SOCIAL SECURITY ADMINISTRATION

OCCUPATIONAL INFORMATION DEVELOPMENT

ADVISORY PANEL QUARTERLY MEETING

APRIL 27, 2009

SHERATON - ATLANTA HOTEL

ATLANTA, GEORGIA

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C O N T E N T S

ITEM:

C O N T E N T S (CON'T.)

P R O C E E D I N G S

MS. TIDWELL-PETERS: Good morning, and welcome to the quarterly meeting of the Occupational Information Development Advisory Panel. This is the Panel's second meeting. We're happy to be here in Atlanta.

My name is Debra Tidwell-Peters, and I am the Designated Federal Officer for the Panel. If you need any information throughout the Panel, please feel free to contact me. Now, I'm going to turn the meeting over to our interim chair, Dr. Mary Barros-Bailey.

DR. BARROS-BAILEY: Thank you. Good morning, everybody. I would like to just start by maybe having the Panel members -- welcoming everybody here, first of all; and maybe having the Panel meetings go around and say your name so everybody here knows who you are.

MS. TIDWELL-PETERS: Just a moment. I am sorry. For the Panel we're having bit of a technical glitch this morning -- we're having just a technical glitch this morning. We will need to use, until our

break, the karaoke mike. Feel free to pass this from panel member to panel member and pick up at the right verse. We will be fixed by the break.

DR. SCHRETLEN: All right. Thank you. My name is David Schretlen. I'm a neuropsychologist on the faculty at Jones Hopkins University in the Department of Psychiatry. And I'm involved in the cognitive behavioral subcommittee of this Panel.

MR. HARDY: Good morning, everyone. I'm Thomas Hardy. I'm from Philadelphia.

MS. KARMAN: Good morning, everybody. I'm Sylvia Karman. I am the Director for the Occupational Information Development Project.

MS. SHOR: I'm Nancy Shor, Executive Director NOSSCR, National Organization of Social Security Claimants' Representatives.

DR. WILSON: Excellent. My name is Mark Wilson from North Carolina State University. I'm an industrial psychologist; and I'm on the work taxonomy subcommittee.

MR. WOODS: My name is Jim Woods, private consultant, retired from the U.S. Department of

Labor.

MS. LECHNER: Hi, I'm Debra Lechner. I'm a physical therapist, former faculty member at University of Alabama, Birmingham; and now the President of ErgoScience.

DR. FRASER: Bob Fraser, Director of Neurological Vocational Services for the University of Washington. I am a rehabilitation psychologist and counselor, with the cognitive behavioral subcommittee.

MS. RUTTLEDGE: Good morning. I'm Lynnae Ruttledge. I am the Director of Vocational Rehabilitation. I'm on the transferable skills subcommittee.

DR. BARROS-BAILEY: Good morning. Thank you. My name is Mary Barros, and I am a rehab counselor in Boise, Idaho.

I wanted to welcome everybody to our first quarterly meeting of the Occupational Information Advisory Panel. So before we get started, I would like to -- in terms of the formal business, I would like to thank all the work of the Panel and the SSA

staff over the last couple months that we have been involved in this process. It's been very, very impressive. We have one of our panel members, Shanan Gwaltney Gibson, who is available to us telephonically. She will be here on Wednesday.

DR. GIBSON: Good morning, everybody.

DR. BARROS-BAILEY: Thanks, Shanan for piping in. I will be asking you to pipe in once in a while, and that will remind us that you are there.

So the first order of business that I would like us to turn to is the charter for the OIDAP. And it's the first piece of paper in our binders here. The charter outlines the mission of the Panel, and it is to provide independent advice and recommendations to Commissioner Astrue and the Social Security Administration on its plans and activities to replace the Dictionary of Occupational Titles used in the Social Security Administration's disability determination process.

The Panel will advise the Agency on creating an occupational information system that's tailored to specifically address SSA's disability

programs and adjudicative needs. Commissioner Astrue has asked that the Panel deliver its recommendations to the type of occupational information that SSA should collect, and have the recommendation by September, 2009.

I think we have talked about this before. We're aware of this deliverable in September, and I just want to make sure that we start this meeting with that in mind.

As we have gone through this process and through the inaugural meeting, we established five subcommittees. And the subcommittees we're looking at taxonomies, physical demands, mental and cognitive demands, user needs -- and we call that the RFC; but it's user needs; and visits -- site visits to learn more about DDS and ODAR.

In addition, as we have gone through this process, I felt that it was necessary to establish another subcommittee; and the subcommittee was that of transferable skills analysis. The subcommittee is going to be helping the Panel to ensure that its recommendations regarding the content model address

SSA's occupational information needs, specifically addressing claimant work histories and the extent to which skills may transfer. And I would like to introduce to you the members of the subcommittee starting with the subcommittee chair, Tom Hardy, who will just announce who is on that subcommittee.

MR. HARDY: Good morning, everyone. On the subcommittee I will be the chair. It will also include Mary Barros, Sylvia Karman, Lynnae Ruttledge, Nancy Shor, and Tim Woods. And we will be meeting probably today at some point to start talking about how to organize the work of the subcommittee.

DR. BARROS-BAILEY: Thank you, Tom.

As we are looking forward to the next few days, I just want to kind of briefly go through what the agenda is going to look like. Today we've going to have an electronic demonstration of an adult disability case that kind of flowed out of the inaugural meeting. This is going to be followed by perspectives from vocational experts, claimant reps, and administrative and appeals judges looking at that case. So doing a simulation across the Board as we

go through the process.

And at the end of the day on Tuesday we will have public comment; then on Wednesday we will hold quite a bit of Panel discussion, deliberation, and administrative meeting to conclude on Wednesday at 3:00 p.m.

One of the things that has -- is helping us through this process is the road map that was put together. And you will see that road map on the second item in our process. And I just want to, as a road map goes, and kind of do the little start where are we along that road map, so we have kind of a sense of where we're going and where we are right now.

As you are going through -- does everybody have that?

It's after the biographies? Okay.

Part one of that road map is completed. That was done during the inaugural meeting.

As we go through part two, there were a couple of documents that had been completed at the inaugural meeting, which is chapter one and chapter

two. And we are now through chapter three of part two -- or we are in the process of working on chapter three of part two. And then as we flip to part three, the plans and methods, we have gone through the first few chapters in that. We are in the process of the fourth chapter, developing a content model, and about the third point along that process. Is that correct? Okay.

As we go through chapter five as well, we're also about starting that process in terms of the classification model, developing a classification system. So looking at that as also a deliverable along with the content model.

Sylvia, do you want anything else -- to say anything else about the road map at this point?

MS. KARMAN: Sorry about that. Just that people might note that the paper for SSA's proposed plan and methods for developing a content model is in the back of the binders; and that's a longer, more detailed version of the "What is a Content Model" paper that we prepared for the inaugural meeting. So just not to confuse that, because you now have two

papers about content model.

And we're also working on a paper for SSA's concerns of DOT, and then what can SSA build on from DOT and O*Net will flow from that. And we're also working on SSA's proposed plans for developing a classification system so that the Panel will have that as -- something as a platform to begin deliberation for that through September. Thanks.

DR. BARROS-BAILEY: Thank you.

Now, to begin our day, I would like to welcome members of the Occupational Information System Development work team. John Owen is the Deputy Director of the Division of Disability Determination Services Operation -- Operation Support. Tom Jones is the branch chief of Disability Quality Branch, the Dallas Office of Quality Performance; and Shirleen Roth is a Social Insurance Specialist on the Occupational Information Development team in the Office of Program Development and Research. They're going to be presenting to us this morning. Thank you for being here.

So I guess we will just go ahead and get

started, and turn it over to you. Thank you.

MR. OWEN: Thank you. Can you hear me?

MS. ROTH: Good morning. Thank you for the opportunity to present this case to you. This is a sample adult disability claim. It was developed so that we might present to you the entire process that we use to evaluate and adjudicate for the adults. It is not a real case, but it's representative of the type of cases that we receive. But I do want to point out to you, even though it's a sample case, we would like you to keep it real in the sense that all of our disability cases we may see them -- we may see them represented in paper; but they're real people with real needs, real concerns, and most of them at very difficult points in their lives.

So as we work through this process try not to think of this in terms of being a sample case or a piece of paper. Try to think of this as being a person in the real world who we're trying to look through and get a good picture of what their situation is.

So what my plan is -- you have all received

paper copies of the sample case. They're in a yellow folder in front of you. Those yellow folders are the kind of folders we use at a point in time where we're still processing cases in paper. We now process the majority of our cases electronically, but our electronic folders look just like those paper folders. They're organized in the same way. And if you notice, everything that you will see before you is in the back two sections. One is the back blue section, and the other is the back yellow section. So if you would turn to that.

You will notice that each of the documents is tabbed. Now, normally, our adjudicators don't have those tabs, although, those tabs are in the way we create an electronic environment. We put those tabs there for you, so as our presenters are moving through the case, you will be able to quickly and easily refer to the different documents that they're talking about. So each of those documents have been named for you.

What I'm going to be doing is to introduce all of the presenters. Mary Barros has already

introduced the three of us.

Thank you, Mary.

I'm going to also mention to you all of the other presenters that will come after us working from the same case and walk through what's going to happen in the next day and a half.

If you would, on the blue section where there is a caveat that says, "this is a sample case." Turn that page over and directly underneath it is that first page. Just lift that up. And underneath there is a road map. There is a document that is going to say "road map."

You open it up, you have a blue section on the left, and a yellow section on the right. On the left-hand side, just lift up that top sheet of paper, and underneath it, it says "road map." That is our road map for the next few days.

And basically, what I want you to understand is how we're going to move through the case, and that will allow you to -- basically, we're going to answer your questions at the point and time in the process when it applies. We don't want you to

hold your questions. If you have a question, ask immediately. We will write that question down and then answer it at the appointed time in the presentation that it will fit.

So the first presentation is going to come from John Owen. He is going to provide a discussion of the field office claim intake and DDS initial case developments of the medical and vocational evidence. And this is going to include a description of claimant -- how the claimant initiates contact with Social Security. The field office interview, the certified electronic file, and the DDS legacy system -- that's the case processing system that the DDS uses. He is going to talk to you about the DDS intake review, and then the initial development of medical and vocational evidence.

Part two of the presentation is going to be from Tom Johns who has already been introduced. His first presentation is going to be a discussion of the evaluation of the physical impairments in the case. His presentation will include descriptions of the evaluation of the information that we receive from

the claimant and evaluation of evidence -- the medical evidence in the file, and then the assessment of the physical residual functional capacity, or what we call the RFC.

His second presentation at part three will be a discussion of the evaluation of the mental impairments. And at that point and time that will basically mirror what he did for physical impairments, again, going through claimant evidence that we receive from the claimant, the evidence that we receive from medical sources, and how we evaluate that evidence.

The fourth part of the demonstration I'm going to be presenting to you. And that's going to be the vocational evaluation of the claimant's ability to do past relevant work. Now I'm going to preface that part by giving you a demonstration of one of the software products that we used to make these evaluations. The software product that we brought with us today is called OccuBrowse. It's by Vertek, Incorporated here in Washington state. The version that we have is actually a Social Security

version. It is not the commercial version, so it does not have some of the functionality that the commercial versions have, but it meets our needs.

And during the discussion of the claimant's abilities to do past work, I'm going to be talking about review and evaluation of the claimant work history and information. A discussion of what is past relevant work. We touched on that last time. We will be going into that in more detail. Evaluation of the claimant's ability to do past work as the claimant actually performed it; and then, evaluation of the claimant's ability to do past work as it's performed in the national economy.

I will also be presenting part five, which is a further discussion of the vocational evaluation. That part of the discussion has to do with the claimant's ability to do other work. And during that, I will discuss consideration of age, education, work experience, medical and vocational guidelines, occupational base, and transferability of skills.

Following that, part six would be presented by two of the judges in our Office of Disability

Adjudication and Review. Judge Cam Oetter is an Administrative Law Judge in the hearing office in Macon, Georgia. And Judge Robert Goldberg is an Administrative Appeals Judge, the Office of Appellate Operations, Office of Disability Adjudication and Review.

Judge Oetter will be discussing adjudication of evidence by the administrative law judge, which will include identification of the claimant's vocational profile, age, education, and work experience. Identification of the claimant's past work. Determination of the hypothetical that will include the claimant's residual functional capacity. A comparison of the RFC hypotheticals with the job demands of past work. A comparison of the RFC hypotheticals and the vocational profile with the medical vocational guidelines and availability of other work.

Then Judge Goldberg will be discussing the review by the Appeals Council of the case, including the application of the substantial evidence standard of review, the review of all the findings, a

comparison of the vocational finding with the evidence, regulations, vocational expert testimony, and Dictionary of Occupational Titles.

We will then discuss ensuring the identifying of past relevant work, satisfying regulatory criteria, and assuring the consistency of the vocational evidence and the DOT information.

Then tomorrow you will be receiving presentations on perspectives on the sample case from vocational experts, Scott T. Stipe, Career Directions Northwest; Scott Stipe & Associates, Incorporated, and from Lynn Tracy of Lynn Tracy and Associates. That will be followed by presentations on perspectives on the sample case from the claimant representatives Art Kaufman of Accu-Pro Disability Advocates; and Charles L. Martin of Martin and Jones.

We hope that the case demonstration provides unique insight into the adjudication of disability claims by Social Security, as well as the perspective on the type of occupational information that Social Security needs to do the adjudication. So as you listen to the presentations I ask you to

consider the elements that you will be recommending to be included in the content model. I suggest that Social Security will want to be sure that the content model includes only those elements which are defensible, and for which the Agency has a clear use.

I believe that we all have an interest in developing occupational information that provides for an accurate and clear decision on the claimant's request for benefits. We also need to ensure that the content model items do not create vulnerability either for the claimant or for Social Security.

And one last comment before we go on. We're going to be discussing today Social Security policy. We can't get away from that. Because the policy describes what we do and why we do it. But keep in mind that we recognize that just as the Dictionary of Occupational Titles informed our policy back when it was first crafted in the '60's and '70's, so will this new occupational system inform our policy development as we go forward.

So we thank you for your attention, and I would like to turn the presentation over to John

Owen. John.

MR. OWEN: Thanks, Shirleen.

I'm going to talk about, initially, how the case gets to the DDS, the Disability Determination Services office where a medical determination is made. There are many avenues in which a claimant or applicant can approach SSA. They can call the 800 number and talk to someone at the telephone service center and ask questions that lead to a request for application. There is also an internet process that you can use to negotiate your claim.

You can call your local field office out of the telephone book and talk to someone. And during that conversation they might determine that you need -- that you might qualify -- or the avenue that you need to take is to apply for disability, in which case they will send you a starter kit. They also might send you out to the telephone service center to answer that call.

You also might walk into a local field office and say, I am hearing disabled. What do I need to get benefits? Or you may have a claimant

representative approach SSA on your behalf.

So there are many different ways that someone might present themselves to SSA to initiate an application or the application process. In most cases where you are not walking into a field office, generally, they do send out what's called a starter kit, which is a three page questionnaire that asks some simple questions about your work history, about your income and resources, and about the impairment from which you indicate that you might be disabled, along with some information about dates when that impairment began.

Once you have got the starter kit returned to the field office, the field office representative will generally set up a disability interview to go over the answers that you provided, and while doing so, the -- actually, it's the field office representative that will complete the -- what appears to us to be a form in the electronic environment. A form that used to be exclusively in paper, called the SSA-3368, which is the adult disability report. It is the report that drives a lot of the beginning of

the application and development at the DDS.

In addition to that, you have the 3373 -- I'm sorry, 3367, which is also under a tab in your book, disability report field office. It provides some technical information that is used by the DDS to determine when they need to begin looking at possible medical onset.

Also, there is some additional development that might -- that form might lead you to about other issues regarding onset and how that might be affected by work that you did after you became disabled or your impairment began to affect you to where you believed you were disabled. That is done during the disability interview process.

Now, a lot of these people, claimants or applicants when they approach the SSA, they -- a lot of people have heard of Social Security; but not everyone -- some people have heard of disability. They have heard through their friends there is this disability program. But what a lot of people don't understand is that there is many different Social Security programs in which a person can receive

disability benefits.

There is the -- one title of the program is someone paid into Social Security a certain number of quarters, and thereby, they have some insurance for themselves, or perhaps their spouse, or their child. Other individuals might qualify for a different program or you might qualify for both programs. If your income and resources are low enough, you might also qualify for Social Security Income, which is SSI.

So when the applicant usually approaches the SSA, they don't know all the programs that are available usually; and it's really the field office representatives job to gather enough information to create an application or help them submit an application for any benefit for which they might be eligible on a technical basis.

Now, everything is technical that we do. But when -- from a DDS perspective and when you hear a disability determination services person say a technical perspective at the field office, we're talking about those things that are not directly

medical decision. It's about whether the income or resources are enough, that's a technical decision for SSI. Whether they have worked enough quarters, that's a technical decision, which a person might be denied for at the field office and the case never gets to the medical decision, gets sent to the DDS.

Of course, the cases that we're interested in at the DDS is the one that the person qualifies on a technical basis for. In other words, they have worked enough quarters in the last ten years to be qualified for benefits on a technical basis, or their income and resources are so low that they qualify for SSI. In that case that's when the disability interview happens, and the field office representative goes over the information provided in the starter kit.

In that, they're going to go over information that you see in the 3368, which is in your book behind the tab 3368 adult function report -- or disability report adult, 3368. In this form it ask some basic questions, including body habitus; height, weight of the claimant's -- I'm on

page one of mine. It asks contact information. It ask if the claim disability understands or reads English. Then it goes on to get -- to capture the impairments that are alleged.

Some information about dates of when the disability began on page two; and as you work towards page two and three of the disability report, that's when they go over the information about their work, which, of course, is very important to us in making the decision at step four and five of the sequential evaluation process.

I say all of this to point out that there is a lot of information the field office representative must go through in order to complete the application process. A lot of their focus in that interview is also to gather information to make sure that they have completed information so that the person is given the complete view of what they might be eligible for in order for the application to move forward.

They have to look at things like unsuccessful work attempts where a person might have

become disabled, or have an impairment, or off of work for a certain period of time, at least 30 days, and then they went back to work; and then the work subsequently did not -- they weren't able to successfully continue employment, and then they stopped.

So we might be able to actually go back and allow benefits prior to when they actually last worked, depending on how long of a break there was between the time that they stopped work because of their impairment, then they went back to work; and then how long the work lasted afterwards.

We also might consider whether there is any -- whether it's sheltered employment or if any assistance was given and accommodations made, which might offset some of the earnings. This is all things that the field office is looking at during their application process and getting information during the disability interview, so that they can -- when they complete also the 3367, which I referred to earlier, the information about the recommended onset date is an accurate date. That's the date that the

disability determination adjudicator looks at to determine, okay, when do we really have to start to consider whether this person is disabled. As we know, a lot of people with impairments work in spite of their impairments for a very long time before they get to a point where they're no longer able to work.

It's not just important to note just when an impairment began, but it is also important to know when an impairment became so severe that it prevented a person from continuing their work.

So the field office goes through the interview process. They capture the information needed to make the technical decision; and then they transfer the case to the field office or to the DDS. When they do that -- hold on, and I will get him to put the screen up in just a second.

Most of our cases now we process in the electronic environment. Excuse me. Can you put -- thank you.

Up on your left screen this is what we see as a disability examiner in E-View. If we were to go outside of our case processing system and look at the

electronic folder, you would see what we call E-View, the electronic view of the folder, is a disability folder selection that we can go and select a folder.

We can search by the Social Security Number. We can search by last name, although, you can imagine how many people have replicated names in the United States. It is not the smartest way to look for a case. But you enter the Social Security Number, and hit "search," and you will come up with either one or multiple folders. For each folder -- there is a folder for each time an applicant applies for disability benefits.

There might be a prior folder from when they were allowed benefits; or in an initial case, it might be the only case that you see in the list. Hold on, I have to reenter.

In this case the claimant's Social Security Number is entered, and what we see is a list of one case. So I can assume, based on this, that since we became electronic, this claimant has not applied before. If I select her name, I can see some basic information that this is an initial claim, that it is

a DIB, which means it's entitled to disability insurance benefits claims.

By selecting it, the hyperlink, it will take me to her case folder. There is a tab that is called "alerts and messages." This might give me an alert or message that this is a high risk case, such as a homeless individual where the person might be more difficult to contact, which I will mention also because there are certain instances at the field office when they're doing their initial development of the case with the claimant that they might take some additional steps.

For instance, with a homeless claimant, one of the things that they will do is they will -- while they have the claimant in the office, because we make an assumption for homeless individuals that it may be harder to contact for follow-up information, is that they will go ahead and take the complete work history for the 15 years when the claimant is initially in the office.

So that information we try to capture right up front. Not just a list of the jobs that they have

done in the last 15 years, and the description of the longest job performed in the last 15 years, but a description of all the jobs performed in the last 15 years. Which 15 years currently is how Social Security defines the past relevant period. And there is some variants to that on whether or not the person is insured or not. That will probably be confusing; but generally speaking, from the date of the decision, the relevant period is the 15 years prior. So they will capture that information.

Also, there is a tab called case data. This is where we can go. We can see all the specific data about this case. We can see the data that was entered into the Social Security system that's been propagated into forms view. Forms are traditionally what we use to capture information, and what people are used to seeing. So a lot of individuals prefer to view the information via forms. There is the case data tab on the left. There is also a forms tab, and then you just go over there real quickly.

There is also a case documents tab, which -- which is really what you have in front of

you in that yellow, what we call MDF, module document folder, is the old paper folder. Once we moved to an electronic environment, we changed the -- everything into an electronic format, but we kind of mirrored the color coding and the division of sections, electronically that we have in the old physical file.

So if you look at the electronic folder that is on your screen on your left, you will see that there is one section called payment, documents and decisions. The second is jurisdiction documents and notices. The third is current or temporary. The fourth is nondisability development. The fifth is disability related development; and "F" is medical records. Where an adjudicator spends most of their time are in the last two sections, the disability related development, and the federal -- or the medical records.

Now, I'm jumping a little bit ahead, because when you see this, this is a case that has already been developed, because it already has medical records in it. So not to confuse anyone, when a case comes in, unfortunately, it doesn't have

all the medical records in it. We have to actually request those, which is also part of what takes time in developing a case.

But in the bottom section you will see -- or in the blue section "E," disability related development, there is a hyperlink to those forms, which were collected at the field office. At the time a case first comes over it is going to be the 3367, which is the disability report; and the 3368 is the adult disability report.

And then there is a status history. If I wanted to hit that tab, I could go in and look at the history of this case. When it moved from the field office to the DDS. When it might have even been sent back to the DDS, because medical evidence show that the person might still be working, and that will be a decision for the field office to determine whether the person really can apply, or perhaps they are working, not earning enough money. The case might be sent back to the field office then come back to the DDS for full development. This is the electronic folder that is sent to the DDS.

The DDS doesn't really develop the case in the Social Security electronics folder. We actually in all the DDSs -- there is 54 throughout the -- 54 states or 50 states, four other DDSs. We use what's called a legacy system to manage the cases. It's a case processing system.

The demonstration I'm going to give you is MIDAS. MIDAS is in one of our bigger states like California. This is actually a -- SSA own case processing system. But this is what the user sees when they go -- the DDS user sees when they go to sign into MIDAS. You will see that over on the right, there is a couple of links. One is for OccuBrowse; and one is to the Denver Dictionary of Occupational Titles.

If I actually would hit the Dictionary of Occupational Titles, the link wouldn't take me anywhere, because we don't use it anymore. The OccuBrowse would actually launch -- my touchy key pad just launched. It is at our fingertips, because it is such a big part of what we do in the medical decision determination process.

Let me cancel this. We don't need OccuBrowse yet.

Once I log in, I can go to a case load summary screen. It will tell me as an individual adjudicator a little summary of all the cases that I have. When I come in to start the day -- sorry. Part of our problem with demos, I will let you know, is that we're connecting to a work station back in Baltimore, and the connection for Sprint is not so great down here. So it's a little bit slow to respond.

So once it lets me log on to my case load summary screen, I can see how many new cases I have, how many cases I have been assigned, how many cases might qualify for expedited processing. It will also give me information regarding what new evidence I have, how many pieces of new evidence. Fortunately, in real world case processing, it doesn't move this below.

For many of the tabs that you are going to see, I can go in, select one of these categories, and it will show me all the cases that fall into any of

these. Like I said, I can see any new cases that I have received in the last 20 days, because this is training. The numbers, of course, I have one Susan Que, which is our test case. A new EM, e-mail tickles to tell me how many pieces of electronic mail that I have. How many new updates after transfer I have. It might have been the claimant contacted Social Security and reported that they have a new address. I would get an alert in this box here to let me know that I have -- I need to update the claimant's mailing address in this system.

Cases that for some reason I took no action in the last 25 days would fall into this. We don't want our cases to fall out of the system. And numerous others, including cases that I have sent for medical evaluation, cases that I have waiting for medical evaluation. In case we somehow lose all tickles on the case, the case will show up as having the alert or a tickle to remind you to do something in the future. We do this if the whole case continues to move forward.

I can go to my open all cases, and there I

will see a list of all open cases. I can then in that screen search for the case by the Social Security Number, by the last name. I can search by all cases at a certain level until I find the case I want. Once I find the case I want, I can enter the case number at the top and begin working on that case.

At this point -- I would first had been alerted that I have a case as a disability examiner by the new cases in the last 20 days category. I would go into that case, and I would launch E-View that I showed you first simultaneously while I did case development. DDS examiners have a dual -- they work on a dual monitor system, and the systems are working a little bit better today, and we probably will be able to demonstrate it a little better.

Generally, we will have E-View on one screen of our desk top, and the other will have our case processing software, so that you can read what the claimant said on one screen while you process and create and generate the kind of letters that you need in the other.

In initial case processing, we do look at the -- we, initially, go in and we actually look at the medical evidence, or the disability forms. I am going to do for you actually the paper form. It is probably going to be easier to follow along.

When we are first developing a case, we look at the 3367. In this case, we are actually going to go through it semi-specifically, because this case is really going to come near and dear to us, because it's the case that we're going to talk about all day long. So we're going to look at this in the same way I would look at it as an adjudicator. I would go in at the 3367, page one, and I would look at the information that's been provided.

After you have some skill at being an adjudicator, you know that the things that are blank and have no answers, meaning that the field office has determined on this form that it does not pertain to this claimant. So I'm not going to worry about things that have no answers. I trust the field office who is responsible for anything that's on this form being correct, that it's correct. So initially,

I'm going to accept it as face value.

It will be slightly different when I get to the 3368, which is the adult disability report. So when I look at this, I see my claimant's name, her Social Security number. I see that she is female, and that her date of birth is May, 1955.

Now, for the purposes of this demonstration our current date when we first got to this claim -- because we're going to walk it through almost a two to three year period today. We're talking about when they initially applied, the application date was in November or December of 2006 -- five; 2005. So imagine that we step back.

MS. ROTH: Onset is 2005, application is 2006.

MR. OWEN: So the application is -- we are in 2006. So let's step back a few years. So this individual, I look at her -- one of the first things I would do in my mind is I would calculate her age. Just kind of in the backwards step, thinking, okay, the older a person is, I know the more likely they are to become disabled with the same impairment.

When we get all way to the end, you are going to hear that a person with like symptoms, like limited function, like impairments, everything being the same might become an allowance at step five in one case, while being a denial in another case based only on their age. And the reason for that -- I'm sure Shirleen will describe; but it is really a presumption that the older a person gets, the less likely they are to move to other kinds of work.

Also, there is some inability at a certain age, especially with impairment limitations to get employment. That's all built into the rules. But as I am approaching this, I know that if this were an individual that was 63 years old, I would know, depending on their past work, the likelihood of whether or not the threshold really -- the evidence that I will need to get to prove that this person is disabled. With a younger individual, that threshold is a little bit higher, so I know that I'm going to have to cross every "T," and dot every "I."

If you can get -- you can stop your medical development at the DDS once you can determine that

the person is disabled. Once the person meets the disability requirements, you don't have to -- and you have medical evidence to demonstrate that, you don't have to have all the medical evidence. If you're going to deny a person, we really hold ourselves to a much higher level of documentation and get all the medical evidence so that we don't miss something that might actually give us more information about whether a person is disabled or not.

So as I look at this I'm just thinking about their age. This person says that they have been disabled since January of '05, so a year prior to when they applied. The detected final date is November of '06, which is the date that they approached Social Security and said, I think I might qualify for disability benefits, how do I apply. And their date last injured is December 31st, 2010.

How that calculation comes about doesn't really matter to the DDS so much. That's something the field office is responsible for determining. What matters for me as a disability examiner is, as of the date that I'm doing my development today, is

that date in the past or is it in the future? If the date is in the past, what I really have to worry about is whether I can establish the claimant's disabled before that date, as opposed to after that date. If it's in the future, then it's all good. I can just kind of ignore it, in fact.

It is kind of like having a car accident. It doesn't matter how long you have paid your payments in advance to be covered for car insurance, if you have an accident today, you are covered. If you stop paying your payments for car insurance previously, and you had another accident while you were still insured for it to count.

So I'm going to look. This individual happens to have a date last insured in the future. I can basically move on without really doing much more consideration.

On page two of your handout I can see that this claimant -- the teleclaimant claimant -- so this claimant probably called into the telephone service center to initiate an application. On here, during the application -- or during the completion of this,

and during that disability interview, there is a place to let us know whether or not there were any observable problems during the interview.

You can see that hearing, reading, breathing, coherence, concentrating, talking, answering are all questions. Depending on how busy an individual might be in the field office, and how perceptive they are to observing a claimant, you can get a variance of answers. But generally, you get a very good idea, especially with someone who appears to be significantly impaired. People do a generally good job of giving us information, which is just another small element to consider about a claimant's function.

Can someone pass Ms. Shor the mike.

The mikes probably should be fixed after the break. So if you will bear with us. Thank you.

MS. SHOR: Just a question. Do you find the fact that applications are being filed now over the phone or electronically, and therefore, this whole section isn't getting completed? Is that working to the detriment of an adjudicator?

MR. OWEN: It's a really good question. I don't think it works to the detriment. Like I said a moment ago, it is a very small piece of a much larger puzzle. And we don't make decisions or determinations based on single elements or single presentations in regard to function.

I mean, quite frankly, someone who is psychotic may have a brilliant day the day that they walk into SSA. They have actually gotten to SSA that day. They can present themselves beautifully. They're articulate. They can tell you their history. They complete the forms, and they can be fine. They can walk out the next day, they could be, you know, having delusions.

So it's very -- it's not safe to make decisions based on one small element, especially denials in a large number of cases. So why it isn't -- we do lose a little bit of that observation to the telephone. We really look at a much bigger puzzle. So I don't think it's really at our detriment.

Here, the contact representative or the

field office representative said the claimant was very personable and pleasant, nothing to note from our phone conversation. Not raising any red flags for me. I still -- I don't know what her particular impairment is, you know, but it doesn't sound like that somebody is psychotic based on the description.

The back page, there is nothing else noted. It tells me who did the interview. The date on this is wrong. In the test case environment, we can't change the dates. It was actually entered into the system. You have to imagine this is 2006. Then I'm going to go, and I'm going to move to the 3368, the adult disability report.

While I'm doing -- going through this in the case processing system, I am entering these elements into the appropriate screen. A lot of them are actually propagated now right into the case processing system from the electronic folder, like the date last insured.

This is the detailed case history on the left screen within MIDAS. And you can see it gives me some basic information, her name, her address, her

birth date, her age, where she lives, Social Security Number, what type of benefits she is applying for. It lets me know what her date last insured was, which is an important thing in this case, because it is Title II. And then occupation, years of occupation, industry.

Interestingly enough, this isn't really captured and propagated into the case processing system within the DDS. It would be great if it were. One of reasons I think that we settled for it not being currently is that the training at the field office -- you know, they have so many elements that they have to worry about in a technical allowance, whether someone technically qualifies for benefits; and that they're going to have an application for everything that they might qualify for.

There is so many other aspects of their job that they have not had the training to define what occupation, industry someone may have worked, and what code that would be; and it's something that we just don't get. We will put it into our case processing system ourselves, because at least at the

DDS, the adjudicators have a lot more training with regard to vocation than the field office.

Field office deals more with earnings, and we deal more with the function of the job actually being performed. We complete those elements that are required within the system.

Now, we go to the disability report under the disability -- 3368, under the blue tab. Again, this is going to give me the basic information about the claimant. Her date of birth, and also her alleged onset date, which I'm going to compare her alleged onset date that she reported on the 3368, which is the field that is propagated in from the claimant's allegation on the starter kit, or if they gave her a paper form when she came -- walked into the field office. This will be her alleged onset date.

In that 3367, the onset date usually presented there is that if there is a difference between what the claimant recommends as her onset, or alleges as her onset, and what the field office recommends. The field office may -- or the claimant

may have said that she has been disabled, having knee problems since January of 2004; but her earnings might show that she was able to work until January of 2005.

So in that case, the field office would determine, yes, she was doing normal work. She was earning more than the substantive gainful activity for that year, then determined that she did qualify, because step one of the sequential evaluation process is, is the claimant engaging in SGA, substantive gainful activity? If the answer to that is "yes," then the claimant is found not disabled at step one.

So when the claimant may allege a date that's earlier or different, then, the field office would list that on the 3367. In this case, the claimant's allegations -- the recommended allegation is not written on the 3367. So that's the date the adjudicator might be developing for her.

There is a protected filing date, the date last insured, which you have already talked about, because that really comes from the 3367 information. It also lets me know that there is a prior filing.

There is a prior filing. I'm going to want to look at that prior evidence in determining whether or not the alleged onset date encroaches that period of time that already has had a decision, because there is some collateral estoppel rules about administrative finality. I can't go in and -- say an administrative law judge made a decision on a case. I can't go in and allow them that is before -- the date of the decision of the administrative law judge. So we look at that. There is also some -- in the Ninth Circuit court there are some additional elements you must consider in that prior folder.

Generally, what we try to do is get the prior folder, the paper folder. Fortunately, in the new electronic environment, it is at your finger tips. It is just in that -- that first E-view shot that I showed you, there would have been multiple hyperlinks, one for each of the folders; and I would have been able to go there and see all the evidence.

On page -- the next page of the 3368, there is the observation and this shows the same thing as from the 3368 or 3367, sorry. Then we will go on

again.

As you can tell, I'm much more used to work with this electronically than on paper. Fortunately, we haven't had to deal with too many more paper cases anymore.

So on page one of the disability report I see the additional information, claimant's height, her weight. I actually will pay attention to that. Especially if there is a musculoskeletal problem. Obviously, a person's body habitus can be more impairing if there is an underlying medical impairment than a person who weighs 400 pounds and has knee problems, may be much more greatly affected in their function than a person that weighs 158 pounds. So it is something of note. It is something I will probably put in my -- if someone has got an abnormal body habitus, someone who is extremely thin, or someone who is extremely overweight, I might actually put a note in my case folder if it pertain -- if that could affect their impairment, which we will get to next on the next page.

Oh, I'm sorry, it also ask about whether

they read or write English on that page, which is important when you are trying to communicate with the claimant, asking them to do things like fill out forms, go to exams. If the person is unable to communicate with you, you might need to take some additional steps, which we will do. We will hire through a telephone service, translation service, get the information or give notice to the claimant.

On the next page we get the important -- what are your illnesses, injuries, and conditions that limit your ability to work? This is on page two of the 3368. And in this case you will see that it's a paragraph form of information. Hip injury, depression, sleeping problem, right knee R-E-P-L, which I'm going to assume is "replacement;" injury to the hip from fall, and herniated L3 and L4 in the back. My hip has a torn labrum, depression from being in pain. Pain is so distracting I have trouble sleeping, degenerative joint disease in the left knee, and total replacement done on the right knee.

Sometimes you get even longer paragraphs. Since the disability interview started, fortunately,

the field office is able to glean a little bit more information. I think this would be typical of what we would see from a field office completed through the interview of the claimant. They want to make sure that we get all the information, so they put everything down. Even though there is some replication probably in this.

We would clean up this paragraph over in the legacy system. In order to send out our medical evidence request, this will propagate whenever we leave the allegation, will propagate into the letters that we generate to the physician asking for the medical evidence. They will also propagate into the final personal denial notice. So we clean it up. We correct misspellings. We make sure that we don't lose any of the allegations that are alleged.

The claimant alleges that in "B" that her impairments are -- her mobility is dramatically decreased, walking is extremely painful, and so is sitting and standing. Causes pain, she says "yes." As far as I am thinking -- in the back of my head I'm thinking, okay, I am probably going to send this

person a pain questionnaire.

In her allegations she indicates that she is depressed because of her pain. She is distracted. She is unable to sleep. Pain seems to be a pretty significant problem for this individual, so I am going to send out a pain questionnaire as part of my development to the claimant. It's a one page questionnaire, but it asks some detailed information about the frequency, how it affects her, which we will go to later, or Shirleen will.

She says that it first interfered with her ability to work in January of '05, which is also her alleged onset date. I keep going down. It says, why did you stop working on that date?

She said, I could not even walk with a chart in my hand. My balance is too far off. I was unable to complete my tasks. This is all information that the field office representative went over with them, including in the next section information about your work.

And you will see that on this form, the adult disability form, 3368, we ask some information

about your past work and those are jobs that you have had in the 15 years before they became disabled or unable to work. And in this individual she has indicated a very short list, only two jobs in the last 15 years. Sometimes you will see more jobs than the space allows you to complete, and then they go over to the remarks section and complete the rest of their jobs by title and date performed; but it's part of the field offices representative's duty to get this information.

What they capture is the title of the job that she held. The business type where the work was performed. The work "from" and "to" dates. Whether it was full time. How many days per week. How many hours a week, et cetera. How many -- and what the pay was. This says hours, although, there is several choices in the electronic version when this is going to be being complete. They can report their income monthly or annually. You just have to compute it if you want to know whether or not it was performed at substantial gainful activity or not.

In this case it looks like she worked full

time. She earned wages -- though, I know from that year to be at the SGA level. She worked as a medical records clerk in the hospital for four (sic) years; and then she worked for seven years as a medical records technician.

The job that she did the longest she is asked on this form to give detailed information about. In this case the job that she did the longest, the medical records clerk, she described this job as, I worked in the medical records department. I set up new patient files, filed the folders, process requests for medical records and mailed them, and retrieved files the hospital needed for patients who came back to the hospital.

She says that used machines, didn't require technical knowledge. She walked four; sat two -- I am sorry, stood two; sat, two; climbed, one. Stoop, she estimated to be two hours. No kneeling. One hour of crouching. Two hours of handling, grabbing, and grasping big objects. And also, she writes -- she described writing, typing or handling objects at two hours.

Lifting, she said she had to carry stacks of patients records and individual folders from floor to floor. Her heaviest weight to lift was 20 pounds; and what she lifted most frequently weighed up to less than 10 pounds. She did not supervise individuals, and she was not a lead worker. And that's the sum of the information I get about her past work that they collect at the field office.

Mr. Hardy, your question, please.

MR. HARDY: A quick question, on the job title, is that what the claimant tells you their job title is, or is that something that at this point you are trying to --

MR. OWEN: This is the claimant's reports.

MR. HARDY: This is the claimant's report.

MR. OWEN: This disability report, 3368, is really the information in the claimant's terms as they understood the question. The question is understood differently by different people; and therefore, it's answered differently by different people; but this is definitely -- and the field office representatives are trained not to really

change what the claimant is telling them in this regard. So in this case this is -- that information is actually propagated from a real case. It's really what someone once said their job was. This is what she said.

We will later determine what that job might be in the Dictionary of Occupational Titles. And the one thing that we won't do is we won't identify that job based on their title alone. We really are going to look at the description as she described the job, and compare it to jobs in the Dictionary of Occupational Titles by the job's description.

Not all jobs, what people call them, are the same. I mean, for instance, you know, someone who works on a fishing boat and guts fish, all they do is clean the fish, in the Dictionary of Occupational Titles their job is a slimmer. I come from Alaska. I have never seen on an application someone describe their job as a slimmer. But in the Dictionary of Occupational Titles, the job is a slimmer.

What we compare is the definition of the

work, how it's described -- the task described, the equipment used to perform the job. That's what we are going to compare. In this case you can see that we have some information that gives us a brief idea of what the claimant does. And because this is a familiar job, perhaps, we might think that we have a pretty good idea of what she did. Of course, there are so many different types of nurse jobs in the Dictionary of Occupational Titles, it's very dangerous even to assume that you know.

Even with this description and then taking her title alone, you have to find a really -- an exact match almost in the Dictionary of Occupational Titles, or you might be -- I mean, the water gets a little merky. So what you do is when you are reviewing the case, which I'm doing as an adjudicator right now, I am looking basically, okay, does this person look like they can explain what they're talking about? I would say that so far she is doing a really good job. Okay. She has had more than one job in the last two years.

Automatically, during my case development,

I see her allegations. Based on her allegations there is nothing there that makes me think oh, this is going to be a meet or equal a listing at step three. As part of my process when I'm reading this is to make kind of a gut reaction determination.

If someone tells me that they have pancreatic cancer, I'm really hardly going to even look at this page, because it really isn't going to matter. I know that I'm going to need to get the path report, the doctor's report and I'm going to allow that person. And I will never do that based on having just reviewed the medical allegation of having a knee problem, a back problem -- multiple knee problems, a back problem, you know, herniated disk, and anything that goes along with her depression, that this is not likely to be -- on the face of it, meets the listing.

Although, that doesn't mean that it may not be, because it very well could be based on those symptoms, or those allegations. The most likely listing that it might be would be a mental listing. If they are so impaired by their inability to

concentrate, their inability to sleep, you know, their lethargy, you know, anything related to the depression, they might actually meet a listing. I don't know going into this that she won't meet a listing. I'm just basing probability based on the impression from what's being said overall and what's being alleged.

This doesn't look on the surface of the allegation to meet or equal. I'm going to look at the work history, and at this point I know I'm going to send out a 3369, which is a work history report. It's more likely than not that I'm going to get to step four or five on the medical decision. In order to do that, I need to make reasonable attempts to get as much information about her past work as I can from her in order to inform me in that decision.

So in case development I'm going to go into the case processing system, and I'm going to send off a letter that basically says, here is this form; we need you to complete it. It gives you a separate page for every job that you have reported that you have worked. And I'm going to ask that they complete

that and send it back to us within two weeks. If I haven't received it in two weeks, I'm going to send off another letter and say, hey, we sent you this form. We really need it in order to make an informed decision, please send it back.

I'm sorry, I can't see your name tag.

DR. SCHRETLEN: Dave Schretlen.

MR. OWEN: Dave Schretlen, please.

DR. SCHRETLEN: Just from taking work history from patients I know that so often people have no idea where they worked, or they have worked places that are no longer in business. I'm just wondering at what point or do -- does SSA attempt to verify the report of work history?

MR. OWEN: We will go into that later. But a case development, if I were to see gaps in a work history, and I didn't think that the person was demonstrating the credibility to self-report, I can go into the SSA system. I can't test for you here, because it's a real system. I can go in and do a detailed earnings query, and I can get all the postings that have been made from Social Security by

employers, and can look and see oh, look, this person worked from 1987 to 1993, and there really was a gap between 1997 and the present. And then it will be oh, this is a good self-reporter, I can move on.

Or I would see, oh, this person has really had 27 jobs, and no wonder they can't get it right, because who would remember, you know, that chronological history. Again, you are using some experience in the development of the case and we do have tools that every level of development do go back and look and see, are things looking consistent.

It's really the inconsistencies that throw up the flag. If someone reports that they have only -- I mean, if someone is 47 years old and they only reported ten years of work in that section, and the field office representative didn't make a note that there really was no note in the other years, I'm most likely as an adjudicator to go in and look at the information at the first step of development.

Because what we don't want to do is postpone some sort of development that we then later have to come back and redevelop, because then that

just asks for processing time and makes the individual have to wait for a decision.

I'm sorry, Mr. Wilson.

DR. WILSON: Yes, could you describe a little bit exactly what the records are that we would look up in the SSA system about the employment?

MR. OWEN: Actually, we will give you an example of that later during Shirleen's presentation. But it basically tells you what the earnings were, what the employer ID was, what -- the year they were earning. It's basic information, but it's helpful; but it's not inclusive of everything.

Self-employment, not everybody reports their earnings in self-employment. So you can't -- even then -- just as a preface, let me just say -- it's not necessarily -- it doesn't cover everything. You still have to look for inconsistencies in the record between what the claimant reported, what's in the SSA system, what shows up in the medical records.

If you are reading medical records and the medical records say that the individual was working on the fishing boat with their brother, you know, and

you happen to come from an area where fishing might actually be an industry and people actually performed that work, you might need to make a phone call and say, you know, were you earning money when you did this, in order to make sure that you weren't allowing benefits during a period of time that somebody was working, because that's step one, engaged in SGA, then, you are not disabled.

So based on this information that I have for this individual claimant, I would also request that they complete a disability -- or a work history report, 3369, so that they have a chance to at least give me the details for the other job that they didn't already give me details for.

As I go on, I see their medical providers, information about their medical records. It's on page four of the 3368. On the 3368 it asks, have you been seen by a physician for your illness and injuries or conditions? They say "yes."

They also have been asked, have you been seen by a doctor, hospital, clinic or anyone else for emotional or mental problems that limit your ability

to work? It says "yes."

It's a very important question, because sometimes people with physical impairment, that's their allegation. It might be the only hint that they have ever been treated for a mental impairment is the answer to this one question. They might not apply for disability benefits based on their mental conditions. They might not give you any information about that medical doctor.

So it's important that when we review these forms that we are looking at all the different elements of the information provided, because it might hint at oh, maybe they didn't give us information. We should call the first day of development and ask a few questions so that we are getting all the information up front that we need in order to make a decision.

In this case they saw Dr. Beene in Coldport, Oregon. We would go into MIDAS and send off a request for medical records. We have to determine what the dates are that we are going to ask for medical records. This is a nurse. She said that

she first began -- I'm sorry, medical records technician; sorry, I misspoke.

Medical records technician. She worked in a hospital. I'm going to assume when she told me started seeing a physician in 2005, and that's recent enough to 2006 that she is probably giving me the full information. So I will probably request -- because it looks specific about when she started seeing them, I'm going to ask for records from January 1st of 2005 to present. I will send off a request to Dr. Beene; I will send off a request to Dr. Palmer.

You can see also that Dr. Beene was probably her physician. I will send off a request to Dr. Deacon Palmer. She doesn't know why she saw him. She doesn't know the dates.

For me, as an adjudicator I know that I need to establish disability from her alleged onset date. Based on her impairments, which include depression, I'm probably going to be compelled to go back a little bit before her alleged onset date so that I can get a longitudinal picture.

Knee replacements don't usually happen overnight. It might give me some information about what happened with her knee that led to the surgery and what her recovery was after the surgery. It also might give me some information about her mental state and how she responded to that loss of function that led to her depression, from what it sounded like.

But I'm not going to go back too far. For one thing, we have to pay for medical evidence when we receive it. So we don't want to just ask for the whole entire period of records. We also don't want to make the records for case information that we don't need in order to make a decision.

But I probably in this case would go back to the year prior to the date last insured, just so that maybe if there were any sort of psychiatric treatment that got worse over a prolonged basis, it would help longitudinally understand where she is. Because one of the things that we consider is whether or not the claimant's impairment or set of impairment is expected to last or will last 12 consecutive months. That's part of the -- or result in death.

That's part of the definition of disability in Social Security.

So getting a little bit of longitudinal history will help in determining the likelihood of an impairment getting better or not. I mean, someone has already established that they're so depressed that they can't leave the house for a year, then that information might be enough to allow a person at the time that you're adjudicating the case.

If someone is depressed because their father just died, and they haven't been able to leave the house for a month, we might look at that case much differently and have some expectation that with treatment the person's impairment may not last 12 consecutive months.

So in determining what evidence we are going to get, we look kind of at a broader picture, and depending on the allegation, request the appropriate evidence. Here she --

DR. BARROS-BAILEY: Mr. Owen, we are a little bit over time in terms of going into the break. Maybe what we could do before you finish that

form is maybe go ahead and take a formal break at this point, and then come back and finish that up.

And just a reminder for the Panel that we are tracking everybody's questions to try to make sure we get those answers. So why don't we go ahead and take a break right now for 15 minutes.

(Whereupon, a recess was taken.)

DR. BARROS-BAILEY: I'm going to ask everybody to take their seats now that we have operational mikes, so we can continue with the demonstration.

Okay. Thank you.

Mr. Owen, when you are ready to continue, I will pass it on to you.

MR. OWEN: Thanks. Let me go back to page five of the 3368. Basically, we go down and look at each of the medical sources. We send out on the left screen as the request. We input criteria based on what the allegations are requesting. In this case we might ask for the sufficient history discharge summary, consultation discharge summary, history, operative notes, outpatient notes. Whatever we think

we need in order to make a medical discrimination. And we send that with the recent information to the medical source in order to get the information.

Occasionally, we might also send something to an employer, but I think Shirleen will talk about that in her development, in her discussion. It usually comes later in development not in the initial development. The next is Doug Heffernan Memorial Hospital. So we would create a request for each of these sources.

Using the same logic I explained before about determining at what date to begin requesting the medical evidence. It's just a replication really of that process for each of these medical sources.

It asks the individual on page six of the disability 3368 if anyone else may have medical records. In this case it looks like she has an insurance company. It might be a workmen's compensation -- actually, reason for visit, workmen's compensation. "Fall was at work."

This little line just gives me a little piece of information. Here is a person who has what

I assume to be degenerative joint disease on her knee that led to total knee replacement. She has a very kind of concrete date on when she alleged being disabled. It coincided with the date that she stopped working, which seemed kind of unusual with someone with a progressive degenerative disease.

However, it makes perfect sense that if she had a fall at work, that that was kind of an acute exacerbation of her problem, and now it all kind of makes sense. Like going through all of the evidence. Just this little line at the bottom of this form that just now gives a little bit better of a picture of how we got to a disability application for this individual that, apparently, worked for something that I would expect to be progressive in nature, but she really alleged this sudden onset.

The next page, on page seven of the 3368 we look at the list of medications. It's always important to look here. There could be additional impairments that they don't allege being an impairment, but something they take medication for. It tells me what her sources of any tests that she

has had. In her case she has had an MRI or x-ray.

There are additional tests that would be listed here had she said she had the test. This is not a comprehensive list that was presented to the claimant. This is propagated in, and those things that she had no response to didn't show up on this list.

Her education and training. I see that she has two years of college, page eight of 3368. She completed this in 1975. She has not been in special education classes, which is always important to note. Usually people with two years of college don't answer that with a "yes." And any kind of special training or vocational skills would also be listed here if the claimant actually had that as part of their history.

Vocational rehabilitation, employment services, or other support services, or individual education programs are also asked from the claimant during the initial application process. So we kind of have a heads up. If someone were involved an IEP when they were in school, that might give us some insight into their -- kind of their long-term

problems with marked.

In the "remarks" section they can add additional information. You can get anything in the remarks section. Many of the other sections ask if you -- if there is not enough room to put all the information that to do it on the last page in the remarks section. In this case she -- looks like she has Deacon Palmer, she had already mentioned; and then there are two other sources of information that we can send a request for. So I would -- to make sure that I have it in the legacy system, case processing system, I would make sure I sent requests to all of the sources that she had indicated that she had seen for her impairment.

I would send her a pain questionnaire. I would send her a functioning questionnaire to ask her about her ability to function on a daily basis, and I would send a work history report to get the detailed information on her past relevant work. I would wait for the evidence to come in. If anything hadn't come in within two weeks, we would probably do a follow-up by mail or fax or even the electronic -- a web site

called Electronic Records Express for those medical providers who use that.

In most cases we don't actually send out a request in the mail, we send it over electronic process, or through an out bound fax process where the adjudicator never generates the letter. The letter just automatically goes to the fax machine of the medical provider. Any of those numerous ways, depending on what the medical provider has chosen, we will send the request out.

We would also do follow-ups with the claimant for any forms that we sent them that we had not received back from them. And we would do that pretty much through the history of holding the case. We generally don't like to make decisions based on not having a form completed. Sometimes you have the report, you might ask for the form you find that they meet or equal a listing. Or if it's a function questionnaire that you had sent the claimant, you might have enough information about the claimant's function on a longitudinal basis on the medical record that you would not really need that functional

report.

With the -- the medical information -- or the work history information, if you attempted to get all the information you might have the information about the one job that they described in the 3369, that you might be able to make a decision that they don't actually meet the disability requirements. In order to allow that, you have to get the whole past relevant work information. So if, you know, requesting it through the mail is not enough, then, you would probably pick up the phone and see if you can contact the claimant. Or if there is a reason you don't think the claimant will provide it, you might even contact the employer to get the information or another third party.

A party with dementia -- a little bit of dementia, not quite enough to meet a listing, may not be able to describe greatly all the past work they have done in the past 15 years, you might talk to a spouse. And I'm sure Shirleen will go into a lot more detail about when a 3369, or the past work information is enough to make a decision. That's

basically the case development process performed at the DDS at the initial intake.

Does anyone have any questions about that before I turn it over to Shirleen? Lynnae.

MS. RUTTLEDGE: Lynnae.

MR. OWEN: Lynnae Ruttledge. Ms. Ruttledge.

MS. RUTTLEDGE: Could you just give us a -- kind of a ballpark of the amount of time it generally would take to be able to do this beginning step in the case development? So from the time that the person has applied for Social Security benefits and you have done this case work up, about how much time is that?

MR. OWEN: I'm sorry, I'm going to have to ask a follow-up question in order to answer that question. So leave the mike with her.

Do you mean until we have gotten all the medical evidence, or do you mean just the initial case processing of sending out the request?

MS. RUTTLEDGE: Both.

MR. OWEN: Okay. It varies. Quite

frankly, if a claimant approached the DDS in Massachusetts right now and they have been treated for pancreatic cancer at Beth Israel Deaconess Hospital, when they hit the transfer of case button to the DDS, a pilot would run sending a request automatically to Beth Israel who has health information technology that is electronic. It would request the evidence. Right now, in approximately 42 seconds that evidence would be received at the DDS probably before the DDS would even assign the case to an adjudicator.

Based on some case rules, they might identify that the case is a likely allowance due to pancreatic cancer, based on the diagnosis codes, and the path reports that were in the electronic evidence that was data mind to get that conclusion. The adjudicator would immediately look at the case, would probably close it that day. It could be a one day process.

In other DDSs, the DDS might have a really good relationship with the dialysis center, and the day that you get in the case, and you see that the

person is on dialysis and might meet a listing, they accept outbound fax, request for medical evidence; and they turn around and fax you back the evidence the same day. The case can be closed the same day.

Those are small fractions of cases that can be done in the same day. Some cases you generally need to wait for medical evidence. The normal process of any medical evidence. Usually our standard is try to -- in most DDSs you try to develop the case from the first few days of getting it. The DDS I work, we try to get them done the same day that we receive them in. That starts the process.

Depending on the complexity of the case and how much contact with the medical provider the claimant has had, the process can be longer. You can get in medical evidence and determine that it's not quite enough to really make a conclusion about their ability to work and what their function is, because you are missing some element. It might be you don't have the x-rays to support the diagnosis in the file.

You may not have a good description of their function, of their ability to walk and stand.

You might need to set up a consultative examination, in which case the DDS would usually contact the treating physician and see if the treating physician was willing to do the exam. If not, then, we would set up an exam with a consultative examiner that we contract, basically, to see the claimant -- excuse me -- and provide the information needed.

You can send a person to an exam, and it can result in a subsequent exam being needed; so it really does vary. But we can get you the average processing time if that would help.

MS. RUTTLEDGE: I think that would help. Thank you.

MR. OWEN: You're welcome. It's variable.

Any other questions? Shirleen Roth, it's all yours.

MS. ROTH: Thank you very much.

MR. JOHNS: Hi. Actually, I'm going to walk you through. John has got the case developed, and the length of time that it can take, as you see it varies. We give providers 14 days -- up to 14 days to respond, up to three weeks; at 20 days you

send a follow-up. So the total -- and the follow-up requires a 10 day response time. So from the initial development we give providers up to 30 days to respond, to get us the medical records. If they hadn't responded to the initial and the second request, then, we go on with what evidence we are then able to gather.

So here we are, we have gotten all the medical evidence in file. All the records that we reasonably are going to be able to expect to get in. We've given them an initial call. We have given them a follow-up. At the follow-up we also contact the claimant as well, and provide them with a list of the doctors or the hospitals that haven't responded, and ask for their assistance in gathering that evidence.

Now, there is a close out language that is required by Social Security that says if you don't help us, you know, we can go ahead and decide a case on what we have got in file. You know, if you don't give us any assistance we can just cut you off. In practice, that's not done. But if we get any sort of response from the claimant, any sort of assistance

from the claimant, we are not going to cut -- you know, we are not going to stop processing the case because we did not get evidence. We will purchase a CE, or do whatever we need to do to get additional information.

But in a situation where the claimant has not responded, won't answer our phone calls, won't answer our letters, it gives us the ability to stop processing the case if we can't get the information that we need.

Now, we have gotten quite a bit of information in this case on Suzy Que. But since I'm actually from Dallas, that would actually be Suzy K. We will pretend that it is Suzy Que. So what we have is the development is complete. We have gotten responses from all of her primary physicians, treating physicians. We have gotten responses from the hospitals that she has received care at, and so now it's time to decide what is it we have got.

We have got her allegations. We have got the medical evidence showing what she has been treated for. And so what -- we know what she says is

wrong with her. We now know what the medical records support, and now it's a matter of putting those together and making our best determination of what -- what is the most that she can do and sustain.

Now, now that we have got the records, we're going to go again as -- what I preached on last time, our last meeting is sequential evaluation. So we're going to start with step one. The field office sent the case to us. So evidently, they didn't identify that she was working.

Now, as we develope the case -- you know, she applied in November of '06. We have gotten the medical records in. If you see the record, it's been about a two to three month period trying to get these records. Now, we're March -- February, March of '07.

So all sorts of things could have happened in that 30 -- the 90 day period. So we'll check the medical records. We will look to the medical records. We will see if there is any indication that she is working. Now, I'm not going to go through each individual record for you; but we will know that flipping through these records there is no indication

that she is working at all. In fact, all the records are consistent in saying that she has not worked since she had the accident at work.

So we know that she is not working. So we know that she is not engaged in SGA. She may -- she has filed for worker's comp. She may be getting worker's comp benefits, but that doesn't count for substantial gainful activity. We don't care how much money she may be getting from worker's comp; it doesn't impact on what we're doing. For our purposes, you know, SGA has to be money you are receiving for performing work. So whatever else she is getting is not going to count. Ms. Shor.

MS. SHOR: I think just to clarify for the Panel, the receipt of worker's compensation makes no difference at this stage in the adjudication of the claim; but it will make a difference if the person is awarded both Social Security and Workers' Compensation benefits. It will be an offset applied at the end. So it's relevant there, but not here.

MR. JOHNS: Right. Exactly. Thank you.

It is relevant to the receipt of benefits,

to the amount that you are going to receive; but that is, you know, after they have been approved for disability if they're approved. At this point deciding whether or not they meet the standards for Social Security disability, whether they're receiving benefits is not relevant.

Now, we would certainly take into account any records from worker's comp that they might have. We might take into account the determination that they may look at their records, but the standards for worker's comp and the standards for disability are not the same. And so just because they receive worker's comp certainly doesn't mean that they would receive disability or vice versa.

So here we are. We have the claimant. We have what she is -- yes, Mr. Woods.

MR. WOODS: It's not that important a question. Just as a follow-up, is that true also of disabled veterans benefits? Is it handled the same way?

MR. JOHNS: Our rules and regulations -- our regulations and policy requires that we consider

any determinations that they make. If we had that directly in the file, that would be another piece of evidence. But the standards for veterans benefits are very different from Social Security. Just as an example, you can get partial disability through veterans. You know, if you have a -- say, you have an amputation below the knee, I don't know that they -- I don't exactly know the veterans benefits, but in a way, they kind of mirror the ADA guidelines -- I mean, for the ADA guidelines if you have -- say that you have an impairment to the leg. A percentage of impairment to the leg, and then a percentage of the impairment to the body as a whole, the VA kind of looks at that the same -- at least the same terminology.

So if you have an injury to the leg, you might get a -- say a 20 percent partial disability saying that that leg injury to the body as a whole would be a 20 percent, so you would get 20 percent disability. Well, in Social Security it's all or nothing. So we don't look at it in terms of percentages, 20 percent or 15 percent. We don't look

at, you know, percentages to the arm, and percentages to the body as a whole. You either meet our standards and you are disabled or you don't. With VA you can have partial disability; with our benefits, you cannot. So the standards are different.

But we would if we had -- we do, of course, get VA records. We would consider their determination of disability or not disability, but their determination would not be binding on our determination.

Okay. So we have all the forms in the file. So what I'm going to do now, as an adjudicator, I have got to look -- I have got to balance what the claimant alleges and -- with what the medical records show. And I'm going to be putting those two things together to determine what the residual functional capacity for this claim is.

Step one, we have determined that there is no SGA. The claimant is not working. So we are pass there. So now we are at step two. The question we're asking at step two, does the claimant have a severe impairment?

And our definition -- we bandy about the word "severe" a lot; but for our purposes a severe impairment is one that implies more than -- impacts more than minimally on basic work activities. So the threshold here is very, very low. We do not deny very many people at step two for saying that they do not have a severe impairment.

An example, perhaps, would be, say, you have a claimant that has grand mal seizures. They even happen to have a seizure in the doctor's office. So the doctor saw them have a seizure, verified that it's a seizure. Had them have an EEG, and the EEG shows that there are no abnormalities that we can tie to that seizure activity. Put them on the medication, but now we're five years later, and the claimant is applying for disability. They have not had a seizure in five years, because they have been well controlled on medication. We would find that person nonsevere.

Because, even though they have an MDI, they have seizures. They have not had those seizures in five years. They're not impacting on their ability

to work. Now, of course, there might be some side effects on the medication, depending on how heavy the dosages are, that might lead to having SSI if they have a severe impairment.

We will pretend for purposes of this example that the medications is -- they are not experiencing any side effects. So bottom line, even though we know they have an impairment, it's not impacting on their ability to work. We will find them nonsevere, and we will deny them at step two saying they do not have an impairment that reaches our level. For most people that have an impairment, they are going to be -- you know, they are going to be able to cross a threshold.

The other part of that is duration. It does have to last 12 months or result in death. So we will get a lot of pregnancy applications where a woman says, you know, I have gestational diabetes, or I am -- I have a high risk pregnancy. I have been confined to my bed. The problem is in nine months it is going to resolve with the birth of the child.

So it may be a severe impairment. It may

impact on their ability to work, but it's just not going to last. At this point there has been a lot of talk over the years, but at this point there is no provision for temporary benefits for Social Security.

So we get occasionally people that have an injury. They will apply within three months of the injury, but they are going to have a surgical intervention that is going to get them -- for example, most fractures is something that is not going to last 12 months. So they may be in a body cast. You know, they may be totally unable to work today, but within 12 months we expect them to be recovered and get back on their feet, and get back to work. So they would be a denial at step two for duration. Severe now, but not expected to last 12 months.

So we have this woman who has alleged that she has knee problems, has hip problems, has back pain, has depression. Do we have a severe impairment?

So if we quickly look at some records -- if we start in the order that we received them -- or the

order that they are on E-View, we will assume that that's an order -- the first record that I have is from Heffernan Hospital. And so that is actually the last tab in the packets of information you have from Heffernan Hospital.

So opening that and looking at that, what I have got actually is an operative report from when they did arthroscopy on her left knee. That was back in April of 2004, approximately, three years prior to where we are today, keeping in mind that we're in February, March of '07 right at the moment.

So three years ago we know she had an arthroscopy on her left knee, some degenerative arthritis. That is probably enough to -- that is enough probably to establish MDI; but I am not sure about severity, because I don't know what happened to her after that arthroscopy. She may have had a full recovery and not had any more problems at all.

So I will go to the second piece of medical that I have here. In this case in my pile, it was medical from Dr. Beene. So I go to the tab that is MER from Beene, MD. He is giving us a history. It

talks about hip injury, talks about knee injury, talks about arthroscopy on the knee. So I'm willing to accept right there that we do have a MDI. We do have some degenerative disease in the hip. We have some problems with the knee, so I have MDI. I have got a medically determinable impairment.

It doesn't tell me there is going to be an allowance, but I do have a medical basis to proceed. Is it severe? Well, she is in a physical therapy. She says she is not able to walk for extensive periods of time. I have injuries to the knees and hip. She give me a reason for her not going to be able to walk, so I am willing to say, okay, step two is satisfied.

We have an MDI, we have an impairment. We have a severity threshold, just enough to establish we have some impairment. I'm past step two now. Where we're -- where I am going to spend the rest of my discussion now is at step three. At step three is where we determine whether or not the claimant's impairments meets our listing, or whether they equal our listings. If they don't meet or equal our

listing, what is her residual functioning capacity?

Now -- so what I'm going to do -- what I am going to start with as an adjudicator, I'm going to start with what the claimant has told me her problems are. What she reports her functioning is. So the first thing I'm going to go to is the blue tab that says "pain questionnaire." This is the report from the claimant telling me what level of pain she is experiencing.

Now, this is not a Social Security form. The -- and if you are looking at the package, the panel's package, it is on the left. It is in the blue section of the folder. The blue section of the folder is for anything that is not medical. So that's where the 3368 would be, the 3367, the work history, the pain questionnaire. Any report from the claimant will be in blue. On the right side, the yellow section is the medical. So anything that has to do with a medical evaluation from an acceptable medical source or even a nonacceptable medical source.

So this pain questionnaire is not an

official SSA form; but the guidelines for what we need to look at when we consider pain are in our regulations and our policy. So each DDS has a form of some kind that they use to develop pain.

So again, looking at this form real quick. When did the pain begin? Again, she is reporting that fall. So January 12, 2005, that's when she fell. So that's when her pain really began. In fact, Dr. Beene's notes that we have -- if we just glance there real quickly -- mentions that her back was fairly stable. She had back disease, but it was fairly stable until this injury, until she fell. Where is her pain? It's in her lower back. She actually even gives us -- the disk level for us, which is nice and convenient.

So L3, L4, she has pain in that area. She has pain in her left hip. The pain radiates. For us is the pain constant? Number two, she is telling us it increases with any activity -- increased activity and ambulating. So she is saying right off, that the more that she is on her feet, the longer she is on her feet, the more that she works, the more pain she

has.

That's going to be a very significant finding for us. If she is not going to be able to walk or be on her feet for a very long period of time, it is going to significantly limit the types of work activity that she is going to be able to complete.

Then she talks about the medication. She is on Advil and Meloxicam, upsets her stomach a bit. She is on Percocet -- she was on Percocet post op, but currently she is on no narcotics. So she is being managed primarily on the Advil for the pain and over-the-counter medications. And she does take -- use ice packs and massages.

Then she tells us a little bit of what she is able to do because of that pain. Light chores, paying bills, can do some driving, small trips. Then she goes on to say that her routine has diminished significantly, or at least she says it is diminished due to the pain.

So the next thing I want to do is go to the function report. That's under the blue tab also on

the left side of your file, function report, adult 3373. Now, this in the history of Social Security is a fairly recent form. Prior to about ten years ago each DDS had their own activities of daily living report, and they varied in the questions they asked widely from DDS to DDS. So establishing that this 3373 was an attempt to get a consistent approach from each DDS. So that we asked the claimant the same questions in the same manner, and hopefully got consistent responses, so that we could have a little bit of consistency to how we evaluate what they said.

Now, the things that I found most significant in looking at this 3373 is on page two, midway down. She reports that she has trouble getting to sleep. Now, that could be because of pain. That could be because of psychiatric symptoms. She has alleged depression. So we will keep that in mind. Could apply to both sides of the physical and mental.

Then under personal care, item 11, she says she is unable to bend or shave her legs. Then she says she can't bend to do her legs. She has pain in

hip -- we will just leave it at increases while seating, not going to where she is sitting. Basically, she is saying she is having difficulty bending her legs. She is having increased pain with prolonged sitting.

So again, one of the things that we're going to ask -- one of the big things that we are going to ask in completing the physical RFC is does the claimant have a medically determinable impairment? If she does -- or he or she does, could that MDI reasonably account for the symptoms that she is alleging?

So we know that -- without looking at the medical in any great depth yet, she says that she has a hip injury. She says that she has a knee injury. She says she has back pain at L3, L4. Are these things that could reasonably account for problems with bending of her legs, sitting? Indeed. She has a hip injury; we would expect that there would be some problems with -- difficulties with bending. With a hip injury, we would expect that there would be some difficulties with sitting.

Right now, just on this basis, I don't see anything that's inconsistent. I just need to know the level of those injuries to determine whether her allegations are a bit more than we would expect or what we would expect.

Then on page three, about two-thirds of the way down, under meals, item 12, any changes in cooking habits. She says she has problems standing in one place over time. That increases her pain. She is limited to small, quick, meals. Requires frequent rest periods; and she keeps a stool by the counter. Again, these things are all very consistent with someone who has a knee injury, hip injury, and back pain. Under house and yard work she says does the laundry, some ironing for 15 minutes. So if we put these two things together, we're talking -- we're looking at someone saying she can be on her feet for about 15 minutes, and then has to rest for 30 minutes before she can be back on her feet again. Very significant.

On page four, again about two-thirds of the way down, item 15, shopping. She says she has

difficulty carrying items. She has problems with balance.

On page -- let's see, I'm skipping ahead to page six. At the top of the page, this is a continuation of a question about her social activities. But under item "C," top of page six, she says she gets annoyed with people when she is out in public. So she has alleged depression. This is going to relate primarily to when we develop her mental, but there we have someone who gets annoyed with people. I get annoyed with people. Maybe I have a disorder.

Two-thirds of the way down, how far can you walk before you need to stop and rest? Again, she is giving a set 15 minutes. She can be on her feet for 15 minutes, then, she has to rest for 30 minutes. That's very significant to whether she is going to be able to work or not. So we want to keep that in mind when we look at the medical. Does the medical support that degree of limitation, someone that can only be on their feet 15 minutes at a time; and then has to rest for 30.

Now, on the next page, page seven, again, midway, again, she is saying she has anxiety over multiple complicated disease process.

Then, item 20, she mentions that she uses crutches and a cane. She uses crutches after the hip surgery, and she says the cane is for increased weakness. So again, we're going to want to look at the medical records. Is there a medical reason for using a cane? Because if you have to use a cane -- if there is a medical diagnosis for -- that says you have to use a cane for ambulation or balance to be on your feet, that is going to be a very significant limitation in our assessing her ability to work.

Someone that has to have a cane for all ambulation, we're going to, then, look at whether they can carry things in that free hand. And we're probably talking about somebody already down to sedentary, or possibility of sedentary just on the basis of using a cane if that is medically documented that she has to have a cane. That is a significant finding as well.

Then she goes down a little -- her next

questions below that says she has left-sided weakness. We know that she has -- she is alleging a left hip injury. We know that she had the arthroscopy back in '04 from trying to determine whether she had a severe impairment or not. So that would be a reason for having left-sided weakness. If I have got a bad knee and a bad hip on the left side, then I would expect to have some weakness in those areas.

Then, finally, on the final page of that function form, she says that she was in the process of scheduling a total knee replacement, and she -- when she had the injury; and that's prevented her from proceeding with that treatment to the left knee. So if she was -- and she had a right knee replacement ten years ago. So we had someone that had a history of significant disease process with both her knees. One that resulted in a replacement. One that was about to result in a replacement. So again, standing for 15 minutes, having to sit for 30 minutes just without even looking at the medical seems to be not out of the bounds of reason that we would expect.

Then, at the last line she says that she is taking an antidepressant. So she has alleged depression. She has alleged treatment. She is on an antidepressant medicine. So right there tells me that I am probably going to have to address the mental RFC as well. I have got some alleged impression, and she has been treated by a physician, or at least alleged treatment by physician for mental impairment. So we are probably going to have to evaluate that as well.

So now I'm going to go to the physical RFC, because now I'm going to try to take the medical records that I have, and I'm going to refer back to these medical records. And we will -- we will show how the medical records lead us to a determination of what we're -- how we're going to rate her on the residual functional capacity.

Let me say real quickly that there is a bit of a difference between how a treating physician approaches a claimant, and how adjudicators in the disability program, including physicians, approach claimants -- in a claimant's record.

For a doctor in the field or a doctor treating a claimant, diagnosis and prognosis are the most important. We want -- a physician wants to find out what is wrong with the claimant, and what can I do to treat that problem. What are my treatment options? What can I do to cure the problems, or at least ameliorate the symptoms? At least reduce the impact.

For us, we're more about prognosis -- we are more about diagnosis and history. How did the claimant get to the point that they are now? Is there a medical basis for where they are? And that's where we stop. We're not as worried -- we are worried about prognosis since duration.

If a doctor says, well, this is a fracture to their femur, but I expect it to be healed within two months, then, I know that I'm not -- I have got something that is not going to last 12 months. It is not even going to be something that we're going to rate.

If I'm six months after the fracture and the doctor tells me that on x-ray there is still no

callous formation, you know, the two ends of the fracture have not joined yet and I'm six months after the fracture, I have probably got someone that's going to meet our duration requirements. The leg is not healing properly. So I'm worried about prognosis in the sense of what does it do for duration?

But to explain what I'm talking about, recently I saw a case where the woman had ankle -- a history of multiple injuries to her ankle. The bone -- the ankle was so unstable that the doctor -- her last physician said that what she needed was a fusion of the bones in her ankle. The claimant reported that she could only stand and walk, perhaps, an hour total out of the day -- total out of the day in like five to ten minutes increments, because the pain was so significant in that ankle, and the instability was so significant.

Well, the DDS -- the DDS physician said, well, if she would get the fusion, she would be okay. So he gave her a rating for six hours standing and walking, saying the fusion would take care of that. The prognosis for that treatment was that she would

be all right; and in a fairly rapid amount of time. But the case history showed a woman who had been out of work for ten years who was not married, had no income, had no insurance, was living in the back room of her sister and brother-in-law's house. She was not going to have this surgery.

There was no likelihood that she was going to be able to afford, or be able to have this treatment for any -- she had been this way for three years. She was going to continue to be this way. So that six hours was based on a prognosis based on treatment that wasn't going to take place. So the proper -- proper evaluation for our program would be to say what is she like now?

Well, we have a person with a significant ankle injury that is not going to get any better without surgical intervention that is unlikely to happen; and therefore, we would have rated her probably one hour standing and walking max, based on her own report and based on what we had in the medical records. Total difference between what is the factual and what could happen. So we're not as

worried in the DDS or in the disability world about what could happen to this person. We're worried about where they are now.

I saw a presentation from a doctor who primarily treats peripheral arterial disease, but he does a lot of doctor exams for us, people that are alleging that they have pain on ambulation. And he was saying that most of the people that we sent to him for doctors he could cure if he could take them upstairs and give them a balloon angioplasty of the femoral artery -- he could cure them.

Well, that's not work we're asking. Are they curable? Possibly. But where are they today? The answer is today, their doctor is significant enough that it meets -- the listing -- it meets a medical listing, and so we are going to allow it, because they haven't had that treatment. They may not be likely -- they may not be able to afford that treatment. We're just assessing them on where they are today.

So bit of difference of approach. We are not as worried about the prognosis. We are worried

about where they are today, and the likelihood that they are going to get better any time soon. So we might end up allowing people under our criteria that could be treated, if they could be treated. Well, maybe if we get them on disability and they get Medicaid benefits, they can get that treatment; but that's not our question. Our question is what is their functioning today?

So we're on the RFC. And as I said, the first thing that we are going to ask in assessing the RFC, in assessing the functional ability is, is there an MDI that would reasonably support what the claimant said they can and cannot do. So what I have got to do now is go through the medical and determine exactly what it is that I have got that shows -- that would relate to the impairments that the claimant has had.

I already said that the treatment from Heffernan Hospital shows that back in '04, she had an arthroscopy in the left knee for a torn meniscus. And she said that she hadn't been able to get a knee replace, so we know that there is probably additional

degeneration there.

Now, if I go to the tab above Heffernan, it's MER Dr. Pyle -- and I won't even comment on the names of these imaginary physicians. But Dr. Pyle has been treating the claimant for some time. He notes that -- he saw the claimant on January 20th, just about eight days after the claimant had her injury. He says that -- he was worried at that time about the possibility of a hip fracture, so he did an x-ray of the pelvis. Shows no obvious fracture. So he just told her to stretch and modify her activity.

At a later date, back in February 2005, about a month after the surgery, he did an MRI. It shows that there is mild arthritis in both hips, but again, he does not see any significant abnormality in that hip. So he continues to treat her all the way up to June of '05, five months after her accident.

Increased knee pain. He says it's consistent with her known degenerative joint disease. Straight leg raising was negative. So there is a finding that would relate back to her knee injury.

So basically, when he last saw her, which

was in June of '05, which is about a year and a half ago, he says low back joint -- low back/SI joint, left hip strain and sprain. So he is just giving her a diagnosis of a sprain and strain, which might not be enough to account for all her functional loss that we are seeing now. A sprain in a year and a half certainly should have gotten better.

So we're going to leave him -- except in the last page of his MER, he gives us his medical opinion. He gives us a medical source statement. Now, he notes that he hasn't seen her since June of '05; but he says, specifically, I believe that she is unable to do any significant amount of prolonged standing, walking, twisting, turning, carrying objects greater than 10 pounds -- greater than ten. Then goes on to say, I'm not aware of any cognitive impairment. I am not aware of any upper extremity impairment.

Now, this medical source opinion would be very important to us in determining the level of functional capacity, because we have to balance what the claimant says, and what the doctor says. And

this is a treating physician. So we will give a lot of weight to the doctor's opinion.

The problem is, is that he last saw her in June of '05. We are now in March of '07. So this medical opinion is based on treatment that is now a year and a half later. A heck of a lot of things have happened to this woman since he last saw her.

So we would not give -- necessarily give a lot of weight to this opinion, even though it is from a treating physician, because we have had a lot of subsequent treatment that he is not aware of. So even though we have a medical source opinion here, it is dated. Whereas, it gave -- might have given an accurate opinion of where she was five months status post accident, we now need to see something that's a little bit more recent.

So if we go to our next physician here back in my records is Dr. Seinfeld and Dr. Seinfeld, let's see, I believe is about the fourth tab from the back. It's labeled MER Seinfeld, MD. Again, I will not comment on the name of that doctor.

And we see reading this -- the first thing

we do is we get our first good description of what happened to this lady on January 12th. She was getting into her car. She was halfway in her car when she slipped on ice and did the splits. That would leave me in quite a bit of pain.

She was able to catch herself. She did not fall to the ground, but they then evaluated her later -- as we know Dr. Pyle did -- for fractures. Did x-rays, did an MRI, was not able to show any fractures.

Right now we are here with Dr. Seinfeld. He is not necessarily the treating physician. He has been consulted by one of the treating physicians to do an EMG, because she is complaining of radiculopathy from her back. She is saying she has low back pain L3, L4, and she is having radiation. Radiculopathy down into her right leg. She is having pain in her buttocks, and in her groin area.

So he does an EMG, which comes back essentially negative. There is no EMG evidence of radio -- radiculopathy. Thank you.

Now, on the second page of his record, he

also -- there is a record from the spine center that shows an MRI of the lumbar spine that was completed in December of '05. Now, that was prior to the accident in -- I am sorry, January of '05 was the accident. This is almost a year post the accident. It shows pretty much mild degenerative changes throughout her lumbar spine all the way down to the S1 level. It shows mild disk disease throughout her spine. It also shows a small bulge at L1, L2, and it shows an HMP, a mild disk herniation at L3, L4.

So certainly, here we have an MDI that would give us some, you know, basis for having sitting problems, walking problems, standing problems. We have degenerative disk disease, and we have a mild bulge, and we have a mild disk herniation from an MRI.

Now, going from there, if we look at the Spine Center, which is the third tab MER from the Spine Center, she injured her back in January. She is on Zoloft now. They reviewed her, they did x-rays over the past year. They did an MRI. Again, they are giving her a diagnosis of low back pain, possibly

radiculopathy from L3. Some scoliosis. They're the ones that recommended the EMG, which, again, we know is negative.

Then, we can go to Shorecoast Orthopedic. It is the fifth tab in your packet. She goes to Shorecoast Orthopedic. This goes back to January of '04. So this goes back prior to her arthroscopy that she had in April. It shows degenerative joint disease of her knee. He thinks that there is probably a meniscus tear. We find out that, indeed, there was. She comes back in December of '06. Now, we are getting somewhere. We are about four months prior to where we are now. So this December of '06 record is going to be very important to give us an idea of where she is at the moment. She comes in for her knees.

Now, they're treating both her knees. They do an x-ray of the left knee that shows arthritic changes with some spurring. The joint spaces is being well maintained. Her right knee shows that everything is fine with the prosthesis. No obvious loosening. He accounts for this pain with the right

knee due to overuse, because she is compensating for the difficulties she is having with left knee.

Also, we don't see any indication that she was being scheduled for a left knee replacement except for own report. She is having increased problems with left knee, and now with her right knee because of overuse.

Now, if we go to Dr. Beene's MER, which is the sixth tab, he has treated her since '05. He has treated her all the way back to her knee injury. Her hip was doing just fine after the accident, which is about six or seven months. Then in September of '06, well over a year after the surgery, she had another injury to the hip. We don't know the exact nature of this injury, but she just says that she injured the left hip again.

It was determined that she had a labral tear. So she was admitted to the hospital. On 11/27/06, about six months prior to where we are today, she had arthroscopy of her left hip. So try to attempt to repair that injury to her hip. She is now post surgery. She is doing well, and he has

prescribed physical therapy for her -- continued physical therapy.

Then, if we go to the seventh tab -- well, that ends -- let's see. I think that ends most of our medical. Real quickly, I'm going to go over a chronology real quick. Back -- we know that ten years prior to this, she had a right knee, total knee replacement.

In February of '04, she had a meniscus tear. In April of '04, three years earlier, she had an arthroscopy of the left knee to treat that meniscus. January 12, '05, two years earlier, she fell on the ice, she did the splits; and after that point she not only had knee pain and hip pain on the side that was, I guess, outside the car. She has also been having back pain. Let's see, February '05, she had an MRI. April '05 she had an MRI. Both were negative in terms of the hip having any permanent injury there.

12/05 she had mild degenerative changes of the spine. She had degenerative disk disease throughout her lumbar spine with a mild bulge at L1,

L2, and a small GP at L3, L4. March '06, one year ago, she was negative EMG for radiculopathy. Then, November '06 after a second injury to her knee in September, she had left hip arthroscopy. In 12/06, the doctor who is treating her, Dr. Beene, has said that she is disabled in terms of usual occupation.

Now, that can be a significant finding. He says that she is disabled in terms of what she normally does. That is what we call an opinion reserved for the commissioner. When we get a medical source opinion what we're looking for is injury to function. A claimant has broke their leg. They can't walk, you know, on their left leg. Claimant has an HMP in your back; they can't do significant lifting. Those are functions related to the diagnosis.

But an opinion that says the claimant is totally disabled, or an opinion that says the claimant can't work, or an opinion that says, the claimant can't do this type of work, those are opinions that we will -- that are reserved for our purposes. We will make the determination if they can

work. We will make the determination if they can do their past work.

So that type of opinion from a physician, we do not -- we note it, but it is an opinion that is reserved for the Social Security Commissioner; and therefore, it does not impact on the determination of injury or disability. We will only look at what they say the functional abilities are related to the injury.

Because, in essence, it is not the physician's, you know, purview to decide what kind of work they can do or whether they can work. Their job is to tell us, you know, what is the functional loss resulting from an injury.

So we know that she has also from the record been undergoing physical therapy, continues to undergo physical therapy. We do not have those physical therapy notes. So we don't know exactly what -- you know, what the increased function has been from there.

So we have a claimant. We know that they have degenerative joint disease in both knees. The

right knee, she is having some pain in because of overuse. Her left knee she has degenerative disease. We know she has degenerative disease in her back, with an HMP and a mild bulge. We know that she has had an arthroscopy in her left knee.

So the question then is, can -- are this -- are the symptoms that the claimant is alleging, could they reasonably be caused by these impairments? I think the answer is generally yes. We would expect someone with a knee injury, a hip injury, and a back injury to have difficulty standing and walking, which is primarily where her allegations are.

So when we go to actually assess the RFC, there is two factors that we have to critically consider. One is the credibility of the claimant's allegation. And number two is any opinions from the medical source that we have in file. And if we find that the claimant's allegations are completely credible, and we -- then our RFC has to match what the claimant says they can and cannot do.

If we take a medical source opinion and we find that it is well supported by the objective

evidence that has been supplied; that it is not inconsistent -- not inconsistent with our total record -- and we make a very fine distinction between consistent and not inconsistent -- not inconsistent with the records, then we have to accept what that doctor told us, so that our RFC has to exactly match what the doctor said and what the claimant has said.

Now -- and we're done. All we have to do is fill the RFC out to match. But the issue is, are the claimant's allegations completely credible, and is what the doctors told us not inconsistent. Let me explain what we mean by that.

For example, if a claimant has been treated by an orthopedic for years for a knee injury and has a problem with their gait, and that's what their main allegations are; then, I'm also looking at treatment records from the cardiologist. Well, the cardiologist doesn't mention their limp. The cardiologist doesn't mention they have pain in their knee. Is that inconsistent? No, because the cardiology is treating their heart problem, is not treating their knee. So it will be unlikely to

comment on their knee. So it is not inconsistent. I don't have a problem with any opinion from that cardiologist.

Now, if the cardiologist were to tell me claimant skips into my office today, and does a back flip landing on both their knees, then, that is not consistent with what the orthopedist has said, and somehow I am going to resolve what the orthopedist is telling me with what the cardiovascular surgeon is telling me.

I had a doctor once told me, presentation in the office is not the same as presentation in the parking lot. In the office the claimant has difficulty getting out of the chair, and getting on and off the exam table. Claimant is unable to tie their shoes or put their socks back on after the examination. He said, looking out the window I see the claimant walk to their car where the door has been stoved in by an apparent accident, claimant climbs in through the window, and then climbs over the seat to get in the back seat of the car. Not consistent with how they presented in my office.

I think he must have been a little bit suspicious in why he was looking out his window. That would be something that we would then have to resolve in the claimant's testimony, and we probably would not find the claimant totally credible. Because what they said they couldn't do in one instance, apparently they could do in another instance.

So we are balancing credibility of allegations. I'm very careful to say credibility of allegations, because we don't make any finding about the credibility of the claimant himself or herself. That's not our issue. We are looking at what the alleged symptoms would be in determining whether they're credible or not.

So we're here on page two of the physical RFC form, and that is on your right side of your folder if you have a marginal folder. If you do not it is under the physical RFC, the 4734. Now, on page one of that form what we're looking at is -- at the top of the page it gives the diagnosis. We're looking at a left hip anterior labral tear. We're

looking at degenerative disc disease. And we're looking at depression and degenerative joint disease. We're noting that this is a current evaluation.

As John said, if this claimant's DLI was in the past, meaning her insurance had expired, then our evaluation would be from the date last insured. So say this claimant had stopped work 15 years ago, and was no longer insured. You're generally insured for five years after you stop work.

So we're more generous than your car insurance company. If I stop paying my car insurance today, if I have an accident tomorrow, they're not going to pay. But Social Security, we continue your coverage for five years after you stop work -- roughly five years after you stop work. So if she had stopped work ten years ago, and her DLI was five years ago, we would only be looking at treatment from before that DLI. Anything that happened after that point, we wouldn't be able to assess.

So page two. The first thing we have to look at is whether the claimant can lift and carry. Now, if you are familiar with the DOT, you will

notice that these items listed on page two are the strength factors out of the Dictionary of Occupational Titles. All right. That's page two of the RFC, the physical -- yes, the disability for this -- sorry, the physical RFC; the one on page two.

MS. SHOR: One quick question.

Could you explain who is completing this form?

MR. JOHNS: Yes, I certainly can.

Now, this form, in most instances -- well, I can't say most instances. I don't really know what the percentage is anymore, but every DDS has a medical staff. And these people are either contractual, so they contract for a number of hours, or they may be paid by the hour. But in some states they're considered employees. In most DDSs they are considered contract workers. They're contracted to do -- to give medical advice to the disability adjudicators.

Now, say 20 years ago most RFCs, physical RFCs would have been completed by a physician, by a physical doctor. So that the disability adjudicator

would have gathered this evidence, would have evaluated it, and would have marked pieces of the evidence that they felt were critical, like the MRIs, the x-rays, and surgical reports. Then, they would have either gone to the doctor and discussed the case with them. And between the two of them arrived at an RFC; or they would just refer the case to the doctor, and the doctor would have written the RFC.

Now, in today's world we have -- in ten states, called the prototype states, there is what's called single decision maker, and adjudicators are allowed to write their own RFC -- their own physical RFC forms. In reality, that is done in most DDSs today. The degree depends on, you know, the case load, that type of thing; but in most every DDS, adjudicators will complete at least some of the physical RFCs that they -- that they have to complete on a case that they have determined doesn't meet or equal a listing. They have to be signed off on by a physician in those situations.

In SDM cases, those ten states that are under SDM, there are certain circumstances under

physical. The physical form does not have to be signed by a doctor. So in ten states the physical form may not even be reviewed by a doctor. In the other 44 states, even if the adjudicator completes the form, it would have to be reviewed and signed off on by a physician.

Our instructions allows for the adjudicator to assist in the evaluation process. In fact, I think that's almost exactly how it's worded, the adjudicator may assist in the evaluation and completion of forms. We will go back to that when we talk about the mental. It gets a little bit tricky on mental. In physical, in many cases it will be an adjudicator.

Now -- so these factors right here on the -- okay. I am being told there is ten prototype states, but 20 states are actually under the SDM. As I said, to some degree or not, most states allow adjudicators to complete physical RFCs.

Now, these items here on page two, the seven strength factors, standing walking, sitting -- standing, walking, sitting, lifting, carrying,

pushing, pulling. So we're going to rate these things. So how do we do that?

Well, we don't have magic charts or magic tables that say if you have a HMP at this level, you get this amount of lifting and carrying. That's been judged over the years to be too much of a cookbook process, whereas, you know, kind of to match up -- you know, fit a claimant into a structure. We don't use the ADA guidelines -- the physical guidelines book that says, if you have this injury, you have 15 percent injury to the left hand. You have this much injury to the arm, and this much percentage to the body as a whole. We don't use those tables.

So what we will do is we have some general guidelines that we start with, and then we look at the specifics of the individual we have before us. Now, the DOT and other information that we have agency wide says to do medium work. To be able to lift 50 pounds occasionally, and 25 pounds frequently -- being able to lift 25 pounds frequently is more important than being able to lift 50 pounds occasionally. And that that weight is frequently

lifted from the floor.

So right off the bat, to be able to do medium work, to be able to lift 50 pounds occasionally -- I mean, 20 pounds frequently, 50 pounds occasionally, I would have someone that would have to be frequently lifting weight from the floor. And to be able to get down there to the floor for proper lifting, that person would have to be crouched to get down there.

I have got a person with bilateral degenerative disease in both knees, and a significant injury to the left hip. The likelihood that that person is going to be able to do any significant crouching to lift weight from the floor is just not there. So already I have knocked out the ability of this person to do medium work. So I know I started off with the max, because of this person's injuries to their knees and hips is going to be -- all he is going to be able to do is 20/10.

So now the question is doing light work. 20/10 work is primarily at a work surface or a counter, primarily standing; but the weight lifted

for light work, for 20 pounds, is primarily at a counter. So you are not necessarily lifting that weight, you are dealing with that weight on a counter or conveyor belt or some kind of work surface.

So there is nothing about this person's knees or hip that would necessarily prevent them from lifting 20 pounds, occasional; 10 pounds, frequent. Now, I also have a back injury. I have a mild bulge at L1, L2. I have a mild disc herniation at L3, L4 with some allegation of pain; but the medical records that I have don't show any significant limitations to reveal that she can't lift and carry.

She had negative straight leg raising. Her -- not a lot of significance there with her ability to deal with weights. So in this assessment they have assessed her for 20 pounds occasional, 10 pounds frequent. So doesn't give us any sort of weight restriction in her own records. We do have Dr. Pyle who limited her to ten pounds, but, again, that was a year and a half ago. So it doesn't necessarily directly relate to what we're doing today.

Dr. Beene did not give her a specific weight limitation due to her back. So I would say the 20/10 is fairly reasonable for what we have got here. Couldn't do much more than that because of the inability to lift weights off the ground. The back is -- is -- not required surgery, been treated with massage. I think at one point in the file the doctor was recommending acupuncture. She is undergoing physical therapy, but not something that is so significant that we would limit her below 20 pounds occasional, 10 pounds frequent.

The next thing we're going to rate is standing and walking. Well, there is a claimant who said that she cannot stand, walk more than 15 minutes, then has to rest for 30 minutes. We know that she has degenerative disease of her hip in both knees so -- but, in addition, the records of Dr. Beene and Dr. Pyle also show a good range of motion in her hip and in her knees.

After the arthroscopy in November, you know, six -- three, four months after the arthroscopy, she has good range of motion in her hip.

So she is still doing physical therapy, but she has pain. So in this case they limit her to at least two hours; and they clarify it on page eight that says, I believe, three hours total; three hours maximum out of an eight hour day is what they have rated her for.

Now, keep in mind she says she can stand and walk for 15 minutes at a time, but we would be considering here the total amount of time that she can stand and walk over an eight hour day. So she could do it in 15 minutes increments, no more than three hours over the entire length of a day.

Sitting she says that -- now, the claimant has alleged that she uses a cane. No where in the medical record is a cane indicated. It wasn't prescribed. It wasn't noted in the treatment records if she is using a cane. In fact, most of the reference is to her gait and station noted. Said that she walks with a slight limp. And that's about the most that they -- they don't go beyond that. So that we don't see any medical reason in the MDR that we have for prescribing a cane.

So that would not affect -- here if they

had said that she was required to use a cane for all ambulation, for example, that would have required us to consider no more than sedentary. This limitation here to two hours -- and actually, the RFC goes on to say three hours max -- is going to limit her to sedentary work. She is not going to be able to do a full range of light because of her inability to walk more than three hours a day. So we have got her at sedentary. Generally, sedentary, even though we are lifting and carrying at light level, her standing and walking is down to a sedentary level.

Now, one thing here that I would probably take some variance here from the RFC that we are given is we're told that she can sit for six hours, and that it doesn't require any sort of alternate sitting and standing to relieve pain and comfort; but the claimant has told us that prolonged sitting, as well as prolonged standing causes her to have difficulties, increased pain.

And this is -- would be consistent with the treatment that she has gotten with the medical evidence that we had. So I probably -- here I might

have said that she could sit for six hours in a day, but I probably would have checked alternate sitting and standing; and I would have said -- you know, would have noted that she can only stand for a maximum of 15 minutes. That she can sit for 30 minutes and has alleged no problems with sitting, but I would have done an alternate sitting and standing here to say that she would have to relieve her sitting posture after a certain length of time to relieve the pain that you might have from sitting.

Number five, we have pushing and pulling is unlimited. This one gets tricky. With pushing and pulling, we expect you to be able to exert the pushing and pulling commensurate with the weight that you can lift and carry. We said this person can lift 20 pounds occasionally. Then, down here, pushing and pulling. What we mean is we would expect that person to be able to exert 20 pounds of pressure when pushing and pulling. We wouldn't expect them to have to do -- to be able to do -- for example, exert 50 pounds of pressure of pushing and pulling. We would hold them down to that 20 pounds, ten in pushing and

pulling.

MR. OWEN: Mr. Hardy has a question.

MR. JOHNS: Yes, Mr. Hardy.

MR. HARDY: Moving back up to alternate sitting and standing.

MR. JOHNS: Yes, sir.

MR. HARDY: I'm trying to remember, could you tell me what does that mean to you in general, definitionally?

MR. JOHNS: Okay. For us definitionally -- what we look at is what we call the base posture, or the posture, you know, either sitting or standing, which posture it is that causes you the most trouble. In this case it is primarily talking about her standing -- her ability to sit -- to stand or walk for periods of time. So we would be talking about her base posture here being her ability to stand.

Then we would look at the relief posture. What she has to do to relieve the problem she has with standing. In this case what she has to do, she says she has to rest for 30 minutes sitting. Actually, in the notes I can't remember right off

hand which doctor. She says she actually will lie down flat to relieve her pain, but that that only -- that only provides relief for a limited amount of time. But in a normal work day we don't expect you to be able to lie down.

So if we had someone that had to alternate between standing and lying down, we would consider that to be a very, very significant restriction or limitation. It might very well -- it might at this point -- we might stop the completion of the RFC and say this person couldn't sustain a 40 hour work week, because they would have to lie down for two hours a day out of every eight. And we would say, well, they can't sustain any type of work because no type of work is going the allow you to lie down.

For what we normally mean is alternate sitting and standing. In this case we would say -- what I would of said, if this person could only stand on their feet for 15, maybe 20 minutes at a time, at that point they would have to sit down to relieve -- to relieve the back pain that they had. And she said that she has to sit for 30 minutes to relieve. So

what I might have said here -- might have said, if I felt that the medical supported it, was here is someone that can stand for 20 minutes, then must sit for 30, stand for 20, sit for 30, during an eight hour day.

And then I would leave it to the vocational people, myself, if I was doing the vocational in the case or whatever to determine if that was a significant enough restriction to prevent her not only from doing her past work as she did it, or as she performed it, but what it does to us at step five.

Now, in this case, the physician that completed this RFC determined that alternate sitting and standing was not required, and the basis of that probably was if you go back to the actual treatment records from her physicians, none -- Dr. Pyle, Dr. Beene, neither one mentions any sort of alternate sitting and standing being required.

We do have -- actually, from the psychiatrist who did the CE for us -- we will get there later -- noted that she, apparently, had

discomfort sitting during the interview; and that she shifted a lot in her chair. He didn't note that she actually -- that she actually had to get up and down to relieve pressure.

Now, that is from a psychologist, but I would have used that as functional evidence in assessing the RFC, because there is an uninvolved third party, because he is a psychologist, giving me some physical -- you know, some notes about the physical.

But alternate normally would be between the base posture and relief posture and trying to determine what balance between those two is required so that the person can function. What's the most they can stand? What's the most they can sit?

MR. HARDY: So this is kind of the gray area where you kind of move away from the DOT definitions that are found on the page, and there is more room later on for the voc person?

MR. JOHNS: Yes. At this point, the alternate sitting and standing, all of that would be -- the voc person would determine how significant

it was, and the impact it was on their work.

MR. HARDY: Past limitations.

MR. JOHNS: Now, it will have different degrees of limitations if you are talking about step four. For example, say I was a telemarketer, and I was on the phone all day. I can do that standing up as well as I can sitting down.

So if it said that every 15 minutes, or 20 minutes I had to stand; then I could only stand for 15 minutes, then I had to sit for 15; up, down, up down. If I am doing something like telemarketing, I might be able to call it -- I might still be able to do my past work.

Now, if I was an over the road semi-truck driver, I'm not going to be able to drive that truck for 15 minutes, pull it over, get out, stand up for 15 minutes. You know, nobody is going to hire me as a truck driver if I have to alternate sitting and standing. Sometimes most impact is past work.

Then, at step five once we are pass past work, how -- the frequency of the alternation can have a great impact on your ability to work, because

at step five we're talking about unskilled work. So if you said this person would have to alternate, could be accommodated by normal breaks, you know, every two hours they had to sit for 15 -- they had to stand for five, 20 minutes. Well, most jobs allow you to break every two hours. Two hours, break. Two hours, lunch. Two hours, break. So that wouldn't be much of an impact on your ability to do past relevant work.

If you told me, again, the 15 minute up, down thing, that's probably going to preclude most unskilled work. So in step five, it might take on a lot more importance than it did even at step four.

MR. HARDY: Thank you.

MR. JOHNS: Mr. Woods, did you have a question?

MR. WOODS: Just real quickly, in discussing item one, you distinguish between -- I think something from a counter, which makes sense. How is that judgment made, you know, in terms of identifying whether you are lifting from the floor and the counter, and how is that reflected? On page

eight -- I know there is no note.

MR. JOHNS: Right. There is no note to that affect. I guess, actually, to be honest, I was probably crossing between medical and vocational.

MR. WOODS: We don't have to go into detail.

MR. JOHNS: But and -- a physician might not even know it. The lifting from the floor thing, a physician might not even be aware of even in our program. I was justifying in my own mind where we were. But it goes back to the DOT, how the DOT describes things; and how we have developed our policy over the years from what the DOT says.

So within our program medium work -- the lifting of 25 pounds frequently is more important than the occasional 50; and the DOT talks about that being lifting frequently, you know, primarily from the floor. I was kind of piecing two things together in there. I kind of cheated.

Ms. Ruttledge.

MS. RUTTLEDGE: The problem I have with this entire conversation is that what we don't --

what we don't include in the analysis currently is anything related to reasonable accommodation. So when we blanket make a decision based on this person needs to rest every half hour, or can't stoop, or can't lift, whatever; there are solutions to that, which is what the Americans with Disabilities Act said is that if the essential functions can be reasonably accommodated, then, the person continues to be a qualified individual with a disability.

So I guess I just add that to the mix of the conversation as we talk, because as we look at the segment that we are responsible for looking at, which is the Occupational Information System, we all bring expertise to this conversation. And I don't want us to go down a route that only says as a profession we're going to look at when an adjudicator is looking at evidence and only looks at the evidence that says a person can and cannot lift 25 pounds.

In the real world when we then say, what are the transferable skills for this person to work or not work, the answer is not often a medical answer.

MR. JOHNS: Right. And I don't disagree. It is not something -- you know, it is not something we consider at the RFC level, because what we're doing is we're determining, in essence, without accommodation, what is the most that we think this person can reasonably do and sustain.

It may be that a person -- you know, I believe we talked about this briefly last time; but a person with MS or MD, especially multiple sclerosis, Monday morning at 6:00 o'clock in the morning they may be fine after a full weekend of rest. What they can lift and carry and stand and walk at 6:00 o'clock on Monday may be a lot different than what they can do on Friday, you know, at 5:00 o'clock in the afternoon after a full week of work.

So what -- we can't pull out the picture Friday at 5:00 o'clock. We can't pull the picture out Monday at 6:00. What we have to do is determine what's the most that they could sustain over that whole week. So sometimes that causes us to lower the RFC; but, again, we don't necessarily look at the impact of accommodation, or are there accommodations

that could affect this. We just look at specifically what can they do? What can they not do? What's the most? And how that raises the question with the ADA certainly is something to consider. It is not something presently we consider in this assessment.

Now, quickly on page three --

MS. LECHNER: Tom.

MR. JOHNS: -- on this form, we have postural limitations.

MS. LECHNER: I just wanted to make a comment and remind everyone that we're not talking about actually measuring the individual's ability to do this. This is just purely speculation from the medical evidence, and what would, you know, make -- or really helps determine something like that is knowing how much flexibility she has in those total needs. If she has almost a full range of motion and strength enough to squat down to the floor and get back up, then, yeah maybe she could lift those 20 pounds; but if she doesn't, it's probably going to be less than 20 pounds.

MR. JOHNS: Right. Indeed.

And I will touch back on something we said the last time in our meeting back in February, is that we're not looking at the claimant's age here. We're not looking at the claimant's sex. We're not even -- you know, we briefly looked at her body habitus. She is 5'5", 158 pounds, which may be at the top end of her weight range; but certainly not obese, or significantly obese. So at this point we are not looking at her body habitus. We are not looking at her age. We are not looking at her sex.

What we're looking at is what would these impairments do to an ideal body, I guess, you could say, or body that has no age or no sex. We're only looking at what the impairment does. And certainly, there have been considerations in the past in purchasing functional capacity evaluations in determining exactly what the person could lift or squat.

The problem is -- again, I'm not an expert in functional capacity evaluations, but the thing, you know, that has always stopped us to some degree in going that route is we would -- in a FCE, we would

get -- we would get an assessment of how much they could lift, and how much they could stand. But we would -- conditioning -- we would have to be able to factor out conditioning. We would have to be able to factor out their sex. We would have to be able to factor out their age. We would have to be able to factor out all those things that aren't impairment related. And there has been some difficulty with that. I will just leave it at that. That's possibly, you know, for future discussion as well.

For RFC, we don't do a FCE. In fact, occasionally we will catch a doctor that does CEs, actually has weights in his office; but this claimant was able to lift a 20 pound dumb bell, but they couldn't lift 25 pounds. Well, that's not exactly what we're doing here, you know. We are taking an estimate based on all their treatment and trying to put that on to the individual. We are not actually having them lift the weight or putting them on a treadmill and seeing how far they can walk before they fall over. That's not what we are actually doing here.

So step three is posturals. For balance it was limited to frequent. Now, she has said she has balance problems. Real quickly, don't want to go into -- go off on that tangent; but these definitions or these factors are based on the DOT. So balancing in the DOT is maintaining equilibrium on a narrow, wet, moving surface.

The example they give in the DOT or in the -- you know, job handbook for analyzing jobs is serving food on a tray on an airplane. So actually, being a -- you know, a steward or stewardess -- flight attendant. That's balance in the DOT. So when we're talking about limitations of balance, talking about limitations on a narrow -- a wet escalator; you know, a escalator in the rain.

So anyway, they have limited to occasional climbing of ramp, stairs; ladder, rope, scaffolds, which is -- considering she has a hip and knee injury is fairly relevant. Stooping, kneeling, crouching, crawling, again, reasonable to limit her to occasional because of her injuries; but whereas all of these limited to occasional might have impacted

her past work, wouldn't necessarily impact the light occupational base or sedentary. Because if you are doing sedentary work or light work, there is not a lot of crouching or crawling involved. You just don't have to be on your hands and knees if you are doing sedentary work, higher exertional ranges.

Page four, no manipulative limitations at all noted in the file. No visual limitations.

Page five, no communication, no environmental limitations.

Page six, they did an assessment of the credibility of her allegations. Noted that her statements are partially credible. And the reason for that is she says she uses a cane, but there is actually absolutely no mention in the medical records of the use of the cane.

She mentions in her ADLs that she has extreme gait alteration; however, records as recent as 12/06 refer only to a slight limp. She complains of pain, but only takes Advil. She is on no narcotics, which is -- that's always an iffy thing. If she said she was on, you know, Hydrocodone, you

know, ten tablets a day, and the doctor is prescribing it; yes, she is probably in a lot of pain. Just because she is not on Hydrocodone doesn't necessarily mean she is not on pain. There may be other reasons they don't want her on narcotics.

I think she said something about itching in the records. When she took narcotics, initially she had a lot of itching. So they may not have her on narcotics because of side effects. But it is an indication that she is managing her pain on Advil. Maybe she is not quite at the level of severity that she is claiming to be.

Then, she is -- but she is seeing consistent treatment. Sometimes the gaps in the treatments records for someone who has insurance or has the ability to get treatment. If there is big gaps in the record, it raises questions about well, if they are in that much pain, why aren't they getting treatments?

In this case the woman consistently had treatment since her injury. She is continuing in physical therapy. That seems to say here is

someone -- there is some credibility to the allegations, and continued pain and stuff. She is continuing to get treatment. I will note that she has been prescribed narcotics in the past. She was on Vicodin in the beginning, you know, right after surgery.

Now, on page seven we have to assess the medical source opinions of the physicians. Number one, we talked about what Dr. Pyle said; but we didn't get a lot of -- give a lot of weight in this assessment, because he hadn't seen her for a year and a half.

Now, Dr. Beene, who has seen her recently, he has said she is on total temporary disability. Again, that sort of statement doesn't have a lot of impact on the RFC, because total disability is -- you know, that's a determination we would make based on the functioning. Temporary disability is not something we assess in our program.

Then it states, in a perfect world, she would be able to do only very limited seated duties; certainly, no standing, walking, extended carrying,

pushing, lifting or carrying. Now, we did not fully adopt that opinion and limit her to only seating with no lifting and carrying, because the objective findings that he provided, in our mind, in our program didn't support that degree of limitations.

She has pretty good range of motion in her hip and knees. She has negative straight leg raising. She only has a slight limp. Diagnostic studies show that her right knee is still in pretty good shape. The replacement is in pretty good shape. She is not being recommended for back surgery. So all of those findings don't seem to point to someone that can only work seated, and who can't do any significant pushing, lifting, or carrying.

So for that point we considered his opinion, but felt that it wasn't totally supported by the objective findings that he and the other physicians provided.

So page eight, our final assessment. There is a quick, brief paragraph that talks about -- that summarizes the treatment. And then what we really need is why are we giving this person a limited RFC?

And the reason here is in the second paragraph, problems persist in spite of multiple surgical procedures and physical therapy, which could be expected to cause pain, loss of function and endurance. She is still having difficulties. She still has some gait abnormalities.

So it's been determined that with the continued difficulties objective findings have led us to a 20/10, which would be light; but it limited her ability to stand and walk for three hours, which would be in the sedentary range.

So as Shirleen gets into the vocation, it's going to be a balance between the light at the top end, and the sedentary at the bottom end, and decide where within what she has done in the past and what she has the potential to do using those skills, what that does for her ability to work in the future. And so that's residual functional capacity, the physical assessment. This is what we -- this is then what the vocational people would use in the DDS to determine her ability to work, both past work and any other work that might exist in the national economy.

We're about five minutes before noon. The mental is not going to take us near as much to walk through, because there is not near as much medical in support of that. So I think we can do that fairly quickly after lunch; and I turn it back over to Mary.

DR. BARROS-BAILEY: Thank you. We will go ahead and break for lunch now. The Panel is going to be having a working lunch in Georgia seven. So if we can all get together and do that, and get back together at 1:15. Thank you.

(Whereupon, a lunch recess was taken, and the proceedings subsequently reconvened.)

DR. BARROS-BAILEY: Okay. Mr. Johns, it's over to you. Thank you.

MR. JOHNS: All right. Since -- I didn't ask pretty much if there were any questions, because we were right before lunch. I always hate that when someone says, and you can go to lunch unless anybody has any questions. Whoever has the question everybody gives them a dirty look, wants to beat them up in the parking lot.

Now that we have had our lunch, if there is

any questions regarding the physical aspects of the cases, any specific questions about how generally disability looks at that evaluation, I will be glad to address those. I will throw out, for what it's worth, that in this situation -- in this case all the records that we were looking at were from what we would call acceptable medical sources.

And generally, you know, for a physical that would be any medical doctor or, you know, osteopaths, of course, is acceptable as well. What we consider nonacceptable sources would be things like physical therapists, nurse practitioners; people that don't have -- chiropractors; people who don't have a medical degree. But I want to qualify that by saying that if we have a medical diagnosis from an acceptable medical source, then we can use the function reports from nonmedical sources.

So for example, in this case she has been seeing a physical therapist. We don't have those physical therapy notes in here; but as long as we have the diagnosis from a medical doctor that she had degenerative joint disease of the knees, and

degenerative disc disease at the back -- if that's all we had and didn't know anything about range of motion, gait, anything else, but we had physical therapy notes in the file telling us, you know, how mobile she is, we could have used those notes to establish the RFC, the functional level. Just as if we had, you know, an orthopedist telling us that the person had disc disease, if we had chiropractor notes giving us range of motion and things like that, we could use those chiropractor notes.

We will even buy -- DDSs are even allowed to buy CEs from like a nurse practitioner or physical therapist or anything like that, as long as we have an MDI established by an acceptable medical source. So I just throw that out for what it's worth.

DR. WILSON: Can I ask you another question.

MR. JOHNS: Yes, sir.

DR. WILSON: From evaluating this case from a physical standpoint, would you characterize it for me in terms of level of complexity, normality. I mean, is this a typical case? Is it atypical in any

way for you. It's not -- it's a fairly common case. We -- probably we have -- the two largest areas that DDSs normally see are orthopedic and mental, are the two largest -- you know, are the two body systems that we see the most cases in.

So seeing a body system like this is -- you know, would be right along with what, you know, we see most often. The -- I wouldn't say that there is anything particularly unusual about it. Let's see, the CE was done, I believe, in April or the end of March. I'm trying to think. The MRFC was signed in April. That's a little bit long. I can't give you the exact average processing times, but they run around the 60's, mid 60's. So the average case, average processing time for DDS is around 65 days, I believe.

So for this case to -- now that doesn't count the processing time at the field office. That's roughly 30 days or less. So she applied in November. DDS probably got the case some time late December, early January. And for them to have the case, making a decision 120 days later, that's a

little bit out of the norm. I'm not sure what it was that -- you know, if this was a real case, what it was that caused the delay in there.

Because normally what they would have done is -- as I said, 20 days to get -- you know, you send out the initial response in 20 days. And at 20 days you send out a second response and wait ten days. If you haven't got responses from all the doctors by 30 days you purchase a CE.

So if this were a typical case, I might have expected to see a CE being purchased late January, early February. A physical CE to evaluate her condition. Because -- they must have waited because physical evidence wasn't coming in. I mean, if this had been a real case, that's what I would be guessing.

Now, if this were a real case, I would have the DDS worksheet in here. The DDS worksheet goes back to the MIDAS system that John was talking about, back to the legacy system. It basically documents every action that the examiner took in the case from the first day they got it to whenever they wrote it.

You can walk through the case, see what is going on. They put in the notes. So I can tell you why it was 120 days old.

But that's a little bit unusual that it is that old without having taken -- now, the other half I could say possibly it was that old is because they were developing, you know, physical only, and thought maybe they had an allowance and they got it back from the physical doctor and realized, oops, we didn't have an allowance and now we have got to document the mental; and so maybe they bought a mental CE and that's why it's old.

All in all, this level of evidence is probably pretty close. It may be a little bit more extensive evidence than we often get. On the other hand, this claimant has had a lot of treatment and has continued at treatment, so that's -- so that you would expect.

But keep in mind that a lot of our claimants are lower income, more physical type jobs; and so a lot of them don't have a lot of money. If this were a Title 16 claim, there might have been no

medical records even with this same injury, this same history. If it had been a Title 16 there might have been no medical for us to look at. Maybe like one item or two items, maybe an ER visit right after the fall, and then nothing else. The person -- you know, the person just doesn't have the money or the resources to get treatment. So it kind of depends.

For a Title II claimant who was of the nature of this woman with her access to medical records, this is probably not out of the ordinary. It may be a little bit more heavy in medical on average than we normally get.

DR. WILSON: Thank you.

MR. JOHNS: So all that said -- so we have got an RFC, a physical completed. In the light range for posturals and lifting and carry. Because of that standing and walking limitation, we're down probably in the sedentary range. So we're somewhere between sedentary and light with this claimant.

Now, we have got the mental to address. Now, there is all sorts of rules about the development of mental evidence. And there are

potential that allow the DDS to rule out mental impairments and not, you know, purchase a CE or complete the development; but in this case we have a claimant who a doctor has diagnosed depression, or at least has given her Zoloft for depression. All the records that we have are really back to her physical.

Now, it was the doctor -- I believe it was the doctor at the Spine Center -- Dr. Deacon Palmer at the Spine Center who prescribed the Zoloft. He doesn't go into details in his records as to why he gave her the Zoloft. So we don't really have a strong medical basis for the mental diagnosis, but we do have treatment with an antidepressant, and we do have a claimant who is alleging depression.

And then on her ADLs, I don't know that we want to go back into that; but on page six of the ADLs, you know, she said that she got annoyed with people when she was out in the public. And at the bottom of the page she said she could pay attention for about 30 minutes before, you know, she loss -- before her attention span -- before she loss concentration.

Now, that's not uncommon, of course, with someone with the degree of pain she is alleging, that she would have difficulty with concentration, that she would be irritable as well, or that she would have problems with some depression because of the degree of pain that she is feeling. But because we have some functional loss that could be attributed back to a mental impairment, and because we have a diagnosis -- at least treatment with an antidepressant by one of the physicians, we're going to have to document that.

Now, she did mention on the 3368 that she had seen a therapist. I believe the name of Jerry Lewis -- I won't comment on that one either; but those records aren't in the file. So all we can assume is that the therapist was contacted and didn't return the records. So the -- as an adjudicator, I'm sitting here with a whole lot of physical with the hints of some underlying mental illness, or you know, it may be directly related to physical, it may not; but I don't know. So I would have probably done what this adjudicator did, they purchased a CE,

consultative exam, from a physician.

Now, briefly on the consultative exams. Every DDS maintains a list of physicians that will do exams for the DDS. They all have public relations staff or medical relations staffs that recruit doctors in various specialties in all of the states. Of course, it depends. Some states say like Florida have six sites now; Michigan has four. Then you have other states like Texas, as huge as it is has one DDS office, one centrally located in the capitol. So they will have people that recruit doctors all over the state.

Because -- programmatically we say we will not require the claimant to go more than 50 miles for the exam. Sometimes we can't keep to that. If you are in Wyoming there may be a hand full of doctors in the entire state that do exams for us. So you may have to go 300, 400 miles to get an exam. That's more of a rarity than what is common. If you live close to a major metropolitan area, it is going to be fairly easy to get a doctor in a specialty. These doctors do exams for us and agree to do them at our

cost -- you know, at the cost that we have.

Now, in virtually every DDS I imagine in this country now there is teledictated -- teledictation services. So as soon as the doctor has completed his exam, he will get on the teledictate and dictate his report, and the DDS will have that report in a matter of, you know, maybe a day or two, maybe that afternoon, depending on how busy the service is.

So these are doctors that are in private practice that don't have any association with the DDS or Social Security, except that they have agreed to do exams for us at our cost. And some doctors will do maybe one a week. Some doctors do more than that. There are doctors that virtually their entire practice is doing exams for the DDS, and they're very high volume producers, and they do a lot of exams. They know what it is we're looking for, the language that we -- you know, the definitions of our terms.

So -- and as I was going back, as I -- the main reason I kind of mentioned the fact that we don't always have to have technically acceptable

sources to do our exams, the area of mental exam is one of those areas where often times even a provider will not necessarily be a Ph.D. Our standard is a clinical licensed psychologist, but sometimes we will allow MAs to do exams if we have a diagnosis in file from a psychiatrist or clinical psychologist. If we have a MDI from an accepted medical source, then an MA with a degree, you know, can do a mental status exam for us.

Now, that -- I don't -- that's an interesting sideline. Almost all the exams we purchase are from Ph.D.'s. It is very rare that we actually purchase a psychiatric exam. But that's just -- I'm not sure that there is any -- there is not really a programmatic reason for that. It is just that -- it's just over -- the history that we have developed it's easier to get exams from psychologists in the field than it has been from psychiatrists. The main part of it might be the fee schedule; I don't know.

So anyway, they purchased a CE from Dr. Smith, a Ph.D. There wasn't any specific testing

done, because the little bit of evidence we have had -- for example, Dr. Beene mentioned -- Dr. Paul mentioned there were no cognitive deficits that he had noticed. So there was no evidence of any cognitive problems. She had been working at a fairly -- you know, a fairly skilled job. So there was no evidence of any mental retardation or anything affecting her cognitive abilities. So the DDS did not purchase an IQ test.

There wasn't any specific things like memory loss alleged. So there were no subtest or any other tests purchased. Basically, what we purchased was a mental status exam to try to get an idea of what this woman's functioning was. So that's what we have under the blue tab labeled -- where is it -- CE Smith, Ph.D. It's a two page report.

The things -- the kind of things that we're looking for are things like in the first paragraph of the presentation. He notes that she is very articulate, organized, goal directed, speaks normal speech and volume. No sign of psycho motor retardation or education; but he notes that she

becomes increasingly irritable as the exam goes on. In fact, she is a little bit irritable when the interview starts and that gets more and more as the exam goes on. He notes that she is also uncomfortable sitting and shifts in her chair periodically.

So she is probably, you know, maybe experiencing increased pain as the exam goes on, as she is sitting there for a long period of time and becomes a little bit more aggravated.

Third paragraph. She alleges feelings of worthlessness, primarily related back to she was a very good wage earner, now she is not making any money. She feels isolated. Again, she talks about being irritable. And she says her sleeplessness that she had mentioned in her ADLs, which could have been pain, she says here it is mainly due to pain, except that now she is beginning to worry about other things as well.

Then there is some more physical stuff. Then on page two, she goes home, watches TV, reads, works on crosswords or other types of puzzle, writes

letters, talks with her husband. Again, no indication necessarily of a cognitive disorder. So we go back -- she finds it more difficult -- but she does note that she finds it more difficult to remain interested in a project for any length of time.

Social contacts are reduced. Doesn't do dinner parties, because she doesn't feel like being around people. She does visit, talk with her friends, but she is doing that at a reduced level from what she was in the past. Depressed, oriented to person and time. Abstract thinking, good. Insight, good. Cognitive function, unimpaired. Memory and concentration are both good. Here we have concentration, good. Affect is irritable, withdrawn, entire. Easily fatigued, limited interest in activities. Again, irritable behavior, withdrawn behavior, lack of energy.

Now, a lot of these relate back to the physical problems that she has, but that's not necessarily -- I wouldn't necessarily have cut us out from assessing that. Some time some of the tricky areas are where a person is alleging lack of

concentration, or lack of memory, things that normally we would think in terms of mental impairment, but they don't really have a mental impairment.

Whereas pain or side effects of medication -- for example, if she had been on a strong medication that interfered with her ability to concentrate, that might be a very important factor to rate, but it's not a mental impairment, because it is all related to the physical condition that she has. So sometimes we will get a mental doctor that's on staff at the DDS to comment on things like concentration, persistence, and pace, even though they don't really have a discrete mental impairment. It may be just straight physical, but that impact is like it's mental.

In this case, the doctor has given her a diagnosis of adjustment disorder with mixed anxiety and depressed mood chronic. So he has given her the mental diagnosis; and therefore, that requires the doctor on staff at the DDS to complete an assessment.

Now, Ms. Shor to go back to your question

about who completes the physical; well, who completes the mental?

Well, the rules within the disability program are a little bit tighter for the mental evaluation. Whereas, it does note that an adjudicator can assist with the completion of that. Even in the SDM it states a psychologist or psychiatrist must review all PRTF and MRFCs. Whereas, the physicals it can go out on just the adjudicator's nickel, with a mental evaluation it has to go through a psychologist or psychiatrist for their review.

Go ahead.

MS. ROTH: That is unless it's fully favorable. So if it is a fully favorable decision that we're going to be making, then, an MD or SDM can make that decision.

MR. JOHNS: Right. Exactly right. I was thinking in terms of this case being a denial.

But certainly, in most cases even before SDM, if a case is going to be fully favorable and the examiner -- it varies from state to state. Some

states will allow adjudicators just to do a note in the file to explain why they found it to be fully favorable.

But for denials, as John was saying, you have to go -- every "I" has to be dotted; every "T" has to be crossed. We are allowed to make shortcuts with allowances. In fact, with the physical RFC, say, if this woman had been 60, or 55 and an RFC would have allowed her, all we would of had to have completed is the first checked box that said 20 pounds, occasional lifting, and then explain because of her back she cannot lift more than 20 pounds. That's all we would of had to say, and would not have had to complete anything more than the RFC form.

Same thing with the MRFC. If any one of these blocks would have allowed her, we would of had to go into the narrative and explained why, but could of -- we can shortcut allowances, because generally claimants don't complain about being given money. It is only when we are not giving them the money they tend to get upset.

That's not always true. I have seen some

claimants that have sued over diagnosis codes, because they didn't like how they were allowed. I had a claimant -- we ended up denying eventually. We had allowed her because she was only alleging physical impairments, but there were things in the file that indicated she had a bipolar disorder. We actually purchased a CE, went to the CE. We allowed her because she was bipolar.

When she got her check, she wanted to know why she was allowed. When they told her at the field office it was because she was bipolar, she threw a fit. She was angry, because we had allowed her on mental. Eventually, we went to the courts where she wanted all of her mental diagnoses and evidence disregarded in her file, which a claimant can do. They can tell us to ignore evidence. We're going to be very careful to document that in the file; but you know, this is the claimant applying. So if they want us to disregard something, we will.

It ended up -- she ended up being a denial, because her physical impairments were, you know virtually nonsevere. That was a strange case. I

won't go any further on that. But sometimes people do get upset why we allow them.

So the first thing that we're going to do is complete a psychiatric review technique form. This is -- it dates back to the early '80's when there was several court cases involving how we evaluate mental impairments, and the result of that was the creation of this form, because the way we adjudicated mental claims changed.

And this psychiatric review technique form basically walks you through the listings, and ask you -- and this was actually -- probably closest to talk about, it is like a teaching tool to reeducate the physicians out in the field how we're going to adjudicate claims from that point on. But it has stayed and it's never gone anywhere.

The usefulness of the form has been debated a lot lately, and there has even been some proposals to eliminate this form, because we're 20 years, 25 years post its creation, doctors understand now how we evaluate. Attorneys understand how we evaluate. The judges -- everyone understands it, so what's the

point? We don't have a similar form for the physical, for example, that walks you through every physical impairment and ask you to complete everything regardless of the body system. So why do we permit them? Well, we do.

So here we have the psychiatric review technique form. On the cover sheet the doctor's note is the RFC is necessary, and if there is a co-existing non-mental impairment, which requires review by another medical specialty, which we have already done; and then says right here, its affective disorders in category C -- I'm sorry, that's the psychiatry -- what's the tab. The tab says psychiatric review, 2506, if you are following along with your tab.

This is the psychiatric review technique form, and on the front page the doctor has noted that the category under which the disposition is based is category three, 12.04, and that's the listing; 12.04 is the listing, affective disorders. And again, that goes back to the CE diagnosis, which was chronic anxiety and depression, which was -- is an affective

disorder.

So we can skip all the first pages, which walk us through every one of the listings, which the person does not meet until we get to page four of the psychiatric review technique form, which is affective disorders.

And the physician completing this form dropped down and felt that the claimant's diagnosis -- the claimant's condition, medical condition as described in the CE didn't really fit into the diagnostic category of 12.04. I mean, it was in that area, but it didn't fit our specifics for the listing, which means it doesn't meet the listing. So David down here checked box at the bottom that says, an MDI is present and does not precisely satisfy the diagnostic criteria; and then gives the diagnosis that the psychologist gave at the CE. Adjustment disorder with mixed anxiety and depressed mood.

Now, in order to -- unlike the physical listings -- or actually, an RFQ physical listing can have two parts; but most physical listings just have

a set of numbered criteria that you have to meet. With the mental we have the A criteria and the B criteria with virtually every listing. The A criteria outlines the diagnostic -- the criteria from the diagnosis the claimant has to meet. The B criteria are the four function areas that the claimant has to meet.

So it is kind of like ordering Chinese food. To meet a listing you have to have some from column A, and you have to have some from column B. The interaction of those two is what is going to get you allowed. So what we have got here on page four is the A criteria. The diagnostic criteria that you have to meet for an affective disorder.

Now, what we also have to review is on page 11 of the PRTF, and this is the B criteria or the functional. And you can see outlined here, here are the four areas that we assess under the B criteria. Activities of daily living, social functioning, concentration, persistence, and pace; and decompensation. So we rate the claimant in those four areas.

In order for a claimant to meet a listing, he has to have a marked limitation in two of these criteria. So if we had to -- in order for us -- this claimant to have meet 12.04, she would of had to have a marked limitation in two of these four areas. As you can see, she doesn't. She has no episodes of decompensation that have been noted. She only has a mild restriction in ADLs, a mild restriction in concentration.

Most of the -- the most significant areas are in -- for social functioning. Again, throughout the CE we saw irritability, irritability, irritability; and again, the claimant herself reports that she suffers from irritability.

Now, before we leave this form on the next page, on page 12, there is a third -- yes, sir.

DR. SCHRETLEN: I have a question.

MR. JOHNS: Yes, please.

DR. SCHRETLEN: Are the behaviorally anchored descriptions of mild, moderate, and marked?

MR. JOHNS: No. I mean, there are -- there is guidelines of what we consider severe and

nonsevere, that type of thing; but it is really for the adult things.

Now, with childhood disability, that's a whole another animal. We don't go into that for this purposes, because we don't assess children under vocational, unless, you know, they were an older child that just happened to be working. But there, there are definitions.

But there is -- there is criteria, but there is not -- you couldn't say this behavior every doctor is automatically going to say it's marked; or every doctor is automatically going to say it is moderate or easily charred. Some of that relies on the judgment of the adjudicator, the physician completing the form.

So no. I guess the short answer is "no." We will get back to that in just a second as we go into the MRFC.

Now, on page 12 there is a third set, there is a C listing -- the C criteria; and this is specifically for -- the most obvious is say, schizophrenia where a person may be under good

control on medications, then goes off the medications, or bipolar where there is ups and downs, where there is repeated episodes of decompensation.

So you can allow someone here even if -- you know, you can't say that they're always bad in social functioning, because some of the time they may be just fine; but you have evidence of repeated times where they just -- they can't cope. So we allow schizophrenics and bipolar a lot here under the C criteria, saying we have documented episodes where they just have not been able to maintain normal behavior, whatever that may be.

Now, once this form is completed, what we have done is we have assessed the area of the listings we are looking at, which is anxiety, depression, affective disorders. Now, since it doesn't meet a listing, we now have to go and complete a MRFC, a Mental Residual Functional Capacity form. Now, that is under the tab Mental RFC 4734 Sup, supplement. So here it is, the MRFC form.

Now, the first thing that has to be stated about this form is that everybody loves these blocks.

We have 20 areas that we ask the doctors to do reviews for us to assess the claimant in. The first thing to keep -- the first thing to keep in mind about this is, these blocks in one sense are meaningless. These blocks are not the RFC.

On the physical form, the completion of the blocks is actually part of the RFC. We're saying the claimant can only lift 20 pounds, or the claimant can only stand and walk two hours. That's part of the RFC. The other half of it is the narrative that clarified -- that said why the doctor checked those blocks.

Now, in an imperfect world if you didn't have the narrative, you might be able to adjudicate the case with just the blocks on a physical case, especially if it limited it to the point where there would be an allowance; you could adjudicate it. You wouldn't have a strong decision. You wouldn't have a defensible -- a really strongly defensible determination, but you might be able to get by with it.

Here, the narrative -- on the MRFC, the

narrative is the MRFC. These check blocks are not the narrative. All these check blocks are intended to do is to make sure that the psychiatrist and the psychologist completing the review addresses all 20 of these areas.

Now, the first thing is -- to go back to your questions about the function areas -- is these terms have no definitions. Well, they do -- the definition for moderately limited is more than nonsignificant and less than marked. So that's the definition. And I'm not joking. That is the official definition.

And the reason for that is because this isn't meant to be the RFC. This is just meant to be the doctor rating -- the relative severity of these items one to another. So what -- if you checked markedly limited in any one of those blocks, it means that looking at this individual claimant -- in item number four this claimant is really, really bad compared to all other 20 items. But I can't take that marked for this claimant and compare it to a marked for any other claimant. Because that other

claimant, how his -- I'm not saying he is marked relatively to anybody else, but himself or herself.

So these markings are just severity relative to this MRFC. A different claimant -- theoretically, if they were schizophrenic, totally schizophrenic, no control on meds, you know, aluminum foil on their head, talking to their dog, absolutely no control, arguably you could say for this claimant every one of the 20 items is the same.

Theoretically, I guess you could say, well theoretically, they are just moderate because for this claimant they are all the same; they are all unified. Now, for another person, they would not certainly be all marked. It is just all relative within the individual's evaluations.

And the other thing here is even for this to be, you know, an acceptable Likert scale, we would have to have an odd number of, you know, responses. We don't really. We only have four, because the fifth one is just we don't have any evidence. So it's not meant to be anything, but a checked block to guide them.

Now, anything on this form that a psychologist or psychiatrist checks moderate or marked, he must address in the narrative -- he or she must address in the narrative. So on this -- on page one, we notice that the only two areas where there is a limitation noted are the ability to maintain attention and concentration for extended periods, and the ability to work in coordination or proximity to others without being distracted. Excuse me.

Especially item number nine ties right back into the CU report and the claimant's own report that she has been very irritable around others. She gets irritable the longer she is out in public. She has decreased her social contacts, so that certainly makes sense.

The concentration, again, at CE she didn't have major problems -- she didn't have any problems noted by the psychologist in completing the exam, but her own report is that she can't stay concentrated on any task for a very long period. And that she can only maintain attention and concentration for 30 minutes, which based on her pain and everything else

is not unreasonable. So the doctor addressed the limitation there.

On page two we have limitations in item 11, which is the ability to complete a normal work week without interruptions from her symptoms. Item 12, the ability to interact with the general public. Item 14 and 15, which has to do with their ability to accept criticism and to work with peers; and then item number 17 to adaptation, the ability to respond appropriately to changes in the work setting.

Now, we have got several moderates. People will sometimes argue that if you have certain blocks checked "marked," it means allowance. If you have a certain number of items checked in a certain way, it means allowance. It means nothing. The blocks in and of themselves means absolutely nothing. It is only what the narrative says, and what the narrative tells us about the claimant.

So I don't spend a lot of time looking at the blocks, because it's just -- it's just -- all I would do is to make sure that areas that I see in the symptomology or the CE have been addressed in the

blocks. If there is some area that hasn't been addressed here that has been checked "slight," that I think appears in the record, I might discuss it with the doctor to say, you know, they said -- here you say they have no problems with concentration; yet, they have reported it. What's that about? And get that addressed.

Now, the real MRFC is on page three, and this is the narrative. And Dr. Wilson, I -- you know, you asked if the -- if anything about this case was a little bit out of the ordinary. I will have to be honest here and say that this MRFC is more detailed than we ever get.

Now, what we will get a lot from DDS physicians, it may be this much wordage, but three-fourths of it will be just telling me what their treatments notes were. What their treatment history was like. What they alleged in their ADLs. You know, really, I don't care about any of that stuff, because I can read the medical reports for myself. What I need in the narrative is why the doctor felt that they were limited. That's both on

the physical and the mental RFC.

So this MRFC probably details why they did the functioning a little bit better than what we normally get. But the idea -- if you remember back from February -- and I am sure Shirleen will talk about this -- we do a function by function assessment of RFC to past work. Physical, it is easy to do, because you see all the areas, lifting, carrying, standing, walking, stooping; they are all rated. We're suppose to be able to do the same thing here based on this MRFC. I should be able to take the claimant's description of what she did in her past work and compare it to this MRFC item by item and decide can she do it, can she not do it.

Okay. She says -- I'm just making this up -- she says I interviewed -- say she was working in the personnel department and says, I interviewed claimants eight hours a day -- not claimants, but interviewed people that came in for jobs, and performed interviews. Well, I should be able to read this MRFC and get an understanding of whether or not she could do these interviews.

I would say based -- if that were this person's past work, based on this MRFC, they probably couldn't, because this is a person who is getting very irritable the longer the day goes, have problems out in the social. I would say based on that this person couldn't do a job of interviewing or dealing with the public. That's just that. So this is probably a little bit better than we normally get.

We have the diagnosis. There is some activities of ADLs in social functioning, and maintaining concentration. Now, ADLs are primarily about mobility, but it does note about the sleeplessness, and reduced interest, and has difficulty staying focused on projects. So what we're using is the claimant's ADL's and we're using what the diagnosis -- what the mental status told us, and put those two together and decide what it is that she can do in a functional environment, a work type environment.

Now, this third paragraph is probably where we are getting key. Would be able to concentrate for one to two hours at a time on similar tasks; but have

difficulty with sustained concentration for prolonged periods; have difficulty multitasking; and due to fatigue, she might have difficulty working at a factory pace.

Now, again, all of this is judgment based on, you know, the experience and the knowledge of the physician completing this in association with what they know about. Now, this area talking about multitasking and sustained concentration. Even though she doesn't have any cognitive deficits that would prevent her from doing very highly skilled work, the deficits in concentration would probably drop her abilities down in what level of jobs she could do because of a lack of concentration.

Now, the fourth category deals primarily with her irritability, with her social functioning, and again talks about -- ties it back into the CE report. How irritable she was. How the fact that she, herself, says that she was irritable. And we get down here, she can interact on a more -- so what we said is she can interact with the general public on a very superficial level. She can interact with

people that she knows on a more detailed level or a more complex level. But that she might respond inappropriately to criticism or rapidly shifting job demands.

She is going to have a short fuse. And that's primarily -- and really, that's primarily because of her physical problems. But the two with her are so intertwined because of the pain that she has alleged and the problems with the pain, that we have to address them somewhere. It is going to address here in the MRFC.

And they finish up with the last area, the adaptation saying that -- there is some question even in my mind why we are talking about adaptation. The physician who completed this felt there would be difficulty in adapting, because she appears to have difficulty in adapting to her changed physical circumstances. You could make a case by reading the whole physical record that her condition -- that she is making it out more severe than, perhaps, the doctors even think that it is. Because the doctors recommended alternate treatments like acupuncture,

continued physical therapy and massage.

It's several points in the file that said, you know, she should be better, or she should be getting better. So she hasn't been able to adapt to these changes, and maybe there is a bit of a psychosomatic or a bit of somatic aspect to her symptoms; I don't know. It wasn't specifically brought up in the CE -- the mental CE itself, but there might be a little bit of that overlay with this because of her lack of ability to adjust to her physical condition.

I think that's why the doctor here took the point of addressing some adaptation -- inabilities to adapt to changes. Probably related to how she has dealt with the changes in the physical condition. Now, that's the MRFC.

Then, as I said, Shirleen will take that and compare it to her past work; and if she can't do that, the ability to do other work in the field, that will go back on a function by function basis with the limitations and restrictions on the MRFC. And I will gladly answer any questions that you might have.

Again, it will take about 30 days -- about 35 days to set up a CE and get a finished report back in hand. So if you get to the point where you think that you are going to need a CE, some DDSs pull the trigger pretty quick, if they haven't been getting a lot of response back on physical or mental. But there is always a balance. You don't want to buy a CE that you don't need. If you have all the evidence that you have in the record from their own physician, that's what you want to use. You only want to go to a CE if you can't do anything else.

In this case she doesn't have any treatment from a psychologist or psychiatrist. We had to evaluate that aspect of her case. So there was no choice but to go that level.

Now, if I were going to fault -- if this were a real case and I was going to fault anything, I would have pulled the trigger on the mental CE quickly. That would have shortened the time span for the claimant, instead of going 120 days, this case might have gone out closer to the average of 70 days -- 65, 70 days if they could have evaluated it a

little bit quicker.

That's just -- you know, it's a fake case, and I am basing it on the dates that have been put into this case file. The very fact that the CE didn't take place until late March, when we had the case since early January, if as a DQB reviewer -- now, that is not something that we would have returned as an error back to the DDS. But if we were returning it back to the DDS for another error, we would have been glad to inform the DDS that we thought that they were a bit lax in their speedy development of this case. Because we're evil, and we do what we want to do.

A prior head of DQB said, we're not happy until you are not happy; but he is no longer with us.

MS. ROTH: Now, we do have an answer from this morning, a question was raised about the average processing time at the DDS.

MR. OWEN: Yes. I think Ms. Ruttledge asked the question about processing time. Currently, as of March 2009, the current processing time for Title II is 79.7 days, and Title 16 is 81.7 days.

MS. RUTTLEDGE: That's how I would call it. Thank you.

MR. JOHNS: Shows you how long I have been out of the DDS saying 65 days.

MR. OWEN: Just to follow up on that, part of that is the increase in receipts in the DDS, really prolonged in some cases to develop one.

MS. ROTH: Any other questions?

MS. RUTTLEDGE: I just wanted to share, it wasn't a value judgment on my part. I was just trying to recall how long it did take. Because as I look through this -- I know we were chatting about this at lunch -- this is extraordinarily well put together, articulated, has lots of information in it, which isn't necessarily the case as you receive claims and as you try to work them.

I was just trying to get a sense in my head of given what I know to be the reality of the workload that you have and the information that you get from the beginning, how long does that take. So that was helpful. Thank you.

MS. ROTH: Are there any other questions?

I'm wondering if we want to break before we start the next section.

DR. BARROS-BAILEY: I think we're going to go ahead and go through until the 3:15 break.

MS. ROTH: Okay. Great. Thank you. Just a moment, I'm going to reset the computer. For this particular part of the demonstration I am going to refer you to the front screens. And we're moving on into the vocational evaluation.

Now, I'm going to be modifying -- just a moment, please. When I'm talking about the screens we're referring to the front of the room. There is something called OccuBrowse that is displayed on these screens. You can look at either one you choose. I'm not going to be making specific reference to the case file in front of you at this point and time.

Now, I'm deviating from your road map a little bit. I had planned to go through the discussion of the ability to do past relevant work as the person actually did it first. Actually, OccuBrowse is helpful to us in a number of ways. One

of which is simply locating that past work.

Now, one of the questions that Mr. Hardy asked earlier had to do with the job title. In this particular case, you are going to find out that we have been very fortunate. The claimant was very accurate in how she reported her job title, and was very consistent with how it's reported in the DOT. Normally, that's not the case.

We -- again, job titles is all dependent upon the establishment of a particular employer and how they phrase that particular job. So a clerk at one location may be quite different than a clerk at a different location. An analyst for one agency or a private employer may be quite different than a analyst from someplace else, and may be different from the DOT. This is one of tools we have to locate that past work.

So I'm going to be giving you a quick demonstration of OccuBrowse and a discussion of the information contained in it before we actually get into the vocational discussion.

Now, I am going to be -- this is a

demonstration. It is not training. I don't expect you to be able to go home and use OccuBrowse. Again, as I have mentioned earlier, this is a version that has been made for Social Security. It's a simplified version. It is not the commercial version.

The goal of the demonstration is to help you understand the data needs that we have, that we need to adjudicate the claim for you to develop a sense of the problems that we experience when attempting to use even some of the existing DOT information, because we certainly don't want those problems that we're now experiencing in recreating a new system.

Now, in addition to OccuBrowse, at Social Security we also provide adjudicators with a program called OASYS, which is also by the same company. It's a transferability of skills software. I'm not demonstrating that particular software, because it is not policy compliant. It can be useful and helpful to adjudicators, but it will not -- couldn't be used to allow a claim. It can only be used to deny a claim. This particular method I'm demonstrating

today could be used either way.

The other two programs that we provide -- it's a program through West Law. Another one is by a company called SkillTRAN, it's called Job Browser Pro. All of these products contain only DOT information. They are not confounded with other occupational information we can't use.

And the last one is actually a citation. It's a text version of the DOT, and that is on Department of Labor's web site, because they have an office called the Office of Administrative Law Judges, and they do have -- they do reference the DOT. And if you are interested in that, that particular web site is http "colon," slash, slash, www.OALJ.DOL.gov "slash" libdot.htm. And again, it's a text version of the DOT without the companion publication of the selected characteristics of occupations or stow, which we use, and it contains information such as the limitations having to do with stooping, standing, crawling; environmental limitations and so on.

Now, I'm going to be using OccuBrowse,

because, as I said, it gives us the most all around use for all of the different stages. At least it's my preference, and many of the adjudicators within Social Security prefer it.

Now, I am going to be demonstrating, first, how we can navigate it. You can see that there are along the top -- they're grayed out now. The first tab is "browse." The next is "list." So once I have created a list, this will come up here. I am going to actually go over there so that they actually turn black; they're easier to say.

We can browse by worker traits. I go into that one. There is a number of worker traits that I can browse by SVP, GED, strength, physical demands, environmental conditions, aptitudes, temperaments, data, people and things, work fields and MPSMS. I'm going to talk about those a little bit later.

Now, I will tell you that -- actually, I will come back to that later. I am going to demonstrate this to you a little bit later. I just want you to know that this is one way you can search.

Another way you can search is by key word

or DOT codes. You can search in the title, in the description, or you can search key words in both, or you can search by the DOT code. This particular one is a "and" search, so that if you use two words, the search will look for both of those. It's important whenever adjudicators is using these tools to know what kind of a search they use, because West Law, for example, uses "and/or" search. They will look for either one or the other.

Along the right hand-side is another way of browsing by occupational groups. And I'm actually going to go through these first, because these are not necessarily DOT items. And I want you to be aware of what they are.

By in large, these are most commonly used within Social Security in a transferability of skills analysis. GOE is the Guide for Occupational Exploration, and it's another Department of Labor publication, which is -- and I'm basically quoting from their own information. It's intended for use by job seekers, such as recently graduated high school and college students, and groups of occupations

based -- it's based on the expected interest, personal preferences, aptitudes, and adaptability of these job seekers rather than on limitation or restrictions resulting from a medically determinable impairment, as is required for Social Security's disability program. But GOE can still be very helpful to us in doing a transferability of skills analysis.

An example of this would be if we're doing transferability of skills for an eligibility worker, one of the ways of looking for transferable skills would be -- I'm going to talk about some more later -- work fields. The work field for an eligibility worker is called investigating. It is just one skill of many that an eligibility worker may be using. In fact, an eligibility worker does quite a bit of interviewing.

It turns out that the GOE code for eligibility worker is interviewing. So by searching through GOE codes, you can actually find related occupation for transferable skills.

We have talked about O*Net in multiple ways

in terms of adjudication of disability claims. Again, O*Net we cannot use it to adjudicate claims in terms of identifying the job demands, but we can use it for job transferable skills. Again, in some cases it provides some very useful information for that.

The 2000 census occupations. This comes from the U.S. Census Bureau. It's information based on the self-reports from individual job incumbents during the census data gathering. Rather than specific job demands, again, it does not provide any information at all regarding job demands, but it does provide us some information on availability and existence of work in the national economy. And again, this can be used to find possibly related occupations for transferability of skills.

SOC, Standard Occupation Classification, and the related occupational employment statistics that come from that. Again, it's a different classification system than the DOT. My understanding it was developed to allow for comparison between all the different classification systems used in the United States. According to the law, each of the

different systems is required to align themselves with SSC occupations and provide a crosswalk. The last time I looked there were approximately 820 occupations in this SSC.

Again, in aggregation levels it is very similar to the census and O*Net. All of these occupations have less than 1,000 occupations, as opposed to 12,000 occupations in the DOT.

Now, the next four items are actually within the DOT itself. The DIC is called the DOT Designated Industry Codes. Now, at Social Security we find the industry designation really helpful when trying to identify the claimant's past work. Because you can have two different occupations with the same name that are only distinguished by industry. So we commonly will use industry codes, not just for finding a claimant's past work, but also transferability of skills that can be also very helpful as well.

Occupational group arrangement. The DOT codes, it's a nine digit number. The first three digits of the DOT codes have to do with the

occupational group arrangement. They have -- each digit has a meaning. So when we do transferability of skills, one way we can do that is to look at the first two digits of the DOT code, or the first three digits of the DOT code in the occupational arrangement.

Work field. Again another DOT item. An occupations work field describes the overall objective of the job, and how the objective is obtained using words such as teaching, drafting, sewing, writing, welding. I mentioned investigating. It answers the question what gets done. In the DOT it lists 96 work fields. Up to three of these may have been assigned to an occupation. Generally speaking though, most occupations have only one.

Some people have argued that work fields are a good proxy for skills. Again, I would argue that most occupations involve anything more than -- most occupations involve more than one skill. So this might have been a good idea, but the way it was carried out is not going to be helpful to us if we only look at that.

The next item is materials products, subject matter, and services. Again, this is something very closely related to Social Security's definition of transferability of skills. Again, it can be very useful. Again, it has the same limitations in terms of the number of items that have been coded.

The last one is military codes. This is simply a cross walk between the military's occupational classification system and the DOT. And it could be very help, because it can be very difficult to find related occupations in the DOT for someone who has a history of military service. Yes.

MR. WOODS: This is really just for future as we look at changes to the Occupational Information System for Social Security. Keep in mind that the DOT is no longer used by Department of Transportation. Anything that might be used out of to be considered in what we do.

Also, that the industry codes in the DOT are actually out of date. The DOT was published in '91. The relationships would not be at that level,

instead the judgments should be at the level of the American Classification System. Again, all -- part of the process.

MS. ROTH: Thank you.

Now, I would like to go through a few minutes and talk about some of the areas within Social Security that we have -- we have difficulty applying the Dictionary of Occupational Titles terms. Now, again, as we have been reminded, the Dictionary of Occupational Titles was developed for a wide variety of uses, none of which was disability adjudication.

It so happens that when the government began the disability program within Social Security, that the Dictionary of Occupational Titles already existed. It was the -- the well-established and well-recognized leader in terms of classifying occupations in the national economy. So Social Security adopted it at that time. But it wasn't necessarily developed for our use. And so some of the items within it don't work for us. So I'm going to come here and talk about some of those.

The first one is GED. My understanding is that some of the early information about General Educational Development and some of the other issues within the DOT were developed by a research of organization contracted by Department of Labor. And originally when GED, or General Educational Development was created, it had a zero scale. It had an acknowledgment that there are some jobs that don't require any reading, any writing.

They don't necessarily -- there could be a GED scale where you simply have a laborer who picks up a sack of cement, for example, and carries it 5 feet and puts it someplace else.

The GED, as it exist today, it has no zero scale. So there is a presumption that every occupation requires reading, writing, and reasoning and mathematical skills. Which for us, again, is problematic, because we do have claimants who could be illiterate. And if you were to -- again, we believe that there are jobs in the national economy that someone who is illiterate could do.

Now, again, the one scale. The level one

scale in GED requires reading of recognizing the meaning of 2500 words, and that's two or three syllable words. And it requires somebody to be able to read at the rate of 95 to 120 words a minute. It requires someone to be able to compare similarities and differences between words and between series of numbers. It requires somebody to be able to print simple senses containing subject, verb and objects, series of numbers, names and addresses, and so on.

In terms of mathematics, it implies that every job in the United States requires a minimum of being able to multiply and divide by 10's and hundreds by the numbers two, three, four and five, to perform basic arithmetic operations, and so on.

So again, from a policy perspective, we don't believe that that's truly the minimum level of requirement for occupations in the United States. And even at the upper levels SVP, I don't have all the details. But I will give you an example that I had to my own personal experience. I was a claim adjudicator in Social Security for many years. In terms of claim representative working in a field

office taking applications and as a disability examiner.

That particular occupation as claims adjudicator, DOT code 169 267.010. Now, if the GED rating for this occupation were to be accurate, I would have been required, for example, on the job to be able to solve quadratic and exponential equations, understand deductive axiomatic geometry, and understand the essentials of trigonometry. Now, in fact, I do; but I didn't need it on the job.

So there was no time in almost ten years that I have needed to do any of those things. So -- and I find that fairly consistent within most of the GED ratings.

So although, SSA's vocational policy doesn't include use of GED for determining a job's cognitive demands, SSA has seen legal challenges to its decision based on the use of GED ratings by plaintiff's counsel. For example, a claimant challenged the agency's final decision that she could perform the job of surveillance system monitor, because the job had a GED reasoning level of three.

The plaintiff's mental residual functional capacity limited her capability of carrying out simple instructions, argued that she could only perform jobs with the GED reasoning code of one. So why is this important to note? We need to be careful about what we include in the new occupational system. Because every element that's selected may be subject to scrutiny -- and should be subject to scrutiny -- and to legal challenge.

SSA will only want to ensure that only that information that's necessary to disability determination and disability evaluation is collected, and that whatever is collected can withstand the legal challenges.

Yes, Mr. Woods.

MR. WOODS: I just reinforce your point, and to me -- and this is editorial -- the GED is an example of really something that's intended as an alternative to having a high school diploma; and by getting down and looking at detailed parts of the GED and being used for another purpose sets you up.

The GED is not designed as -- it's

basically another measure of high school equivalency. So I want to second your point. I think it's very important to look at what something is intended to do, and how it's used. This may be an example if you look at SVP and GED with whatever we come up with that you may want to have a single system that measures your educational training requirements, and not have multiple measures.

I mean, they have -- you know, different levels, but it is a single measure. To me, this is a classic case of GED; it was never intended to say you should have trigonometry or anything else. It was an equivalency of a high school degree. That's all it was intended.

MS. ROTH: Thank you.

Now, one of the other areas that we have some difficulties with have to do with ranges of work. Now, we know that actual job demands probably ranges rather than at fixed rates. So we have, in terms of strengths levels -- we have descriptions of sedentary work, light work, medium work, heavy work and very heavy work. They're very well defined

within the Dictionary of Occupational Titles. In fact, we find that there is actually some overlap between the description of sedentary work and light work.

Notwithstanding that, one of our problems in adjudicating claims is that when we do the function by function comparison of the individual's abilities with the types of work as its described in the national economy, we don't know, when we're looking at any particular occupation, whether the demand for that specific occupation is at the lower range of light work, for example, requiring mostly just standing and walking with no lifting and carrying; or perhaps it's at the higher level of light work where it involves significant standing and walking, plus significant lifting and carrying. We don't know where it falls within that range.

And so we, in fact, have to make an assumption when we're adjudicating claims that all occupations described as light, that they fall at the top most point. That, in fact, they involve every single descriptor that's brought to bear for light

work. And in fact, our regulations acknowledge that.

Our regulations at 20-CFR, 404.1567, and there is -- that's for Title II claims, Social Security claims. There is another one that's the same for Title 16. And it basically says, for Section B for light work. It says, to be considered capable of performing a full or wide range of light work, you must have the ability to do substantially all of these activities. So we have to make a basic presumption. We know that in the actual world that is not really true. Some of them may fall at the lower range or middle range, but we cannot make that comparison.

Now, the next issue we have, creates some problems for us is how the ratings are obtained -- now, I'm going to be talking about job analysis. There were a number of ways that these analysis could be obtained. We make a basic presumption in making presentations that there were a certain number of jobs analyses completed for the job. Basically, after a number of individual job analyses were performed for a given DOT occupation, the results

were average. There is no data available to show whether the individual job ratings were consistently, again, at the low, medium, or high level.

Very similar to the one we talked about before. The first one had to do with the fact that there are ranges. Again, in medium work from 25 to 50 in terms of lifting. The other one has to do with how individual jobs are analyzed. One other issue has to do with what we call the importance of job demands. Now, in rating physical job demands, climbing, stooping, and so on -- I'm going to go back to that. This is not showing all that I need to be able to see.

We're looking at all the physical demands. The job analyst rated only those elements that were critical to the performance of a job or performed to an unusual degree, which in a generalized occupational system makes a lot of sense; because basically a baseline of functioning for a job incumbent was assumed. It was assumed that somebody could sit and stand, and so on; could actually do the functioning of moving, and sitting, and standing.

So if a physical demand or environmental condition did not meet this important criteria, it was rated "end," for not present. When we're evaluating disability, there are those cases where someone can't do something even once. So I have seen claimants who couldn't climb even one step. That's to an unusual degree. That's -- that baseline -- so that baseline of functioning, you can't make that assumption when you are looking at evaluating disability claims.

So we would in that particular job, for job demands, we would want to know, perhaps -- we may need to know, perhaps, if the person is required to climb even one step, even though climbing one step would not be to an unusual degree when looking at the occupations throughout the country.

Do we have any questions about that?

Now, another item that we have some issue with has to do with job demands versus individual functioning. This has to do with the linkage between how we describe work in terms of the individual, the person side; and how we describe work on the

occupational side, the work side. We oftentimes use the same language to describe the two, but sometimes that linkage is not very well defined or not well connected. And it is something we need to be very careful about.

So for example, within the Dictionary of Occupational Titles, stooping may not be a demand that is identifying a lot, or it's found to be a significant issue in a number of jobs. From a policy standpoint, however, within Social Security, we would say that someone who is unable to stoop even one time -- somebody who is completely unable to stoop would have difficulty going from a standing position to a seated position, because most people when they sit down bend forward. So that's a policy call from our standpoint.

So again, from an occupational standpoint, the Dictionary of Occupation does well describe stooping from a generalized standpoint. We look at it quite differently when we're looking at it from the person side.

Another area where we have some problems is

in reaching. Now, we have a lot of claimants who have difficulty with, quite frankly overhead reaching, because a lot of people have torn rotator cuffs -- so watch your shoulders, folk.

Torn rotator cuffs can commonly cause difficulty reaching overhead. The DOT description for reaching is reaching in all directions. So that's only going to be rated, or it's going to be rated for reaching in all directions. So if somebody has to reach forward directly at shoulder height, if they're going to reach at waist height, if they are going to reach on the floor, if they're going to reach overhead. If they reach in any direction, this will be rated. Commonly within Social Security we need to know a specific direction.

The difference between not present and never within the DOT. Not present might be if it's simply not important. It's not present in the occupation. For us, that's quite different than saying never. When we say that somebody can never do something, that's fairly strained. If we say somebody can never climb, or never stoop, oftentimes

those ratings will lead to an almost automatic allowance.

So even -- and so sometimes people will see this end rating, and connect that with the end rating from memory and think that they mean the same thing, and they don't. So then we have to be careful about how those ratings are shown.

Tom mentioned one of the rating barriers where we had some problems a little bit earlier, balancing. We find people -- people with neurological problems commonly have difficulty balancing. So making the assessment about whether they can work can be very tricky.

Do they need to use a cane? Do they need to use both hands to balance themselves? Do they put one hand on a pole? Do they put one hand on the wall just simply to walk a straight line? That's what we're looking at.

The Dictionary of Occupational Titles definition is quite different. It looks at slippery surfaces, uneven surfaces, moving surfaces. It is not related to some issues that we are looking at.

Again, we need to be cognizant of the fact that we are using these terms to make a linkage in the new system. Again, this was not built for disability adjudication necessarily; but in the new system we are going to need to make sure that the definitions and what we are actually looking at sync up.

DR. WILSON: Are their other physical demands from your standpoint that -- are you happy with the sort of taxonomy of physical demands regardless of -- in some cases the multi-dimensionality, and the mental scalene issues? Are there things you could add, or things you could subtract from that list?

MS. ROTH: You are asking my personal opinion. I think we -- Social Security has a long, adjudicated history in using the physical demands as they're shown in the Dictionary of Occupational Titles. Quite frankly, I think we're very close. I think refinements need to take place in some of the areas we have discussed; and I'm sure other people can find some other refinements in terms of definitions and rating scales. I think in terms of

the kinds of things we're looking at, we're fairly close.

There is a few elements that we need to look at a little bit more closely, some of the -- issues; and again, reaching issues. So there are some refinements that need to be taken -- need to take place.

One of my personal concerns has to do with the aggregation of occupations in terms of sedentary, light, medium, heavy and very heavy. I think that that's a fairly high aggregation. There is actually five groups of occupations in the United States.

When you talk about the O*Net being highly aggregated for thousands, five is pretty aggregated. I think that there are some problems there. I would like to see that broken out. In the physical realm, I think we're fairly close with some refinement.

Any other questions before I move on?

A few other areas where we're having some difficulty actually comes back to what the Social Security Act requires. Actually, I'm going to break those out a little differently. Let me do one more

in that area, worker environmental concerns, environmental conditions. This is one area where we need some refinement.

We have individuals who -- these by in large are fairly appropriate for our use, and are very helpful. We do have those individuals that cannot be exposed to an environmental issue even once. Those people with severe asthma. You expose them to dust and they are going to end up in the hospital almost immediately. People with heart impairments have difficulty being exposed to, for example, vibration, extreme heat, and extreme cold.

So it would be helpful for those to know -- of us to know if you're going to have any exposure to any of those things. And then not just -- when we're talking about environmental conditions, we're taking about both the degree of the condition, and the duration of the condition. In the DOT it only rates the degree -- excuse me, the duration. So it would help to know the degree as well.

Now, there are a couple areas where we have some difficulty, and that has to do with what we call

aptitudes and temperaments. Social Security Act is very specific -- let me back up. The Congressional history in the Social Security Act makes it clear that Congress intended there be a distinction between disability benefits and unemployment benefits.

In doing that, they included in the Social Security Act language which directly affects what we may consider in determining disability. And also, what we're precluded by law from considering. So Social Security's Act says, 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 able to do his previous work, but cannot, considering his age, education, and work experience, engage in any other kind of substantial gainful work, which exist in the national economy, regardless of whether such work exist in the immediate area of which he lives or whether a specific job vacancy exist for him, or whether he would be hired if he applied for work.

Now, I am going to go on. That language is further carried out in our regulations, which say --

and this is in section -- if you need to refer to it, it's in Section 20 CFR 404.1566, Section C, inability to obtain work. We will determine that you are not disabled if your residual functional capacity and your vocational abilities make it possible for you to do work, which exist in the national economy, but you remain unemployed because of your inability to get work, lack of work in your local area, the hiring practices of employers, technological changes in the industry in which you have worked, cyclical economic conditions, no job openings for you. You would not actually be hired to do work you could otherwise do, or you do not wish to do a particular type of work.

So when we're looking at a person's disability, we can factor in only the results of the functional effects of their physical or mental impairments, their age, education, work experience. You can't consider what they like. We can't consider what they're good at. And we can't consider factors that employers might find are helpful for job placement. So for example, there are some ratings scales, which will give employers fairly good

information about who is going to be the most successful candidate for a particular job. That's not something that we can consider in evaluating an individual's disability.

So when I come back to the concept of aptitudes and temperament, aptitudes -- both aptitudes and temperaments are basically based on -- aptitudes are based on natural abilities and the personal preferences of job incumbents, not related to physical and mental impairments; not related to age, education, work experience. You can't consider those.

Temperament. Now, temperament when you read them they look like they could be used as a proxy for the mental demands of work. And if we had a different rating scale, perhaps, that might be true; but temperaments, as they are currently included in the Dictionary of Occupational Titles, are measured based on personality characteristics and personal preferences of job incumbents. Again, not related to issues that we can use. So we need to be careful not just about what we develop and how it is

measured to make sure it stays within the meaning of the Social Security Act.

Do you have any questions about that before I go on?

Now, I will be coming back to a bit of a demonstration of OccuBrowse in a few minutes. First, we are going to go back to our case, our sample case, and we are going to now start walking through the sequential evaluation process. And I will start answering some of the questions that you raised this morning.

Now, when we evaluate -- do the vocational evaluation -- both John and Tom mentioned these earlier today. What we do at this point in time -- I am going to make the basic assumption at this point and time that the RFC has been completed, and that I'm looking to apply it to the vocational aspects of the claim. So I'm not going to be going back and questioning the RFC, but there were some issues raised in the RFC that I may bring up, because it affects the vocational application.

So for example, Tom talked about the sit,

stand option. Well, if you have that in the case, it makes a difference. There were some analysis that he did of the mental residual functional capacity. His analysis would affect my analysis. So I may go back and circle back on those issues.

When I start looking at the claim, the vocational aspects, I'm going to look at all of the information that we received from the claimant. Now, first of all, one of the documents that we went over earlier today was, if I can find it, the 3368. The 3368 is the disability report for an adult.

It is the basic information we use the first completed statement that we receive from the claimant having to do with their medical condition, kind of problems that they're having, the medical sources that they see, and so on.

Particular document I'm looking for, there is one that's a field office observation. It's a disability report by the field office. Let me see. Give me just a moment, please.

We had to make some adjustments, because the electronic demonstration that we had provided for

you, we had some systems problems this morning.

This is the first information that we received. It's something filled out by the field office. John did go over it with you, but this is an actual physical copy that you would see in your paper case as well.

Basically, it goes through and gives us information about the gender, and birth date, and so on. Now, I am going to look at this, find out about work history; because, in fact, it could contain some work information.

In this particular case, it's not explaining the work information, because the answer was "no." If there had been work around the time of onset, the field office would have recorded that on this particular form. I am going to point -- since I have it up, I am going to point something out to you, because it is going to come back into my discussion when we apply the mental residual functional capacity examination -- thanks -- assessment -- and that is the field office observation.

Now, a field office disability interview

normally takes between an hour and a hour and a half. This particular one was conducted by phone, which is represented here, teleclaimant, claimant. During that time, during that hour to an hour and a half on the phone with the claimant, the claims representative noted no difficulty with reading, hearing, reading, understanding, coherency, concentrating, talking, or answering. And further she said, the claimant was very personable and pleasant, nothing to note from our phone conversation. So that may come back to play later on. The next item I'm going to be looking at -- excuse me.

DR. SCHRETLEN: How would a claims examiner evaluate reading over the telephone? Would you just ask the person? Because they say "observation."

MS. ROTH: Over the phone they may -- that would be very difficult; but over the phone there may come a time when somebody has to read something to them. For example, when someone sets up -- teleclaims are normally handled after a claimant has set up an appointment. So the claimant calls our 800

number, sets up an appointment for a particular time and date. Then the claims representative calls them back at that time and date.

When that appointment is set up, our teleservice centers send out what's called an adult disability starter kit. That starter kit provides the claimant a list of information that is going to be needed during the interview, as well as something to get started in terms of recording what doctors she is seeing, what the dates of the visits were, and the doctor's address and so on. It's basically a head start for that interview.

So during the teleclaim, it may come to past -- the claims rep says, you know, do you have any questions about the information we sent you? Or what did you think about this, or that kind of thing? So there may come a time when the claimant says, I couldn't read it. I had to have someone read it to me; or you know, I didn't fill that out. The claimant says, I didn't fill it out. The claims rep might say, why didn't you feel it out? And it might lead to a discussion.

Now, on the disability report form, as John pointed out earlier today, we did have a description of the work, two jobs were listed. Only one job was described. I don't have enough information to complete my vocational analysis. So the other forms I'm going to be looking at, I'm going to be looking to see -- there is what we call a work history report. It's called SSA 3369; and as John mentioned, it provides an opportunity for the claimant to completely describe the work. Okay.

Okay. So this is the work history report. We're going to be looking at that. And the last thing I would be looking for -- actually, it would be my responsibility as the adjudicator to look through all of the medical evidence in the file to find out any reference to work.

It can happen that the claimant doesn't report, for example, work that she did -- she may have forgotten work that she did five years ago, or provided more detail to a doctor. It would be my responsibility to go through the medical evidence to find any reference to work history.

I will tell you instead of going through each piece of medical evidence, I did review all of the medical evidence in file. The only reference to her work history that I found was on a consultative examination from Will Smith, Ph.D.; and there was some history about work. There were no discrepancies. So I'm not going to further refer to that now.

I did review, also, a comparison between the work information provided on the adult disability report where one job was described and the way the work was described on this work history report, the SSA 3369; and again, she did use exactly the same words for all of the tasks, but the tasks were consistent between the two occupations.

So because of those analysis I have already done, I'm not going to refer to those other documents. I am just going to be working now from this work history report.

In your file you will find that -- if you look at -- if you open that up. On the left-hand side, there should be something that says "disability

report, work history 3369." That's going to be the document we're going to work from.

And the other two documents we're going to be working from the comparison we're going to be making between this and the other ones is the residual functional capacity assessment, and the mental residual functional capacity assessment. Those are both on the right-hand side of the folders with the tabs, mental RFC; and right under the red tab, which says "medical records" -- excuse me -- a tab which says physical RFC. So those are the documents we will be using. Jim.

MR. WOODS: I may be jumping the gun here, but I assume you are going to show us how we get information from the DOT to help us in this comparison. At any point do we get more information from the client or the claimant --

MS. ROTH: We can.

MR. WOODS: -- in terms of the work history?

MS. ROTH: We can. That's part of what -- there were some questions asked about this morning,

and that's one of the things I am going to go through as well. What kind of information is available; and when do we go to that extent, and why we would go there. Okay.

So the first thing I'm going to talk about -- again, I'm going to go into a little bit more detail than what we did last time. That is describing what past relevant work is, because that's going to play into the amount of vocational analysis I do.

Because the first thing I have to determine is, does she have past relevant work? She can have a long work history, and if it's not relevant it doesn't apply, and I simply go on. I am not even going to evaluate any further.

So somebody could work a few hours a week and it wouldn't be relevant to the determination, because it's not substantial gainful activity. So, again, past relevant work is work that the claimant has done within the past 15 years, work that was substantial gainful activity, and it had to have lasted long enough for him or her to learn how to do

it.

Now, we count the 15 years from the date of the adjudication. This is not in your package. I am just going to be talking through this with you. The 15 years we count it from the date of adjudication, so you might think of it as a rolling date. The date of adjudication of a DDS is quite different than a date of adjudication when the claimant gets to the hearing. So there may be some work that the DDS considered that the judge will not consider.

It needs to be substantial gainful activity. So to be substantial -- substantial work activity would involve doing significant physical or mental activities; it needs to be gainful. Now, for somebody who is an employer -- or excuse me, an employee, this year substantial gainful activity is considered to be $980 a month. Now, that's for somebody who is an employee.

For someone who is self-employed there is a different standard. Because self-employed individuals are in a position to control the work -- the dollar amount of the earnings reported for them.

So we use a different standard. You can think in terms of the $980 a month. Bear that in mind, because somebody can be working 35 hours a week at Federal Minimum Wage and be earning less -- or just barely above the substantial gainful activity level. So somebody working 30 hours a week is not earning above the substantial gainful activity level.

Also keep in mind when we're looking at SGA, substantial gainful activity, we don't consider activities such as household task, hobbies, therapy, school attendance, club activities. We're considering work activities.

Now, in terms of lasting long enough to learn how to do it, that is something -- quite frankly, we refer to the DOT to figure that out, and we look at the SVP level. Now, that is not -- is not a fast -- a hard and fast rule. We do have to look at the specifics of the case.

So for example -- I'm going to back up a little bit. Lasted long enough for him or her to learn how to do it. A job must have lasted long enough for the person to learn the techniques,

acquire the necessary information, and develop the facilities needed for average performance of the job. The length of time that this takes depends on the nature and complexity of the work.

For example, unskilled work by definition can be learned in 30 days or less. So if a person has performed an unskilled job in 30 days or more, we're going to generally find they know how to do that job.

In semi-skilled and skilled jobs they require adjudicated judgment. Because we are looking at time on the job, but we could also look at related work experience, for example.

Now, for all work that meets the definition of past relevant work, we are going to, then, consider whether or not the claimant retains the RFC to actually do that work. If he or she does retain the RFC, the residual functional capacity to do their past work, we're going to deny the claim. Do we have any questions before we go on? Okay.

In this particular -- I'm sorry, Tom.

MR. HARDY: I'm assuming you may need to

get into this. In looking at the files we don't always see a DOT printed up and put in the file, because I know that doesn't happen in all the cases. At what point do you go to the DOT to get the exertional demands or whatever? Where does that appear in here? Are you coming up to that in a few minutes?

MS. ROTH: I'm going to get to that right now.

MR. HARDY: Okay. Thank you.

MS. ROTH: Good lead in. Thank you.

So in this particular case I am going to be looking at SSA 3369 -- the SSA 3369 work history report that I referred to before. And on the 3369 -- on pages two and three she has described past work.

The first job is medical records clerk. She earned $9 an hour. She worked eight hours per day, five days a week. I know, because I have already figured this out in terms of minimum wage and so on; I know that that is more than $980 a month, so I know that that's SGA. Now, keep in mind the SGA level goes up every year. This year it is $980. In

the past it was slightly less or significantly less depending on how far back you go. So this was SGA.

I'm going to look now at the next job, which was medical records tech. Again, she earned $15 per hour, eight hours a day, five days a week. Again, that's also SGA.

The question that Tom asked just a moment ago -- and I need to get to it -- did the work last long enough to do it? The other thing is both of these jobs were within the past 15 years.

Let's go to the first page of the SSA 3369. In the middle it is going to show you the dates that she worked, and all of that work was within the past 15 years.

Now, you will notice that medical records clerk started in 1984. So it actually lasted 14 years. It started before that 15 year period began. If necessary, I can consider that entire -- since it ended within the 15 year period, I can consider that job if -- I can consider that entire period if she needed that -- all of that time to learn how to do that job, because it ended within that 15 year

period.

Now, the last question is did she work long enough to learn how to do these occupations? Now, the claimant -- when we looked at the job description, when we looked at the 3368, she did not report any performance issues. When we asked her why she stopped working, she didn't say anything about that she couldn't do the job; that she couldn't keep up with it. There was no indication about there were performance issues. There was no information in the medical record to indicate any kind of performance issues that would contraindicate that this performance, for example, of the medical records technician from 1998 to 2005. Nothing to indicate that it was other than fully satisfactory. That's the first thing.

Now, the next thing in order to figure out whether that seven year period of time was long enough to learn how to do it, we're going to have to look at the DOT. So I'm going to go into OccuBrowse and find these occupations. A couple different ways of doing it. I am just going to pick one. I'm going

to go into industry.

This happens to be in the medical service -- medical records. So I am going to scroll down to medical services industry. And this brings me up a list of 208 occupations. Her first occupation was listed as clerical. And so -- and she mentioned that she did a lot of standing and walking. So I'm going to assume that's it's a light occupation, and I'm basically going to sort the list by clicking on the top of the column. And I'm going to go past all the sedentary work. This is just one technique I'm going to have to find it.

I'm just going to start scrolling down. I got lucky. Here I have, medical record clerk. I don't know -- this is just a guess; I don't know if this is her occupation. I want to find out if it might be. I have this particular occupation. I'm going to go back to her disability report form and find out what tasks she did.

Now, on tasks for medical records clerk, she said "see remarks." So I'm going to have to go to the last page, which is page eight. And in

this -- this is how she describes her work; I worked in a medical records department. I set up the medical records files for new patients. I made sure that all the records from all of the departments were included. I made sure that the records were put in the right files and that the files matched the patients. I made sure that the records were in the right order. I filed the folder according to the hospital protocol. I processed requests for medical records by making sure that the patient gave permission. I made copies of the records and mailed them.

If the patient came back to the hospital, the file would be needed again, so I'd find it and send it to the department that needed it. If the patient died, I'd record that in the file and move the file to the closed section. A lot of the work of keeping the medical records was done on the computer, but we had a paper file on all of the patients with all of the records in it.

Now, one of the questions we had this morning is, is this a typical case? And I am going

to tell you no. Finding the claimant's type of work is not this easy. It seldom happens that they hand it to us quite this easily.

Quite honestly, my experience as an adjudicator was that when I got to the vocational aspect of the claim, I almost always had to call the claimant and get more information, because seldom did I have enough information to do this. For the sake of this particular discussion, though, we wanted to be able to make sure it was clear.

One of the things that I always thought would be helpful would be to have a list of tasks -- a wide variety of tasks even, and have an opportunity to have in an interview setting -- to have an opportunity for the claimant's representative to go through the list of tasks with the claimant and say, did you do this? Either endorse it or not endorse it. Endorse or not endorse. If we had that as an interviewing tool, it would be quite helpful to us.

So now I have job description, and I'm going to come back to the Dictionary of Occupational Titles to see whether or not this description matches

what she has told us. Again, it could be in very different terms, but I'm looking for, generally speaking, the same tasks, no additional tasks, and pretty much all of the tasks to be included. It doesn't have to be a perfect match. Quite often it is not, but I'm looking for it to be close.

This medical record clerk -- oh, I'm sorry, Mr. Fraser.

DR. FRASER: Just a quick point. That's one of the most ideal descriptions of work activity I have ever seen. You don't get anything like that. You might get the title and one sentence, but that's amazing.

MS. ROTH: Right. We didn't want you to have to hear about all of our interviews, because those interviews can be quite time consuming.

Mr. Wilson.

DR. WILSON: You said it would be nice to have a list of tasks. And I was just curious, do you mean light tasks, sedentary tasks, or all possible work tasks?

MS. ROTH: Again, I worked in a field

office interviewing claimants for quite a few years. I guess the way I would envision it -- this is off the top of my head -- again, often times we find that the industry -- I recognize the industry codes in the DOT are out dated. But we often find that it is the industry that tells us what the task are, and helps us to narrow down the past relevant work.

That's actually why I came in this direction. We could have gone in a different direction just by checking key words. We often find that the industry is quite helpful to us. So no, I can't imagine that we would have sedentary task or light task. You might have tasks that are associated with an industry, for example.

I mean, there is quite a difference in the medical services industry. Quite different, somebody who is performing services, giving treatment to a patient, or conducting some kind of medical test versus somebody who is doing some kind of clerical function within the medical services industry.

So, perhaps, it's something we can talk about afterwards.

DR. BARROS-BAILEY: Shirleen, we're at 3:15. Maybe we could just wrap this up at this point. How much further do you have?

MS. ROTH: It's going to take maybe five minutes to get through this part.

So in this particular occupation, compiles, verifies type, files medical records. That's the function. That's the purpose of the job. The tasks are preparing folders, maintaining records, reviewing records for completeness, sending medical records to the requested department, compiling statistical data such as admissions; she did mention death; and operating a computer to enter the information.

I am going to find that there is a consistency between the way she described this occupation, and the way that it was described here in Dictionary of Occupational Titles.

The requirements for this occupation -- this is a specific vocational preparation level four. It requires three to six months to learn how to do that occupation. In fact, she performed it for 14 years. So we would note from that, that she had

performed this occupation long enough to learn how to do it.

Now, her second occupation had to do with a medical records technician. Now, that clearly looks like a promotion. It was a higher level. She is doing coding. I am going to actually go to the disability report and talk about that one very briefly. Most of you received this file ahead of time. So I am going to go quickly over it.

I worked with patient records so that the hospital could file appropriate reports with state, local, and federal government. I made sure the records were complete and coded patient medical condition using ICD codes. I coded treatments using procedure codes. I recorded demographic information, insurance information, eligibility for medical assistance, hospital usage data; and I entered the information into hospital databases. If there was a problem with the statistical analysis done by the computer, I take that to my -- the attention of my department administrator.

I'm looking for that in the DOT. One of

the ways, again, medical laboratory technician. She wasn't in the lab; so we are going to keep coming down. I am just basically scrolling through and taking a look.

And wasn't that nice of her, she gave me the right job title. Again, medical record technician. I'm going to be looking and saying, compiling and maintaining medical records, completeness, did some abstractions, and coding of clinical data and so on. Statistical reports, insurance. I'm seeing many of the same words. Use of hospital beds, hospital usage, and operates computer to process it.

So again, comparing the tasks in what she said to this, I'm going to find that this is the same occupation. It's not as simple as that in the real world. I tell you that straight up.

In this particular case, the specific vocational profile is level six. It takes one to two years. And in fact, when we look at the report she did this for, I believe, seven years. From 1998 to 2005, seven years. So she did, in fact, perform this

long enough to do it. We would find both of these occupations to be past relevant work.

So all of that analysis was simply to determine is this past relevant work that we then need to go on with. And the analysis of whether she can do that work at step four, the vocational assessment, we will take that up after the break. Thank you.

DR. BARROS-BAILEY: Thank you. Take a 15 minutes break. Thank you.

(Whereupon, a recess was taken.)

MS. ROTH: I'm going to skip to the Office of Disability Adjudication and Review to comment on the case as well. So we're going to skip over the evaluation of past relevant work. We're going to skip over the evaluation of the persons's ability to do other work, other than transferability of skills. So I am skipping forward for those of you who are familiar with this process. Basically -- and we will discuss it more at a later time what I am talking about.

We have medical vocational guidelines, and

those guidelines help us either through directing a decision or giving us a framework to make a decision based on age, education, and work experience and the RFC level of the individual. They basically -- they're tables that tell us what to do.

Now, in this particular case for the sample case, it comes down to a choice between Vocational Rule 201.14 and 201.15. And basically what that means is the decision is going to be based on transferability of skills. If the claimant has skills that transfer to other occupations, then her claim will be denied. If she does not have skills that transfer to other occupations, her skill -- her claim will be allowed.

Now, again, I mentioned that there are no -- at this point and time there are no transferability of skills analysis. Software applications they are completely policy compliant. We are looking within Social Security developing something for our own particular use, but that's not ready yet. So right now, it's a manual search.

Transferability of skills -- now we did

send you some background materials ahead of time, which had to do with the Code of Federal Regulations. And the citation for that, the transferability of skills is in 20 CFR, Code of Federal Regulations, 404.1568; and the title of that section is skill requirements. And Section D talks about skills that can be used in other work transferability. I'm using this particular citation, because it's the shortest statement of what we do.

What we mean by transferable skills, we consider you to have skills that can be used in other jobs when the skill or semi-skilled work activities you did in past work can be used to meet the requirements of skill or semi-skilled work activities of other jobs or kinds of work. This depends largely on the similarity of occupational and significant work activities among different jobs.

How we determine the skills can be transferred to other jobs. Transferability is most probable and meaningful among jobs in which the same or lessor degree of skill is required, the same or similar tools and machines are used, and same or

similar raw materials, product, processes, or services are involved.

Again, that sounds a lot like what we said before about this thing called MPSMS. Now, there are degrees of similarity -- excuse me, degrees of transferability. Degrees of transferability of skills ranging from very close similarities to remote and incidental similarity among jobs, a complete similarity of all three factors is not necessary for transferability.

However, when skills are so specialized and have been acquired in such an isolated vocational setting, like many jobs in mining, agricultural, and fishing, they are not readily usable in other industries, jobs and work settings, and we consider that they are not transferable.

Then we have special transferability of skills requirements or special rules for those people who are age 55 or older who have a sedentary residual functional capacity; and special rules for people who are 60 or older with a light residual functional capacity. So that's some background on our

transferability of skills rules.

Now, a few programmatic rules. Skills are defined in terms of -- excuse me, skills are defined if terms of work activities. They are acquired doing relevant work. They cannot be acquired in hobbies. They're acquired in engaging and demonstrating proficiency in work activities and not based upon education. Skills cannot be acquired doing unskilled work.

Now, you may have heard the phrase "those who can't do, teach." We would disagree, because teaching is a skill. While an individual may have a genuine aptitude or talent for an activity, this is not a skill. It is engaging in work activity, proficiency in work activity is a skill. The ability to manage and supervise are also skilled. So we would not find that somebody with no managerial experience could do that kind of occupation.

Now, what do we consider when determining if transferability of skills applies? Transferability of skills is only found at the same or lower SVP level. Skills cannot be transferred to

unskilled work for SVP one and two. Again, for skills to be transferable, all of the factors do not have to be identical. There are degrees of transferability ranging from close approximation of work to only remote and incidental similarities. The factors that determine how closely the similarities must be are the claimant's age and the RFC. The older the claimant, the more restrictive the RFC; the closer those occupations of the transferability of skills need to be.

People with highly skilled work backgrounds, generally speaking, are going to have more -- greater potential to transfer their skills to other work. Those skills that are required in areas where there is universal applicability tend to have a greater opportunity for transferability of skills. So, for example, people with clerical work background, we find clerical jobs in a wide variety of industries. So then since there is a wide application, or universal application of that type of job, we would find a high likelihood of transferability of skills. Again, with special

consideration for people who -- based on their age.

And lastly, we need to look at a significant number of jobs. In order to find transferability of skills, we not only have to find there are jobs to which this person's acquired skills could apply, but we also need to find that those jobs exist in significant numbers in the national economy.

Now, in this particular claim, the claimant is 51 years old, almost 52. She is restricted to a sedentary RFC. We call it a sedentary RFC, because even though she can lift and carry -- she can lift up to 20 pounds, she is limited to pretty much sitting during the day. So we are going to call that a sedentary RFC.

In her particular case, age is not a significant barrier to transferability of skills, because she is not yet 55; but define transferability of skills, there should be greater than a mere incidental similarity between occupations.

She has past relevant work at the SVP six level. So we're going to be looking for occupations between level three and level six. Her past work is

medical records clerk, has fairly universal application. Her work as a medical record technician where she was coding ICD codes and procedure codes is much more specialized and a very limited field. So that's less likely to transfer.

Again, skills can only transfer to sedentary occupations that do not require sustained concentration or prolonged interactions with others. She can interact with the public on a superficial or rote level.

Now, we have not, again, gone over the MRFC, but I mentioned to you earlier today that I was going to bring this back up. Again, we need to take that RFC as written and think in terms of what she can do, and what problems she has. It said that she could deal with the RFC as it was written and send it to you. It said that she could deal with the general public on a rote superficial level, as long as it didn't involve prolonged interaction; and that she could deal with her co-workers once she got to know them, again, as long as it did not involve prolonged interaction.

Sustained concentration. She could concentrate for one to two hours at a time. During a typical work day we work for two hours, and then we have a break. We work for two hours, and then we have a break. And so she could accomplish that in a normal work day.

One of the other issues having to do with concentration was that she couldn't -- she could concentrate on a series of short task, perhaps, but not necessarily one long task that was going to take a long period of time. So those are the elements I am going to be looking for in the occupations to which she could transfer her job.

Again, now I am going back to page eight of her work history report. She gives us a description of her work. I'm just going to go through and describe some task -- some work activities. Again, we describe skills in terms of work activities. So using these descriptions, I just came up with some key words.

She can set up and prepare files. She can file the folders. She can process requests for

records. She can make copies of records. She has mailed copies -- mailed the copies of records, retrieved files, sent the files to the requester, recorded information in file, recorded demographic information, insurance information, eligibility for assistance, hospital usage.

She has moved files to the correct location. She has made sure that the files are complete and accurate. She has recorded information using the computer. She has entered information into databases. She made sure records were complete. She coded patient medical conditions. She coded patient treatment. She reviewed computerized statistical analysis. She brought problems to the attention of her administrator. She maintained files.

Those were some of the work activities, some of the skills that she acquired during her past work. What we're going to do is now look for those kind of skills, those tasks within other occupations that are at the sedentary level to see whether or not there are any occupations to which she could transfer those skills.

Now, we don't have any information in the Dictionary of Occupational Titles regarding the mental demands of work. So all that I talked about in terms of sustained concentration, prolonged interaction with others. The difference between dealing with the general public versus dealing with co-workers, I'm going to have to get at that from the tasks that are described from the other occupations, because I have no other data to use.

Now, generally speaking, a transferability of skills analysis is done using a series of searches. So for example, what I would do -- I'm just going to do one of these. But what I would do or what I could do is to go through this list and look for other occupations that have the same code as hers. So there is any number of ways I can pull up a list. The more complete the list, the more accurate the transferability of skills analysis is going to be.

The first part of the transferability of skills analysis is simply to get a list of potential occupations to which she could transfer her skills.

Once I have that list, it's a matter, then, of going through and analyzing specific occupations to see whether or not, first of all, there is a correspondence in terms of the work activities and tasks; and then second of all, to make sure that it's within her residual functional capacity.

So the way I'm going to do this as quickly as possible is to go to the worker trade search. Now, I have already told you -- this is simply one way of doing this search. Again, to do a complete search I have to search multiple sources, not just this one.

When we went over the physical RFC, there were physical demands, but there were no environmental conditions. Level three is my minimum. Level six is my maximum. My strength level is at sedentary. That's the maximum I can use.

Her physical demands, she was limited to occasionally climbing. I think she could frequently balance. Occasionally stoop. Occasionally kneel. Occasionally crouch, and crawl. And there were no other physical limitations. In this particular case,

her work field for both occupations is the same, and the work field is 231, which is verbal recording and record keeping.

MPSMS for the medical records technician is 929, and for the medical records clerk, it's 891, which is clerical services. Then I am simply going to do a search, and it came up with 57 different occupations. Now, again, these are possibilities; they aren't necessarily accurate. I mean, it's not -- to actually determine if it's possible to do those, I would need to go through an analysis process.

Now, I'm going to go through several that I found through that analysis process; and when I have my finished completed, I will hand this off to the next presenter so they will have this in written form.

The first one would be order clerk, DOT code and so on. This particular occupation is at SVP four. It's semi-skilled, and it's sedentary. She processes orders from material or merchandise received by mail, telephone, or personally from

computer or company employee. Again, we have this -- in this particular case the common skills would be both occupations involve processing orders received from internal or external sources, records or files copies of orders according to company protocol, enter past work sheet, record a wide variety of information in the file or a computer database. And she also maintains files by filing records, and file in the folders.

Again, both occupations involve entering data into the file or into the computer. So we would find a similarity here as more than simply an incidental similarity. I am going to go to find out whether or not this occupation exist in significant numbers in the national economy or in her local area. She lives in Oregon.

So in this particular case for this occupation nationally, there is 264,520 occupations. In Oregon there is 3,190. Now, I do want you to keep in mind this is based on what we call OES statistics, Occupational Employment Statistics. This is based on SOC codes; our Standard Occupational Classification

codes, and within this one SOC code, there are 11 other occupations. That all of those she shares -- all of those occupations are included in these particular numerical statistics.

There is no -- there is no national information at a greater level of specificity than that. Lets' go back to our list, and I find another one. Let's look at insurance clerk. Just for my own use, I'm going to put those in numerical order. OccuBrowse allows you to sort this as you want, which makes it much faster.

Now, again this is insurance clerk in the clerical and kindred industries. The commonalities here is that she compiles records in her past work. She also compiled records in a variety of data using such information as demographic information, insurance information, eligibility for assistance, and hospital usage. This job requires filing records, which she did, and this job requires compiling statistical data for reports; and again, she did that in her past work. It is more than an incidental similarity.

In this occupation nationally there is more than 3 million job incumbents. In Oregon, there is 39,000 plus.

Now, again, for this particular SOC code there are 73 related occupations that share this data -- that share those numbers.

Now, for another insurance clerk -- again, this is the insurance clerk in the kindred -- clerical and kindred. We could go to another one, which is not on this list. I will come back there another way.

One other would be data examination clerk. Again, clerical and kindred. The commonalities between these occupations, reviewing documents to ensure completeness and appropriateness prior to data entry. In her past work she ensured that records were complete, and that records were filed in the correct folder. She also entered the data into computer databases. Both occupations require notifying the supervisor when errors and shortage of output are detected. And then comparing the corrected -- yes, Mr. Woods.

MR. WOODS: Just a quick question. I know you said go over the process for the sake of time. Just out of curiosity, the medical records clerk and the records technician, what ruled that out? Was it the sedentary or light?

MS. ROTH: Yes. Yes. When we're looking at past work -- again, we will come back to that later -- it is a function by function analysis. Normally, we're going to go -- to look at the least -- at the most restrictive item first, because that's the most likely to rule out.

MR. WOODS: This example -- again, come back to the data issue, what to look for does raise a question as to whether there is a relative difference between light and sedentary.

MS. ROTH: Exactly. Because we do find in terms of classification of light and sedentary applications, there is some overlap.

DR. FRASER: Those are still -- the best number we have is for that code?

MS. ROTH: The best number we have for employment statistics nationally or locally -- I

mean, as far as I am aware -- are the OES statistics. There are also census numbers available nationally, and they're not in this particular --

MR. WOODS: Census numbers are actually aggregates of the national --

MS. ROTH: So for the data examination clerk, the last item would be comparing corrected input and output data with source documents, worksheets, and so on. Enter past worksheets in databases; and again, responsible for accuracy of work.

So there is more than an incidental similarity between this clerk occupation and her last job. This is SVP level three at the sedentary level. And the employment, again this is 3 million. That number may look familiar to you, because it's the same SOC grouping as the other occupation, insurance clerk.

Now, this morning you had a variety of questions having to do with a development of vocational evidence, including what kind of earnings information is available within the Social Security

Administration. I want to answer that quickly, because I can answer that in less than two minutes.

Social Security receives -- when an employer sends the W-2 form to the IRS, they also send a copy to Social Security. So we have W-2 form information of every employee in the United States. That comes out on what we call summary earnings record. It also feeds into what we call the detailed earnings query, which shows the name of employer and an annual earnings amount only. Someone asked about whether that was reported at the level of industry only or agricultural work, military and government work. And that's not anything necessarily to do with the industry per se. It has to do with Social Security coverage issues.

Often times, again, the W-2 form information comes to us, so the employer name is going to be that which is shown on the W-2 form. So for example, for Social Security our employer is shown as the Department of Interior because they complete our W-2 forms. That doesn't mean I work for the Department of Interior. It just means that's

what on the W-2 form.

So there has to be some kind of analysis. It is not a one for one correlation. There has to be some work done with the claimant to make sure that that's accurate. It is a lead for earnings information.

Lastly, we do have access to something called a new hire report. That comes from state unemployment insurance records. Those are reported on a quarterly basis. The states are required to report information for federal unemployment insurance, and those are, in fact, more recent commonly than the W-2 form information; and it comes out on a quarterly basis. So that's also available to us. Those are those reports.

Now, there were a number of questions this morning that I can take up when we take this up later. Thank you very much.

DR. BARROS-BAILEY: Thank you, Shirleen, for all our information and for the modification. We will be having Shirleen present tomorrow morning. We're going to start a little earlier to be able to

cover some of that at 8:15 instead of 8:30. So thank you.

Okay. At this point we're going into part six of the case demo, and it begins with the perspective section. I would like to present our two presenters, Judge Cam Oetter, Administrative Law Judge with the Hearing Office in Macon, Georgia; and Judge Robert Goldberg at the Office of Appellate Operations, Office of disability Adjudication and Review with the Social Security Administration. So welcome, Judge Oetter and Judge Goldberg.

JUDGE OETTER: Thank you all for the invitation. What we will do in the next hour is divide the time evenly. I will save plenty for remarks and questions. I am sure he will do the same.

What we have done is put together a small handout. Does everyone have that? I will come to that in just a moment. It's entitled "adjudicator comments; complete only the applicable sections." Those are pretty good instructions for all of us.

MS. SHOR: It's right in front of tab two,

just three pages in.

JUDGE OETTER: So Bob and I have been here today. We have listened along, and I know that many pieces of information you have heard already. What I will try to do is present a high level of quick view, concentrated view from ODAR's perspective. After all, if the case has been in the system for a certain amount of time, and so much information has been gathered, why isn't it complete? Why isn't a decision done and a claimant has gone away home either satisfied or not with the result?

Well, of course, it is the appellate process, while we don't technically appeal a decision that was made at the initial reconsideration level, what we conduct in ODAR is a de novo proceeding, it's a case of first expression. It is as if the case starts over; and quite literally, it does.

I will give you a couple of examples why that's the case. You might think we will know, for example, what a claimant's age is when a case reaches ODAR, has been in the system for quite a while; but under the regulations, the age as a vocational

factor, is actually a fungible. The adjudicator can adjust the age upward if it advantages the claimant. So we are encouraged to consider all of the possible factors that might make this person feel and act older than they actually are.

Well, you think, for example, that a case has been in the system for a couple of years, the education might be a concrete established fact. Well, the Regulations actually allow the adjudicator to consider other information about a person, such as formal or informal education, previous work, community projects, hobbies.

After all, the numerical grade level may not represent a person's actual educational abilities. This is from the Regulations. These may be higher or lower. The adjudicator is charged with that responsibility of making that fact finding, and we do that.

Most administrative laws judges hold six or eight hearings a day, up to 50 a month. It is not unusual. We will spend the time that it takes -- it is quite consistent with the field office interview

you heard about earlier. You know, it just depends on the complexity of the case; but all of the topics that we have discussed so far are, again, on the table at ODAR.

Sometimes it might be that what we do is we participate in the indeterminate redevelopment of the case, because the evidence is there, most of it. The files we have discussed today have been incomplete in some particulars. The adjudicator will often do additional evidence of medical and vocational issues.

Now, I will say at the outset I have a hearing office perspective from two different states, Georgia and Texas, but much of my personal experience is with the training team for ODAR with the administrative law judges. So please don't think experience speaks to any particular office or individual. It's fairly generic.

What we encounter at ODAR is, first of all, an older individual. The claimant has aged. As you well know, there is a backlog of cases, and some time elapses between the filing date and the ODAR adjudication. Quite often the claimants are more

impaired in terms of development of new conditions; perhaps, they have had a deterioration of health due to chronic disorders. I am just listing the differences of what we encounter when a case comes in the door.

There is always, for the most part, new evidence. And that can be under either the medical or vocational categories. A very important factor we see at ODAR is, of course, representation by an attorney or a nonattorney, someone who helps the claimant focus their issues and does an interview and points to the law and Regulations that do control the case.

And the most important thing, of course, is a claimant actually appears and testifies. This is the first time in the process since the initial interview that a claimant has actually sat down, taken an oath, and promised to explain about their condition.

So how do we set up and prepare for that in order to give what our responsibility is called a full and fair hearing. Refer to your notes, if you

will, for just a moment. This type of sheet that I have is a screening mechanism.

Now, in the prototype office, the most functional office in the future, this would be prepared by a case technician, a paralegal specialist, perhaps, a staff attorney who exams the records and makes these observations and recommendations. That process has been somewhat reduced and constricted because of the pressure of the backlog. Many of the judges would be doing their own summary.

What you see here is a work product of about 30 minutes that the judge would have the time to take a look at the file and prepare for the hearing. Obviously, a case that can be resolved on the record, as we call it, would be. Most judges will not schedule a case if they feel like the claimant is disabled.

Serving as the prototype ALJ for the Susan Que matter, however, I had a few questions, and I went ahead and put this one down for a hearing. I asked that a vocational witness would be there,

because this case, as you have heard, turned somewhat on transferability of skills and some of the important issues of classifying past work. I'm not a vocational expert, but I know several. We assign them in rotation to a case, and they will come in and testify, or perhaps provide evidence through interrogatories. It's a very standard practice in my experience.

The evidence, the record; oh, my goodness, we see files that have 1,000 pages. Susan Que is rather minimal on the scale of evidence accumulation. The Department of Veterans Affairs is always a good provider of comprehensive records. The judges may be seeing huge, voluminous files. Back in the days before the electronic folders, there were some that had nylon traps to hold them together. Mere rubber bands would not suffice.

But as Tom pointed out earlier, it is an all or nothing proposition. The question is not for the ALJ whether this person can do part time work in the main, or whether this person can do intermittent employment. It's all or nothing, permanent

disability.

So what RFC does the medical evidence support? Is the file complete? Are all the claimant statements and allegations credible? What's the role of opinion evidence, if any, in the case? Those are the questions we answer again and again.

But even at the entry level of a case, discuss current substantial gainful activity, for example. Shirleen just pointed out the earnings history we see. These all lead to evidentiary questions.

I usually start interviewing a claimant with the detailed earnings query in front of me. I am asking questions about a particular employer. Well, these are the days of seasonal, temporary, work labor pools, things of that nature, job sharing. Do we actually know what job the claimant had? We don't, at ODAR. At this level we don't.

The claimant comes in and responds to something they have seen in the file and testifies, I have never performed that job before. That's a mistake. We hear that quite often. The same with

the earnings. You have heard of identity theft, I'm sure. Claimant's actually come in and say, that's not me. I didn't work that year. I don't know where that income originated. Even at the late stage of an ODAR hearing. So we are still doing work history verification. We are still doing past work analysis even as we go into a hearing level case.

We will consider evidence from the Workers' Compensation sources, private long term disability insurance companies, the Department of Veterans Affairs. We will take records from incarceration where that might explain a claimant's absence from the work force for two to five, cash work, self-employment, temporary hires; and of course, the role of unemployment, which, again, explains how a person occupied themselves in a period of time that's under review. We will look at all this evidence.

We will consider the medical factors; and of course, we will consider the prior findings. Again, these are not on appellate review. The opinions of the state agency doctors or single decision makers just become part of the record at

this point.

As Tom pointed out earlier in the Susan Que case, a use of a cane, for example, an assistive device would be very significant. Yes, it would be. But it goes into a credibility question without some sort of subjective measurement is, does the person actually require the device? It would be for help with ambulation of balancing or for some other purpose.

We will be considering if the past relevant work is consistent with a physician that we, perhaps, have encountered before. In my current part of the country, there was a large employer. I will give you one example -- a geographic example. It was a tobacco plant. And of course, recently it closed with the downturn of that product.

The vocational witnesses, the adjudicators and the representatives were all very familiar with the duties of that plant, and the kind of jobs that people there performed. But once in a while, a claimant would appear and say, that's not exactly what I did. That's why, among other reasons, we need

a comprehensive work measurement tool that includes all the broad aspects of employment. And that's one of your missions, I know.

Oh, I saw a sign out in the hallway for one of the other groups, and it was headlined, you may have noticed, "great expectations." I think that applies to this table as well.

We must evaluate the work history and compare it with hypotheticals. Now, where do these hypotheticals originate? Well, by in large, here; because I will consider all of the evidence that's in front of me, and I will decide the permeations of limitation.

Quite often, just in practice, I will start with a hypothetical that's based in large part on the state agency, a medical opinion. That represents a starting point in the case. At one point in time the commissioner had decided that was the status of the case. Then I will add to it limitations, modify the hypothetical. And what you see in the second page of this hand out is going to be exactly that. The bottom of page two is -- represents proposed

hypotheticals for this case.

Now, there is another important concept about a case at ODAR is the record never closes. This is not a situation where the judge can look at all the evidence at some point between book ends and say that's it; that's all there ever will be. Right up until the minute of the hearing, the claimant's representatives are supplementing the file. If they are not satisfied or the ALJ is not satisfied with the sufficiency of the file, the case record will be held open post hearing for additional evidence.

So it becomes an art or a practice of developing hypotheticals that will include not just today's limitations, but potentially tomorrow's limitations. Let's say that the claimant goes out for an examination scheduled on a consultative basis. That may bring in new evidence that no one has yet seen.

Shall we try and anticipate that hypothetical today, schedule a supplemental hearing later? Of course, the claimant has rights to respond to that examination if it is done post hearing. All

of that flows into these hypotheticals. But we attempt to get substantially all of the limitations and capacities that would apply to that claimant. We try to use consistent taxonomy. Terms that the vocational expert will understand. Things that they use in the Department of Labor and other professional sources. Those are all representative in the regulations, and in your material. A little local knowledge is a good thing.

As Shirleen mentioned earlier about the interview, wouldn't it be helpful if we had a list of job characteristics, and we could ask the claimant yes, no. An experienced ALJ will do exactly that. Upon hearing a job that sounds familiar, ask the claimant, did you perform it standing or sitting? Did you perform it this way or that? That, then, fills out the record and the vocational witness has something to respond to when the ALJ asks a hypothetical.

So we take those terms out of the selected characteristics of occupation, which is a subset of the DOT; and over the years we have tried to develop

that vocabulary. If I hear a claimant's representative ask something that sounds a little vague, and I really don't recognize the terminology, I will ask for a clarification. The vocational expert deserves that. We need to know that we are using the same terminology to describe that capacity or limitation.

As the doctor asked earlier, where is the definition for mild or moderate? Well, we have to pin that down at the hearing. We don't leave the record unclear as to what the limitations was.

Is the worker operating at the counter top, or do they lift from the floor? The sitting and standing, great area, you heard Tom mention earlier. And the balancing example I thought was terrific, because that's the kind of balancing we discuss. It's not just balancing in a hotel conference room; but it is, in fact, can they balance on an unstable or moving surface.

We talk quite often about terms like task time. This is dealing with a person who must take breaks. Perhaps more than the standard morning,

midday, and afternoon break. How long are they actually away from tasks? This needs to be quantified. The vocational experts needs to hear that in terms of minutes how much time away.

But, see, this is where the vocational world is modified, and we haven't responded. Because when the Dictionary of Occupational Titles was prepared, I am offering to you that the telemarketer was fixed in place. You remember -- maybe some of you -- telephones had cords back then. You see, there weren't such things as handset telephones where a person could actually walk about and carry their communication method with them.

So we hear questions all the time from claimant's representative -- and that is probably 85 percent of the cases are represented -- about modifications to jobs, things that have happened over the last 15 to 20 years. New positions that have been created, older positions that have, perhaps, sunset, and should be adjudicated accordingly.

We -- representatives are right up to the minute, ladies and gentlemen. We have questions now

about the effect of the economic recession on the availability of jobs; and perhaps, they are up in some areas, down in others. Representatives are being challenged -- they are challenging the adjudicator to know if the expert has given the latest information. So it's up to the minute. It happens very quickly.

I would offer several hypotheticals where I adjudicate this case, beginning with the concept that the claimant had some limitations in standing or walking. The lifting we have discussed was in the range of 20/10. Under the heading of "alternate postures," I consider whether the claimant can climb ladders, ropes, or scaffolds; whether they could handle exposure to hazards. That would be something like an unprotected height or commercial driving.

We have discussed the balancing. Under item four, I would actually strike that as alternate posture, because it was already covered in the original example.

Under sample number six there, you know, I put that down as alternate exertion, because I was

thinking of the effect on standing and walking; but I believe you have heard by now that would be alternate posture. So we would work in that idea using a cane for balance. Of course, that might occupy the hand. Does the claimant carry the cane in their dominant hand? That's the kind of question we ask in a hearing.

Alternate exertion on page three, we would limit the lifting. Of course, as you heard, if this case drops down to the sedentary only, there is going to be an issue of transferability based on the claimant's age.

We put in the mental factors of concentration, persistence in pace; but it was the social limitation that played the most part in Susan Que. We would be asking questions about a person who has a short fuse, as she was described. Can she tolerate regular continuing interaction with other people.

Just as an offering here, a final hypothetical would be something like this. Assuming everything the claimant testified is true and she can

not socially function, physically exert and sustain the endurance and nonexertional capacity required to complete an eight hour day, 40 hour week on a regular and continuing basis. And I would ask the vocational witness, would there be jobs in the national economy this person could perform. And then we have an answer to that question too.

All of that I would consider. The claimant's attorney would have an opportunity to interview and question the expert as well. If at any time the vocational expert's testimony varied from the Dictionary of Occupational Titles, we have a requirement that we must ask about that and give the expert an opportunity to explain.

So you have several interesting items in your notebook. I saw that includes the functional characteristic survey that we have seen lately and the Social Security rulings 8515 and 969-P. I will challenge you, just when you have time, put yourself in the adjudicator's position. Respond to those rulings, and think about a hypothetical worker. Could they sustain a work day? Could they be a

reliable employee. And those are the kind of questions that we consider pretty much everyday. It's a sequential evaluation in a strict disability system. Shirleen gave you the definition just a little while ago.

What we do in my position is use as complete a record as we can. Apply professional judgment and experience to that. We try and articulate findings that will be accurate, clear and consistent over time, and we understand our responsibility is we're making potentially the final decision of the commissioner on these cases, and put as much quality into that as we can under, of course, the time demands of the backlog.

Now, I really rushed through that, and I'm sorry, when I saw how well prepared the morning presenters were, I went back to my car, I got my Wegmans's shopping bag full of information. And there are so many things I would be happy to share, but if you have specific questions, would you please ask me now. Yes, sir.

MR. HARDY: You said -- there we go.

You said that at times the vocational expert might vary from the Dictionary of Occupational Titles. Can you give us some anecdotal stories about that and how do you rectify the difference and clarify that?

JUDGE OETTER: Yes, Mr. Hardy, I can. I appreciate that you asked that question, because the gray area of the sitting and standing alteration is job one. That's the specific question that comes up again and again, because that's not covered in the Dictionary of Occupational Titles.

Here is one thing I didn't mention earlier, what a vocational witness brings to the hearing in some part is going to be personal observation. The Social Security Administration is contracting with these experts, like some of you, to give a broad range of information. And one thing that may qualify there is either personal observation or a study or a survey that they know of. That can take the place of the Dictionary of Occupational Titles to answer that question.

So that gray area of sitting and standing

is one thing that is always outside the Dictionary of Occupational Titles. We have some variation of that expert evidence. I know that is one thing you will discuss over time. Because after all, with 1200 adjudicators, 140 hearing offices in brick and mortar, plus an equal number of what we call remote sites, plus all the video equipment we have now, there is a huge variation of practice and performance across the spectrum. There are local differences, regional differences.

One thing the Commissioner is pretty clear about is this should be a consistent and uniform program. You will hear that from a colleague in a moment who is over my shoulder when we make these decisions. There should be nothing really nilly about it. The evidence should be reproducible from a reliable source.

DR. BARROS-BAILEY: Anymore questions for Judge Oetter? Thank you.

Judge Goldberg.

JUDGE GOLDBERG: Good afternoon. My role is as an administrative appeals judge. In that role

we serve as the final administrative reviewer of the Social Security Administration. So Judge Oetter, he is an Administrative Law Judge. If a claimant appeals that determination to the appeals Council, we will review his decision; and we use substantial review of substantial evidence. That means evidence that is more than just a mere scintilla, and which is a very low standard.

So essentially, we try to follow what the ALJ say, since they are the ones who observe the claimants; they're the ones who studied the record in a lot of detail; they are ones who developed the record. We don't do any of that at the Appeals Council level. We don't do development. We don't hold hearings. We review the records, and we try not to reweigh the evidence whatsoever. That's not our role.

For example, today, I listened to the presentations. I looked at the file that we have, and as far as I was concerned we could come up with four different residual functional capacities based on the evidence that I saw in that file. We might be

able to say that that claimant could do limited light work based on the fact that they can't do a lot of standing and walking, but they can do the lifting and carrying that was required for light work.

So if a Judge got a vocational expert to identify light jobs within that functional capacity, I might have found that to be supported by substantial evidence. If the Judge had given a light RFC with a sit, stand option, and had given the vocational expert those limitations, I could have found that those jobs were again supported by substantial evidence, and the judge's decision based on that was supported by substantial evidence.

If the judge had found a sedentary RFC, I could have supported that decision by substantial evidence. However, there were also mental limitations. So if we had mental limitations based on the claimant's age, education, and vocational factors, it would have meant a transferability at the sedentary level.

Again, the judge could have said that there was transferability based on the presentation that we

just had when we went through, you know, all of the different jobs, and we said that there were skills and there were jobs to which they could transfer those skills. Again, I could have found substantial evidence for that. He also could have paid that case. The judge could have said that the claimant could only sustain concentration based on similar activity. And based on that, we could have concluded that that type of RFC was most consistent with unskilled work.

We have said -- the presenter said basically that the claimant could concentrate for one and two hour intervals, and that was sufficient, because we could either have lunch or breaks after two hours. If we took that RFC apart it said one to two hours. So an adjudicator could say, well, that's not two hours; therefore, it's possible that that would mean that they couldn't sustain a sufficient work activity to do a skilled or a semi-skilled job.

So based on what the judge found, I could have found four different RFCs supported by substantial evidence. Now, personally, I could have

reweighed that case and came up with any of those four RFCs, but that's not my role. My role is not to make sure that the ALJ leaves with what I would have found. I have to determine whether what he found or she found is supported by substantial evidence. So I could look at any of those conclusions, and I could have found them supported by the facts in this particular case.

So we have a unique role. We don't adjudicate cases de novo. We adjudicate cases based on the record as it appears before us. Now, we see most of the claimants that are denied at the ALJ level. The claimants have nothing to lose by appealing to the Appeals Council. It doesn't cost them any money. There is not a filing fee. Like if you go into district court, you have to pay money. The claimant doesn't have to pay any money to get their cases reviewed by the Appeals Council.

Furthermore, there is no evidentiary submissions that are required to the Appeals Council. You don't have to submit to a detailed brief with 12 copies as you have to do in the district court. All

you have to do is fill out a piece of paper that says, I don't agree with the ALJ; he was a bomb, or she was a bomb or whatever they want to say. There is no requirement that you do any evidentiary submission.

There is no issue conclusion at the Appeals Council level. If you appeal to us, we do the review for you. However, many of the claimants are, in fact, represented by terrific attorneys who provide detailed briefs. However, the briefs that are submitted to the ALJs and the Appeals Council are generally different.

To the ALJ, the lawyer generally lays out what his theory of the case is. He may argue that you should pay my case because it meets the -- the claimant's case because it meets the listing or equals the listing, or it should be a step five pay, or you know, whatever.

However, at the Appeals Council level, basically, we hear about all of the deficiencies in the ALJ's decision. They comment upon developmental errors, articulations errors. By articulations

errors, I mean, they didn't discuss the lay witness evidence. They didn't provide adequate rationale for rejecting opinion evidence. They didn't provide adequate rational for rejecting subjective complaints, et cetera, et cetera. They can find more reasons to disagree. They have handouts with hundreds of reasons that you can disagree with an ALJ decision, and some representatives produce many, many arguments; but the ones that are really do the best jobs, and the ones that detail what they consider to be the main argument in the case, put that on page one or two, and you know, we take it from there.

Okay. I mentioned that he reviews, approximately, 50 cases a month. He puts out about 50 decisions a month. At the Appeals Council I'm reviewing closer to 200 cases a month. I review, approximately, 15 cases every day. So again, I depend upon the lawyers to give me the briefs; and if necessary, you know, I have to -- if it's an unrepresented claimant, then, I basically have to do the review on my own. And we do that. We try to make sure that every claimant gets due process.

Now, the arguments we see sometimes they're substantive. Some time they're related to due process. The attorney may argue that, you know, at the hearing, the claimant didn't have a lawyer, and the judge didn't tell them about all the rights and representation they could have had. They may argue that they did some post hearing consultative work up, and it was never proffered to him. So you can have due process errors. You can have substantive errors.

When it comes to the Appeals Council we have to make the decision as to whether we are going to remand the case back to the judge, whether we can pay the case, or whether we are going to deny review. The cases that we pay are generally limited. We only pay, approximately, 3 percent of the cases at the Appeals Council level. The reason is, it has already been denied at the initial, the recon, and the ALJ level. The cases that we are probably going to pay are the cases where new and material evidence are presented to us.

We don't have what we call a closed record. The claimant can produce additional evidence at any

time, even at the Appeals Council level. So when I get this new and material evidence, I can only review it if it's relevant to the period during which the ALJ adjudicated the case. So it does have to relate to that period that was adjudicated.

Many times we get some additional evidence that, in fact, shows the condition was more restrictive than what the ALJ found at the time that he found it. This can be because many of the claimants don't have a lot of resources, and don't get a lot of medical treatment; and it's only later on when their lawyer sends them out for the examination that we learn the true limitations that a claimant has.

It's a pretty common problem. Many of these claimants haven't worked for a number of years. They can't afford medical treatment, and the records tend to be sometimes sparse. Some time you can get a lot of medical records depending on what area of the country you are, and the resources that a claimant has, and that varies greatly.

Now, what we see at the Appeals Council

differs; but what we do try to do, as Cam said, is we try to be uniform and consistent in our approach, despite the fact that we review cases from all over the country. However, we react to particular circuit courts, decisions -- and district court decisions in a given circuit.

For example, I work in the Ninth and Tenth circuits. They're extremely tough circuits as far as their review goes. They are very interested in making sure we dot all our I's, and cross all our T's, and vice versa. And what they do is they make sure that we apply all of our rulings and regulations.

We have some detailed -- what we call "but" rulings that we put in the Administrative Law Judge to the file. They require that they write detailed rationale, and that's a difficult problem when the program is a mass adjudication program. There are thousands and thousands of claimants, and the amount of rationale that the judge has to be able to put into his decision, his time is limited.

So he oftentimes, or she has difficulty in

writing the detailed rationale that the court system wants. And we're sympathetic to that at the Appeals Council level. Some time we deny review on cases, because we think the judge has done the very best job that he can with the information that he has. We're not going to get a lot of claimants at the ALJ level where they say spend their day bowling, and playing volley ball, no. Most of the claimants will, you know, basically testify to very limited activity, and it's hard to be able to prove otherwise. And therefore, the courts tend to be pretty sympathetic, and they want to make sure that we follow all of our regulations.

In the ninth circuit, as I said, they are very big on late witness evidence, and they have a doctrine, which is known as credit is true. If a judge doesn't provide sufficient rationale for rejecting opinion evidence, or if he doesn't provide sufficient rationale for rejecting credibility, the court is going to find the statements of the doctors to be true, or the statements of claimant to be true. And whether or not the medical evidence supports

those statements since they credited these statements as true and these statements would require that finding of disability be made, they just go ahead and pay cases in the court system, even though some of these individuals are probably not disabled. But because the judges haven't offered sufficient rationale, the court goes on and pays them.

It is a little unusual in the Ninth and Tenth circuit, but it shows you the burden that the Administrative Law Judges have. Because the court placed this burden on them, and the Appeals Council has to take a pretty tough stance and make sure that the rationale is sufficiently articulated. That could be a difficult proposition.

So does anybody have any questions at this point?

The Appeals Council -- I have served on the Appeals Council now for 15 years. I have worked in different parts of the country, you know. As we talked about, the judges have some differences in the way they are able to adjudicate. Some of the areas are more SSI claimants. Some of the areas have more

Title II claimants, depending upon the particular area where the hearing office is; and the claimants who generally apply for SSI, generally, have a bit less medical evidence, because they don't have the financial resources. The claimant who have Title II who are applying for disability, generally, it's a little easier for them to get representation, because their cases can generate more revenue for the private bar; and generally, they also have more access to the medical system.

Unfortunately, in some of the areas in the big cities where we see a lot of SSI claimants, a person doesn't see the same doctor all of the time. You go in, you see an intern or a resident, and three years later when you are trying to get medical records from that source, they don't know who that physician is. He has long since departed, you know, the city hospital. He is not there. He can't produce a medical assessment. And -- you know, it's difficult to get continuity of care, and it's difficult to get adequate medical documentation of your impairments when you are dealing with some of

these big city hospitals.

I know I worked in a hearing office for about ten years. We used to write to some of the hospitals three or four times without any result. And you can send all the subpoenas you want, but unless somebody is out there to enforce them, you know, they do no good. Obviously, the Justice Department and the Federal Marshal have better things to do with their time than to run to city hospitals, and you know, try to enforce these subpoenas and arrest some doctor who hasn't completed the medical assessment who is not -- probably not there anymore.

So it's a very difficult proposition to sometimes get adequate medical development; and you know, we understand the administrative law judges do the best they can with the resources that they have. Fortunately, the situation is improving a little bit. At the Appeals Council level we have been able to hire several new analysts to assist the administrative appeals judges.

The stimulus package opened up some new funding for the federal government, and they passed

it along to some of the agencies, which is helping us get necessary resources. But for the past ten years or so, we have had significantly declining resources; and with that our period of time to adjudicate cases, you know, rose to nearly unconscionable levels really.

Now, we have slowly been able to get that work in the right direction; and even though it's nothing that we're proud of, but we're down to about 240 days. Maybe ten years ago we were about at 150 days. It crept up, and it crept up to 400, 500 days; and now we have been able to get it back to a much more manageable number. With the new resources, we really expect that we really are going to be able to give the type of public service that, you know, we believe that we can.

Anything else? Okay.

JUDGE OETTER: Final words of wisdom here.

DR. SCHRETLEN: I do have a question. Other presenters have been asked how typical this case is, and we have heard so much about this hypothetical Susan Que, and her past relevant work,

and her medical history, and her orthopedic and psychological problems, and impairments and residual capacity. I guess I'm wondering at this point, Judge Oetter, do you have a gut level feeling about what kind of determination you would make in a case like this? And this is a close call; and then, perhaps, Judge Goldberg, you can comment.

JUDGE OETTER: I would be happy to. Thanks for the opportunity. I really like the example, by the way. I hope we get to see it in some of our classes later on.

To my approach going through the file, it is a close call. I want to interview Ms. Que. I would like to spend a little time with her and get the feel of her holistic situation. Let me see if I can just point out a couple of things from the file.

The daily activities, for example, they are light and limited; but you know, she pointed out they are limited because of family finances in one particular, not maybe because of physical and mental impairment.

The transferability of skill, obviously, is

paramount. Medical is an area where there are many subsidiary jobs and occupations that a person might be able to perform at a reduced level of duty. So I would be interested in greeting and meeting Ms. Que, and asking her about some of those particulars.

We didn't discuss in detail the medical source opinions in this case; but an ALJ is very constrained when a medical opinion appears in the file. We have some really specific rules about how we are required to deal with those. For example, as you heard earlier, the DDS can reach a conclusion that that is the opinion that belongs to the commissioner. The DDS is permitted in some areas to find insufficient evidence.

Well, at our level, those questions have to be resolved. There needs to be an articulated finding as to what that is. So we would be -- most of my experience we would be hearing this case and we would have a few questions.

JUDGE GOLDBERG: As I previously was pointing out -- of course, my role wouldn't be to weigh the evidence, it would be actually to review

what comes out. I would be concerned about this case, because the claimant does have a significant combination of musculoskeletal impairments affecting the back, the knee, the hip. And superimposed upon that are mental impairment, depression. It's not exactly clear to me from this record how significantly limiting that mental impairment is. And I think that is really the key to this case. The key is, is the claimant's mental capacity sufficiently diminished that they can no longer do semi-skilled and skilled work?

I really think the claimant really should be reduced to the sedentary base, based on the combination of musculoskeletal impairments. They can't do that past work because of the standing and walking requirements. So we're basically at the fifth step in the sequential evaluation; and in order to deny this case, we basically do need transferable skills. In order -- we can only transfer to a skilled or semi-skilled job. Generally, you do need a fairly high degree of concentration.

In this case we said the claimant was

limited to similar tasks and had difficulty multitasking. In my judgment, in order to be able to do most semi-skilled or skilled jobs, you got to be able to do multi-tasking and to be able to sustain concentration for, perhaps, the full two hours. You know, it's not clear to me is the concentration in one hour intervals or two hour intervals, you know? I think they couldn't really sustain concentration for a two hour interval -- you may really have difficulty in transferring skills in this particular case, which could result in an allowance at least at age 50, based on the medical and vocational guidelines.

But as I said, in this given case, depending upon whether the judge is able to write sufficient rationale to overcome the opinion evidence, most of the opinion evidence in this case would suggest that the claimant couldn't sustain competitive employment. I'm not saying you couldn't overcome that based upon a detailed review of the medical evidence, but it would have to be in that decision for it to pass Appeals Council muster. I

would want to make sure that the articulation on the opinion evidence is sufficient, that it truly shows that those opinions are not supported by the evidence. And it's a close call based on the combination of impairments that do exist.

JUDGE OETTER: And now that I am thinking of unrebuttable presumption, I will back away from that, if I may, by saying that if you recall, the expert suggested earlier a consultative psychological evaluation. Also, we know that there are some counseling and physical therapy notes floating around out there that could be added to the file.

One of the challenges I would always say is, was any vocational rehabilitation attempted on this case? Did Ms. Que ever talk to anyone who tried to place her into another type of job?

JUDGE GOLDBERG: I get the one benefit, at the Appeals Council I have the middle ground. I can always remand the case back to the Administrative Law Judge. Instead of making the hard call, I can just say, okay, go develop that physical therapy. Maybe We need a second consultative examination. I can

postpone the ultimate decision for another day. Sometimes we do that, and then the ALJ's aren't very happy.

JUDGE OETTER: No; no. We follow their guidelines and advice to the letter and give this claimant another opportunity to discuss their case as necessary.

JUDGE GOLDBERG: Most do. But occasionally we get the judge that writes in his decision to the claimant what a terrible individual we are at the Appeals Council.

JUDGE OETTER: Oh, what a beauty it is to have a large diverse agency.

I would like to try and help the Panel, if I may, based on what I understand about your mission. Could I take just a few minutes and try to do that?

I have looked at the charter, and I saw in here that you have many things to accomplish in a short period of time, including some capture of the demands of work -- I see that -- data collection, and use of occupational information in our programs, and -- here is the big one -- any other areas that

would enable SSA to develop an occupational information system.

What I would like to ask is, if possible, when you hear the remainder of your presenters, and as you go on through the summer and fall, if you consider are there any short-term alternatives? Are there any near term deliverables that we can operate on before we get to the five or ten year horizon? You know, that's a long-term project. And as you have heard, I hope, today, we were brought in to be users, consumers of the information and try to explain what that is.

Your point, sir, was about these gray areas, things that the vocational expert has to explain differs from the DOT. We encounter that with the sitting and standing. We encounter that with the handling of manual dexterity; it comes up quite often. The social interaction, and work schedules; things like absence, tolerance is a question. And this comes up. A representative will challenge the vocational expert and say, well, what is the tolerance of absence or unscheduled breaks in this

occupation? Well, vocational experts have statistics. They are taken out of national surveys, and they will respond to that answer.

Here is my point, what if there could be a standardized list of these characteristics? What if there was a short sheet of occupations and jobs that allowed a sit/stand alternation? If you could supply your adjudicators with some of that information before the actual revision of the DOT, it might be something helpful in the near term. That might can be accomplished through Regulations, rulings, things that we are all familiar with incorporating.

Some people call this the supplemental grid, we would be taking it a step forward, since the grids were created in the 1970's and dealing with some of the changes that we have all seen in the jobs in the economy. The challenge, of course, always is the Dictionary of Occupational Titles is out of date just simply because it hasn't been recently updated or revised. Some of the new positions that it created, some of the old positions that have fallen off. It puts a lot of responsibility on a single

witness at the hearing. The vocational expert carries a lot of weight in terms of these decisions. Where you have variability of those opinions, you have variability about those.

JUDGE GOLDBERG: I just can only second what Cam has said. At the Appeals Council we don't have any access to any vocational information outside of the DOT. At the DDS level, have vocational consultants. At the ALJ level we have vocational experts. At the Appeals Council I have got nothing, but the DOT. Obviously, the DOT is many years outdated. I can't oftentimes get the information. If the judge doesn't identify the skills that are transferable for me. It's very, very difficult, you know, to go through other sources to try to get that type of information.

So I think the work that you are going to do is very valuable, and I'm also -- the other area that I mentioned that's difficult for us is dealing with work stresses. If anybody can, you know, get that term more narrowly defined so that we get a better understanding, you know, how stress interferes

with various work functioning, that would also be something that would be very helpful.

JUDGE OETTER: But we're really enthusiastic. Discussions we had just today, for example, what might be called data mining the record. Oh, my goodness, you heard that 42 seconds to collect a medical record from a large hospital. We think more like 42 months in some places. We're really on the front end of a huge improvement in our use of the data, and how we can respond to these things in the field.

So I am really glad that your Panel has come online at this important time; in fact, you individually and collectively for being committed to this. Because that's all we have asked for all along was just provide us the tools that we need on the front end.

Now, I hope what we have discussed today was a descent substitute for not actually being an observer at a hearing. I hope you do get that chance if the time is right. That's one thing we do with new employees in the hearing office is actually try

to show them -- because over the years I think we have lost a little bit of focus as to where we're really going with all this data, this information that we constantly process in the hearing offices in the appellate level.

There is a claimant out there, that person deserves an outcome. Whether or not they're pleased with it, they need to have their day of consideration and get the highest quality of vocational information to make that happen.

MS. KARMAN: Thank you both very much. I just wanted to respond to Judge Oetter's request that we take a look at the possibility of supplying some interim guidance with regard to these gray areas that you have mentioned.

And we're about to embark on a study. Hopefully, it will begin this summer, you know, to take a look at our claims and examine not only what the past relevant work was with the claimant; but as well, what their limitations were as noted in the RFC; and then when it gets to the final decision by the -- at the initial level and at the appellate

level, what jobs -- or you know, what jobs you may have cited -- the Agency may have cited for certain kinds of denials.

We're hoping that that kind of information might enable us to then take a look at some of these issues that you have cited, because when we then began our initial testing for instruments, we would want to target those occupations first. The ones that are most likely to be representative among our claimant's; and as well some of the occupations that seem to be coming up time and again when certain limitations are in play. That might help us get at what you have asked for, so hoping that we may be able to do just what you mentioned. So thank you both very much.

JUDGE GOLDBERG: Thank you.

DR. BARROS-BAILEY: Thank you, Judge Oetter and Judge Goldberg for your presentation. And I also would like to thank the members of the demonstration workgroup team members who presented today.

Before we close for today, I wanted to turn it over very quickly to Sylvia to talk about

something that's going to be going on tomorrow, probably with what we're doing.

MS. KARMAN: I need training.

Okay. I just -- actually, what we wanted to just mention was that among the other things that we're also beginning is further user needs now -- user needs analyses. And one thing that we're going to do tomorrow is the Center for Disability in Atlanta -- thank you very much -- and the DQB in Atlanta have -- some of the -- our colleagues have agreed to participate in helping us test user needs analysis, interview, and focus group protocol. And what we intend to do is conduct the interviews with these folks and do a focus group, and then see how well our protocol works and whether or not we're getting at what we want.

One of the things we are attempting to do here is really sort of take another tack at getting at what things might users be identifying as items or worker traits, work requirements that they do not have access to now in the Dictionary of Occupational Titles that would be very helpful for disability

evaluation; but we're trying to do it in a way that might free them, liberate them of the current process whereby everything is very DOT based, and, you know, everything is sort of built around that, and our policy is built around that.

So what we have done is basically come up with a -- a fact sheet of things about the -- an imaginary claimant and imaginary impairments, and what kinds of allegations this person might have. What kinds of work this person might have had. Just ask a series of questions of the individual, in this case, CD and DQB members, but it's designed to try to get at what users might be thinking and might be needing, maybe a little more holistically -- I don't know. Just getting them a survey. We have tried in a limited way, and thought that maybe we would try something -- something different.

So thank you very much, those of you who are here from Atlanta Regional Office to help us out. Thank you.

DR. BARROS-BAILEY: Okay. So very briefly, what we will be doing tomorrow morning, we will be

hearing from Shirleen in the morning again; and also from vocational experts and claimant reps, in terms of their perspective on the demo case. So we are approaching 5:00 o'clock, and I would entertain a motion to adjourn for today.

MS. RUTTLEDGE: So moved.

DR. BARROS-BAILEY: So we have Lynnae who moved; and I heard a second from Sylvia.

MS. KARMAN: So moved.

DR. BARROS-BAILEY: So we are adjourned.

Tomorrow morning at 8:15. We will start a little earlier. Thank you.

(Whereupon, at 4:58 p.m., the meeting was adjourned.)

CERTIFICATE OF REPORTER

I, Stella R. Christian, A Certified Shorthand Reporter, do hereby certify that I was authorized to and did report in stenotype notes the foregoing proceedings, and that thereafter my stenotype notes were reduced to typewriting under my supervision.

I further certify that the transcript of proceedings contains a true and correct transcript of my stenotype notes taken therein to the best of my ability and knowledge.

SIGNED this 11th day of May, 2009.

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STELLA R. CHRISTIAN