorten case processing time and conserve resources.¹⁵⁰ I posit that SSA could not be more wrong. Not only will the new permissive recontact Regulation lengthen case processing time and result in a greater depletion of resources, it will deprive claimants of “just, speedy, and inexpensive determination[s]”¹⁵¹ of their cases while encouraging adjudicators to overstep the bounds of legal decision-making.

1. *SSA’s Expectations that ALJs Will, of Their Own Volition, Recontact Medical Sources First are Misguided.* Why would SSA “expect” ALJs to voluntarily recontact medical sources? The better question is, what evidence does SSA have that makes it so confident, to the extent that it has the audacity to change a mandatory requirement to a permissive one, that ALJs will recontact the way that they should? As painfully evidenced by the Second Circuit’s holding in *Selian*, ALJs still do not have a solid grasp of when they should be recontacting claimants’ medical sources because they are still getting it wrong. That is my optimistic interpretation of *Selian*. Another interpretation of *Selian* is that some ALJs simply choose not to recontact medical sources even when they know that they should do so. Instead, these bold ALJs skirt the law and decide to substitute their own lay opinions for that of licensed medical professionals in deciding disability claims.

Looking first at my more optimistic assessment, *Selian*’s ALJ failed to recontact *Selian*’s medical sources in the most fundamental ways, the ways in which SSA contends are such obvious examples of situations where ALJs are “expected” to

149. *Id.*

150. How We Collect and Consider Evidence of Disability, 76 Fed. Reg. 20,282, 20,282-83 (proposed Apr. 12, 2011) (to be codified at 20 C.F.R. pts. 404 & 416).

151. FED. R. CIV. P. 1.

recontact medical sources first. Dr. Corey provided an RFC assessment that was consistent with an inability to perform substantial gainful activity on a sustained basis.¹⁵² Dr. Corey also specifically diagnosed fibromyalgia and documented clinical findings supporting his diagnosis.¹⁵³ Further, a specialist in Selian's impairment, rheumatologist Dr. Dura, also diagnosed fibromyalgia.¹⁵⁴ Despite the seemingly consistent medical evidence, the ALJ perceived inconsistencies and discredited Dr. Corey's medical opinion without any attempt to obtain clarification and/or more information from Dr. Corey regarding his medical opinion.¹⁵⁵ *Selian* exemplifies the need for a mandatory recontact regulation. Without it, ALJs will feel even less pressure to recontact claimants' medical sources. The permissive recontact Regulation naturally sends the message to ALJs that recontacting sources for the purposes of developing a full and fair case record is being de-emphasized by SSA. This would truly be a detriment to the reliable adjudication of disability claims because a claimant's medical sources are generally in the best position to evaluate the claimant.¹⁵⁶

Turning to the less optimistic version, the permissive recontact Regulation makes it even easier for ALJs who already have a tendency of using their own opinion or biases to evaluate disability claims to perpetuate that behavior. Recently, the Office of Disability Adjudication & Review¹⁵⁷ located in Jamaica, New York, ("Jamaica ODAR") came under fire for being biased against Social Security disability claimants.¹⁵⁸ The Urban Justice Center and Gibson, Dunn & Crutcher filed a class action lawsuit on behalf of thousands

152. *Selian v. Astrue*, 708 F.3d 409, 415 (2d Cir. 2013).

153. *Id.*

154. *See id.*

155. *Id.* at 419.

156. 20 C.F.R. § 404.1527(c)(2) (2014).

157. *Hearings and Appeals*, SOC. SEC. ADMIN., http://www.ssa.gov/appeals/about_odar.html (last visited Nov. 10, 2014).

158. Sam Dolnick, *Suit Alleges Bias in Disability Denials by Queens Judges*, N.Y. TIMES, Apr. 13, 2011, at A23.

of New Yorkers on April 12, 2011.¹⁵⁹ The complaint alleges that five out of the eight ALJs from the Jamaica ODAR deprived claimants of a “full and fair hearing” by

conduct[ing] adversarial hearings, routinely cherry-pick[ing] and manipulat[ing] facts to support their preordained conclusions, willfully ignor[ing] established law, even with explicit instructions from federal district courts and the Social Security Appeals Council, disregard[ing] evidence from treating physicians, engag[ing] in bullying and unprofessional behavior, thwart[ing] meaningful review of their decisions by deliberately failing to develop the evidentiary record, and effectively hold[ing] claimants to a higher evidentiary standard than what is set forth by law.¹⁶⁰

Notably, each of the five ALJs were accused of essentially acting like doctors and failing to develop the administrative record by recontacting the claimant’s medical sources.

According to the complaint, ALJ David Nisnewitz was found to have committed error in ten district court cases since January 1, 2008.¹⁶¹ In one case, the United States District Court for the Eastern District of New York (“Eastern District”) noted that ALJ Nisnewitz was instructed by the Second Circuit to resolve inconsistencies in the record regarding the opinions of two physicians, yet ALJ Nisnewitz failed to do so, even on remand from the Second Circuit.¹⁶² Instead of sending the case back for another hearing, the Eastern District simply awarded benefits.¹⁶³ In another case, the United States District Court for the Southern District of New York (“Southern District”) found that ALJ Nisnewitz

159. *Historic Class Action Settlement Provides New Hearings and Protections to Thousands of Disabled New Yorkers Wrongly Denied Social Security Benefits*, GIBSON DUNN (Jan. 14, 2013), <http://www.gibsondunn.com/news/Pages/HistoricClassActionSettlementProvidesNewHearingsandProtections.aspx> [hereinafter *Historic Class Action Settlement*].

160. Amended Complaint at 2-3, *Padro v. Astrue*, No. 11-CV-1788 (CBA) (RLM) 2011 U.S. Dist. LEXIS 91277 (E.D.N.Y. 2011) [hereinafter *Padro Complaint*].

161. *Id.* at 24 (No. 11-CV-1788).

162. *Id.* at 26 (No. 11-CV-1788); see also *Larkins v. Astrue*, No. 07-CV-1700 (NG), 2009 U.S. Dist. LEXIS 90129, at *32 (E.D.N.Y. Sept. 29, 2009). Significantly, this case stretched over twelve years. Clearly, had this ALJ developed the record in the way he should have originally, there would have been a massive amount of time and resources saved.

163. *Larkins*, 2009 U.S. Dist. LEXIS 90129, at *33.

“failed to meet his responsibility to resolve ambiguities or evidentiary gaps in the record.”¹⁶⁴ The Southern District remanded the case based on ALJ Nisnewitz’s “plain error.”¹⁶⁵ In yet another case, the Eastern District found that ALJ Nisnewitz “should have examined the physician’s treatment records and addressed any remaining questions or doubts to that physician.”¹⁶⁶ As a result of ALJ Nisnewitz’s failures, the case was remanded.¹⁶⁷

ALJ Cofresi was also faulted for too often relying on his own lay opinion.¹⁶⁸ Since January 1, 2008, ALJ Cofresi was found to have committed error in fourteen cases.¹⁶⁹ In one case, the Eastern District accused him of “read[ing] conclusions into the Medical Expert’s testimony that are not supported therein.”¹⁷⁰ In another case, the Eastern District found that ALJ Cofresi “failed in his fundamental duty ‘to elicit further supporting information’ before rejecting a doctor’s medical opinion.”¹⁷¹ In still another case, the Eastern District found that “ALJ Cofresi disregarded medical testimony because of inconsistencies in, or an absence of, those physicians’ medical records” and “‘failed’ or ‘made no attempt’ to get the records.”¹⁷²

164. Padro Complaint, *supra* note 160, at 27; *see also* Baldwin v. Astrue, No. 07-Civ. 6958 (RJH) (MHD), 2009 U.S. Dist. LEXIS 125638, at *71 (S.D.N.Y. Oct. 22, 2009).

165. Padro Complaint, *supra* note 160, at 27.

166. *Id.* at 28-29 (No. 11-CV-1788); *see also* Smith v. Astrue, No. 09-CV-4999 (JG), 2011 U.S. Dist. LEXIS 34367, at *25 (E.D.N.Y. Mar. 31, 2011).

167. Padro Complaint, *supra* note 160, at 29.

168. *Id.* at 34 (No. 11-CV-1788).

169. *Id.* (No. 11-CV-1788).

170. *Id.* at 35 (No. 11-CV-1788); *see also* Day v. Astrue, No. 07-CV-157 (RJD), 2008 U.S. Dist. LEXIS 340, at *18 (E.D.N.Y. Jan. 3, 2008).

171. Padro Complaint, *supra* note 160, at 35; *see also* Taylor v. Astrue, No. CV-07-3469 (FB), 2008 U.S. Dist. LEXIS 46619, at *10 (E.D.N.Y. June 17, 2008).

172. Padro Complaint, *supra* note 160, at 36; *see also* Lopez v. Comm’r of Soc. Sec., No. 08-CV-4787 (CPS), 2009 U.S. Dist. LEXIS 81214, at *55-56 (E.D.N.Y. Sept. 8, 2009).

Each of the three other ALJs exhibited a comparable level of disregard for medical evidence.¹⁷³ I see no need to detail their failures here any further. I will tell you though that at the time the lawsuit commenced, the Jamaica ODAR was ranked third in the nation for denials of Social Security benefits.¹⁷⁴ As far as reversals, more than eighty percent of the decisions issued by the five named ALJs were reversed on appeal.¹⁷⁵ On October 18, 2013, the Eastern District approved a settlement agreement, which provided that SSA would “take certain actions on all unfavorable and partially favorable decisions issued by the five ALJs through a specified time period.”¹⁷⁶ Basically, under the settlement, thousands of New Yorkers who were denied benefits by any of the five ALJs will get to have their cases heard again.¹⁷⁷

The Queens ODAR disaster is a prime, though extreme, example of how relaxing the recontact requirement will lead to expending more of SSA’s limited time and resources in the long run. Cutting corners on properly adjudicating claims in earlier stages will leave more work for our federal courts to handle on appeal. For that matter, even cases that do not progress to the federal court level will still waste time and resources simply by progressing through the administrative appeals system. Moreover, claimants will be denied the benefits that they need for however long it takes for the courts to get things right.

2. Both Circumstances that SSA Cites as Examples Where a Permissive Recontact Provision Would Be Beneficial Are Unrealistic Situations. As stated above, in its Notice, SSA cited two examples of situations where ALJs need the freedom to decide who to contact to resolve insufficiencies or

173. See Padro Complaint, *supra* note 160, at 42-66.

174. *Historic Class Action Settlement*, *supra* note 159.

175. *Id.*

176. HALLEX I-5-4-71, SOC. SEC. ADMIN., http://ssa.gov/OP_Home/hallex/I-05/I-5-4-71.html#i-5-4-71-ii (last visited Nov. 10, 2014).

177. See *Historic Class Action Settlement Provides New Hearings and Protections to Thousands of Disabled New Yorkers Wrongly Denied Social Security Benefits*, *supra* note 159.

inconsistencies in the evidence.¹⁷⁸ First, where a claimant's medical source is not a specialist in the area of the claimant's impairment, SSA argued that ALJs should be free to order a consultative examination by a specialist instead of recontacting the claimant's medical source.¹⁷⁹ For example, suppose a claimant treats only with a family practitioner, but the claimant alleges severe pulmonary impairments. In that case, SSA wants an ALJ to be able to order a pulmonary consultative examination (which presumably would include pulmonary function tests) instead of first wasting time recontacting the family practitioner who would likely be unable to perform such tests anyway. However, SSA did not need to amend the recontact Regulation to accomplish that effect. Under the former recontact Regulations, ALJs did not have to first recontact a claimant's medical source if the ALJ had reason to believe that the claimant's medical source could not provide the necessary evidence.¹⁸⁰ Moreover, the Regulations that dictate when a consultative examination will be purchased also provides clear evidence that ALJs can order consultative examinations when "[h]ighly technical or specialized medical evidence" is needed but is not available from a claimant's medical sources.¹⁸¹ Significantly, the consultative examination Regulations only require that consideration be given first to whether the additional information is readily available from the records of the claimant's medical sources—after due consideration, not after recontacting, an ALJ is free to order a consultative examination after determining that the information cannot be obtained from the claimant's medical sources. For this reason, SSA's rationale for the need of the permissive recontact Regulation is unreasonable.

178. How We Collect and Consider Evidence of Disability, 76 Fed. Reg. 20,282, 20,283 (proposed Apr. 12, 2011) (to be codified at 20 C.F.R. pts. 404 & 416).

179. *Id.*

180. 20 C.F.R. § 404.1512(e)(2) (1996) (*amended by* 20 C.F.R. § 404.1520(b) (2013)) ("We may not seek additional evidence or clarification from a medical source when we know from past experience that the source either cannot or will not provide the necessary findings.").

181. 20 C.F.R. § 404.1519(b)(3) (2013).

The only other circumstance provided by SSA as a reason why the recontact Regulation had to be amended was regarding records that indicated a claimant had returned to work. SSA argued that it would be “more appropriate” to contact the claimant himself instead of the author of the records; SSA explained that it would want “to obtain any related information, such as [the claimant’s] schedule, earnings, and job duties.”¹⁸² This rationale fails for two reasons.

First, when a claimant files a claim for Social Security disability benefits, a claimant is required to complete an array of forms.¹⁸³ These forms become part of the administrative record, and many of them require a claimant to provide information regarding his schedule, earnings, and job duties.¹⁸⁴ Therefore, an ALJ need not contact a claimant to obtain information regarding any of the aforementioned topics because it is already part of the administrative record. Second, it is always possible that a claimant may be working “off the books.” A claimant working in that way would likely be reluctant to provide that information to an ALJ if asked. However, a claimant may disclose that he injured himself working to a doctor who would then notate the claimant’s medical records accordingly. Therefore, I believe that a doctor could provide special insight into the true work status of a claimant, and that insight could only be obtained by recontacting the doctor who authored the medical records. An ALJ would likely receive the same information obtained through SSA’s intake forms as the ALJ would receive from contacting the claimant regarding a reference to work in the claimant’s medical records. Obviously it would then be beneficial to get a third party’s input regarding the claimant’s work status.

182. How We Collect and Consider Evidence of Disability, 76 Fed. Reg. 20,282, 20,283 (Apr. 12, 2011) (to be codified at 20 C.F.R. pts. 404 & 416).

183. See, e.g., Form SSA-3368, SSA-3369, SSA-820, SSA-821, available at <http://www.socialsecurity.gov/forms> (last visited Nov. 10, 2014).

184. See *id.*

3. *Reforming the Recontact Regulation.* ALJs need to be reminded that they are not doctors. This can only be accomplished by implementing safeguards throughout the Regulations that guide their evaluations of disability claims. When confronted with a record that contains insufficient evidence upon which to base a decision, ALJs should be required to recontact a claimant's medical sources to obtain the needed information. Moreover, when the claimant's medical sources have provided inconsistent information or ambiguous information, ALJs should be required to develop the record by recontacting those sources to obtain clarification. Before relying on consultative examinations, which are often performed by doctors who have not had the opportunity to establish a longitudinal relationship with the claimant, it should be mandated that ALJs appeal first to the claimant's medical sources.

But I recommend that the recontact requirement not simply be reinstated as it stood before the amendment. The recontact requirement should be strengthened: it should specifically delineate the circumstances under which an ALJ should recontact a claimant's medical sources. The former recontact requirement was apparently unable to convey to ALJs the grounds that mandated recontacting a claimant's medical sources.

Further, the Regulations should incorporate a documenting requirement that is currently only pre-regulatory.¹⁸⁵ Whenever efforts are made to develop a case record, adjudicators should be required to document such efforts in a case development summary. This document should be made available to claimants and their representatives. This will create more accountability in the case development system and should encourage ALJs to fulfill their affirmative duties.

CONCLUSION

In *Selian v. Astrue*, the Second Circuit reiterated many of the points it has been making for decades. Primarily, the Second Circuit emphasized an ALJ's duty to develop a full

185. See *DI 22505.008 Developing Supplemental Evidence*, SOC. SEC. ADMIN., <https://secure.ssa.gov/poms.nsf/lnx/0422505008> (last updated June 25, 2013).

and fair case record, all the while paying special deference to opinions provided by a claimant's treating medical sources. The Second Circuit also cautioned that ALJs must refrain from substituting their own lay opinions for that of competent medical opinions; they should instead make the effort to obtain clarification and/or more information from professional medical sources. *Selian* coupled with SSA's recent settlement in *Padro v. Astrue* demonstrate that ALJs still are not evaluating and developing evidence in the ways that they should. The unintended consequence of *Selian* is that it makes a mockery of SSA's rationale behind its recent amendment to the Regulations, which actually expands an ALJ's discretion in evaluating and developing evidence. If SSA truly wants to shorten case processing time and conserve resources, it should strengthen the recontact Regulation by making it a mandatory requirement instead of weakening it by making it a permissive one.