06-4568-cv

To Be Argued By:
ANN M. NEVINS

==========

United States Court of Appeals

FOR THE SECOND CIRCUIT

Docket No. 06-4568-cv

JAMES WRIGHT, JR.
Plaintiff-Appellant,

-vs-

MICHAEL J. ASTRUE,
COMMISSIONER OF SOCIAL SECURITY,
Defendant-Appellee.

ON APPEAL FROM THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF CONNECTICUT

==========

BRIEF FOR MICHAEL J. ASTRUE COMMISSIONER OF SOCIAL SECURITY

==========

KEVIN J. O'CONNOR
United States Attorney
District of Connecticut

ANN M. NEVINS
Assistant United States Attorney
WILLIAM J. NARDINI
Assistant United States Attorney (of counsel)

TABLE OF CONTENTS

TABLE OF AUTHORITIES

CASES

PURSUANT TO "BLUE BOOK" RULE 10.7, THE GOVERNMENT'S CITATION OF CASES DOES NOT INCLUDE "CERTIORARI DENIED" DISPOSITIONS THAT ARE MORE THAN TWO YEARS OLD.

STATUTES

RULES

OTHER AUTHORITIES

STATEMENT OF JURISDICTION

The United States District Court for the District of Connecticut (Mark R. Kravitz, J.) had subject matter jurisdiction over Wright's appeal from a final decision of the Social Security Administration pursuant to 42 U.S.C. § 405(g). Judgment entered on August 31, 2006. (GA 354, 388). Wright filed a timely notice of appeal within the 60 days permitted by Fed. R. App. P. 4(a), on October 2, 2006. (GA 354, 389). This Court has appellate jurisdiction pursuant to 28 U.S.C. § 1291.

STATEMENT OF ISSUE PRESENTED FOR REVIEW

Was the administrative law judge's determination – that plaintiff failed to meet his burden to establish that he was disabled and that the defendant established that the plaintiff would be able to perform other work in the national economy – based on substantial evidence and based on application of the correct legal standards?

United States Court of Appeals

FOR THE SECOND CIRCUIT

Docket No. 06-4568-cv

JAMES J. WRIGHT, JR.
Plaintiff-Appellant,

-vs-

MICHAEL J. ASTRUE,
COMMISSIONER OF SOCIAL SECURITY,
Defendant-Appellee.[1]

ON APPEAL FROM THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF CONNECTICUT

BRIEF FOR MICHAEL J. ASTRUE, COMMISSIONER OF SOCIAL SECURITY

[1] On February 12, 2007, Michael J. Astrue succeeded Jo Anne Barnhart as Commissioner of Social Security, and he is thereby automatically substituted as the defendant pursuant to Fed. R. App. P. 43.

Preliminary Statement

This is a social security disability appeal. Plaintiff James J. Wright, Jr., proceeding *pro se*, seeks supplemental security insurance (SSI) and asks this Court to remand the case to the Commissioner of Social Security for a finding of disability, alleging generally that he has been disabled since March 30, 1995, as a result of a 1989 injury to his right hand and due to psychiatric issues.[2] The administrative law judge (ALJ) appropriately determined that Wright was not disabled under the Social Security Act, 42 U.S.C. § 406 et seq. (the Act), based on substantial evidence including Wright's testimony at two ALJ hearings, testimony from a vocational expert (VE), and medical records. Because substantial evidence supports the ALJ's finding that Wright failed to prove he had a *per se* disabling condition during the period after March 30, 1995, and the ALJ's finding that the Commissioner carried his burden of establishing that Wright would be able to perform other work available in the national economy, Wright's appeal should be denied and the order of the district court should be affirmed.

---

[2] The issue of Wright's alleged disability from July 16, 1989 (alleged as the onset date in his application) through March 29, 1995, is precluded by the doctrine of *res judicata*, as Wright previously applied for SSI and Title II Disability Insurance Benefits but had been denied at the ALJ level on March 29, 1995, without further appeal. No good cause to reopen that claim, and accordingly the only issue before the ALJ in the present case was whether Wright was disabled as of March 30, 1995. (GA 17, 22 at Finding 1). *See* 20 C.F.R. § 416.1457(c)(1).

Statement of the Case

Wright filed an application for disability insurance benefit payments on January 10, 1997, alleging he had become disabled on August 21, 1992. (GA 58-60). His application was denied initially and on reconsideration. (GA 34-37; 39-42). He requested a hearing before an ALJ, which was held on April 7, 1998, before ALJ James Packer. (GA 279-311). On June 25, 1998, ALJ Packer issued an unfavorable decision finding Wright not disabled or entitled to SSI payments. (GA 202-09). Wright requested review of that decision from the Appeals Council, which after review remanded the case for further administrative proceedings. (GA 216; 221-24). A second administrative hearing was held before ALJ Joseph Faraguna on February 7, 2002, at which Wright and a vocational expert testified. (GA 312-51). ALJ Faraguna issued his decision on July 25, 2002, again finding Wright not disabled or entitled to SSI payments. (GA 15-23). Once again, Wright filed a Request for Review of Hearing Decision. (GA 11). This time, the Appeals Council denied review on December 3, 2004, rendering ALJ Faraguna's decision the Commissioner's "final decision" and ripe for judicial review. *See* 42 U.S.C. § 405(g). (GA 5-8).

On January 20, 2005, Wright filed a timely appeal from the ALJ's decision by filing a complaint in the United States District Court for the District of Connecticut. (GA 352).

On August 4, 2006, United States Magistrate Judge William I. Garfinkel issued a ruling, recommending that the district court affirm the decision of the ALJ. (GA 354, 356-386).

On August 30, 2006, United States District Judge Mark R. Kravitz entered a ruling accepting the recommended ruling in its entirety. (GA 354, 387). Judgment entered on August 31, 2006. (GA 354, 388). On October 2, 2006, Wright filed a timely notice of appeal. (GA 354, 389).

STATEMENT OF FACTS AND PROCEEDINGS RELEVANT TO THIS APPEAL

Part A below reviews the medical evidence before the ALJ. Part B reviews the ALJ's decision determining Wright was not disabled. Part C reviews the district court's decision affirming the ALJ's decision.

A. The Medical Evidence

On July 6, 1989, Wright was admitted to Hartford Hospital with significant soft tissue injuries to his right forearm. (GA 122). He was intoxicated upon admission, and at that time it was noted that he had driven his arm through a plate glass window while abusing ethanol. (GA 122). The following day, he underwent surgery which "loosely reapproximated" the damaged soft tissues. (GA 123). On July 10, 1989, surgery was again performed, this time to perform further muscle, soft tissue, and nerve repairs. (GA 123). Wright tolerated the procedures well,

and was discharged to home on July 13, 1989, with the arm in a splint. (GA 123-24).

No additional medical records for the period 1989 through January 1997 were submitted by Wright. On February 19, 1997, state disability determination services ("DDS") sent Wright to a consultative physical examination with Dr. Steven Isaacs. (GA 137-38). Wright reported weekly headaches since having been hit on the head five years before, as well as constant aching in his right arm. (GA 137). On examination, Dr. Isaacs noted discomfort on range of motion in the right shoulder with loss of ten degrees of internal and external rotation. (GA 137). There was good range of motion in the right elbow. The right wrist had good flexion but decreased extension. Fingers on the right hand were held flexed, and Wright reported he could not straighten them. (GA 137). Joints in the left arm and in both legs had good range of motion. (GA 137). Wright had decreased tactile sensation and diminished grip, grasp, and fine finger dexterity in the right upper extremity. (GA 137-38). Wright told Dr. Isaacs that he was right-hand dominant, and that he had no functional use of that hand. (GA 138). Dr. Isaacs noted that Wright was able to walk unassisted. (GA 138).

DDS sent Wright to Dr. Timothy Wallace for a consultative psychological evaluation on February 28, 1997. (GA 147-51). Wright reported living alone, and spending his days "getting high, drinking, and doing coke." (GA 148). He had drunk alcohol the day before the evaluation, and had last had cocaine "the other day." (GA 148). Wright denied any history of psychiatric

treatment or inpatient admission. (GA 148). His social skills were reasonably good and his demeanor was friendly and appropriate. (GA 149). There was no evidence of psychosis or thought disorder. (GA 149). Dr. Wallace administered several evaluative tests, but disclaimed the results, stating that he "strongly believe[d] that the results of the intelligence test are invalid and that Mr. Wright purposely attempted to do poorly." (GA 149). Wright's score on the Rey's Visual Memory Test, often considered as a measure of malingering, was only 6 out of 15 when all but the most impaired subjects could usually score 9; Dr. Wallace found that Wright's "very poor performance is consistent with my earlier observations that he may be greatly exaggerating his level of impairment." (GA 150). Dr. Wallace estimated, based on Wright's presentation, that his intelligence level was in the borderline to low average range. (GA 151). His invalid test results did not reflect on his ability to understand, remember, and carry out simple instructions or perform routine, repetitive tasks. (GA 151). Dr. Wallace stated Wright was a poor candidate for employment because he was actively abusing drugs and alcohol. (GA 151).

DDS consultant physician Dr. Khurshid Khan reviewed Wright's file to date and, on February 25, 1997, completed a Physical Residual Functional Capacity ("RFC") Assessment. (GA 139-46). In it, Dr. Khan indicated that he believed Wright was capable of occasionally lifting twenty pounds and frequently lifting ten; standing, walking and/or sitting for six hours each out of an eight-hour work day; and could push and/or pull with all extremities. (GA 140). He suggested Wright should be

limited to occasional climbing, crouching, and crawling. (GA 141). Dr. Khan found that Wright's ability to reach, handle, finger, and feel was limited in the right upper extremity, but unlimited in the left. (GA 142). Another DDS consultant physician, Dr. Firooz Golkar, reviewed Wright's file and on June 11, 1997, completed a second Physical RFC Assessment which was largely consistent with Dr. Khan's. (GA 162-169).

DDS consultant psychologist Dr. Kirk Johnson reviewed Wright's file on March 6, 1997, and completed a Psychiatric Review Technique Form (PRTF). (GA 152-61). Based on Wright's failure to cooperate with Dr. Wallace's testing, Dr. Johnson found insufficient evidence to make a decision as to whether Wright suffered from any severe mental impairment. (GA 152, 154). A second DDS consultant psychologist, Dr. Richard Maloney, concurred with Dr. Johnson in a June 17, 1997, PRTF. (GA 170-78).

Wright participated regularly in twelve-step addiction recovery meetings from June 16, 1997, through at least April 6, 1998. (GA 186-98).

One of Wright's treating physicians, Dr. Carlo Manalo, wrote in support of Wright's SSI claim on August 19, 1997, stating that Wright's right arm was permanently disabled as a result of his injuries and subsequent surgeries. (GA 180).

Dr. Manalo again wrote in support of Wright's SSI claim on November 28, 1997, certifying that Wright was

right-hand dominant, that he was suffering from a contraction deformity in the fingers of his right hand, and that the hand did not have full functioning. (GA 182).

There are no medical records in the administrative record for the period December 1997 through August 2001. Wright received treatment from Dr. M. Macrea on September 5, 2001. (GA 255, 259). Dr. Macrea's primary diagnosis was right hand trauma causing pain, with reduced sensation and contractures, but he noted no supportive diagnostic tests. (GA 259). Dr. Macrea noted secondary diagnoses of gastro-esophageal reflux disease resulting in occasional dyspepsia, and depression which was not then active. (GA 259). Based on this examination, Dr. Macrea assessed that Wright could sit for six hours and stand for three hours out of an eight hour work day, that he could occasionally lift or carry up to ten pounds but could never lift twenty, and that he could use his left hand but not his right hand for grasping, pushing/pulling, and fine manipulation. (GA 257).

On September 8, 2001, DDS sent Wright to a psychiatric evaluation with Dr. Yunus Pothiawala. (GA 243-45). Wright reported that he got depressed a lot and that he did not feel like doing things. (GA 243). He had had alcohol the previous night. (GA 243). He had been cocaine-dependent for over thirty years but had not had any for six months. (GA 243). Wright reported that he spent his days visiting family members and watching television. (GA 244). He could take care of his apartment and cook simple meals. (GA 244). He took short walks, shopped, and was able to socialize at least on a superficial

basis. (GA 244). He was able to perform self-care and hygiene functions. (GA 244). On mental status examination, he was cooperative but vague and hardly verbal. (GA 244). There were no signs of psychosis, delusions, or disorganized thinking. (GA 244). Dr. Pothiawala felt Wright was "poorly functioning at a borderline range of intelligence." (GA 244). His memory for past and recent events was fair but his responses were somewhat slow. (GA 244). His attention span and concentration were somewhat decreased. (GA 244). He had partial insight, and his judgment was fair. (GA 244). Dr. Pothiawala believed Wright's symptoms were suggestive of dysthymia and below-average intelligence functioning, but that he could manage funds on his own behalf. (GA 244-45).

Dr. Pothiawala completed a Medical Source Statement of Ability To Do Work-Related Activities (Mental), based on his evaluation of Wright. (GA 246-47). He indicated that Wright had moderate limitations in the ability to understand, remember, and carry out detailed instructions, interact appropriately with supervisors and co-workers, and respond appropriately to work pressures and changes in routine. (GA 246-47). He assessed slight limitations in the ability to understand, remember, and carry out short, simple instructions, and interact appropriately with the public. (GA 246-27).

DDS sent Wright to Dr. C. David Bomar for a physical examination on September 11, 2001. (GA 248). Dr. Bomar noted moderate muscular atrophy and clawing of the right little and middle fingers. (GA 248). Wright had

full extension of the fingers except for the right middle finger, but had poor grip and was unable to pinch. (GA 248). Thumb motion was limited and there was decreased right hand sensation. (GA 248). Wrist motion was limited to thirty degrees of flexion and extension. (GA 248). Dr. Bomar observed mild contracture of a joint in the left thumb, resulting in loss of about twenty degrees of extension, due to a different laceration. (GA 248). Dr. Bomar indicated that significant right hand neurological loss made fine manipulations difficult and resulted in poor grip strength, but that Wright could use the right hand for gross manipulations or to assist. (GA 248). Dr. Bomar further assessed that Wright could sit, stand, walk, and use his left hand with no restrictions, and could lift twenty-five pounds despite his right hand injury. (GA 248). Dr. Bomar completed a Medical Source Statement of Ability To Do Work-Related Abilities (Physical) consistent with that assessment. (GA 249-52).

Wright returned to Dr. Macrea on February 6, 2002. (GA 260). He reported that he still had intermittent, severe right hand pain. (GA 260). He was taking Elavil for pain and his dose had recently been increased. (GA 260). He was receiving psychiatric treatment for depression, mood swings and anger. (GA 260).

On February 27, 2002, Dr. Macrea completed a Medical Assessment of Ability To Do Work-Related Activities (Physical). (GA 263-64). He indicated that Wright could not lift or carry anything with his right hand due to contraction. (GA 263). Wright's ability to stand, walk, and sit was not affected by his impairment. (GA

263). Dr. Macrea believed Wright could never climb or crawl, but could occasionally balance, stoop, crouch, and kneel. (GA 264). Wright's ability to reach, bend, feel, and push/pull with his right hand were limited. (GA 264).

After ALJ Faraguna issued his unfavorable decision, Wright submitted additional medical evidence to the Appeals Council in support of his request for review. (GA 265-76). He submitted a medical report from Dr. M. Dada, who contradictorily reported that he began treating Wright on November 21, 2003 but had last seen him on October 8, 2003. (GA 266-276). Dr. Dada diagnosed increased lipids, depression, GERD, and right forearm pain. (GA 266). He expected Wright would be unable to work for 2 or more months, but less than six months "[b]ecause pt. in counseling for drug abuse." (GA 266). Dr. Dada stated that Wright "does not have a significant physical disability to deem him incompetent to work." (GA 266). He estimated that Wright could sit or stand for eight hours and walk for four hours out of an eight-hour day. (GA 267). Dr. Dada indicated Wright could occasionally lift up to twenty pounds and could frequently lift up to ten, while he could carry up to ten pounds. (GA 268). He did not believe Wright could use his right hand for simple grasping, pushing/pulling, or fine manipulation, and he could not climb or reach with his right hand. (GA 268).

Linda Spiegel, APRN, of PATH Outpatient Services, wrote to DDS on February 18, 2004. (GA 276). She stated that Wright had been in treatment with PATH since July, 1998. (GA 276). He was diagnosed with depressive

disorder, alcohol dependence in full remission, cocaine dependence in full remission, and cannabis dependence in full remission. (GA 276). Ms. Spiegel indicated that Wright had been clean and sober for "almost two full years." (GA 276). She assessed Wright with decreased concentration and decreased energy. (GA 276). Wright had not been hospitalized, but had been in the Mount Sinai Partial Hospital Program (not described here or elsewhere in the record) for the last three months of 2002. (GA 276).

B. The ALJ's Decision

The ALJ issued a written decision dated July 25, 2002, in which he found that Wright had filed a previous application for SSI benefits and for DIB which had been denied by a different ALJ in a March 29, 1995, opinion. (GA 15). The ALJ determined that the ALJ decision on March 29, 1995, had not been appealed and thus became the final decision of the Commissioner as to SSI and DIB claims through the date of the opinion. Accordingly, the ALJ determined that Wright's claim for SSI benefits for the period prior to March 30, 1995, was barred by *res judicata* and dismissed that portion of the claim. (GA 15-23).

Based upon a record which included Wright's testimony on April 7, 1998, and on February 7, 2002, and upon medical evidence in the record, the ALJ determined: Wright had not engaged in substantial gainful activity since March 30, 1995; Wright had severe impairments causing significant limitation in his ability to perform basic work related activities (including a significant

limitation of his right arm and hand but not his left arm and hand) but those impairments did not meet or equal an impairment listed in in the regulatory Listing of Impairments, 20 C.F.R. pt. 404, subpt. P, app. 1 (the Listings), and Wright lacked the residual functional capacity to return to his former employment. Further, based on testimony of a vocational expert, the ALJ determined that Wright could perform other work existing in significant numbers in the national economy. (GA 15-23).

The ALJ applied a five-step analysis to Wright's claim, finding for Wright at steps 1, 2 and 4. The ALJ determined against Wright at step 3 (finding that Wright's impairments did not conclusively require a determination of disability) and at step 5 (finding that Wright was able to perform other jobs which existed in significant numbers in the national economy). Therefore, the ALJ determined Wright was not disabled during the period March 30, 1995, through the date of his decision. (GA 15-23).

C. The District Court's Decision

Magistrate Judge William I. Garfinkel issued a Recommended Ruling, dated August 4, 2006, in which he determined, *inter alia*, that the ALJ correctly applied the law respecting the claimant's burden of proof at step 1, finding that Wright was not engaged in substantial gainful activity, and at step 2, finding that Wright's right hand and arm impairment, depression and history of drug and alcohol abuse were severe impairments. (GA 376). The Magistrate Judge also found that the ALJ correctly determined, based on objective medical evidence, that

Wright's impairments did not meet or equal in severity any impairment listed in the Listings. (GA 376-82). At step 4, the Magistrate Judge determined that the ALJ correctly found in Wright's favor that he could not perform his past relevant work as a warehouse worker and maintenance worker. (GA 382).

The Magistrate Judge then found that the burden of proof shifted to the Commissioner at step five, requiring the Commissioner to show that Wright had the residual functional capacity to perform work existing in significant numbers in the national economy. (GA 382). The Magistrate Judge determined that the ALJ evaluated the medical evidence and concluded – more conservatively than most of the doctors of record – that Wright was limited to lifting 0 to 5 pounds with his right hand and 5 to 15 pounds with his left, that he could sit/stand for one-half to one hour at a time and that he could walk one to two blocks. (GA 382-384). The Magistrate Judge found that the ALJ correctly posed hypothetical questions to the VE who testified at the second hearing which were based on substantial evidence in the record. (GA 384).

The Magistrate Judge thus concluded that the ALJ's determinations that Wright was not disabled, and that there were a significant number of jobs in the national and local economy that Wright could perform, were based on substantial evidence of record. (GA 384).

Finally, regarding the Appeals Council's decision not to review the ALJ's decision, the Magistrate Judge concluded that the Appeals Council's decision was correct.

(GA 384). In particular, the Magistrate Judge noted that the letters Wright submitted to the Appeals Council in support of his request for review did not provide any evidence supporting his claim of disability. One report noted that Wright "does not have a significant physical disability to deem him incompetent to work," while another provided no new evidence not already considered by the ALJ. (GA 384-385).

By order dated August 30, 2006, the district court (Kravitz, J.) accepted the recommended ruling of the Magistrate Judge. (GA 354, 387). Judgment entered in favor of the government on August 31, 2006. (GA 354, 388).

SUMMARY OF ARGUMENT

The ALJ's determination, that Wright had failed to meet his burden to establish that he was disabled under the Act, and that the Commissioner had met the government's burden to show that Wright was capable of performing other work which existed in substantial numbers in the national economy, was supported by substantial evidence in the record. The district court properly affirmed, determining that the record before the ALJ contained substantial evidence supporting the ALJ's application of the five-step analysis set forth in the SSA regulations. *See* 20 C.F.R. § 416.920(a)(4).

This Court should decline any invitation to substitute its judgment for that of the ALJ, as substantial evidence supports the ALJ's decision.

The judgment of the district court affirming the ALJ's decision should therefore be affirmed.

ARGUMENT

I. SUBSTANTIAL EVIDENCE SUPPORTS THE ADMINISTRATIVE LAW JUDGE'S DETERMINATION THAT WRIGHT WAS NOT DISABLED

A. Relevant Facts

The facts pertinent to consideration of steps 3 and 5 of the SSA's five-step analysis are set forth in Parts A and B, respectively, of the Statement of Facts, above.

B. Governing Law and Standard of Review

The Social Security Act creates an entitlement program for qualifying persons who are "disabled" within the meaning of the Act. *See* 42 U.S.C. § 423. "To show 'disabled' status a claimant must establish 'inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment . . .which has lasted or can be expected to last for a continuous period of not less than 12 months.'" *Shaw v. Chater,* 221 F.3d 126, 131 (2d Cir. 2000) (quoting 42 U.S.C. § 423(d)(1)(A)). "The impairment must be of 'such severity that [the claimant] is not only unable to do his previous work but cannot, considering his age, education, and work experience, engage in any other kind of substantial gainful work which exists in the national

economy.'" *Id.* at 131-32 (quoting 42 U.S.C. § 423(d)(2)(A)). *See also Draegert v. Barnhart,* 311 F.3d 468, 472 (2d Cir. 2002) (same).

In light of the foregoing standards, the Commissioner has issued regulations prescribing a five-step analysis for the consideration of disability claims. *See* 20 C.F.R. § 404.1520 (reproduced in Statutory Addendum to this brief). "In essence, if the Commissioner determines (1) that the claimant is not working, (2) that he has a 'severe impairment,' (3) that the impairment is not one that conclusively requires a determination of disability, and (4) that the claimant is not capable of continuing in his prior type of work, the Commissioner must find him disabled if (5) there is not another type of work the claimant can do." *Draegert*, 311 F.3d at 472; *see also Shaw,* 221 F.3d at 132 (outlining 5-step analysis); *Curry v. Apfel*, 209 F.3d 117, 122 (2d Cir. 2000) (same). "The Commissioner bears the burden of proof on th[e] last step, while the claimant has the burden on the first four steps." *Shaw*, 221 F.3d at 132; *see Butts v. Barnhart*, 388 F.3d 377, 381 (2d Cir. 2004); *Curry,* 209 F.3d at 122.

In considering whether a claimant has a "severe impairment," an ALJ may consult the Listings, which contain diagnostic criteria for impairments which are of *per se* disabling severity. *See* 20 C.F.R. § 416.925(a) ("The Listing of Impairments describes . . . impairments that we consider to be severe enough to prevent an individual from doing any gainful activity . . . .") If a claimant presents medical evidence meeting each diagnostic criterion for a Listed impairment, he may be

found disabled at step 3 without need to proceed through steps 4 and 5 of the disability inquiry. However, in recognition that the Listings cannot exhaustively list every potentially disabling condition, Social Security regulations provide that a claimant may also be found disabled at step 3 if his impairment(s) are equal in severity to a Listed impairment. *See* 20 C.F.R. § 416.926(a) ("An "impairment(s) is medically equivalent to a listed impairment . . . if it is at least equal in severity and duration to the criteria of any listed impairment.") In either case, the step 3 inquiry must be decided on the basis of objective medical evidence. *See* 20 C.F.R. §§ 416.908, 416.925(d), 416.926(c).

Section 1.00 of the Listings states criteria for disabling disorders of the musculoskeletal system. Listing 1.02 states that "Major dysfunction of a joint" is disabling when "characterized by gross anatomical deformity . . . and chronic joint pain and stiffness with signs of limitation of motion . . . and findings on appropriate medically acceptable imaging of joint space narrowing, bony destruction . . . ." Also present must be "involvement of one major peripheral weight-bearing joint (i.e., hip, knee, or ankle)" or "involvement of one major peripheral joint in each upper extremity."

Listing 1.03 governs "[r]econstructive surgery . . . of a major weight-bearing joint, with inability to ambulate effectively." Listings 1.04, "Disorders of the spine;" 1.05, "Amputation;" 1.06, Fracture of a tarsal bone such as a femur or the pelvis; and 1.07, "Fracture of an upper

extremity ... under continuing surgical management," each concern impairments not alleged by Wright.

Listing 1.08, "Soft tissue injury (e.g., burns) of an upper or lower extremity," is specifically directed at burns, but lists criteria by which other soft tissue injuries might be found equal. The injuries must be "under continuing surgical management . . . directed toward the salvage or restoration of major function."

The Act provides that "the findings of the Commissioner . . . as to any fact, if supported by substantial evidence, shall be conclusive . . . ." 42 U.S.C. § 405(g). *See Richardson v. Perales*, 402 U.S. 389, 401 (1971); *Veino v. Barnhart*, 312 F.3d 578, 586 (2d Cir. 2002). A court does not "determine *de novo* whether [a claimant] is disabled . . . ; [instead, the court] ascertain[s] whether the decision was supported by substantial evidence." *Halloran v. Barnhart*, 362 F.3d 28, 31 (2d Cir. 2004) (per curiam) (internal citations and quotation marks omitted). Where the Commissioner's determination is supported by substantial evidence, the decision must be upheld. *See Alston v. Sullivan*, 904 F.2d 122, 126 (2d Cir. 1990).

The term "substantial" does not require that the evidence be overwhelming, but it must be "more than a mere scintilla. Substantial evidence need not compel the Commissioner's decision; rather substantial evidence need only be evidence that "a reasonable mind might accept as adequate to support [the] conclusion." *Richardson*, 402 U.S. at 401 (quoting *Consol. Edison Co. of N.Y. v. NLRB*,

305 U.S. 197, 229 (1938)) (internal quotation marks omitted); *Veino*, 312 F.3d at 586.

This Court's review of the Commissioner's denial of disability benefits is limited to determining whether the denial was premised on an error of law or is otherwise not supported by substantial evidence. *See* 42 U.S.C. § 405(g); *Veino,* 312 F.3d at 578; *Yancey v. Apfel,* 145 F.3d 106, 111 (2d Cir. 1998). "Where the Commissioner's decision rests on adequate findings supported by evidence having rational probative force, we will not substitute our judgment for that of the Commissioner." *Veino,* 312 F.3d at 586; *see also Yancey,* 145 F.3d at 111.

C. Discussion

1. Substantial Evidence Supports the ALJ's Determination That Wright Failed to Establish at Step Three That He Had a Severe Impairment or Combination of Impairments Which Required a Determination of Disability

The Court should reject Wright's request for a determination that he is disabled under the Act because substantial evidence supports the ALJ's adverse determinations at steps 3 and 5 of the five-step analysis. The Court should therefore affirm the district court's decision which affirmed the ALJ's decision.

The ALJ decided in Wright's favor at steps 1 and 2 of the five-step disability determination process, finding that he had no substantial gainful activity since March 30, 1995 and that he had severe physical and mental impairments. At step 3, the ALJ determined that Wright's right hand and arm disorders, depression, and history of substance abuse did not meet or equal in severity any impairment in the Listings. (GA 18-19, 22 at Finding 3). This finding was supported by substantial evidence.

Section 1.00 of the Listings states criteria for disabling disorders of the musculoskeletal system. Listing 1.02 states that "Major Dysfunction of a Joint" is disabling when "characterized by gross anatomical deformity . . . and chronic joint pain and stiffness with signs of limitation of motion . . . and findings on appropriate medically acceptable imaging of joint space narrowing, bony destruction . . . ." Also present must be "involvement of one major peripheral weight-bearing joint (i.e., hip, knee, or ankle)" or "involvement of one major peripheral joint in each upper extremity." Wright's right arm and hand disorders do not meet Listing 1.02, as there are no medically acceptable imagings in the record, no involvement of a weight-bearing joint, and only one affected upper extremity. Nor are there any findings equaling Listing 1.02 in severity, especially in light of the absence of medical imagings such as X-rays, CAT scans, or MRI's.

Listing 1.03 governs "reconstructive surgery . . . of a major weight-bearing joint, with inability to ambulate effectively." As there are no alleged impairments of

Wright's weight-bearing joints and his ability to walk is unlimited, this Listing is inapplicable. Also facially inapplicable are Listing 1.04, "Disorders of the Spine"; Listing 1.05, "Amputation"; Listing 1.06, fracture of a tarsal bone such as a femur or the pelvis; and 1.07, "fracture of an upper extremity . . . under continuing surgical management." Each of these Listings concerns impairments not alleged by the Wright, and are not met or equaled based on evidence in the record.

Listing 1.08, "Soft tissue injury (e.g. burns) of an upper or lower extremity," appears potentially applicable. While this Listing is specifically directed at burns, it states criteria by which other soft tissue injuries might be found equal. Specifically, the injuries must be "under continuing surgical management . . . directed toward the salvage or restoration of major function." The term "continuing surgical management" means "surgical procedures and any other associated treatments related to the efforts directed toward the salvage or restoration of functional use of the affected part." 20 C.F.R. pt. 404, subpt. P, app. 1 § 1.00M. The medical evidence in the record establishes that Wright received surgical treatment for his right arm and hand disorders only during his initial, post-injury hospitalization in 1989. (GA 122-124). There is no evidence of any continued surgical or other treatment geared towards restoring function in Wright's right arm and hand. In the absence of any such objective medical evidence, Wright's right upper extremity injury cannot be found to equal Listing 1.08.

The ALJ's determination that none of the physical impairment Listings were met or equaled was supported by Dr. Isaacs' examination report, stating that Wright had good range of motion in his three unaffected extremities and could walk unassisted. (GA 137-38). Similarly, Dr. Bomar reported that Wright could sit, stand, walk, and use his left hand with no limitations. (GA 248).

Nor can Wright's mental impairments be found to equal any Listed impairment. Listing 12.04 governs affective disorders, and sets out various requirements for depressive syndrome of disabling severity. Among those requirements are alternative measures of diminished functioning. To be found disabled, Wright would have had to demonstrate markedly diminished abilities in two out of three areas of functioning (concentration, persistence and pace; maintaining social functioning; and activities of daily living), or one markedly limited area of functioning plus repeated episodes of decompensation, each of extended duration. 20 C.F.R. pt. 404, subpt. P, app. 1 § 12.04(B). Alternately, Wright would have had to establish a medically documented history of a chronic disorder of at least two years' duration, attenuated by medication or psychosocial support, *plus* one of the following: repeated, extended episodes of decompensation; inability to tolerate a minimal increase in mental demands without decompensation; or a continuing history of at least one year's ability to function outside a highly supportive living arrangement. None of these measures of impaired mental functioning are present in the record.

Consultative examiner Dr. Wallace was unable to determine the extent to which Wright's mental impairments limited his functioning, due to Wright's apparent attempts to exaggerate his limitations. (GA 149-50) Fellow consultative examiner Dr. Pothiawala assessed only moderate and slight, not marked, functional limitations (GA 246-47), and believed Wright was competent to manage his own funds. (GA 245). Both DDS non-examining consultant psychologists who examined the record concurred that there was insufficient medical evidence to substantiate the presence of even a severe mental impairment, let alone one meeting or equaling Listing 12.04. (GA 152-61, 170-78). This constituted substantial evidence supporting the ALJ's determination that Wright's mental impairments did not meet or equal a Listing at step 3.

Finally, the Commissioner notes that, under the Contract with America Advancement Act of 1996, Public Law No. 104-121, Congress eliminated disability benefits under Title II and Title XVI where the basis of the disability was alcohol or drug abuse. *Brown v. Apfel,* 192 F.3d 492, 496 n.3 (5th Cir. 1999); *Torres v. Chater*, 125 F.3d 166, 169 (3d Cir. 1997). *See also* Social Security Act, 42 U.S.C. §§ 423(d)(2)(C), 1382c(a)(3)(J) ("An individual shall not be considered to be disabled for purposes of this subchapter if alcoholism or drug addiction would (but for this subparagraph) be a contributing factor material to the Commissioner's determination that the individual is disabled.") There is, accordingly, no Listing under which Wright's history of drug and alcohol abuse

might be found to be of *per se* disabling severity at step 3.

The ALJ here properly applied the Act and the regulations to the record before him and properly determined that Wright had failed to establish a severe impairment meeting or equaling a listing. The ALJ then properly proceeding to step 4 of the five-step analysis, and determined in Wright's favor that he did not have the residual functional capacity to perform his past relevant work. The ALJ then proceeding to step 5, discussed in Section 2, below.

2. Substantial Evidence Supports the ALJ's Determination That the Commissioner Met His Burden at Step Five To Establish That There Is Other Work That Wright Can Perform, in Significant Numbers in the National Economy

The ALJ decided step 4 in Wright's favor, stating that Wright could not return to any of his past relevant work. (GA 21, 22 at Finding 6). Then, at step 5, the ALJ relied on VE testimony from the administrative hearing to find that Wright could perform alternate work and was, accordingly, not disabled. The ALJ's step 5 decision was correct and supported by substantial evidence.

At the hearing, the ALJ posed to the VE a hypothetical claimant whose vocational background and RFC were the same as Wright's. (GA 340). The VE responded, stating that such a claimant could perform work as a ticket taker,

with about 400 positions in Connecticut; cashier, with about 2,000 suitable positions; or usher, with about 500 positions statewide. (GA 340-41, 347-48). The ALJ properly obtained this VE testimony, given that he found non-exertional in addition to strength-based limitations. *See* Social Security Ruling ("SSR") 83-14 ("Where the adjudicator does not have a clear understanding of the effects of additional [non-strength] limitations on the job base, the services of a [vocational specialist] will be necessary.") And the ALJ was entitled to meet his step 5 burden of production by relying on this VE testimony:

> [T]here is substantial record evidence to support the assumption upon which the vocational expert based his opinion. Consequently, his opinion . . . satisfied the Secretary's burden of showing the existence of alternative substantial gainful employment suited to Dumas' physical and vocational capabilities.

Dumas v. Schweiker, 712 F.2d 1545, 1554 (2d Cir. 1983).

The VE's testimony was appropriate given the ALJ's uncertainty as to the effects of Wright's non-exertional limitations on his ability to perform work. The ALJ had substantial evidence before him, in the form of the VE's testimony, to support his conclusion that Wright could perform other work which existed in substantial numbers in the national economy.

Accordingly, because the ALJ had substantial evidence before him to support both steps on which he

ruled against Wright, there is no error and the denial of SSI benefits should be affirmed.

CONCLUSION

For the foregoing reasons, the judgment of the district court should be affirmed.

Dated: June 5, 2007

Respectfully submitted,

KEVIN J. O'CONNOR
UNITED STATES ATTORNEY
DISTRICT OF CONNECTICUT

ANN M. NEVINS
ASSISTANT U.S. ATTORNEY

WILLIAM J. NARDINI
Assistant United States Attorney (of counsel)

ADDENDUM

STATUTES

42 U.S.C. § 405. Evidence, procedure, and certification for payments

(a) Rules and regulations; procedures

The Commissioner of Social Security shall have full power and authority to make rules and regulations and to establish procedures, not inconsistent with the provisions of this subchapter, which are necessary or appropriate to carry out such provisions, and shall adopt reasonable and proper rules and regulations to regulate and provide for the nature and extent of the proofs and evidence and the method of taking and furnishing the same in order to establish the right to benefits hereunder.

. . .

(g) Judicial review

Any individual, after any final decision of the Commissioner of Social Security made after a hearing to which he was a party, irrespective of the amount in controversy, may obtain a review of such decision by a civil action commenced within sixty days after the mailing to him of notice of such decision or within such further time as the Commissioner of Social Security may allow. Such action shall be brought in the district court of the United States for the judicial district in which the plaintiff resides, or has his principal place of business, or, if he does not reside or have his principal place of business

within any such judicial district, in the United States District Court for the District of Columbia. As part of the Commissioner's answer the Commissioner of Social Security shall file a certified copy of the transcript of the record including the evidence upon which the findings and decision complained of are based. The court shall have power to enter, upon the pleadings and transcript of the record, a judgment affirming, modifying, or reversing the decision of the Commissioner of Social Security, with or without remanding the cause for a rehearing. The findings of the Commissioner of Social Security as to any fact, if supported by substantial evidence, shall be conclusive, and where a claim has been denied by the Commissioner of Social Security or a decision is rendered under subsection (b) of this section which is adverse to an individual who was a party to the hearing before the Commissioner of Social Security, because of failure of the claimant or such individual to submit proof in conformity with any regulation prescribed under subsection (a) of this section, the court shall review only the question of conformity with such regulations and the validity of such regulations. The court may, on motion of the Commissioner of Social Security made for good cause shown before the Commissioner files the Commissioner's answer, remand the case to the Commissioner of Social Security for further action by the Commissioner of Social Security, and it may at any time order additional evidence to be taken before the Commissioner of Social Security, but only upon a showing that there is new evidence which is material and that there is good cause for the failure to incorporate such evidence into the record in a prior proceeding; and the Commissioner of Social Security shall, after the case is

remanded, and after hearing such additional evidence if so ordered, modify or affirm the Commissioner's findings of fact or the Commissioner's decision, or both, and shall file with the court any such additional and modified findings of fact and decision, and, in any case in which the Commissioner has not made a decision fully favorable to the individual, a transcript of the additional record and testimony upon which the Commissioner's action in modifying or affirming was based. Such additional or modified findings of fact and decision shall be reviewable only to the extent provided for review of the original findings of fact and decision. The judgment of the court shall be final except that it shall be subject to review in the same manner as a judgment in other civil actions. Any action instituted in accordance with this subsection shall survive notwithstanding any change in the person occupying the office of Commissioner of Social Security or any vacancy in such office.

. . . .

42 U.S.C. § 406. Representation of claimants before Commissioner of Social Security

(a) Recognition of representatives; fees for representation before Commissioner of Social Security

(1) The Commissioner of Social Security may prescribe rules and regulations governing the recognition of agents or other persons, other than attorneys as hereinafter provided, representing claimants before the Commissioner of Social Security, and may require of such agents or other persons, before being recognized as representatives of claimants that they shall show that they are of good character and in good repute, possessed of the necessary qualifications to enable them to render such claimants valuable service, and otherwise competent to advise and assist such claimants in the presentation of their cases. An attorney in good standing who is admitted to practice before the highest court of the State, Territory, District, or insular possession of his residence or before the Supreme Court of the United States or the inferior Federal courts, shall be entitled to represent claimants before the Commissioner of Social Security. Notwithstanding the preceding sentences, the Commissioner, after due notice and opportunity for hearing, (A) may refuse to recognize as a representative, and may disqualify a representative already recognized, any attorney who has been disbarred or suspended from any court or bar to which he or she was previously admitted to practice or who has been disqualified from participating in or

appearing before any Federal program or agency, and (B) may refuse to recognize, and may disqualify, as a non-attorney representative any attorney who has been disbarred or suspended from any court or bar to which he or she was previously admitted to practice. A representative who has been disqualified or suspended pursuant to this section from appearing before the Social Security Administration as a result of collecting or receiving a fee in excess of the amount authorized shall be barred from appearing before the Social Security Administration as a representative until full restitution is made to the claimant and, thereafter, may be considered for reinstatement only under such rules as the Commissioner may prescribe. The Commissioner of Social Security may, after due notice and opportunity for hearing, suspend or prohibit from further practice before the Commissioner any such person, agent, or attorney who refuses to comply with the Commissioner's rules and regulations or who violates any provision of this section for which a penalty is prescribed. The Commissioner of Social Security may, by rule and regulation, prescribe the maximum fees which may be charged for services performed in connection with any claim before the Commissioner of Social Security under this subchapter, and any agreement in violation of such rules and regulations shall be void. Except as provided in paragraph (2)(A), whenever the Commissioner of Social Security, in any claim before the Commissioner for benefits under this subchapter, makes a determination favorable to the claimant, the Commissioner shall, if the claimant was represented

by an attorney in connection with such claim, fix (in accordance with the regulations prescribed pursuant to the preceding sentence) a reasonable fee to compensate such attorney for the services performed by him in connection with such claim.

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

(i) an agreement between the claimant and another person regarding any fee to be recovered by such person to compensate such person for services with respect to the claim is presented in writing to the Commissioner of Social Security prior to the time of the Commissioner's determination regarding the claim,

(ii) the fee specified in the agreement does not exceed the lesser of--

(I) 25 percent of the total amount of such past-due benefits (as determined before any applicable reduction under section 1320a-6(a) of this title), or

(II) $4,000, and

(iii) the determination is favorable to the claimant,

then the Commissioner of Social Security shall approve that agreement at the time of the favorable determination, and (subject to paragraph (3)) the

fee specified in the agreement shall be the maximum fee. The Commissioner of Social Security may from time to time increase the dollar amount under clause (ii)(II) to the extent that the rate of increase in such amount, as determined over the period since January 1, 1991, does not at any time exceed the rate of increase in primary insurance amounts under section 415(i) of this title since such date. The Commissioner of Social Security shall publish any such increased amount in the Federal Register.

(B) For purposes of this subsection, the term "past-due benefits" excludes any benefits with respect to which payment has been continued pursuant to subsection (g) or (h) of section 423 of this title.

(C) In any case involving--

(i) an agreement described in subparagraph (A) with any person relating to both a claim of entitlement to past-due benefits under this subchapter and a claim of entitlement to past-due benefits under subchapter XVI of this chapter, and

(ii) a favorable determination made by the Commissioner of Social Security with respect to both such claims,

the Commissioner of Social Security may approve such agreement only if the total fee or fees specified in such agreement does not exceed, in the aggregate,

the dollar amount in effect under subparagraph (A)(ii)(II).

. . . .

42 U.S.C. § 423. Disability insurance benefit payments

(a) Disability insurance benefits

(1) Every individual who--

(A) is insured for disability insurance benefits (as determined under subsection (c)(1) of this section),

(B) has not attained retirement age (as defined in section 416(l) of this title),

(C) if not a United States citizen or national--

(i) has been assigned a social security account number that was, at the time of assignment, or at any later time, consistent with the requirements of subclause (I) or (III) of section 405(c)(2)(B)(i) of this title; or

(ii) at the time any quarters of coverage are earned--

(I) is described in subparagraph (B) or (D) of section 1101(a)(15) of Title 8,

(II) is lawfully admitted temporarily to the United States for business (in the case of an individual described in such subparagraph (B)) or the performance as a crewman (in the case of an individual described in such subparagraph (D)), and

(III) the business engaged in or service as a crewman performed is within the scope of the terms of such individual's admission to the United States.

(D) has filed application for disability insurance benefits, and

(E) is under a disability (as defined in subsection (d) of this section),

shall be entitled to a disability insurance benefit . . . .

. . .

(d) "Disability" defined

(1) The term "disability" means--

(A) inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months; or

(B) in the case of an individual who has attained the age of 55 and is blind (within the meaning of "blindness" as defined in section 416(i)(1) of this title), inability by reason of such blindness to engage in substantial gainful activity requiring skills or abilities comparable to those of any gainful activity in which he has previously engaged with some regularity and over a substantial period of time.

(2) For purposes of paragraph (1)(A)--

(A) An individual shall be determined to be under a disability only if his physical or mental impairment or impairments are of such severity that he is not only unable to do his previous work but cannot, considering his age, education, and work experience, engage in any other kind of substantial gainful work which exists in the national economy, regardless of whether such work exists in the immediate area in which he lives, or whether a specific job vacancy exists for him, or whether he would be hired if he applied for work. For purposes of the preceding sentence (with respect to any individual), "work which exists in the national economy" means work which exists in significant numbers either in the region where such individual lives or in several regions of the country.

(B) In determining whether an individual's physical or mental impairment or impairments are of a sufficient medical severity that such impairment or impairments could be the basis of eligibility under this section, the Commissioner of Social Security shall consider the combined effect of all of the individual's impairments without regard to whether any such impairment, if considered separately, would be of such severity. If the Commissioner of Social Security does find a medically severe combination of impairments, the combined impact of the impairments shall be considered throughout the disability determination process.

(C) An individual shall not be considered to be disabled for purposes of this subchapter if alcoholism or drug

addiction would (but for this subparagraph) be a contributing factor material to the Commissioner's determination that the individual is disabled.

. . .

(5)(A) An individual shall not be considered to be under a disability unless he furnishes such medical and other evidence of the existence thereof as the Commissioner of Social Security may require. . . .

42 U.S.C. § 1382c. Definitions

(a)(1) For purposes of this subchapter, the term "aged, blind, or disabled individual" means an individual who--

(A) is 65 years of age or older, is blind (as determined under paragraph (2)), or is disabled (as determined under paragraph (3)), and

(B)(i) is a resident of the United States, and is either (I) a citizen or (II) an alien lawfully admitted for permanent residence or otherwise permanently residing in the United States under color of law (including any alien who is lawfully present in the United States as a result of the application of the provisions of section 1182(d)(5) of Title 8), or

(ii) is a child who is a citizen of the United States, and who is living with a parent of the child who is a member of the Armed Forces of the United States assigned to permanent duty ashore outside the United States.

(2) An individual shall be considered to be blind for purposes of this subchapter if he has central visual acuity of 20/200 or less in the better eye with the use of a correcting lens. An eye which is accompanied by a limitation in the fields of vision such that the widest diameter of the visual field subtends an angle no greater than 20 degrees shall be considered for purposes of the first sentence of this subsection as having a central visual acuity of 20/200 or less. An individual shall also be considered to be blind for purposes of this subchapter if he is blind as defined under a State plan approved under subchapter X or XVI of this chapter as in effect for October 1972 and received aid under such plan (on the basis of blindness) for December 1973, so long as he is continuously blind as so defined.

(3)(A) Except as provided in subparagraph (C), an individual shall be considered to be disabled for purposes of this subchapter if he is unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than twelve months.

. . .

(J) Notwithstanding subparagraph (A), an individual shall not be considered to be disabled for purposes of this subchapter if alcoholism or drug addiction would (but for this subparagraph) be a contributing factor material to the Commissioner's determination that the individual is disabled.

. . . .

REGULATIONS

20 C.F.R. § 404.1520 Evaluation of disability in general.

(a) General--

(1) Purpose of this section. This section explains the five-step sequential evaluation process we use to decide whether you are disabled, as defined in § 404.1505.

(2) Applicability of these rules. These rules apply to you if you file an application for a period of disability or disability insurance benefits (or both) or for child's insurance benefits based on disability. They also apply if you file an application for widow's or widower's benefits based on disability for months after December 1990. (See § 404.1505(a).)

(3) Evidence considered. We will consider all evidence in your case record when we make a determination or decision whether you are disabled.

(4) The five-step sequential evaluation process. The sequential evaluation process is a series of five "steps" that we follow in a set order. If we can find that you are disabled or not disabled at a step, we make our determination or decision and we do not go on to the next step. If we cannot find that you are disabled or not disabled at a step, we go on to the next step. Before we go from step three to step four, we assess your residual functional capacity. (See paragraph (e) of this section.) We use this residual functional capacity assessment at both step four and step five when we evaluate your claim at these steps. These are the five steps we follow:

(i) At the first step, we consider your work activity, if any. If you are doing substantial gainful activity, we will find that you are not disabled. (See paragraph (b) of this section.)

(ii) At the second step, we consider the medical severity of your impairment(s). If you do not have a severe medically determinable physical or mental impairment that meets the duration requirement in § 404.1509, or a combination of impairments that is severe and meets the duration requirement, we will find that you are not disabled. (See paragraph (c) of this section.)

(iii) At the third step, we also consider the medical severity of your impairment(s). If you have an impairment(s) that meets or equals one of our listings in appendix 1 of this subpart and meets the duration

requirement, we will find that you are disabled. (See paragraph (d) of this section.)

(iv) At the fourth step, we consider our assessment of your residual functional capacity and your past relevant work. If you can still do your past relevant work, we will find that you are not disabled. (See paragraph (f) of this section and § 404.1560(b).)

(v) At the fifth and last step, we consider our assessment of your residual functional capacity and your age, education, and work experience to see if you can make an adjustment to other work. If you can make an adjustment to other work, we will find that you are not disabled. If you cannot make an adjustment to other work, we will find that you are disabled. (See paragraph (g) of this section and § 404.1560(c).)

(5) When you are already receiving disability benefits. If you are already receiving disability benefits, we will use a different sequential evaluation process to decide whether you continue to be disabled. We explain this process in § 404.1594(f).

(b) If you are working. If you are working and the work you are doing is substantial gainful activity, we will find that you are not disabled regardless of your medical condition or your age, education, and work experience.

(c) You must have a severe impairment. If you do not have any impairment or combination of impairments

which significantly limits your physical or mental ability to do basic work activities, we will find that you do not have a severe impairment and are, therefore, not disabled. We will not consider your age, education, and work experience. However, it is possible for you to have a period of disability for a time in the past even though you do not now have a severe impairment.

(d) When your impairment(s) meets or equals a listed impairment in Appendix 1. If you have an impairment(s) which meets the duration requirement and is listed in Appendix 1 or is equal to a listed impairment(s), we will find you disabled without considering your age, education, and work experience.

(e) When your impairment(s) does not meet or equal a listed impairment. If your impairment(s) does not meet or equal a listed impairment, we will assess and make a finding about your residual functional capacity based on all the relevant medical and other evidence in your case record, as explained in § 404.1545. (See paragraph (g)(2) of this section and § 404.1562 for an exception to this rule.) We use our residual functional capacity assessment at the fourth step of the sequential evaluation process to determine if you can do your past relevant work (paragraph (f) of this section) and at the fifth step of the sequential evaluation process (if the evaluation proceeds to this step) to determine if you can adjust to other work (paragraph (g) of this section).

(f) Your impairment(s) must prevent you from doing your past relevant work. If we cannot make a determination or

decision at the first three steps of the sequential evaluation process, we will compare our residual functional capacity assessment, which we made under paragraph (e) of this section, with the physical and mental demands of your past relevant work. (See § 404.1560(b).) If you can still do this kind of work, we will find that you are not disabled.

(g) Your impairment(s) must prevent you from making an adjustment to any other work.

(1) If we find that you cannot do your past relevant work because you have a severe impairment(s) (or you do not have any past relevant work), we will consider the same residual functional capacity assessment we made under paragraph (e) of this section, together with your vocational factors (your age, education, and work experience) to determine if you can make an adjustment to other work. (See § 404.1560(c).) If you can make an adjustment to other work, we will find you not disabled. If you cannot, we will find you disabled.(2) We use different rules if you meet one of the two special medical-vocational profiles described in § 404.1562. If you meet one of those profiles, we will find that you cannot make an adjustment to other work, and that you are disabled.

20 C.F.R. § 416.908 What is needed to show an impairment.

If you are not doing substantial gainful activity, we always look first at your physical or mental impairment(s) to determine whether you are disabled or blind. Your impairment must result from anatomical, physiological, or psychological abnormalities which can be shown by medically acceptable clinical and laboratory diagnostic techniques. A physical or mental impairment must be established by medical evidence consisting of signs, symptoms, and laboratory findings, not only by your statement of symptoms (see § 416.927). (See § 416.928 for further information about what we mean by symptoms, signs, and laboratory findings.)

20 C.F.R. § 416.920 Evaluation of disability of adults, in general.

(a) General--

(1) Purpose of this section. This section explains the five-step sequential evaluation process we use to decide whether you are disabled, as defined in § 416.905.

(2) Applicability of these rules. These rules apply to you if you are age 18 or older and you file an application for Supplemental Security Income disability benefits.

(3) Evidence considered. We will consider all evidence in your case record when we make a determination or decision whether you are disabled.

(4) The five-step sequential evaluation process. The sequential evaluation process is a series of five "steps" that we follow in a set order. If we can find that you are disabled or not disabled at a step, we make our determination or decision and we do not go on to the next step. If we cannot find that you are disabled or not disabled at a step, we go on to the next step. Before we go from step three to step four, we assess your residual functional capacity. (See paragraph (e) of this section.) We use this residual functional capacity assessment at both step four and at step five when we evaluate your claim at these steps. These are the five steps we follow:

(i) At the first step, we consider your work activity, if any. If you are doing substantial gainful activity, we will find that you are not disabled. (See paragraph (b) of this section.)

(ii) At the second step, we consider the medical severity of your impairment(s). If you do not have a severe medically determinable physical or mental impairment that meets the duration requirement in § 416.909, or a combination of impairments that is severe and meets the duration requirement, we will find that you are not disabled. (See paragraph (c) of this section.)

(iii) At the third step, we also consider the medical severity of your impairment(s). If you have an impairment(s) that meets or equals one of our listings in appendix 1 to subpart P of part 404 of this chapter and meets the duration requirement, we will find that you are disabled. (See paragraph (d) of this section.)

(iv) At the fourth step, we consider our assessment of your residual functional capacity and your past relevant work. If you can still do your past relevant work, we will find that you are not disabled. (See paragraph (f) of this section and § 416.960(b).)

(v) At the fifth and last step, we consider our assessment of your residual functional capacity and your age, education, and work experience to see if you can make an adjustment to other work. If you can make an adjustment to other work, we will find that

you are not disabled. If you cannot make an adjustment to other work, we will find that you are disabled. (See paragraph (g) of this section and § 416.960(c).)

(5) When you are already receiving disability benefits. If you are already receiving disability benefits, we will use a different sequential evaluation process to decide whether you continue to be disabled. We explain this process in § 416.994(b)(5).

(b) If you are working. If you are working and the work you are doing is substantial gainful activity, we will find that you are not disabled regardless of your medical condition or your age, education, and work experience.

(c) You must have a severe impairment. If you do not have any impairment or combination of impairments which significantly limits your physical or mental ability to do basic work activities, we will find that you do not have a severe impairment and are, therefore, not disabled. We will not consider your age, education, and work experience.

(d) When your impairment(s) meets or equals a listed impairment in Appendix 1. If you have an impairment(s) which meets the duration requirement and is listed in Appendix 1 or is equal to a listed impairment(s), we will find you disabled without considering your age, education, and work experience.

(e) When your impairment(s) does not meet or equal a listed impairment. If your impairment(s) does not meet or equal a listed impairment, we will assess and make a finding about your residual functional capacity based on all the relevant medical and other evidence in your case record, as explained in § 416.945. (See paragraph (g)(2) of this section and § 416.962 for an exception to this rule.) We use our residual functional capacity assessment at the fourth step of the sequential evaluation process to determine if you can do your past relevant work (paragraph (f) of this section) and at the fifth step of the sequential evaluation process (if the evaluation proceeds to this step) to determine if you can adjust to other work (paragraph (g) of this section).

(f) Your impairment(s) must prevent you from doing your past relevant work. If we cannot make a determination or decision at the first three steps of the sequential evaluation process, we will compare our residual functional capacity assessment, which we made under paragraph (e) of this section, with the physical and mental demands of your past relevant work. (See § 416.960(b).) If you can still do this kind of work, we will find that you are not disabled.

(g) Your impairment(s) must prevent you from making an adjustment to any other work.

(1) If we find that you cannot do your past relevant work because you have a severe impairment(s) (or you do not have any past relevant work), we will consider the same residual functional capacity assessment we

made under paragraph (e) of this section, together with your vocational factors (your age, education, and work experience) to determine if you can make an adjustment to other work. (See § 416.960(c).) If you can make an adjustment to other work, we will find you not disabled. If you cannot, we will find you disabled.

(2) We use different rules if you meet one of the two special medical-vocational profiles described in § 416.962. If you meet one of those profiles, we will find that you cannot make an adjustment to other work, and that you are disabled.

20 C.F.R. § 416.925 Listing of Impairments in appendix 1 of subpart P of part 404 of this chapter.

(a) What is the purpose of the Listing of Impairments? The Listing of Impairments (the listings) is in appendix 1 of subpart P of part 404 of this chapter. For adults, it describes for each of the major body systems impairments that we consider to be severe enough to prevent an individual from doing any gainful activity, regardless of his or her age, education, or work experience. For children, it describes impairments that cause marked and severe functional limitations.

(b) How is appendix 1 organized? There are two parts in appendix 1:

(1) Part A contains criteria that apply to individuals age 18 and over. We may also use part A for individuals who are under age 18 if the disease processes have a similar effect on adults and children.

(2)(i) Part B contains criteria that apply only to individuals who are under age 18; we never use the listings in part B to evaluate individuals who are age 18 or older. In evaluating disability for a person under age 18, we use part B first. If the criteria in part B do not apply, we may use the criteria in part A when those criteria give appropriate consideration to the effects of the impairment(s) in children. To the extent possible, we number the provisions in part B to maintain a relationship with their counterparts in part A.

(ii) Although the severity criteria in part B of the listings are expressed in different ways for different impairments, "listing-level severity" generally means the level of severity described in § 416.926a(a); that is, "marked" limitations in two domains of functioning or an "extreme" limitation in one domain. (See § 416.926a(e) for the definitions of the terms marked and extreme as they apply to children.) Therefore, in general, a child's impairment(s) is of "listing-level severity" if it causes marked limitations in two domains of functioning or an extreme limitation in one. However, when we decide whether your impairment(s) meets the requirements of a listing, we will decide that your impairment is of "listing-level severity" even if it does not result in marked limitations in two domains of functioning, or an extreme limitation in one, if the listing that we apply does not require such limitations to establish that an impairment(s) is disabling.

(c) How do we use the listings?

(1) Each body system section in parts A and B of appendix 1 of subpart P of part 404 of this chapter is in two parts: an introduction, followed by the specific listings.

(2) The introduction to each body system contains information relevant to the use of the listings in that body system; for example, examples of common impairments in the body system and definitions used in the listings for that body system. We may also include specific criteria for establishing a diagnosis,

confirming the existence of an impairment, or establishing that your impairment(s) satisfies the criteria of a particular listing in the body system. Even if we do not include specific criteria for establishing a diagnosis or confirming the existence of your impairment, you must still show that you have a severe medically determinable impairment(s), as defined in §§ 416.908, 416.920(c), and 416.924(c).

(3) The specific listings follow the introduction in each body system, after the heading, Category of Impairments. Within each listing, we specify the objective medical and other findings needed to satisfy the criteria of that listing. We will find that your impairment(s) meets the requirements of a listing when it satisfies all of the criteria of that listing, including any relevant criteria in the introduction, and meets the duration requirement (see § 416.909).

(4) Most of the listed impairments are permanent or expected to result in death. For some listings, we state a specific period of time for which your impairment(s) will meet the listing. For all others, the evidence must show that your impairment(s) has lasted or can be expected to last for a continuous period of at least 12 months.

(5) If your impairment(s) does not meet the criteria of a listing, it can medically equal the criteria of a listing. We explain our rules for medical equivalence in § 416.926. We use the listings only to find that you are disabled or still disabled. If your impairment(s) does

not meet or medically equal the criteria of a listing, we may find that you are disabled or still disabled at a later step in the sequential evaluation process.

(d) Can your impairment(s) meet a listing based only on a diagnosis? No. Your impairment(s) cannot meet the criteria of a listing based only on a diagnosis. To meet the requirements of a listing, you must have a medically determinable impairment(s) that satisfies all of the criteria of the listing.

(e) How do we consider your symptoms when we determine whether your impairment(s) meets a listing? Some listed impairments include symptoms, such as pain, as criteria. Section 416.929(d)(2) explains how we consider your symptoms when your symptoms are included as criteria in a listing.

20 C.F.R. § 416.926 Medical equivalence for adults and children.

(a) What is medical equivalence? Your impairment(s) is medically equivalent to a listed impairment in appendix 1 of subpart P of part 404 of this chapter if it is at least equal in severity and duration to the criteria of any listed impairment.

(b) How do we determine medical equivalence? We can find medical equivalence in three ways.

(1)(i) If you have an impairment that is described in the Listing of Impairments in appendix 1 of subpart P of part 404 of this chapter, but--

(A) You do not exhibit one or more of the findings specified in the particular listing, or

(B) You exhibit all of the findings, but one or more of the findings is not as severe as specified in the particular listing,

(ii) We will find that your impairment is medically equivalent to that listing if you have other findings related to your impairment that are at least of equal medical significance to the required criteria.

(2) If you have an impairment(s) that is not described in the Listing of Impairments in appendix 1 of subpart P of part 404 of this chapter, we will compare your findings with those for closely analogous listed

impairments. If the findings related to your impairment(s) are at least of equal medical significance to those of a listed impairment, we will find that your impairment(s) is medically equivalent to the analogous listing.

(3) If you have a combination of impairments, no one of which meets a listing described in the Listing of Impairments in appendix 1 of subpart P of part 404 of this chapter (see § 416.925(c)(3)), we will compare your findings with those for closely analogous listed impairments. If the findings related to your impairments are at least of equal medical significance to those of a listed impairment, we will find that your combination of impairments is medically equivalent to that listing.

(4) Section 416.929(d)(3) explains how we consider your symptoms, such as pain, when we make findings about medical equivalence.

(c) What evidence do we consider when we determine if your impairment(s) medically equals a listing? When we determine if your impairment medically equals a listing, we consider all evidence in your case record about your impairment(s) and its effects on you that is relevant to this finding. We do not consider your vocational factors of age, education, and work experience (see, for example, § 416.960(c)(1)). We also consider the opinion given by one or more medical or psychological consultants designated by the Commissioner. (See § 416.1016.)

(d) Who is a designated medical or psychological consultant? A medical or psychological consultant designated by the Commissioner includes any medical or psychological consultant employed or engaged to make medical judgments by the Social Security Administration, the Railroad Retirement Board, or a State agency authorized to make disability determinations, and includes a medical or psychological expert (as defined in § 405.5 of this chapter) in claims adjudicated under the procedures in part 405 of this chapter. A medical consultant must be a physician. A psychological consultant used in cases where there is evidence of a mental impairment must be a qualified psychologist. (See § 416.1016 for limitations on what medical consultants who are not physicians can evaluate and the qualifications we consider necessary for a psychologist to be a consultant.)

(e) Responsibility for determining medical equivalence. In cases where the State agency or other designee of the Commissioner makes the initial or reconsideration disability determination, a State agency medical or psychological consultant or other designee of the Commissioner (see § 416.1016 of this part) has the overall responsibility for determining medical equivalence. In claims adjudicated at the initial level under the procedures in part 405 of this chapter, the medical or psychological expert (as defined in § 405.5 of this chapter) has the overall responsibility for determining medical equivalence. For cases in the disability hearing process or otherwise decided by a disability hearing officer, the responsibility for determining medical equivalence rests with either the disability hearing officer or, if the disability hearing

officer's reconsideration determination is changed under § 416.1418 of this part, with the Associate Commissioner for Disability Programs or his or her delegate. For cases at the administrative law judge or Appeals Council level, the responsibility for deciding medical equivalence rests with the administrative law judge or Appeals Council. In claims adjudicated at the Federal reviewing official, administrative law judge, and the Decision Review Board levels under the procedures in part 405 of this chapter, the responsibility for deciding medical equivalence rests with the Federal reviewing official, administrative law judge, or Decision Review Board.

20 C.F.R. § 416.1457 Dismissal of a request for a hearing before an administrative law judge.

An administrative law judge may dismiss a request for a hearing under any of the following conditions:

(a) At any time before notice of the hearing decision is mailed, you or the party or parties that requested the hearing ask to withdraw the request. This request may be submitted in writing to the administrative law judge or made orally at the hearing.

(b)(1)(i) Neither you nor the person you designate to act as your representative appears at the time and place set for the hearing and you have been notified before the time set for the hearing that your request for a hearing may be dismissed without further notice if you did not appear at the time and place of hearing, and good cause has not been found by the administrative law judge for your failure to appear; or

(ii) Neither you nor the person you designate to act as your representative appears at the time and place set for the hearing and within 10 days after the administrative law judge mails you a notice asking why you did not appear, you do not give a good reason for the failure to appear.

(2) In determining good cause or good reason under this paragraph, we will consider any physical, mental, educational, or linguistic limitations (including any lack of facility with the English language) which you may have.

(c) The administrative law judge decides that there is cause to dismiss a hearing request entirely or to refuse to consider any one or more of the issues because--

(1) The doctrine of res judicata applies in that we have made a previous determination or decision under this subpart about your rights on the same facts and on the same issue or issues, and this previous determination or decision has become final by either administrative or judicial action;

(2) The person requesting a hearing has no right to it under § 416.1430;

(3) You did not request a hearing within the stated time period and we have not extended the time for requesting a hearing under § 416.1433(c); or

(4) You die, there are no other parties, and we have no information to show that you may have a survivor who may be paid benefits due to you under § 416.542(b) and who wishes to pursue the request for hearing, or that you authorized interim assistance reimbursement to a State pursuant to section 1631(g) of the Act. The administrative law judge, however, will vacate a dismissal of the hearing request if, within 60 days after the date of the dismissal:

(i) A person claiming to be your survivor, who may be paid benefits due to you under § 416.542(b), submits a written request for a hearing, and shows that a decision on the issues that were to be considered at the hearing may adversely affect him or her; or

(ii) We receive information showing that you authorized interim assistance reimbursement to a State pursuant to section 1631(g) of the Act.

20 C.F.R. § 404.1512 Evidence.

(a) General. In general, you have to prove to us that you are blind or disabled. Therefore, you must bring to our attention everything that shows that you are blind or disabled. This means that you must furnish medical and other evidence that we can use to reach conclusions about your medical impairment(s) and, if material to the determination of whether you are blind or disabled, its effect on your ability to work on a sustained basis. We will consider only impairment(s) you say you have or about which we receive evidence.

(b) What we mean by "evidence." Evidence is anything you or anyone else submits to us or that we obtain that relates to your claim. This includes, but is not limited to:

(1) Objective medical evidence, that is, medical signs and laboratory findings as defined in § 404.1528 (b) and (c);

(2) Other evidence from medical sources, such as medical history, opinions, and statements about treatment you have received;

(3) Statements you or others make about your impairment(s), your restrictions, your daily activities, your efforts to work, or any other relevant statements you make to medical sources during the course of examination or treatment, or to us during interviews, on applications, in letters, and in testimony in our administrative proceedings;

(4) Information from other sources, as described in § 404.1513(d);

(5) Decisions by any governmental or nongovernmental agency about whether you are disabled or blind; and

(6) At the administrative law judge and Appeals Council levels, and at the reviewing official, administrative law judge, and Decision Review Board levels in claims adjudicated under the procedures in part 405 of this chapter, findings, other than the ultimate determination about whether you are disabled, made by State agency medical or psychological consultants and other program physicians or psychologists, and opinions based on their review of the evidence in your case record expressed by medical experts or psychological experts that we consult. See §§ 404.1527(f)(2) and (f)(3).

(c) Your responsibility. You must provide medical evidence showing that you have an impairment(s) and how severe it is during the time you say that you are disabled. You must provide evidence, without redaction, showing how your impairment(s) affects your functioning during the time you say that you are disabled, and any other information that we need to decide your claim. If we ask you, you must provide evidence about:

(1) Your age;

(2) Your education and training;

(3) Your work experience;

(4) Your daily activities both before and after the date you say that you became disabled;

(5) Your efforts to work; and

(6) Any other factors showing how your impairment(s) affects your ability to work. In §§ 404.1560 through 404.1569, we discuss in more detail the evidence we need when we consider vocational factors.

(d) Our responsibility. Before we make a determination that you are not disabled, we will develop your complete medical history for at least the 12 months preceding the month in which you file your application unless there is a reason to believe that development of an earlier period is necessary or unless you say that your disability began less than 12 months before you filed your application. We will make every reasonable effort to help you get medical reports from your own medical sources when you give us permission to request the reports.

(1) "Every reasonable effort" means that we will make an initial request for evidence from your medical source and, at any time between 10 and 20 calendar days after the initial request, if the evidence has not been received, we will make one followup request to obtain the medical evidence necessary to make a determination. The medical source will have a minimum of 10 calendar days from the date of our followup request to reply, unless our experience with that source indicates that a longer period is advisable in a particular case.

(2) By "complete medical history," we mean the records of your medical source(s) covering at least the 12 months preceding the month in which you file your application. If you say that your disability began less than 12 months before you filed your application, we will develop your complete medical history beginning with the month you say your disability began unless we have reason to believe your disability began earlier. If applicable, we will develop your complete medical history for the 12-month period prior to (1) the month you were last insured for disability insurance benefits (see § 404.130), (2) the month ending the 7-year period you may have to establish your disability and you are applying for widow's or widower's benefits based on disability (see § 404.335(c)(1)), or (3) the month you attain age 22 and you are applying for child's benefits based on disability (see § 404.350(e)).

(e) Recontacting medical sources. 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. To obtain the information, we will take the following actions.

(1) 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. In every instance where medical evidence is obtained over the telephone, the telephone report will be sent to the source for review, signature and return.

(2) 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.

(f) Need for consultative examination. If the information we need is not readily available from the records of your medical treatment source, or we are unable to seek clarification from your medical source, we will ask you to attend one or more consultative examinations at our expense. See §§ 404.1517 through 404.1519t for the rules governing the consultative examination process. Generally, we will not request a consultative examination until we have made every reasonable effort to obtain evidence from your own medical sources. However, in some instances, such as when a source is known to be unable to provide certain tests or procedures or is known to be nonproductive or uncooperative, we may order a consultative examination while awaiting receipt of medical source evidence. We will not evaluate this evidence until

we have made every reasonable effort to obtain evidence from your medical sources.

(g) Other work. In order to determine under § 404.1520(g) that you are able to make an adjustment to other work, we must provide evidence about the existence of work in the national economy that you can do (see §§ 404.1560 through 404.1569a), given your residual functional capacity (which we have already assessed, as described in § 404.1520(e)), age, education, and work experience.

20 C.F.R. Part 404, Subpart P, Appendix 1--Listing of Impairments

. . .

Part A

Criteria applicable to individuals age 18 and over and to children under age 18 where criteria are appropriate.

Sec.

1.00 Musculoskeletal System.

. . .

12.00 Mental Disorders.

. . .

1.00 Musculoskeletal System

A. Disorders of the musculoskeletal system may result from hereditary, congenital, or acquired pathologic processes. Impairments may result from infectious, inflammatory, or degenerative processes, traumatic or developmental events, or neoplastic, vascular, or toxic/metabolic diseases.

B. Loss of function.

1. General. Under this section, loss of function may be due to bone or joint deformity or destruction from any cause; miscellaneous disorders of the spine with or without radiculopathy or other neurological deficits; amputation; or fractures or soft tissue injuries, including burns, requiring prolonged periods of immobility or convalescence. For inflammatory arthritides that may result in loss of function because of inflammatory peripheral joint or axial arthritis or sequelae, or because of extra-articular features, see 14.00B6. Impairments with neurological causes are to be evaluated under 11.00ff.

2. How We Define Loss of Function in These Listings

a. General. Regardless of the cause(s) of a musculoskeletal impairment, functional loss for purposes of these listings is defined as the inability to ambulate effectively on a sustained basis for any reason, including pain associated with the underlying musculoskeletal impairment, or the inability to perform fine and gross movements effectively on a sustained basis for any reason, including pain associated with the underlying musculoskeletal impairment. The inability to ambulate effectively or the inability to perform fine and gross movements effectively must have lasted, or be expected to last, for at least 12 months. For the purposes of these criteria, consideration of the ability to perform these activities must be from a physical standpoint alone. When there is an inability to perform these activities due to a mental impairment, the criteria in 12.00ff are to be used. We will determine whether an individual can ambulate effectively or can perform fine and gross movements to

the individual's ability to perform the specific activities listed as examples in 1.00B2b(2) and 1.00B2c.

b. What We Mean by Inability to Ambulate Effectively

(1) Definition. Inability to ambulate effectively means an extreme limitation of the ability to walk; i.e., an impairment(s) that interferes very seriously with the individual's ability to independently initiate, sustain, or complete activities. Ineffective ambulation is defined generally as having insufficient lower extremity functioning (see 1.00J) to permit independent ambulation without the use of a hand-held assistive device(s) that limits the functioning of both upper extremities. (Listing 1.05C is an exception to this general definition because the individual has the use of only one upper extremity due to amputation of a hand.)

(2) To ambulate effectively, individuals must be capable of sustaining a reasonable walking pace over a sufficient distance to be able to carry out activities of daily living. They must have the ability to travel without companion assistance to and from a place of employment or school. Therefore, examples of ineffective ambulation include, but are not limited to, the inability to walk without the use of a walker, two crutches or two canes, the inability to walk a block at a reasonable pace on rough or uneven surfaces, the inability to use standard public transportation, the inability to carry out routine ambulatory activities, such as shopping and banking, and the inability to climb a few steps at a reasonable pace with the use of a single hand rail. The ability to walk independently about one's home

without the use of assistive devices does not, in and of itself, constitute effective ambulation.

c. What we mean by inability to perform fine and gross movements effectively. Inability to perform fine and gross movements effectively means an extreme loss of function of both upper extremities; i.e., an impairment(s) that interferes very seriously with the individual's ability to independently initiate, sustain, or complete activities. To use their upper extremities effectively, individuals must be capable of sustaining such functions as reaching, pushing, pulling, grasping, and fingering to be able to carry out activities of daily living. Therefore, examples of inability to perform fine and gross movements effectively include, but are not limited to, the inability to prepare a simple meal and feed oneself, the inability to take care of personal hygiene, the inability to sort and handle papers or files, and the inability to place files in a file cabinet at or above waist level.

d. Pain or other symptoms. Pain or other symptoms may be an important factor contributing to functional loss. In order for pain or other symptoms to be found to affect an individual's ability to perform basic work activities, medical signs or laboratory findings must show the existence of a medically determinable impairment(s) that could reasonably be expected to produce the pain or other symptoms. The musculoskeletal listings that include pain or other symptoms among their criteria also include criteria for limitations in functioning as a result of the listed impairment, including limitations caused by pain. It is, therefore, important to evaluate the intensity and

persistence of such pain or other symptoms carefully in order to determine their impact on the individual's functioning under these listings. See also §§ 404.1525(f) and 404.1529 of this part, and §§ 416.925(f) and 416.929 of part 416 of this chapter.

C. Diagnosis and Evaluation

1. General. Diagnosis and evaluation of musculoskeletal impairments should be supported, as applicable, by detailed descriptions of the joints, including ranges of motion, condition of the musculature (e.g., weakness, atrophy), sensory or reflex changes, circulatory deficits, and laboratory findings, including findings on x-ray or other appropriate medically acceptable imaging. Medically acceptable imaging includes, but is not limited to, x-ray imaging, computerized axial tomography (CAT scan) or magnetic resonance imaging (MRI), with or without contrast material, myelography, and radionuclear bone scans. "Appropriate" means that the technique used is the proper one to support the evaluation and diagnosis of the impairment.

2. Purchase of certain medically acceptable imaging. While any appropriate medically acceptable imaging is useful in establishing the diagnosis of musculoskeletal impairments, some tests, such as CAT scans and MRIs, are quite expensive, and we will not routinely purchase them. Some, such as myelograms, are invasive and may involve significant risk. We will not order such tests. However, when the results of any of these tests are part of the

existing evidence in the case record we will consider them together with the other relevant evidence.

3. Consideration of electrodiagnostic procedures. Electrodiagnostic procedures may be useful in establishing the clinical diagnosis, but do not constitute alternative criteria to the requirements of 1.04.

D. The physical examination must include a detailed description of the rheumatological, orthopedic, neurological, and other findings appropriate to the specific impairment being evaluated. These physical findings must be determined on the basis of objective observation during the examination and not simply a report of the individual's allegation; e.g., "He says his leg is weak, numb." Alternative testing methods should be used to verify the abnormal findings; e.g., a seated straight-leg raising test in addition to a supine straight-leg raising test. Because abnormal physical findings may be intermittent, their presence over a period of time must be established by a record of ongoing management and evaluation. Care must be taken to ascertain that the reported examination findings are consistent with the individual's daily activities.

E. Examination of the Spine

1. General. Examination of the spine should include a detailed description of gait, range of motion of the spine given quantitatively in degrees from the vertical position (zero degrees) or, for straight-leg raising from the sitting and supine position (zero degrees), any other appropriate tension signs, motor and sensory abnormalities, muscle

spasm, when present, and deep tendon reflexes. Observations of the individual during the examination should be reported; e.g., how he or she gets on and off the examination table. Inability to walk on the heels or toes, to squat, or to arise from a squatting position, when appropriate, may be considered evidence of significant motor loss. However, a report of atrophy is not acceptable as evidence of significant motor loss without circumferential measurements of both thighs and lower legs, or both upper and lower arms, as appropriate, at a stated point above and below the knee or elbow given in inches or centimeters. Additionally, a report of atrophy should be accompanied by measurement of the strength of the muscle(s) in question generally based on a grading system of 0 to 5, with 0 being complete loss of strength and 5 being maximum strength. A specific description of atrophy of hand muscles is acceptable without measurements of atrophy but should include measurements of grip and pinch strength.

2. When neurological abnormalities persist. Neurological abnormalities may not completely subside after treatment or with the passage of time. Therefore, residual neurological abnormalities that persist after it has been determined clinically or by direct surgical or other observation that the ongoing or progressive condition is no longer present will not satisfy the required findings in 1.04. More serious neurological deficits (paraparesis, paraplegia) are to be evaluated under the criteria in 11.00ff.

F. Major joints refers to the major peripheral joints, which are the hip, knee, shoulder, elbow, wrist-hand, and ankle-foot, as opposed to other peripheral joints (e.g., the joints of the hand or forefoot) or axial joints (i.e., the joints of the spine.) The wrist and hand are considered together as one major joint, as are the ankle and foot. Since only the ankle joint, which consists of the juncture of the bones of the lower leg (tibia and fibula) with the hindfoot (tarsal bones), but not the forefoot, is crucial to weight bearing, the ankle and foot are considered separately in evaluating weight bearing.

G. Measurements of joint motion are based on the techniques described in the chapter on the extremities, spine, and pelvis in the current edition of the "Guides to the Evaluation of Permanent Impairment" published by the American Medical Association.

H. Documentation

1. General. Musculoskeletal impairments frequently improve with time or respond to treatment. Therefore, a longitudinal clinical record is generally important for the assessment of severity and expected duration of an impairment unless the claim can be decided favorably on the basis of the current evidence.

2. Documentation of medically prescribed treatment and response. Many individuals, especially those who have listing-level impairments, will have received the benefit of medically prescribed treatment. Whenever evidence of such treatment is available it must be considered.

3. When there is no record of ongoing treatment. Some individuals will not have received ongoing treatment or have an ongoing relationship with the medical community despite the existence of a severe impairment(s). In such cases, evaluation will be made on the basis of the current objective medical evidence and other available evidence, taking into consideration the individual's medical history, symptoms, and medical source opinions. Even though an individual who does not receive treatment may not be able to show an impairment that meets the criteria of one of the musculoskeletal listings, the individual may have an impairment(s) equivalent in severity to one of the listed impairments or be disabled based on consideration of his or her residual functional capacity (RFC) and age, education and work experience.

4. Evaluation when the criteria of a musculoskeletal listing are not met. These listings are only examples of common musculoskeletal disorders that are severe enough to prevent a person from engaging in gainful activity. Therefore, in any case in which an individual has a medically determinable impairment that is not listed, an impairment that does not meet the requirements of a listing, or a combination of impairments no one of which meets the requirements of a listing, we will consider medical equivalence. (See §§ 404.1526 and 416.926.) Individuals who have an impairment(s) with a level of severity that does not meet or equal the criteria of the musculoskeletal listings may or may not have the RFC that would enable them to engage in substantial gainful activity. Evaluation of the impairment(s) of these individuals should proceed through the final steps of the

sequential evaluation process in §§ 404.1520 and 416.920 (or, as appropriate, the steps in the medical improvement review standard in §§ 404.1594 and 416.994).

I. Effects of Treatment

1. General. Treatments for musculoskeletal disorders may have beneficial effects or adverse side effects. Therefore, medical treatment (including surgical treatment) must be considered in terms of its effectiveness in ameliorating the signs, symptoms, and laboratory abnormalities of the disorder, and in terms of any side effects that may further limit the individual.

2. Response to treatment. Response to treatment and adverse consequences of treatment may vary widely. For example, a pain medication may relieve an individual's pain completely, partially, or not at all. It may also result in adverse effects, e.g., drowsiness, dizziness, or disorientation, that compromise the individual's ability to function. Therefore, each case must be considered on an individual basis, and include consideration of the effects of treatment on the individual's ability to function.

3. Documentation. A specific description of the drugs or treatment given (including surgery), dosage, frequency of administration, and a description of the complications or response to treatment should be obtained. The effects of treatment may be temporary or long-term. As such, the finding regarding the impact of treatment must be based on a sufficient period of treatment to permit proper consideration or judgment about future functioning.

J. Orthotic, Prosthetic, or Assistive Devices

1. General. Consistent with clinical practice, individuals with musculoskeletal impairments may be examined with and without the use of any orthotic, prosthetic, or assistive devices as explained in this section.

2. Orthotic devices. Examination should be with the orthotic device in place and should include an evaluation of the individual's maximum ability to function effectively with the orthosis. It is unnecessary to routinely evaluate the individual's ability to function without the orthosis in place. If the individual has difficulty with, or is unable to use, the orthotic device, the medical basis for the difficulty should be documented. In such cases, if the impairment involves a lower extremity or extremities, the examination should include information on the individual's ability to ambulate effectively without the device in place unless contraindicated by the medical judgment of a physician who has treated or examined the individual.

3. Prosthetic devices. Examination should be with the prosthetic device in place. In amputations involving a lower extremity or extremities, it is unnecessary to evaluate the individual's ability to walk without the prosthesis in place. However, the individual's medical ability to use a prosthesis to ambulate effectively, as defined in 1.00B2b, should be evaluated. The condition of the stump should be evaluated without the prosthesis in place.

4. Hand-held assistive devices. When an individual with an impairment involving a lower extremity or extremities uses a hand-held assistive device, such as a cane, crutch or walker, examination should be with and without the use of the assistive device unless contraindicated by the medical judgment of a physician who has treated or examined the individual. The individual's ability to ambulate with and without the device provides information as to whether, or the extent to which, the individual is able to ambulate without assistance. The medical basis for the use of any assistive device (e.g., instability, weakness) should be documented. The requirement to use a hand-held assistive device may also impact on the individual's functional capacity by virtue of the fact that one or both upper extremities are not available for such activities as lifting, carrying, pushing, and pulling.

K. Disorders of the spine, listed in 1.04, result in limitations because of distortion of the bony and ligamentous architecture of the spine and associated impingement on nerve roots (including the cauda equina) or spinal cord. Such impingement on nerve tissue may result from a herniated nucleus pulposus, spinal stenosis, arachnoiditis, or other miscellaneous conditions. Neurological abnormalities resulting from these disorders are to be evaluated by referral to the neurological listings in 11.00ff, as appropriate. (See also 1.00B and E.)

1. Herniated nucleus pulposus is a disorder frequently associated with the impingement of a nerve root. Nerve root compression results in a specific neuro-anatomic

distribution of symptoms and signs depending upon the nerve root(s) compromised.

2. Spinal Arachnoiditis

a. General. Spinal arachnoiditis is a condition characterized by adhesive thickening of the arachnoid which may cause intermittent ill-defined burning pain and sensory dysesthesia, and may cause neurogenic bladder or bowel incontinence when the cauda equina is involved.

b. Documentation. Although the cause of spinal arachnoiditis is not always clear, it may be associated with chronic compression or irritation of nerve roots (including the cauda equina) or the spinal cord. For example, there may be evidence of spinal stenosis, or a history of spinal trauma or meningitis. Diagnosis must be confirmed at the time of surgery by gross description, microscopic examination of biopsied tissue, or by findings on appropriate medically acceptable imaging. Arachnoiditis is sometimes used as a diagnosis when such a diagnosis is unsupported by clinical or laboratory findings. Therefore, care must be taken to ensure that the diagnosis is documented as described in 1.04B. Individuals with arachnoiditis, particularly when it involves the lumbosacral spine, are generally unable to sustain any given position or posture for more than a short period of time due to pain.

3. Lumbar spinal stenosis is a condition that may occur in association with degenerative processes, or as a result of a congenital anomaly or trauma, or in association with

Paget's disease of the bone. Pseudoclaudication, which may result from lumbar spinal stenosis, is manifested as pain and weakness, and may impair ambulation. Symptoms are usually bilateral, in the low back, buttocks, or thighs, although some individuals may experience only leg pain and, in a few cases, the leg pain may be unilateral. The pain generally does not follow a particular neuro-anatomical distribution, i.e., it is distinctly different from the radicular type of pain seen with a herniated intervertebral disc, is often of a dull, aching quality, which may be described as "discomfort" or an "unpleasant sensation," or may be of even greater severity, usually in the low back and radiating into the buttocks region bilaterally. The pain is provoked by extension of the spine, as in walking or merely standing, but is reduced by leaning forward. The distance the individual has to walk before the pain comes on may vary. Pseudoclaudication differs from peripheral vascular claudication in several ways. Pedal pulses and Doppler examinations are unaffected by pseudoclaudication. Leg pain resulting from peripheral vascular claudication involves the calves, and the leg pain in vascular claudication is ordinarily more severe than any back pain that may also be present. An individual with vascular claudication will experience pain after walking the same distance time after time, and the pain will be relieved quickly when walking stops.

4. Other miscellaneous conditions that may cause weakness of the lower extremities, sensory changes, areflexia, trophic ulceration, bladder or bowel incontinence, and that should be evaluated under 1.04 include, but are not limited to, osteoarthritis, degenerative

disc disease, facet arthritis, and vertebral fracture. Disorders such as spinal dysrhaphism (e.g., spina bifida), diastematomyelia, and tethered cord syndrome may also cause such abnormalities. In these cases, there may be gait difficulty and deformity of the lower extremities based on neurological abnormalities, and the neurological effects are to be evaluated under the criteria in 11.00ff.

L. Abnormal curvatures of the spine. Abnormal curvatures of the spine (specifically, scoliosis, kyphosis and kyphoscoliosis) can result in impaired ambulation, but may also adversely affect functioning in body systems other than the musculoskeletal system. For example, an individual's ability to breathe may be affected; there may be cardiac difficulties (e.g., impaired myocardial function); or there may be disfigurement resulting in withdrawal or isolation. When there is impaired ambulation, evaluation of equivalence may be made by reference to 14.09A. When the abnormal curvature of the spine results in symptoms related to fixation of the dorsolumbar or cervical spine, evaluation of equivalence may be made by reference to 14.09B. When there is respiratory or cardiac involvement or an associated mental disorder, evaluation may be made under 3.00ff, 4.00ff, or 12.00ff, as appropriate. Other consequences should be evaluated according to the listing for the affected body system.

M. Under continuing surgical management, as used in 1.07 and 1.08, refers to surgical procedures and any other associated treatments related to the efforts directed toward the salvage or restoration of functional use of the affected

part. It may include such factors as post-surgical procedures, surgical complications, infections, or other medical complications, related illnesses, or related treatments that delay the individual's attainment of maximum benefit from therapy. When burns are not under continuing surgical management, see 8.00F.

N. After maximum benefit from therapy has been achieved in situations involving fractures of an upper extremity (1.07), or soft tissue injuries (1.08), i.e., there have been no significant changes in physical findings or on appropriate medically acceptable imaging for any 6-month period after the last definitive surgical procedure or other medical intervention, evaluation must be made on the basis of the demonstrable residuals, if any. A finding that 1.07 or 1.08 is met must be based on a consideration of the symptoms, signs, and laboratory findings associated with recent or anticipated surgical procedures and the resulting recuperative periods, including any related medical complications, such as infections, illnesses, and therapies which impede or delay the efforts toward restoration of function. Generally, when there has been no surgical or medical intervention for 6 months after the last definitive surgical procedure, it can be concluded that maximum therapeutic benefit has been reached. Evaluation at this point must be made on the basis of the demonstrable residual limitations, if any, considering the individual's impairment-related symptoms, signs, and laboratory findings, any residual symptoms, signs, and laboratory findings associated with such surgeries, complications, and recuperative periods, and other relevant evidence.

O. Major function of the face and head, for purposes of listing 1.08, relates to impact on any or all of the activities involving vision, hearing, speech, mastication, and the initiation of the digestive process.

P. When surgical procedures have been performed, documentation should include a copy of the operative notes and available pathology reports.

Q. Effects of obesity. Obesity is a medically determinable impairment that is often associated with disturbance of the musculoskeletal system, and disturbance of this system can be a major cause of disability in individuals with obesity. The combined effects of obesity with musculoskeletal impairments can be greater than the effects of each of the impairments considered separately. Therefore, when determining whether an individual with obesity has a listing-level impairment or combination of impairments, and when assessing a claim at other steps of the sequential evaluation process, including when assessing an individual's residual functional capacity, adjudicators must consider any additional and cumulative effects of obesity.

1.01 Category of Impairments, Musculoskeletal

1.02 Major dysfunction of a joint(s) (due to any cause): Characterized by gross anatomical deformity (e.g., subluxation, contracture, bony or fibrous ankylosis, instability) and chronic joint pain and stiffness with signs of limitation of motion or other abnormal motion of the affected joint(s), and findings on appropriate medically

acceptable imaging of joint space narrowing, bony destruction, or ankylosis of the affected joint(s). With:

A. Involvement of one major peripheral weight-bearing joint (i.e., hip, knee, or ankle), resulting in inability to ambulate effectively, as defined in 1.00B2b;

or

B. Involvement of one major peripheral joint in each upper extremity (i.e., shoulder, elbow, or wrist-hand), resulting in inability to perform fine and gross movements effectively, as defined in 1.00B2c.

1.03 Reconstructive surgery or surgical arthrodesis of a major weight-bearing joint, with inability to ambulate effectively, as defined in 1.00B2b, and return to effective ambulation did not occur, or is not expected to occur, within 12 months of onset.

1.04 Disorders of the spine (e.g., herniated nucleus pulposus, spinal arachnoiditis, spinal stenosis, osteoarthritis, degenerative disc disease, facet arthritis, vertebral fracture), resulting in compromise of a nerve root (including the cauda equina) or the spinal cord. With:

A. Evidence of nerve root compression characterized by neuro-anatomic distribution of pain, limitation of motion of the spine, motor loss (atrophy with associated muscle weakness or muscle weakness) accompanied by sensory or

reflex loss and, if there is involvement of the lower back, positive straight-leg raising test (sitting and supine);

or

B. Spinal arachnoiditis, confirmed by an operative note or pathology report of tissue biopsy, or by appropriate medically acceptable imaging, manifested by severe burning or painful dysesthesia, resulting in the need for changes in position or posture more than once every 2 hours;

or

C. Lumbar spinal stenosis resulting in pseudoclaudication, established by findings on appropriate medically acceptable imaging, manifested by chronic nonradicular pain and weakness, and resulting in inability to ambulate effectively, as defined in 1.00B2b.

1.05 Amputation (due to any cause).

A. Both hands;

or

B. One or both lower extremities at or above the tarsal region, with stump complications resulting in medical inability to use a prosthetic device to ambulate effectively, as defined in 1.00B2b, which have lasted or are expected to last for at least 12 months;

or

C. One hand and one lower extremity at or above the tarsal region, with inability to ambulate effectively, as defined in 1.00B2b;

or

D. Hemipelvectomy or hip disarticulation.

1.06 Fracture of the femur, tibia, pelvis, or one or more of the tarsal bones. With:

A. Solid union not evident on appropriate medically acceptable imaging and not clinically solid;

and

B. Inability to ambulate effectively, as defined in 1.00B2b, and return to effective ambulation did not occur or is not expected to occur within 12 months of onset.

1.07 Fracture of an upper extremity with nonunion of a fracture of the shaft of the humerus, radius, or ulna, under continuing surgical management, as defined in 1.00M, directed toward restoration of functional use of the extremity, and such function was not restored or expected to be restored within 12 months of onset.

1.08 Soft tissue injury (e.g., burns) of an upper or lower extremity, trunk, or face and head, under continuing surgical management, as defined in 1.00M, directed toward the salvage or restoration of major function, and such major function was not restored or

expected to be restored within 12 months of onset. Major function of the face and head is described in 1.000.

. . .

12.04 Affective Disorders: Characterized by a disturbance of mood, accompanied by a full or partial manic or depressive syndrome. Mood refers to a prolonged emotion that colors the whole psychic life; it generally involves either depression or elation.

The required level of severity for these disorders is met when the requirements in both A and B are satisfied, or when the requirements in C are satisfied.

A. Medically documented persistence, either continuous or intermittent, of one of the following:

1. Depressive syndrome characterized by at least four of the following:

a. Anhedonia or pervasive loss of interest in almost all activities; or

b. Appetite disturbance with change in weight; or

c. Sleep disturbance; or

d. Psychomotor agitation or retardation; or

e. Decreased energy; or

f. Feelings of guilt or worthlessness; or

g. Difficulty concentrating or thinking; or

h. Thoughts of suicide; or

i. Hallucinations, delusions or paranoid thinking; or

2. Manic syndrome characterized by at least three of the following:

a. Hyperactivity; or

b. Pressure of speech; or

c. Flight of ideas; or

d. Inflated self-esteem; or

e. Decreased need for sleep; or

f. Easy distractibility; or

g. Involvement in activities that have a high probability of painful consequences which are not recognized; or

h. Hallucinations, delusions or paranoid thinking;

Or

3. Bipolar syndrome with a history of episodic periods manifested by the full symptomatic picture of both manic

and depressive syndromes (and currently characterized by either or both syndromes);

And

B. Resulting in at least two of the following:

1. Marked restriction of activities of daily living; or

2. Marked difficulties in maintaining social functioning; or

3. Marked difficulties in maintaining concentration, persistence, or pace; or

4. Repeated episodes of decompensation, each of extended duration;

Or

C. Medically documented history of a chronic affective disorder of at least 2 years' duration that has caused more than a minimal limitation of ability to do basic work activities, with symptoms or signs currently attenuated by medication or psychosocial support, and one of the following:

1. Repeated episodes of decompensation, each of extended duration; or

2. 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; or

3. Current history of 1 or more years' inability to function outside a highly supportive living arrangement, with an indication of continued need for such an arrangement.

SSR 83-14, 1983-1991 Soc.Sec.Rep.Serv. 41, 1983 WL 31254 (S.S.A.)

Program Policy Statement

TITLES II AND XVI: CAPABILITY TO DO OTHER WORK--THEMEDICAL-VOCATIONAL RULES AS A FRAMEWORK FOR EVALUATING A COMBINATION OF EXERTIONAL AND NONEXERTIONAL IMPAIRMENTS

SSR 83-14
(PPS-105)

1983

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

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

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

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

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

POLICY STATEMENT: The term “exertional” has the same meaning in the regulations as it has in the United States Department of Labor's publication, the *Dictionary of Occupational Titles* (DOT). In the DOT supplement, *Selected Characteristics of Occupations Defined in the Dictionary of Occupational Titles* (SCO), occupations are classified as sedentary, light, medium, heavy, and very heavy according to the degree of primary strength requirements of the occupations. These consist of three

work positions (standing, walking, and sitting) and four worker movements of objects (lifting, carrying, pushing, and pulling).

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

Effects of Nonexertional Impairments

Maintaining body equilibrium; using the fingers and finger tips to work with small objects; using the eyes and ears to see and hear; and using the vocal apparatus to speak are considered nonexertional activities. Limitations

of these functions can affect the capacity to perform certain jobs at all levels of physical exertion. An entire range of jobs can be severely compromised. For example, section 201.00(h) of Appendix 2 calls attention to the fact that bilateral manual dexterity is necessary for the performance of substantially all unskilled sedentary occupations.

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

Working conditions (environmental demands) which a person may not be able to tolerate as a result of an impairment include exposure to extremes of heat or cold,

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

After it has been decided that an impaired person can meet the primary strength requirements of sedentary, light, or medium work--sitting, standing, walking, lifting, carrying, pushing, and pulling--a further decision may be required as to how much of this potential occupational base remains, considering certain nonexertional limitations which the person may also have. For example, at all exertional levels, a person must have certain use of the arms and head to grasp, hold, turn, raise, and lower objects. Most sedentary jobs require good use of the hands and fingers. In jobs performed in a seated position which require the operation of pedals or treadles, a person must have the use of his or her legs and feet. Relatively few jobs in the national economy require ascending or descending ladders and scaffolding. Two types of bending must be done frequently (from one-third to two-thirds of the time) in most medium, heavy, and very heavy jobs because of the positions of objects to be lifted, the amounts of weights to be moved, and the required repetitions. They are stooping (bending the body downward and forward by

bending the spine at the waist) and crouching (bending the body downward and forward by bending both the legs and spine). However, to perform substantially all of the exertional requirements of most sedentary and light jobs, a person would not need to crouch and would need to stoop only occasionally (from very little up to one-third of the time, depending on the particular job).

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

Evaluating the Claim

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

the case in accordance with the definitions and discussions of each factor in the appropriate sections of the regulations, which will provide insight into the adjudicative weight to be accorded each factor."

Disabled Based on Strength Limitations Alone

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

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

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

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

Use of a vocational resource may be helpful in the evaluation of what appear to be "obvious" types of cases. In more complex situations, the assistance of a vocational resource may be necessary. The publications listed in sections 404.1566 and 416.966 of the regulations will be sufficient for relatively simple issues. In more complex cases, a person or persons with specialized knowledge would be helpful. State agencies may use personnel termed

vocational consultants or specialists, or they may purchase the services of vocational evaluation workshops. Vocational experts may testify for this purpose at the hearing and Appeals Council levels. In this PPS, the term vocational specialist (VS) describes all vocational resource personnel.

Examples of Evaluation Involving Combinations of Exertional and Nonexertional Limitations

1. *Sedentary exertion combined with a nonexertional impairment*. Example 1 of section 201.00(h) in Appendix 2 illustrates a limitation to unskilled sedentary work with an additional loss of bilateral manual dexterity that is significant and, thus, warrants a conclusion of "Disabled." (The bulk of unskilled sedentary jobs requires bilateral manual dexterity.) An example of nonexertional impairment which ordinarily has an insignificant effect on a person's ability to work is an allergy to ragweed pollen. Many individuals who have this allergy experience no more discomfort during the ragweed season than someone who has a common cold. However, others are more affected by the condition. Assuming that an individual has a severe impairment of the low back which limits that person to sedentary work, and that the assessment of RFC also restricts him or her from workplaces which involve exposure to ragweed pollen, the implications for adjustment to sedentary work are relatively clear. Ragweed grows outdoors and its pollen is carried in

the air, but the overwhelming majority of sedentary jobs are performed indoors. Therefore, with the possible exclusion of some outdoor sedentary occupations which would require exposure to ragweed pollen, the unskilled sedentary occupational base is not significantly compromised. The decisionmaker may need the assistance of a VS in determining the significance of the remaining occupational base of unskilled sedentary work in more difficult cases.

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

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

On the other hand, there are nonexertional limitations or restrictions which have very little or no effect on the unskilled light occupational base. Examples are inability to ascend or descend scaffolding, poles, and ropes; inability to crawl on hands and knees; and inability to use the finger tips to sense the temperature or texture of an object. Environmental restrictions, such as the need to avoid exposure to feathers, would also not significantly affect the potential unskilled light occupational base.

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

3. *Medium exertion combined with a nonexertional impairment.* Most medium jobs, like most light jobs, require the worker to stand or walk most of the time. Also, as in light work, most unskilled medium jobs require gross use of the hands to grasp, hold, and turn

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

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

As in light work, inability to use the finger tips to sense the temperature or texture of an object is an example of a nonexertional limitation which would

have very little effect on the potential unskilled medium occupational base. The need to avoid environments which contain objects or substances commonly known not to exist in most workplaces would be an obvious example of a restriction which does not significantly affect the medium occupational base.

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

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

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

In reaching judgments as to the sufficiency of the remaining exertional job base (approximately 2,500

unskilled medium, light, and sedentary occupations, approximately 1,600 unskilled light and sedentary occupations, and approximately 200 unskilled sedentary occupations), there are three possible situations to consider:

1. Where it is clear that the additional limitation or restriction has very little effect on the exertional occupational base, the conclusion directed by the appropriate rule in Tables No. 1, 2, or 3 would not be affected.

2. Where it is clear that additional limitations or restrictions have significantly eroded the exertional job base set by the exertional limitations alone, the remaining portion of the job base will guide the decision.

3. Where the adjudicator does not have a clear understanding of the effects of additional limitations on the job base, the services of a VS will be necessary.

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

CROSS-REFERENCES: Program Operations Manual System, Part 4 (Disability Insurance State Manual Procedures), section DI 2388. A.5.b.; SSR 83-10,

PPS-101, Determining Capability to Do Other Work--The Medical-Vocational Rules of Appendix 2 (with a glossary); SSR 83-11, PPS-102, Capability to Do Other Work-- The Exertionally Based Medical-Vocational Rules Met; SSR 83-12, PPS-103, Capability to Do Other Work--The Medical-Vocational Rules as a Framework for Evaluating Exertional Limitations Within a Range of Work or Between Ranges of Work; and SSR 83-13, PPS-104, Capability to Do Other Work--The Medical-Vocational Rules as a Framework for Evaluating Solely Nonexertional Impairments.

Social Security Administration
Department of Health and Human Services

ANTI-VIRUS CERTIFICATION

Case Name: Wright v. Astrue

Docket Number: 06-4568-cv

I, Louis Bracco, hereby certify that the Appellee's Brief submitted in PDF form as an e-mail attachment to **briefs@ca2.uscourts.gov** in the above referenced case, was scanned using CA Software Anti-Virus Release 8.3.02 (with updated virus definition file as of 6/5/2007) and found to be VIRUS FREE.

Louis Bracco
Record Press, Inc.

Dated: June 5, 2007