



Administrative Conference of the United States

EVALUATING SUBJECTIVE SYMPTOMS IN DISABILITY CLAIMS

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ADMINISTRATIVE CONFERENCE OF THE UNITED STATES

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I.	INTRODUCTION	1
	Disabling Impairments and Pain	3
II.	EVOLUTION IN LEGAL STANDARDS FOR THE EVALUATION OF SUBJECTIVE SYMPTOMS IN SOCIAL SECURITY DISABILITY PROCEEDINGS	6
	A. Early controversy surrounding subjective symptom evaluation	6
	B. CDRs, class-action litigation, and a statutory standard for symptom evaluation	7
	C. The Commission on the Evaluation of Pain and Institute of Medicine studies	9
	D. Settling non-acquiescence on the evaluation of subjective symptoms	10
	E. Nationwide standards for the evaluation of subjective symptoms	11
III.	SYMPTOM EVALUATION IN THE MODERN CONTEXT	12
	A. Legal standards for the evaluation of subjective symptoms	13
	B. Process unification rulings relating to subjective symptom evaluation	15
	C. Policies relating to development of the administrative record	17
IV.	SSA’S PRESENT ADJUDICATORY PRACTICES	18
	A. Initial and reconsideration levels	18
	B. ODAR hearing office and Appeals Council levels	27
V.	JUDICIAL REVIEW AND REMANDS OF SUBJECTIVE SYMPTOM EVALUATIONS	32
	A. Judicial review standards	33
	B. Federal case law overview	34
	C. Appellate review	35
	D. District court review	39
	E. Case law conclusions	44
VI.	EXTERNAL PERSPECTIVES ON SSA’S EVALUATION OF CLAIMANTS’ SYMPTOMS	45
	A. Academic literature	45
	B. Congressional and oversight authorities	46
	C. Stakeholder perspectives	47
VII.	RECOMMENDATIONS	50
	A. Statutory and regulatory revisions	50
	B. Policy recommendations	52
VIII.	APPENDICES	
	A. Changes to SSA’s Subjective Symptom Regulations Since 1991	
	B. Additional Policies Implicating Subjective Symptom Evaluation	
	C. The Electronic Claims Analysis Tool	
	D. Summary of Request for Program Consultation Files Discussing Subjective Symptom Evaluation	
	E. ODAR Data on Subjective Symptom-Related Remands	
	F. Appellate Case Law Citations	
	G. Stakeholder Questionnaire Responses	



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I. INTRODUCTION

Approximately 100 million U.S. adults suffer from chronic pain, and its prevalence is on the rise.¹ Chronic pain costs the U.S. economy and American workers more than \$540 billion each year, including more than \$261 billion in annual incremental health care costs² and \$297-336 billion per year in lost productivity costs.³ According to the 2009 National Health Interview Survey, which asked Americans about the health problems they experience, pain (principally knee and back pain) is the most commonly reported cause of limitations in daily activities.⁴ One in eight respondents to the American Productivity Audit telephone survey said that pain reduced their productivity.⁵ Respondents to the American Productivity Audit survey who had severe pain missed an average of five more days of work per year than those who were pain free.⁶ For some individuals, chronic pain may be so severe that they cannot work at all.

The Social Security Administration (SSA) administers the Social Security Disability Insurance (SSDI) and the Supplemental Security Income (SSI) programs, which were created by Congress to insure and aid individuals who are unable to work because they are disabled.⁷ Under the Social Security Act, an individual is disabled when his or her mental or physical medical impairments are so severe as to limit his or her ability to engage in substantial gainful activity in the national economy.⁸ In fiscal year 2004 and in every fiscal year (FY) thereafter, more than 2.5 million Americans applied for disability benefits. The percentage of the population aged 18-64 receiving disability benefits has increased steadily since FY 2004, from 5.25 percent (5.25%) in FY 2004 to 6.38 percent (6.38%) in FY 2013. The number of Americans receiving disability benefits grew from 9.75 million to 12.71 million beneficiaries over the same period.⁹

SSA and state agency disability program administrators decide individual cases through a legally prescribed process of adjudication. The process begins when a claimant files a disability benefits application, either in-person at a SSA field office or online. Most cases are then sent to a federally funded state Disability Determination Service (DDS), which makes an initial disability determination based on the evidentiary record. In most states, a team of state agency officials consisting of a state disability examiner and a state agency medical and/or psychological consultant makes the initial determination of eligibility on behalf of SSA. In some states, known as Prototype or Single Decision Maker (SDM) States, the disability determination in many cases is made by a state disability examiner without medical or psychological consultant signoff.¹⁰ Except in Prototype States, where there is no reconsideration step of the administrative review process, a claimant who is denied benefits may request reconsideration of this decision by a different state agency reviewer.¹¹ If benefits are again denied at the reconsideration level, or if they are denied at the initial level in Prototype States, the claimant may file an appeal and request a hearing with SSA's Office of Disability Adjudication and Review (ODAR).

Administrative appeals at the ODAR hearing office level are heard by SSA's Administrative law judges (ALJs) and frequently offer claimants a first opportunity for an in-person (or more recently video) hearing of their claim. If claimants are denied benefits by an ALJ, a final administrative appeal may be made to SSA's Appeals Council. Denial or dismissal of a claim at this level, which is ordinarily made on the administrative record, is the final step in the administrative process. A claimant may then seek judicial review in a U.S. district court, although Appeals Council dismissals are not appealable in most circuits.¹²

SSA's adjudicators at all levels of agency review follow a five step sequential process in evaluating adult disability claims.¹³ At step one the adjudicator considers a claimant's work activity and earnings. If a claimant is working and has earnings at levels of substantial gainful activity (SGA), then he or she is found not disabled. At step two the adjudicator considers whether the claimant has a medically determinable impairment (or combination of impairments) that is severe and that is expected to last at least twelve continuous months or result in death. If the impairment meets these requirements, SSA at step three determines whether the impairment meets or equals one of the listed impairments it considers to be disabling. If the listing is met or equaled, then the claimant is found to be disabled. If not, then the claimant's residual functional capacity (RFC) is assessed. The RFC is a "*function-by-function* assessment of an individual's maximum ability to do *sustained* work-related physical and mental activities on a regular and continuing basis (8 hours a day, for 5 days a week) despite the limitations and restrictions resulting from his or her medically determinable impairments."¹⁴ At step four, the adjudicator compares the RFC and past relevant work to see if the claimant retains the ability to perform past relevant work. If not, then at step five SSA considers whether the claimant could make an adjustment to any other work that exists in significant numbers in the national economy.

At all levels of review, after the threshold showing that a claimant is not presently working at levels of SGA, the adjudicator looks to a claimant's physical and mental impairments. Both medical evidence of an impairment and the claimant's descriptions of his or her subjective experience of symptoms may be considered at various steps of the disability determination process.¹⁵ Objective medical evidence from an acceptable medical source is required to establish the existence of an impairment; a claimant's statements about his or her symptoms alone are not sufficient to establish the existence of an impairment.¹⁶ Nonetheless, the subjective experience of symptoms of a mental or physical impairment—especially pain—and the functional effects of those symptoms are, for millions of Americans, integral to claims for government assistance because of disability. Pain and certain other symptoms introduce subjectivity into a system tasked with making objective judgments consistently.

SSA commissioned the Office of the Chairman of the Administrative Conference of the United States to conduct an independent study of subjective symptom evaluation at the initial, reconsideration, and hearing office adjudicative levels. The Office of the Chairman was also asked to review appropriate federal court case law involving hearing-level adjudicator evaluations of claimants' subjective symptoms and credibility. Data provided by SSA indicate that improper credibility evaluation at the hearing office level is a reason for remand in about twenty percent (20%) of decisions remanded after internal Appeals Council or external judicial review. This high rate of remands evidences not only the frequency with which decisionmakers must evaluate a claimant's testimony regarding his or her subjective symptoms, but also the difficulty of this task.

Disabling Impairments and Pain

SSA provides disability benefits to individuals suffering from chronic and acute pain. Though SSA does not specifically track awards by subjective symptom, it is clear that pain and other subjective symptoms inhere in a variety of disabling impairments. SSA's disability regulations identify pain as a symptom for twenty different impairments in its Listing of Impairments, Part A, which define medical criteria for evaluating disability claims for adults and, where appropriate, children.¹⁷ Pain is also identified as a symptom in five additional impairments uniquely affecting children, identified in Part B of the Listing of Impairments.¹⁸

Disability based on the Listing of Impairments is established when a claimant meets the medical criteria for a specified impairment; otherwise the adjudicator must evaluate whether the claimant's disabling impairment (or impairments) is medically equivalent to the criteria in a listing or a related listing. Pain is implicated in seven of the fifteen body system listings.¹⁹ Generally, the intensity of pain need not be evaluated in identifying whether an impairment meets listing criteria so long as it is present in combination with other criteria.²⁰

Pain is a criterion for seven musculoskeletal and three cardiovascular system impairments, as well as in identifying impairments in these body systems more generally.²¹ In the musculoskeletal system, pain plays an important role in assessing loss of function. Functional loss is defined in the listings as the inability to ambulate effectively on a sustained basis for any reason, including pain associated with the underlying musculoskeletal impairment, or the inability to perform fine and gross movements effectively on a sustained basis for any reason, including pain associated with the underlying musculoskeletal impairment.²² In the cardiovascular system, pain is one of the four consequences of heart disease that may indicate a cardiovascular impairment.²³

Using data provided by SSA, Administrative Conference staff examined dispositions at the initial, reconsideration, and hearing office level for impairments in which pain is identified in the medical listings as a diagnostic criterion ("pain criterion impairments").²⁴ This data, summarized below, provides a crude estimate of the number of cases in which pain, and in many cases subjective symptom evaluation, are likely to be important.²⁵

The results are striking: pain criterion impairments are the primary impairment for more than one in five dispositions at the initial level, nearly one in three dispositions at the reconsideration level, and more than one in three dispositions at the hearing office level.

FY 2009 – FY 2013 Totals			
Adjudicative Level	Pain Criterion Impairments	All Dispositions	Percentage
Initial	4,415,326	19,633,070	22.49%
Reconsideration	1,546,393	5,113,733	30.24%
Hearing Office	1,473,585	3,806,085	38.72%

This report reviews and analyzes SSA's laws, regulations, policies, and practices establishing how its adjudicators, at all levels, are to evaluate the intensity and persistence of a claimant's self-reported subjective symptoms, such as pain, including how SSA's adjudicators determine the extent to which a claimant's symptoms limit his or her capacity for work, or in the case of a child, his or her limitations on functioning, under SSA's sub-regulatory policy, *SSR 96-7p Titles II and XVI: Evaluation of Symptoms in Disability Claims: Assessing the Credibility of an Individual's Statements* (SSR 96-7p).²⁶

Part II examines the historical evolution in legal standards for the evaluation of subjective symptoms in social security disability proceedings. As this part demonstrates, controversy over how subjective symptoms are to be considered during the adjudicatory process dates to the 1960s. SSA's legal approach, as established by its regulations and relevant policy guidance documents (i.e., superseded Social Security Rulings 82-58 and 88-13, as well as 90-1p (which was applicable in the U.S Court of Appeals for the Fourth Circuit only)), evolved in response to judicial feedback and directives issued in litigation over the agency's policies for subjective symptom evaluation. This history of conflict in the courts has been occasionally punctuated by congressional interventions, first, to specify that medically acceptable clinical or laboratory findings are necessary to establish a disabling medical impairment (1968), and second, to reiterate that an individual's subjective symptoms alone are not conclusive evidence of disability under the Social Security Act (1984).

As set forth in **Part II, Subpart E**, SSA undertook a major revision of its regulations in 1991 to incorporate the 1984 statutory standard for evaluating subjective symptoms and to codify its prior policy rulings and other agency policies. Revisions to the agency's regulations since 1991 have been of a primarily ministerial nature. More substantive changes to its policy rulings were driven largely by internal agency research and initiatives, specifically the Process Unification initiative of the late 1990s, but did not deviate from the equilibrium the agency finally established with the courts. Despite a long history of class-action litigation and some judicial non-acquiescence concerns, it appears that SSA's present legal approach to subjective symptom evaluation has been both responsive to and accepted by the federal courts.

Part III examines the agency's approach to symptom evaluation in the modern context. **Part III, Subpart A** details the current legal standards for the evaluation of subjective symptoms and, in particular, the regulatory two-step analysis, which requires: first, a finding of a medically determinable impairment capable of producing pain or other symptoms and, second, a determination regarding the functional limitations and restrictions that those symptoms impose on a claimant's ability to work. It also identifies the regulatory factors that SSA's adjudicators are to consider in evaluating the limiting effects of a claimant's medically determinable impairments. **Part III, Subpart B** examines SSR 96-7p. As well, it identifies a variety of additional policies that authorize or prohibit certain tools for record development.

Part IV, Subparts A and B describe a number of present agency practices that impact or relate to subjective symptom evaluation, including: agency information technologies and adjudicator use of decision-writing tools, agency quality or internal reviews of cases involving subjective symptom evaluation as well as related dispute resolution mechanisms, and internal treatment of bias complaints against ALJs. These practices demonstrate the agency's commitment to quality decision-making and nationally uniform program administration at all levels of adjudicative review.

Part IV, Subpart B concludes by examining ODAR’s data-driven findings on internal and judicial remands of adjudicator decisions due to problems with subjective symptom evaluation. ODAR’s data show that in recent years the two most common reasons for remand from the Appeals Council and federal district courts have been that the adjudicator “Failed to Discuss Appropriate Credibility Factors” required by the regulations and/or “Other Issue.” Remand rates for failure to discuss the appropriate factors are similar at the Appeals Council and district court levels. Remands occurred in eighteen to twenty-one percent (21%) of cases decided at these levels. “Other Issue[s]” are more commonly identified in judicial remands (9% of cases) than in internal agency review (3-5% of cases). These high remand rates stand in stark contrast to seeming judicial acceptance of the agency’s regulations and policy rulings.

Part V offers an in-depth look at judicial review and remands of subjective symptom evaluations at the hearing office level. This part is supported by an independent examination of both appellate (**Subpart C**) and district court (**Subpart D**) opinions citing SSR 96-7p between 2009 and 2013. Conference staff identified five common bases for remand in cases involving subjective symptom evaluations:

- Problems in considering limitations in a claimant’s daily activities imposed by symptoms, and in comparing these activities to those needed to sustain substantial gainful activity.
- Improper consideration of the absence of treatment, where treatment was unavailable, unadvisable, or occasionally even pursued, and in some cases where further record development was necessary.
- Reliance on conclusory or template language rather than specific analysis as required by SSR 96-7p.
- Requiring objective medical evidence of subjective symptoms.
- Unconsidered or inappropriately rejected medical evidence supporting subjective symptom complaints.

These remands are due to flawed implementation of existing rules and policies, rather than judicial opposition to the rules and policies. Remand rates due to problematic subjective symptom evaluation were similar in the courts of appeals (28% of cases citing SSR 96-7p) and in a ten percent simple random sample of district court cases (26% of sampled cases citing SSR 96-7p).

Part VI presents some perspectives on subjective symptom evaluation from academics, Congress, and external stakeholders. Academic literature and congressional attention to subjective symptom evaluation is relatively limited, although several academic articles raise concerns and examples of bias in credibility evaluations. In response to a questionnaire prepared and distributed by the Office of the Chairman, stakeholders from disability examiner, ALJ and claimant representative organizations provided detailed feedback regarding SSA’s existing approach to symptom evaluation. Taken together, these responses indicate that: the regulations and SSR 96-7p are generally accepted by stakeholders, opportunities exist to improve their implementation, claimants have concerns with several of the common bases for remand, and diverse interests advocate for additional resources and record development (especially of medical evidence), though supported approaches may vary.

Part VII offers the Office of the Chairman’s recommendations. They suggest how SSA can best articulate the scope of symptom evaluation in its adjudication process and tools, so as to: improve consistency in disability determinations, reduce complaints of bias and misconduct against SSA adjudicators, and reduce the frequency of Appeals Council remands as well as judicial remands on grounds of symptom evaluation. To this end, this part offers suggestions concerning potential improvements in the language and administration of SSR 96-7p.

II. EVOLUTION IN LEGAL STANDARDS FOR THE EVALUATION OF SUBJECTIVE SYMPTOMS IN SOCIAL SECURITY DISABILITY PROCEEDINGS

The definition of disability is a fundamental question for the Social Security program, and has been the focus of numerous government inquiries dating back to the 1930s.²⁷ At the program’s inception in the 1950s, Congress made the decision to cover only those disabilities that were medically determinable.²⁸ A study on Disability and Pain by the National Academy of Sciences’ Institute of Medicine summarized the definitional concern as follows:

The notion that all impairments should be verifiable by objective evidence is administratively necessary for an entitlement program. Yet this notion is fundamentally at odds with a realistic understanding of how disease and injury operate to incapacitate people. Except for a very few conditions, such as the loss of a limb, blindness, deafness, paralysis, or coma, most diseases and injuries do not prevent people from working by mechanical failure. Rather, people are incapacitated by a variety of unbearable sensations when they try to work.... Thus, pain is a major problem for the disability program because it does not fit the medical model of impairment on which the program rests.²⁹

This “problem” began manifesting in the federal courts in the early 1960s. In the words of one commentator, “[t]he history of the law in this area may be described as struggle over the need for objective findings.”³⁰

A. Early controversy surrounding subjective symptom evaluation

From the beginning, SSA’s subjective symptom evaluation process and requirements were a basis for remand in courts across the country. In two of the most notable early appellate cases—the 1963 *Page v. Celebrezze* and 1964 *Ber v. Celebrezze* cases in the Second and Fifth Circuits—SSA decisions to deny disability benefits were overturned in part because of the adjudicators’ failure to adequately consider subjective complaints of severe pain that were not fully supported by objective clinical and laboratory findings.³¹ By the 1970s, the Second Circuit had firmly established that “subjective pain may serve as the basis for establishing disability, even if such pain is unaccompanied by positive clinical findings or other ‘objective’ medical evidence,” and the Fifth, Sixth, Tenth, and Eleventh Circuits had issued similar holdings.³² In kindred cases, the Third and Seventh Circuits had ruled that medical opinion evidence could not be rejected “simply because it is based on a claimant’s symptomology....”³³ Various circuits took the position that “the Social Security Act is a remedial statute, to be broadly construed and liberally applied.”³⁴

Some of these early cases relied on the Social Security Act’s lack of a definition of medically determinable impairment in holding that subjective symptoms could establish disability.³⁵ However, Congress amended the Social Security Act in 1968 to require objective clinical or laboratory findings to establish a medically determinable impairment.³⁶ Subsequent judicial cases accounted for this change in law and focused on whether clinical findings and

objective medical evidence were needed to establish the extent of subjective symptoms.³⁷ Several courts of appeals held that they were not and remanded SSA decisions to the contrary, though not all circuits adopted the same position, and, at times, inconsistent rulings were made even within the same circuit.³⁸

Likely as a result of this non-uniformity, SSA did not attempt to adopt wholesale the varied judicial directives on subjective symptoms in subsequent promulgations of agency policy and guidance.³⁹ Its 1980 regulations on symptom evaluation stated: “We will never find that you are disabled based on your symptoms, including pain, unless medical signs or findings show that there is a medical condition that could be reasonably expected to produce those symptoms.”⁴⁰ Similarly, in 1982, SSA adopted internal policy guidance (SSR 82-58) stating that “there must be an objective basis to support the overall evaluation of impairment severity. It is not sufficient to merely establish a diagnosis or a source for the symptom.”⁴¹ SSA’s Program Operations Manual System (POMS) directive 401.570, which was cross-referenced in SSR 82-58 and provided to the agency’s adjudicators, required objective medical proof of the severity of alleged pain.⁴²

B. CDRs, class-action litigation, and a statutory standard for symptom evaluation

SSA implemented a new program of Continuing Disability Reviews (CDRs) from 1980 to 1981, as required by the Social Security Disability Amendments of 1980, to determine whether program beneficiaries were still eligible for benefits.⁴³ While this review process is now a well-established and generally accepted part of the disability benefits program, initial implementation was problematic. Class-action litigation ensued as disqualified claimants sought reinstatement of their benefits. According to the 1987 Institute of Medicine Study *Pain and Disability*, there was a perception that claimants with subjective symptom complaints were disproportionately represented among those disqualified in initial reviews.⁴⁴ Litigants attacked SSA’s standard for evaluating subjective complaints and the implementation of SSR 82-58.

In 1984, the SSA settled a class-action lawsuit, *Polaski v. Heckler*, in the Eighth Circuit, by formalizing a standard for the evaluation of pain as a disability.⁴⁵ SSA conceded that its adjudicators might have misinterpreted its guidance in SSR 82-58 on pain, in violation of Eighth Circuit precedent, “to allow allegations of pain to be disregarded solely because the allegations are not fully corroborated by objective medical findings typically associated with pain.”⁴⁶ The agency agreed to transmit the following standard to its adjudicators:⁴⁷

While the claimant has the burden of proving that the disability results from a medically determinable physical or mental impairment, direct medical evidence of the cause and effect relationship between the impairment and the degree of claimant's subjective complaints need not be produced. The adjudicator may not disregard a claimant's subjective complaints solely because the objective medical evidence does not fully support them.

The absence of an objective medical basis which supports the degree of severity of subjective complaints alleged is just one factor to be considered in evaluating the credibility of the testimony and complaints. The adjudicator must give full consideration to all of the evidence presented relating to subjective complaints, including the claimant's prior work record, and observations by third parties and treating and examining physicians relating to such matters as:

1. the claimant's daily activities;
2. the duration, frequency and intensity of the pain;
3. precipitating and aggravating factors;
4. dosage, effectiveness and side effects of medication;
5. functional restrictions.

The adjudicator is not free to accept or reject the claimant's subjective complaints *solely* on the basis of personal observations. Subjective complaints may be discounted if there are inconsistencies in the evidence as a whole.⁴⁸

Although this standard was applicable only in the Eighth Circuit, it was transmitted to all agency adjudicators “because *Polaski* class members who now reside in states outside the Eighth Circuit must have their claims processed in accordance with the requirements of the court orders, regardless of their current state of residence.”⁴⁹

SSA also faced extended class-action litigation in the Fourth Circuit arising from its policies and practices in evaluating complaints of pain in disability claims.⁵⁰ In a 1986 decision, *Hyatt v. Heckler (Hyatt II)*, the Fourth Circuit equitably tolled administrative exhaustion deadlines to permit North Carolina claimants who were denied disability solely on the basis of SSR 82-58’s application by adjudicators to challenge that decision in the class action litigation.⁵¹ In doing so, the court relied on the Supreme Court’s finding in *Bowen v. City of New York* that SSA’s unpublicized non-acquiescence policy prevented claimants from learning the facts necessary to pursue systematic procedural irregularities in a timely fashion (in *Hyatt II* the alleged irregularity was not following the law of the circuit with respect to pain).⁵² Similar relief was granted by the U.S. District Court for the Western District of Tennessee in 1986 to Tennessee claimants who were denied disability benefits or whose benefits were terminated because SSA’s internal agency guidance required objective proof of the severity of alleged pain, in violation of the law of the Sixth Circuit.⁵³

In response to litigation, and to varying standards for the treatment of subjective symptoms and pain in the courts of appeals, Congress adopted an interim standard for the evaluation of subjective symptoms in the Social Security Disability Benefit Reform Act of 1984, with an expiration date of December 31, 1986.⁵⁴ Under the new law:

An individual’s statement as to pain or other symptoms shall not alone be conclusive evidence of disability as defined in this section; there must be medical signs and findings, established by medically acceptable clinical or laboratory diagnostic techniques, which show the existence of a medical impairment that results from anatomical, physiological, or psychological abnormalities which could reasonably be expected to produce the pain or other symptoms alleged and which, when considered with all evidence required to be furnished under this paragraph (including statements of the individual or his physician as to the intensity and persistence of such pain or other symptoms which may reasonably be accepted as consistent with the medical signs and findings), would lead to a conclusion that the individual is under a disability. Objective medical evidence of pain or other symptoms established by medically acceptable clinical or laboratory techniques (for example, deteriorating nerve or muscle tissue) must be considered in reaching a conclusion as to whether the individual is under a disability.

In adopting the statutory standard, Congress overrode a rule that was still in effect in several circuits—that testimony regarding subjective symptoms alone could form the basis of a disability under the Social Security Act.⁵⁵ Congress also created a Commission on the Evaluation of Pain and asked it to study how SSA evaluated pain as well as asked to consider the appropriateness of the new statutory standard.

Courts generally gave effect to this new statutory language, even overturning their inconsistent prior precedent.⁵⁶ For example, in 1986, both the *Hyatt* and the *Samuels* courts acknowledged that class-action claims would be reconsidered in light of the Disability Benefit Reform Act of 1984 standard for the evaluation of pain.⁵⁷ Not long after these opinions were issued, however, the statutory standard for subjective symptom evaluation in the Social Security Disability Benefit Reform Act of 1984 quietly expired.⁵⁸

C. The Commission on the Evaluation of Pain and Institute of Medicine studies

In 1986, the Commission on the Evaluation of Pain released its highly anticipated report, which was summarized in the Social Security Bulletin as follows:

The Commission clearly recognized that SSA does have a problem in evaluating disability claims where disability is alleged due primarily to pain, that this problem is related to the lack of any objective tool to measure an individual's pain, and that, although this problem was the reason for the Commission's existence, it was highly unlikely the Commission would be able to satisfactorily resolve all of these questions.⁵⁹

The Commission's major findings were that: the current law handles acute pain relatively well; administrative tools to clinically assess or measure pain could produce only relative results; chronic pain and chronic pain syndrome are not psychogenic pain disorders and lack objective laboratory and clinical evidence of physical impairment that could reasonably cause the reported pain; there is insufficient data on the number of individuals who demonstrate chronic illness behavior because of pain but who are denied benefits for failure to substantiate pain allegations; and fabrication or exaggeration of symptoms (malingering) is not a significant problem nor one that would be exacerbated by increased attention to subjective evidence in the evaluation of the existence and nature of pain.⁶⁰

The Commission made a number of recommendations specific to pain-related claims, such as encouraging the use of trained pain specialists, where possible, in the examination and evaluation of such claims. It considered but ultimately did not make a recommendation for an impairment due primarily to pain, though it did recommend that SSA conduct an experiment or experiments to evaluate whether to create such a listing category. It recommended that SSA improve its regulations defining RFC by requiring explicit consideration of potential pain-based restrictions on basic work activities. It also urged SSA to incorporate pain more fully into its analysis of nonexertional employment-related limitations. The Commission recognized the administrative need for a statutory standard to ensure a uniform policy, and recommended a temporary extension of the 1984 statutory standard for the evaluation of pain. It also urged further study to ensure that any future change in the statute would be informed by additional data and would properly and clearly define pain (and, in particular, pain not clearly attributable to objectively determinable physical or mental causes). To that end, in 1985, it contracted with the National Academies' Institute of Medicine to continue research on these issues.

The Institute of Medicine corollary study, entitled *Pain and Disability*, was released in 1987. The study did not recommend (or even consider recommending) changes in the legal definition of disability under which SSA operated.⁶¹ Consistent with prevailing judicial precedent, the Institute of Medicine study found that "[s]ignificant pain, even in the absence of clinical findings to account for it, should trigger a functional assessment of the capacity for work."⁶² It expressed concern that "a pain claimant without clinical findings to account for the symptom would be denied benefits" at step two of the sequential evaluation process, prior to an assessment by the adjudicator of how that pain affected the individual's RFC.⁶³ The Institute of Medicine recommended that "a primary complaint of pain" should allow an evaluation of disability, comparable to the SSA's approach to mental illness in its recently revised mental illness listings.⁶⁴ It found:

Disability benefits have not been awarded on the basis of self-reported pain uncorroborated by objective findings, nor does the committee believe they should be. However, the kinds of acceptable evaluation and corroboration should not be limited to medical evidence of an underlying disease process. With or without such findings, consideration should also be given to serious functional

limitations and serious problems on measures of integrated behavior. This means not only assessing physical abilities such as sitting, standing, lifting, and walking, but also examining how the limitations imposed by pain affect aspects of the individual's daily life: sleeping, eating, self care, interpersonal relationships, the ability to concentrate, and work activities.⁶⁵

This suggestion was not implemented in SSA's ensuing regulations and operating policies, which continue to require objective medical evidence of an underlying medical impairment prior to assessing the impact of pain on a claimant's functional limitations.

D. Settling non-acquiescence on the evaluation of subjective symptoms

SSA responded to these legal and policy developments by updating SSR 82-58 with a superseding Program Policy Statement, SSR 88-13, *Titles II and XVI: Evaluation of Pain and Other Symptoms*.⁶⁶ SSR 88-13 required all of the agency's adjudicators to develop the record regarding subjective complaints of pain to permit reasonable inferences as to any limitations on the claimant's ability to do basic work activities, "consistent with court decisions which require that statements of the claimant or his/her physician as to the intensity and persistence of pain or other symptoms which may reasonably be accepted as consistent with the medical signs and laboratory findings are to be included in the evidence to be considered in making a disability determination."⁶⁷ It adopted some of the language of the standard for subjective symptom evaluation in the Social Security Disability Benefit Reform Act of 1984, as well as gave nationwide applicability to the factors SSA had agreed in *Polaski* to require some of its adjudicators to consider as evidence of pain or other symptoms.⁶⁸ Consistent with precedent from the First Circuit and internal SSA policy guidance, SSR 88-13 also added treatment (other than medication) for relief of pain to the list of factors an adjudicator should consider in making a benefit determination.⁶⁹ SSR 88-13 was specifically upheld by the Seventh and Ninth Circuits.⁷⁰ Notably, the Seventh Circuit was the only circuit that then still required some objective medical evidence of the extent of subjective symptoms.⁷¹ It is striking that SSR 88-13 was upheld in two circuit courts with conflicting positions on whether objective medical evidence of the extent of subjective symptoms was required to establish disability.

However, SSR 88-13 was not accepted in the Western District of North Carolina, which continued to hear challenges to SSA's adjudications in the *Hyatt* class-action litigation and which, in 1989, ordered SSA to distribute a new SSR on the pain standard for adjudicators in North Carolina.⁷² This judicial directive made it clear that "subjective evidence of pain, its intensity or its degree, is an adequate basis for a finding of disability, once medically acceptable objective evidence has established an underlying impairment capable of causing pain."⁷³ In *Hyatt III*, the Fourth Circuit agreed with the substance of the District Court's findings on SSR 88-13, but permitted SSA to retain SSR 88-13 with an amendment to clearly indicate the change in policy from SSR 82-58—that medical findings are not required to corroborate the severity of alleged pain.⁷⁴ On August 6, 1990, SSA issued SSR 90-1p, *Titles II and XVI: Evaluation of Pain and Other Symptoms*, superseding SSR 88-13 only in states in the Fourth Circuit.⁷⁵ SSR 90-1p was identical to SSR 88-13 except for its statement of purpose, which was updated to reflect the change in policy from SSR 82-58, and effective date. The *Hyatt III* litigation settled in 1994 with an agreement by SSA to review 77,000 claims that included allegations of pain and that were denied before November 1991.⁷⁶

In 1992, SSA settled another class action lawsuit, *Stieberger v. Sullivan*, in the Southern District of New York.⁷⁷ The settlement followed a 1990 district court opinion finding that SSA had “non-acquiesced” with respect to several specific holdings of the Second Circuit.⁷⁸ They included the Second Circuit’s holdings that “an ALJ may accord his personal observations of the claimant’s physical and mental condition only limited weight in deciding the substantive issues in the case” and that “the testimony of a claimant with a good work record claiming an inability to work because of a disability is to be deemed substantially credible.”⁷⁹ The 1990 opinion noted that judicial precedent regarding the ALJ’s consideration of his or her own personal observations and claimant work history had not been incorporated into SSA’s policy during the 1980s, when the alleged non-acquiescence occurred, as well as that the judicial rulings tended to be more specific than SSA’s more general policy on credibility.⁸⁰

Under the *Steinberger* settlement, SSA agreed to publish a *Manual of Second Circuit Disability Decisions* (the Steinberger Manual) and to direct its decisionmakers and reviewers of its decisions for New York resident claimants to comply with the holdings identified therein.⁸¹ They require SSA’s decisionmakers to: make a specific finding on the credibility of testimony regarding pain, find that a claimant with a good work record is entitled to substantial credibility, give limited weight to observations on a claimant’s demeanor, accept that objective findings of pain itself are not needed, and afford great weight to subjective complaints when they are accompanied by objective medical findings.⁸² These holdings are still legally binding in the Second Circuit.

E. Nationwide standards for the evaluation of subjective symptoms

On November 13, 1991, SSA issued an extensive revision to its nationwide regulations concerning the evaluation of subjective complaints, including pain.⁸³ According to SSA, these regulations “incorporate[d] the terms of the statutory standard for evaluating pain or other symptoms contained in section 3 of the Social Security Disability Benefits Reform Act of 1984” and codified much of the SSA’s earlier Social Security Rulings and program operating instructions (POMS directives) on the evaluation of pain and other symptoms.⁸⁴ **Appendix A: Changes to SSA’s Subjective Symptom Regulations** documents the regulatory updates adopted in 1991, as well as the relatively minor revisions to the regulations thereafter.

SSRs 88-13 and 90-1p remained in effect until 1995, when they were superseded by SSR 95-5p, Titles II and XVI, *Considering Allegations of Pain and Other Symptoms in Residual Functional Capacity and Individualized Functional Assessments and Explaining Conclusions Reached*.⁸⁵ Because much of SSA’s policy on the evaluation of symptoms had been codified in the 1991 regulatory updates, the SSR was limited to the subject of how adjudicators should consider allegations of subjective symptoms in assessing a claimant’s RFC. The SSR required adjudicators to explain their assessment of the functional impact of symptoms. It clarified that the agency’s policies on subjective symptoms applied not just to pain, but to all symptoms (such as fatigue, shortness of breath, weakness, or nervousness).⁸⁶

Amidst these regulatory and policy developments, internal quality review research identified decisional inconsistency in the evaluation of subjective symptoms among different levels of adjudicators.⁸⁷ Variance in procedures and evaluation standards (including standards for the treatment of pain) at the different levels of review had long been cited as a major reason for

this inconsistency, even in a study that controlled for differences in evidence at each level of review.⁸⁸ Although judicial remands indicated that subjective symptom findings were negatively impacting some award determinations, administrative research showed that claimants' in-person testimony contributed to favorable benefit decisions at the hearing office adjudicative level.

SSA and U.S. Government Accountability Office reports indicated that ALJs were granting disability benefits more frequently than state DDS decision-makers in part because "DDS adjudicators tend to rely on medical evidence such as the results of laboratory tests; ALJs tend to rely more on symptoms such as pain and fatigue."⁸⁹ A 1994 SSA Office of Program and Integrity Reviews study "identified the credibility of the claimant and the claimant's allegations about pain as two of the top five reasons for an ALJ allowance decision."⁹⁰ This study found that the claimant's credibility was a factor in thirty-four percent (34%) of sampled hearing allowances.⁹¹ At the DDS level, however, claimant testimony was found to have minimal or no impact.⁹² DDS medical consultants were found to have sometimes "overstated the claimant's capacity to function in the workplace."⁹³ This may be attributable, at least in part, to the fact that ALJ hearings were often the first opportunity for claimants to have in-person contact with the adjudicators deciding their claims.⁹⁴ A 1994 survey of ALJs conducted by the Office of the Inspector General for the Department of Health and Human Services (which then housed SSA) reported that ninety percent (90%) believed that a claimant's presence at a hearing had at least a moderate effect on whether an award is made, and more than half thought the effect was strong.⁹⁵ This finding was consistent with the 1980s research on consistency in decisionmaking, which found that the ALJ award rates declined by seventeen percent (17%) when records documenting a claimant's testimony were removed from the case file.⁹⁶ (While no recent research on this subject was identified, award rates continue to be higher at the ALJ level—where the claimant has the opportunity for a face-to-face hearing—than at the state DDS level.⁹⁷ It should be noted, however, that personal observations about a claimant might be recorded at SSA field offices, and available for review by DDS decisionmakers.⁹⁸ Further, other factors—such as new evidence—can also influence award rates at the ALJ level compared to those at the DDS.)

In the early 1990s SSA sought to develop a single presentation of policies for all of its decisionmakers, with the goal of "achiev[ing] correct, similar results in similar cases at all stages of the administrative review process." This resulted in issuance of what are known as the "process unification" rulings.⁹⁹ SSA's present guidance on subjective symptom evaluation, SSR 96-7p, discussed further below, superseded SSR 95-5p and was adopted together with nine other Social Security Rulings. Issuance of the rulings was followed by a major agency-wide training effort that reached more than 15,000 adjudicators and quality reviewers.¹⁰⁰ The process unification rulings remain in effect today.

III. SYMPTOM EVALUATION IN THE MODERN CONTEXT

SSA's 1991 regulations and 1996 process unification guidance on the evaluation of subjective symptoms appear to have been relatively well accepted by the public and the courts.¹⁰¹ The regulations have been cited by numerous courts of appeals—including the Fourth Circuit, the forum for the *Hyatt* class-action litigation, and the Eight Circuit, the forum for the *Polaski* class-action litigation—as consistent with judicial precedent.¹⁰² They were upheld in the Seventh Circuit despite their conflict with that court's precedent (requiring some objective medical evidence to support subjective symptom claims) due, the court explained, to their consistency with the

approach taken by “every other circuit” and SSA’s prerogative to issue clarifying regulations “[t]idying-up’ a conflict in the circuits.”¹⁰³

Nonetheless, as set forth below in **Section V: Judicial Review and Remands of Subjective Symptom Evaluations**, evaluation of pain and other subjective symptoms has continued to play an important role in federal judicial disability decisions. Many of these cases relate to whether SSA’s adjudicators properly implement the regulations and SSR 96-7p.¹⁰⁴ For example, in a recent settlement of class-action litigation in the Eastern District of New York alleging bias in credibility and disability determinations, SSA agreed to conduct training programs instructing its ALJs on credibility assessment, record development, and hearing conduct.¹⁰⁵ Further judicial attention has been given to chronic pain disorders, as well as somatoform mental disorders, which are a listed medical impairment that cannot be verified by organic findings or known physiological mechanisms.¹⁰⁶

This section of the report provides an overview of the statutory and regulatory standards that SSA adjudicators are required to follow in evaluating subjective symptoms. It offers a detailed summary of SSR 96-7p, the agency’s sub-regulatory guidance on evaluating claimant credibility.

A. Legal standards for the evaluation of subjective symptoms

Since the expiration of the Disability Benefit Reform Act of 1984, SSA has operated without a statutory definition of disability that specifically accounts for subjective symptoms, such as pain. Rather, 42 U.S.C. § 423(d)(5)(a) defines disability by reference to “medical and other evidence of the existence thereof as the Commissioner of Social Security may require.”¹⁰⁷ A physical or mental impairment—defined as “an impairment that results from anatomical, physiological, or psychological abnormalities which are demonstrable by medically acceptable clinical and laboratory diagnostic techniques”¹⁰⁸—must cause the disability.¹⁰⁹

SSA’s regulations set forth the Commissioner’s evidentiary requirements for a showing of disability. Subjective symptoms are evaluated at various steps in the five-step sequential evaluation process for determining disability set forth in 20 C.F.R. §§ 404.1520(a)(4) and 416.920(a)(4). Specifically, subjective symptoms are to be considered in evaluating the medical severity of a claimant’s medically determinable impairment (which must be established at step two), whether the listing of impairments is met or whether the claimant’s already established impairment medically equals a listed impairment (step three), and their impact on a claimant’s RFC and ability to do past relevant work (step four).¹¹⁰ Exertional and nonexertional limits on RFC imposed by a claimant’s impairment(s) and symptoms are also considered at step five if the claimant is unable to do his or her past relevant work.¹¹¹

20 C.F.R. §§ 404.1520 and 416.929 codify the standards SSA’s adjudicators use to evaluate symptoms, including pain. As depicted in **Appendix A: Changes to SSA’s Subjective Symptom Regulations since 1991**, these regulations have undergone only minor amendments since they were promulgated in 1991. These regulations establish a two-part test for the evaluation of subjective symptoms. First, adjudicators must review the evidence for “medical signs and laboratory findings which show that [a claimant has] a medical impairment which could reasonably be expected to produce the pain or other systems alleged, and, when considered with all of the other evidence (including statements about the intensity and persistence of [the claimant’s] pain

or other symptoms which may reasonably be accepted as consistent with the medical signs and laboratory findings), would lead to a conclusion that [the claimant is] disabled.”¹¹² This finding “does not involve a determination as to the intensity, persistence, or functionally limiting effects” of symptoms.¹¹³ If medical signs and laboratory findings do not establish the existence of any physical impairment(s) capable of producing the pain or other symptoms, and evidence suggests the possibility of a medically determinable mental impairment, then SSA adjudicators must develop evidence regarding this possibility.¹¹⁴

Second, when such a medical impairment is established, the adjudicator must “determine the extent to which [a claimant’s] alleged functional limitations and restrictions due to pain or other symptoms can reasonably be accepted as consistent with the medical signs and laboratory findings and other evidence to decide how [the claimant’s] symptoms affect [his or her] ability to work.”¹¹⁵ This determination requires an evaluation of the intensity and persistence of related symptoms, and SSA must attempt to obtain objective medical evidence that would assist in making “reasonable conclusions” about the effect of those symptoms on a claimant’s ability to work.¹¹⁶ Consistent with the *Hyatt* class-action litigation and substantial circuit-level judicial precedent, statements about subjective symptoms may not be rejected solely because they are not substantiated by objective medical evidence.¹¹⁷ Under the regulations, nonmedical evidence of subjective symptoms and their disabling impact will be carefully considered, but must reasonably be acceptable “as consistent with the objective medical evidence.”¹¹⁸

The regulations include seven factors that adjudicators are to consider as part of the second step of symptom evaluation (as well as in evaluating the limiting effects of severe impairments that do not meet the medical listings at step three of the sequential evaluation process).¹¹⁹ It is worth emphasizing that these regulatory factors are primarily derived from the *Polaski* litigation. They were adopted by SSA but were established by federal appeals courts reviewing only civil action appeals of hearing and Appeals Council level decisions that denied claimants benefits. They now bind adjudicators at all levels of administrative decisionmaking. As discussed further below, federal officials have worked to ensure their consistent consideration even during the state agency initial and reconsideration processes.

Subjective symptoms are to be evaluated based on all evidence presented, including information about the claimant’s prior work history, statements about symptoms, evidence submitted by treating or nontreating sources, and observations by SSA employees and “other persons.”¹²⁰ The seven regulatory factors SSA’s adjudicators must consider (where applicable) are:

- The claimant’s daily activities;
- The location, duration, frequency and intensity of the claimant’s pain or other symptoms;
- The type, dosage, and effectiveness, and side effects of any medication the claimant takes or has taken to alleviate pain or other symptoms;
- Precipitating and aggravating factors;
- Treatment, other than medication, the claimant receives or has received for relief of pain or other symptoms;
- Any measures the claimant uses or has used to relieve pain or other symptoms; and
- Other factors concerning a claimant’s functional limitations and restrictions due to pain or other symptoms.¹²¹

Functional limitations imposed by symptoms may be categorized as exertional or non-exertional and are considered in determining whether the claimant is able to do past relevant work or adjust to other work that exists in the national economy.¹²²

B. Process unification rulings relating to subjective symptom evaluation

Three of the process unification rulings deal directly with symptoms: *SSR 96-3p, Titles II and XVI: Considering Allegations of Pain and Other Symptoms in Determining Whether a Medically Determinable Impairment is Severe*; *SSR 96-4p, Titles II and XVI: Symptoms, Medically Determinable Physical and Mental Impairments and Exertional and Nonexertional Limitations*; and *SSR 96-7p, Titles II and XVI: Evaluation of Symptoms in Disability Claims, Assessing the Credibility of an Individual's Statements*. These rulings were published in the Federal Register and, by regulation, are binding on all SSA components.¹²³ The first of these three SSRs was published to restate and clarify SSA's long-standing policies. SSR 96-3p clarifies that an individual's symptoms can cause limitations and restrictions in functioning that may require a finding of a "severe" impairment(s) at step two of the sequential evaluation process, and hence additional evaluation under the sequential process, if the limitation or restrictive effect on the individual's ability to do basic work activities is "more than minimal."¹²⁴ SSR 96-4p clarifies that symptoms may impose limitations or restrictions that are exertional or nonexertional in nature (or both) and are to be considered during step five of the sequential evaluation process.¹²⁵

SSR 96-7p, Titles II and XVI: Evaluation of Symptoms in Disability Claims, Assessing the Credibility of an Individual's Statements, formally expanded SSA's nationwide consideration of symptom evaluation into the realm of the claimant's credibility. Notably, however, credibility analysis was a major issue in the 1984 settlement in *Polaski*, in which SSA agreed that, in the Eight Circuit, "[t]he absence of an objective medical basis which supports the degree of severity of subjective complaints alleged is just one factor to be considered in evaluating the credibility of the testimony and complaints."¹²⁶ Circuit-level discussion of Social Security cases had long referred to SSA decisionmaker evaluations of claimant's subjective symptoms as "credibility determinations," and numerous Social Security decisions from ALJs and the Appeals Council dating to as early as 1985 denied disability benefits at least in part due to a finding that a claimant's pain testimony was "not fully credible."¹²⁷ The agency's practice of assessing the credibility of a claimant's statements about his or her subjective symptoms thus appears to substantially pre-date the SSR. It is possible that the "credibility" terminology came from the federal courts, which frequently make or review credibility determinations in a variety of contexts, such as when reviewing immigration asylum credibility determinations.¹²⁸ In the words of the Eleventh Circuit, writing in 1982, "findings as to credibility... are necessary and crucial where subjective pain is an issue."¹²⁹

With SSR 96-7p, SSA for the first time required its adjudicators to make an explicit credibility finding in cases where subjective symptoms are alleged and where an underlying medical impairment has been found but objective medical evidence does not substantiate the claimant's statements about pain or other symptoms.¹³⁰ The advisability of using "credibility" in SSR 96-7 to describe the fact-finding exercise used to evaluate symptoms required under 20 C.F.R. § 404.1529 and § 416.929—neither of which employ the term—is at least open to question. While "credibility" will certainly bear the meaning to which it is assigned in SSR 96-7p, it is more commonly used in litigation (whether before agencies or courts) in a much narrower sense: to

characterize the believability, truthfulness, or honesty of a testifying witness.¹³¹ That is the sense (in fact the only sense) in which “credibility” is used in the Federal Rules of Evidence, which allow a witness’s credibility to be attacked or supported by reference to his “*character for truthfulness*.”¹³² Credibility determinations are often bound up with an assessment of a witness’s demeanor in an investigatory adversarial setting. That explains why administrative agencies often adopt rules requiring strong deference to their judges’ credibility findings¹³³—even though no deference is required by the Administrative Procedure Act for formal adjudications¹³⁴—or why a federal district court’s credibility findings receive special deference on appeal.¹³⁵

It may be that that SSR 96-7p’s use of “credibility” to describe the fact-finding exercise required under the above regulations is harmless enough. But there are some contrary indications that should give SSA pause. As we note below, the focus on “credibility” may misdirect the factual inquiry required by SSR 96-7p—with consequences both for the quality of ALJ decisionmaking and remand rates—and unnecessarily invite charges of ALJ bias into a nonadversarial adjudicative process. As discussed later in the report, SSA’s internal data show that symptom evaluation—and more specifically credibility determination—continues to be one of the most cited reasons for remand from federal courts in recent years. Hence, SSR 96-7p is a central focus of this report, and the guidance is described at a high level of detail below. Additional (non-process unification) SSR’s implicating subjective symptom evaluation are described in **Appendix B: Additional Policies Implicating Subjective Symptom Evaluation**.

Summary of SSR 96-7p, Titles II and XVI: Evaluation of Symptoms in Disability Claims, Assessing the Credibility of an Individual’s Statements

SSR 96-7p begins by reiterating the two-step process for symptom evaluation contained in the regulations (20 C.F.R. §§ 404.1529, 416.929). For the first time, it described the regulatory requirement of determining how symptoms affect a claimant’s capacity to perform basic work activities as a “requirement for a finding on the credibility of the individual’s statements about symptoms and their effects.”¹³⁶ It provides that “whenever the individual’s statements about the intensity, persistence, or functionally limiting effects of pain or other symptoms are not substantiated by objective medical evidence, the adjudicator must make a finding on the credibility of the individual’s statements based on a consideration of the entire case record.”¹³⁷ The ruling defines the “credibility” of a claimant’s statements about pain or other symptoms as “the degree to which the statements can be believed and accepted as true.” The SSR clarifies that an adjudicator may accept some, all, or none of a claimant’s statements about his or her subjective symptoms, but also that a finding that not all of a claimant’s statements are credible is not “in itself sufficient to establish that the individual is not disabled.”

The SSR directs that credibility findings may not be made on the basis of “intangible or intuitive notion[s].” Rather, they must contain reasoning, “supported by the evidence in the case record, and . . . sufficiently specific to make clear to the individual and to any subsequent reviewers the weight the adjudicator gave to the individual’s statements and the reasons for that weight.” Adjudicators are to evaluate the record, recorded agency observations or the adjudicator’s own recorded observations of the claimant, and the claimant’s statements about his or her subjective symptoms to draw appropriate inferences and conclusions about the credibility of the individual’s statements.

SSR 96-7p directs adjudicators to consider the regulatory factors in light of the:

- consistency of the individual’s statements, both internally and with other information in the case record;
- medical evidence and the claimant’s medical treatment history, including: clinical observations as to the onset, description, character, effects, and treatment of subjective symptoms, evidence of other impairments that could account for alleged symptoms, and medical treatment history that demonstrates persistent efforts by the claimant to obtain relief of pain or other symptoms;
- information provided by other sources, such as statements by third parties about the factors listed in the regulations; and
- the adjudicator’s own and recorded agency observations of the claimant, with the caveat that an adjudicator may not accept or reject an individual’s subjective symptom complaints solely on the basis of personal observations.

These guidelines elaborate on the regulations, which obligate adjudicators to carefully consider any information a claimant submits about his or her symptoms (including medical evidence and observations by SSA employees or other persons).¹³⁸

Finally, the SSR states that findings by state agency consultants and other program physicians and psychologists on the credibility of the individual’s statements about limitations or restrictions due to symptoms are findings of fact that should be weighed under the applicable regulations and policy rulings governing non-examining sources.

C. Policies relating to development of the administrative record

Development of the administrative record regarding subjective symptoms can help the DDS decisionmaker(s) or ODAR adjudicator(s) determine whether a claimant’s subjective symptoms are disabling. A few SSA policies, contained in POMS or in other official agency directives, pertaining to record development are worth noting.

Consultative Pain Evaluations—SSA’s adjudicators are permitted to use the treating source, a pain specialist, a pain center, or a consultative examination panelist who is not a pain specialist as consultative examination sources in evaluating pain, but only if: a fully favorable determination is not otherwise possible, an assessment of the existence and extent of any limitations due to pain is essential to make a determination, and the necessary evidence is not otherwise available from medical sources of record, the claimant, and others.¹³⁹ While such consultations can be beneficial in these circumstances, routine consultative examinations may be costly or inappropriate, particularly in cases where there are treating sources.

Use of Social Media—SSA prohibits personnel from reviewing a claimant’s social media accounts to develop the record prior to making a decision on whether to award benefits, despite feedback from some ALJs that access to social media would be useful in evaluating claimant credibility.¹⁴⁰ In response to congressional inquiries, SSA has expressed concern that permitting review of social media as part of the disability determination process “could be found to violate a claimant’s due process right” absent the corresponding ability to corroborate information that may easily be falsified or presented without context.¹⁴¹ The agency noted, however, that its employees and Office of Inspector General, as well as law enforcement partners, may review social media (with subsequent corroboration or refutation) to develop investigations.¹⁴²

Tests for Malingering—SSA limits the ability of decisionmakers to order symptom validity tests (SVTs), such as the Minnesota Multiphasic Personality Inventory-2 or Test of Memory Malingering, to help determine whether a claimant is malingering.¹⁴³ According to a 2012 letter sent by Linda Dorn, Associate Commissioner to state DDS, “SSA does not support the purchase of tests for malingering or credibility. While the results of these tests can provide evidence suggestive of poor effort, or of intentional symptom manipulation, results from such information are not programmatically useful in resolving the issue of the credibility of an individual’s statements.”¹⁴⁴ Also in 2012, the Chief ALJ issued a memorandum barring ALJs from ordering SVTs as part of a consultative examination.¹⁴⁵ SSA will, however, consider SVT results when they are a part of the medical evidence of record (*i.e.*, when they are submitted by claimants).¹⁴⁶ SSA has distinguished between the use of SVTs by clinicians and by its own adjudicators, which it says would require development of weighting and training criteria.¹⁴⁷

IV. SSA’S PRESENT ADJUDICATORY PRACTICES

Given the sheer volume of SSDI and SSI claims received each year, a comprehensive evaluation of SSA’s present adjudicatory practices is impractical. However, several practices, including electronic disability initiatives, data collection, and internal review processes, are worth exploring given their direct impact on or relation to subjective symptom evaluation. This section of the report provides an overview of such practices as they relate to subjective symptom evaluation at the initial and reconsideration levels. The focus of this examination is on federal practices and federal program administration, rather than on state actors and the multitude of individual state business processes. Next, this section describes the agency’s quality review process. It concludes with an examination of adjudicatory practices at the hearing level as well as ODAR’s empirical findings regarding judicial remands due to problematic subjective symptom evaluation by administrative law judges. The discussion was informed by review of nearly 150 quality review partial case files provided by SSA, described in further detail below.

A. Initial and reconsideration levels

State DDSs are fully funded by the federal government but are operationally independent in many significant respects, such as selection of personnel.¹⁴⁸ The focus of federal involvement, consistent with federal law and regulations, is on promoting uniform decisionmaking standards and procedures at all levels of review.

The Social Security Act (the Act) requires State agencies to make disability determinations in accordance with the Act, as well as with SSA’s regulations or other written guidelines.¹⁴⁹ The Commissioner is authorized to promulgate regulations specifying performance standards and administrative requirements and procedures to be followed in performing the disability determination function “in order to assure effective and uniform administration of the disability insurance program throughout the United States.”¹⁵⁰ The Commissioner is to establish by notice-and-comment regulation “uniform standards which shall be applied at all levels of determination, review, and adjudication” in determining disability.¹⁵¹

SSA’s regulations, at 20 C.F.R. Part 404, Subpart Q—Determinations of Disability, generally elucidate the basic responsibility of SSA and state DDS agencies:

We [SSA] will work with the State to provide and maintain an effective system for processing claims of those who apply for and who are receiving benefits under the disability program. We will provide program standards, leadership, and oversight. We do not intend to become involved in the State's ongoing management of the program except as is necessary and in accordance with these regulations. The State will comply with our regulations and other written guidelines.¹⁵²

Under these rules, DDSs are to certify their disability determinations in individual cases on federally provided forms, as well as furnish SSA with all evidence it considered in making its determination.¹⁵³

Federally prescribed forms and others practices that further the congressional goal of nationally uniform program administration, particularly with respect to the evaluation of subjective symptoms, are described below. SSA's Office of Disability Determinations (overseen by the Deputy Commissioner of Operations), Office of Disability Policy (overseen by the Deputy Commissioner of Retirement and Disability Policy), and Office of Disability Systems (overseen by the Deputy Commissioner of Systems) each play key roles in developing, deploying, and administering federal mechanisms for oversight of state DDSs. Informational interviews with SSA officials in these offices provided helpful background for this section of the report, and the authors are grateful for their time and assistance.

SSA's electronic disability (eDib) process

Historically, record evidence and forms were stored in paper folders (Modular Disability Folders), but SSA began a transition to the Electronic Disability (eDib) process in 2004.¹⁵⁴ Using federally funded and developed information technology, state DDSs now use an Electronic Folder to store all information and evidence for a disability determination and they also use electronic forms to document disability case issues and actions.¹⁵⁵ Where the Electronic Folder is the official file for Field Offices and state DDSs, the file is fully electronic through any subsequent quality reviews, as well as at the reconsideration, hearing, appellate and district court levels.¹⁵⁶ All states are now certified to process disability claims in a fully electronic environment.¹⁵⁷

The eDib process has several components, such as video and digitally recorded hearings, and encompasses several distinct information technology systems.¹⁵⁸ For example, field office staff collect information about claimants' disability and work history in the Electronic Disability Collect System (EDCS).¹⁵⁹ It is worth noting that field office disability interviews may capture some information about claimant credibility in this system.¹⁶⁰ SSA states that "these observations are very valuable because DDS examiners do not have face-to-face contact with the claimants."¹⁶¹ An Electronic Folder is opened for a claim after it is established in EDCS¹⁶² and includes recorded field office observations and other case materials from EDCS.¹⁶³ Information about recorded field observations may factor into the DDS disability determination; for example, twelve of fifty Disability Determination Explanations reviewed by ACUS specifically referenced observations made by field officers.

Federal development and maintenance of the eDib process allows SSA to structure information capture by state actors. This facilitates data collection for purposes of performance management, as well as provides infrastructure and evidence for quality review and claimant appeals. For example, these systems permit SSA to calculate performance indicators such as the average processing time for initial disability claims, the total processing time for initial disability claims, the total processing time for disability insurance and SSI claims, and total claims processed

for disability insurance and SSI disability.¹⁶⁴ These performance and other similar management information (MI) indicators help SSA to understand state agency operations and to provide oversight and management of state business processes, consistent with the agency's statutory and regulatory responsibilities. MI systems may focus on production goals.¹⁶⁵

SSA guides development and collection of DDSs' administrative records (including prescribed federal forms) through the eDib process. For example, before an electronically processed case can be closed, the DDS adjudicator(s) must complete a Form SSA-831 (Disability Determination and Transmittal), technically considered the disability decision, and submit it to the Electronic Folder.¹⁶⁶ To close out an electronic case, the Disability Examiner must ensure that all case development and determination documents, including evidence and forms, have been added to the Electronic Folder.¹⁶⁷ DDSs are also required to submit a decision rationale containing a number of elements defined in POMS DI 26515.001, including an evaluation of the credibility of the claimant's statements about his or her symptoms.¹⁶⁸ As discussed below, DDS articulation of the decision rationale is also federally structured through the electronic Claims Analysis Tool (eCAT) initiative.

SSA's electronic Claims Analysis Tool

Historically, state disability examiners prepared narrative determination rationale statements to address each of the elements enumerated in POMS. Increasingly, decision rationales are now prepared and documented through the eCAT, which offers a template for DDS decisionmaking. SSA's eCAT was designed to provide DDS decisionmakers with "guidance and assistance for consistent, policy-compliant disability determinations" as well as to ensure that there is a complete claim explanation in one eCAT generated document, known as the Disability Determination Explanation. SSA's OIG reports that previously DDS "examiners were not in the habit of providing the level of detailed documentation that eCAT requires."¹⁶⁹ The Disability Determination Explanation is used for internal purposes and is not provided to the claimant when he or she is notified of the agency's decision, although it may be available to the claimant on appeal to ODAR. (Hence, ALJ opinions may be the first time that claimants learn how the agency evaluated their subjective symptoms and that their statements about symptoms were evaluated for credibility.)

This is not to say that eCAT is merely a decision-writing tool. Rather, eCAT is intended to aid decisionmaking as it occurs, including through intelligent pathing that recognizes decisional dependencies and promotes policy compliance by—in the words of SSA's Chief Information Officer and Deputy Commissioner of the Office of Systems Bill Zielinski—prompting users to "consider the appropriate questions based on the unique characteristics of each case."¹⁷⁰ Policy compliant pathing helps to reduce potential user errors. Of course, the software is not able to ensure that users answer questions appropriately; even with eCAT there could be a very well documented incorrect decision.¹⁷¹ DDSs have the burden of understanding and properly applying the applicable policies.¹⁷² Links to relevant regulations and policies within eCAT provide users with immediate access to the appropriate resources.¹⁷³

Adjudicator preparation of Disability Determination Explanations using eCAT allows SSA to gather both structured and unstructured data about decisionmaking. Structured data is captured in a uniform format that is intended to enable SSA to "collect and analyze consistent data."¹⁷⁴ For

example, users might select an option from a list of pre-populated entries or they might select one or more relevant check boxes corresponding to fixed fields. In eCAT, unstructured data would be captured where the user enters comments or an explanation into a text box in a free-form narrative format, perhaps bounded by character limits on text entry. The irregular nature of such entries can present serious challenges for data analysis.

SSA built eCAT to guide decisionmakers through the sequential process and help reach a policy compliant outcome, including addressing symptoms and credibility and weighing of medical opinion evidence. **Appendix C: The Electronic Claims Analysis Tool** documents the portions of eCAT most relevant to the evaluation of a claimant’s subjective symptoms. The system captures both structured and unstructured data about symptom evaluation. For example, in cases that require a step two analysis of subjective symptoms, eCAT users are asked to select by check box the regulatory factors that “were the most informative in assessing the credibility of the individual’s statement.”¹⁷⁵ These selections are captured as structured data. Where “Other factors” has been selected, users are required to provide an explanation in an associated text box. The explanation is captured as unstructured data.

The accompanying screenshot illustrates the eCAT interface where an evaluation of a claimant’s subjective symptoms using the regulatory factors is required.¹⁷⁶

Search New Case Save Preview DOE EAT Print Screen Spell Check Toggle Size View PDF/AE Exit

Claim Communications (0) - via Select Claim Types DI DRB Helpful Links

Claim Type: DIB

New Evidence Received

Claimant Information

Technical Issues

Evidence of Record

Consultative Exams

Findings and Analysis

Impairment Severity/Sign

► Symptoms and Credibility

Weighing Opinion Evidence

Reconciling Source Opinion

Past Relevant Work

Other Work

Determination

Claim Communications

eCAT

Training

Build No: 9.1.6

Symptoms and Credibility

Evaluate the individual's statements about symptoms and their functional effects and, if required, the credibility of the individual's statement(s).
(20 CFR 404.1529; 20 CFR 416.929; SSR 96-7p)

Can one or more of the individual's medically determinable impairment(s) (MDI(s)) reasonably be expected to produce the individual's pain or other symptoms?

Yes No Not Yet Answered

Are the individual's statements about the intensity, persistence, and functionally limiting effects of the symptoms substantiated by the objective medical evidence alone?

Yes No Not Yet Answered

Whenever the individual's statements about the intensity, persistence, or functionally limiting effects of pain or other symptoms are not substantiated by objective medical evidence, the adjudicator must make a finding on the credibility of the individual's statements based on a consideration of the entire case record (SSR 96-7p)

When considering the following factors, which were the most informative in assessing the credibility of the individual's statements?

- ADLs
- The location, duration, frequency and intensity of the individual's pain and other symptoms
- Precipitating and aggravating factors
- Medication Treatment
- Treatment other than medication
- Other Measures to relieve symptoms
- Other factors

Use sentences to explain:

Text...

243 / 250

Because of this data capture, eCAT has the potential to provide SSA with a wealth of information about subjective symptom evaluation at the initial and reconsideration levels. This could permit the agency to better understand the frequency with which subjective symptoms contribute to a finding of disability (as compared to the rough estimate above in **Disabling Impairments and Pain**), as well as to empirically test the validity of the multi-factor test for subjective symptom evaluation. As discussed above, federal courts, which review only a fraction of the agency’s cases, established this test. The agency has previously not had the data necessary to proactively analyze its applicability at the initial and reconsideration levels, where the vast majority of claims are processed.

SSA mandated the use of eCAT by all state DDSs by the end of September 2012 for initial claims, as well as for reconsideration decisions that were initially decided using eCAT.¹⁷⁷ In January 2012, over two-thirds of the agency’s initial and reconsideration claims were processed using eCAT for electronic case analysis.¹⁷⁸ As of June 2014, SSA’s Chief Information Officer reported that the agency had exceeded its FY 2014 target of processing ninety-five percent (95%) of eligible initial and reconsideration cases using eCAT to generate the Disability Determination Explanation (DDE), with an actual use rate for eligible claims of 99.46 percent (99.46%).¹⁷⁹ As the accompanying chart demonstrates, eCAT has been used to document more than ten million initial and reconsideration level claims since FY 2010.¹⁸⁰

NATIONAL eCAT DETERMINATION REPORT						
INITIAL ADJUDICATIVE LEVEL						
Decision	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	Total
Allowances	95,651	440,330	728,365	936,750	903,244	3,104,340
Denials	168,876	830,887	1,398,295	1,814,350	1,798,874	6,011,282
Total	264,527	1,271,217	2,126,660	2,751,100	2,702,118	9,115,622
RECONSIDERATION ADJUDICATIVE LEVEL						
Decision	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	Total
Allowances	4,623	24,706	58,272	82,756	82,371	252,728
Denials	35,278	200,062	403,517	619,199	636,804	1,894,860
Total	39,901	224,768	461,789	701,955	719,175	2,147,588

According to SSA officials, “FY 2014 was the first complete year that eCAT collected nationwide data for most initial and reconsideration disability determinations. With broad use, including both state and federal sites, SSA can analyze and validate the data recorded in eCAT for quality and consistency. Once this validation is complete, SSA will be in a position to build MI reports.”¹⁸¹ Only then can management information be used to gauge DDS compliance with the requirements of the tool (such as providing narrative elaboration on certain fields) or to more generally inform the agency’s policy choices. Unfortunately, as of early 2015, SSA is not yet able to take advantage of the subjective symptom evaluation structured data it presently captures.

Time and resources are required to analyze and validate eCAT-captured data, and there is competition within the agency for both. For example, much of SSA’s present work on eCAT is focused on expanding the system to cover additional claim types, such as adult Continuing Disability Reviews (CDRs).¹⁸² And, SSA’s Office of Disability Systems, which handles this expansion, is also responsible for other agency technology initiatives, such as developing a new Disability Case Processing System and the Electronic Bench Book discussed below.¹⁸³ (SSA plans

to incorporate eCAT into the Disability Case Processing System.¹⁸⁴) As discussed in the concluding recommendations, SSA should ensure continued capture of structured information about subjective symptom evaluation at the initial and reconsideration stages of claim processing so that it can study and improve subjective symptom evaluation at these levels. It should also ensure that adequate resources are provisioned to analyze this information.

Quality review at the initial and reconsideration levels

Federal forms and information technologies influence the DDS decisionmaking process as it occurs. SSA also reviews state and federal disability determinations after they are made, but before they are effectuated. The Office of Quality Review (OQR) (overseen by the Deputy Commissioner for Budget, Finance, Quality, and Management) is responsible for quality review of DDS decisions. OQR also reviews decisions made by ODAR adjudicators, including ALJs. The focus of federal quality review at all levels of decisionmaking is on ensuring “effective and uniform administration of the disability program.”¹⁸⁵ Federal quality review processes and dispute resolution mechanisms at the initial and reconsideration levels, as well as in some continuing disability reviews, are described below. This discussion was informed by review of fifty files provided by SSA, discussed in-depth below. Given the report’s limited focus on federal actors and processes, varying state quality assurance systems and state quality reviews that occur prior to federal quality reviews are omitted from this analysis.

SSA conducts three major types of quality reviews at the initial and reconsideration levels: quality assurance, preeffectuation review, and targeted denial reviews. The different types of quality review vary in purpose and selection methodology more than in process. Quality assurance reviews are focused on assessing the accuracy of the adjudicating component’s disability determinations. “Performance accuracy” statistics are calculated from some quality assurance reviews “to determine if individual adjudicating components perform acceptably in terms of decisional accuracy and documentation requirements.”¹⁸⁶ Preeffectuation reviews (PERs) aim to correct erroneous decisions prior to effectuation. The Social Security Act, as amended, requires SSA to review fifty percent (50%) of favorable Title II, Title XVI, and concurrent initial and reconsideration level Disability Determination Services (DDS) determinations on a preeffectuation basis.¹⁸⁷ Recently, SSA has begun targeted denial reviews (TDRs) as well, for cases in which benefits were denied.¹⁸⁸ The purpose of random denial review is to maintain consistency and quality among denial determinations and to provide equity in disability adjudication. PER and TDR reviews are selected using a sampling methodology that relies on predictive modeling to identify error-prone decisions.¹⁸⁹ Credibility or subjective symptom evaluation is not a coefficient in the selection algorithm, although cases where there are likely issues include those with musculoskeletal impairments.¹⁹⁰

Quality reviews of DDS decisions are conducted by a team of individuals, including a disability examiner, a program leader, and a federal review physician/psychologist or a medical consultant.¹⁹¹ The quality review process is designed to identify deficiencies in decisionmaking.¹⁹² OQR categorizes deficiencies into two groups: *Group I* deficiencies are substantive, and could affect the basic decision to allow, deny, continue, or cease disability benefits; *Group II* deficiencies are also substantive, but affect only the onset date, ending date, or cessation date for periods of disability. Only Group I deficiencies are used to calculate performance accuracy statistics. OQR further characterizes deficiencies within Group I or II as either decisional, where an erroneous

decision was made in a fully documented case, or documentation, where a case requires additional evidentiary development.¹⁹³

When OQR identifies a returnable deficiency, the case is sent back to the adjudicating component for correction. All Group I deficiencies are returnable; in some cases, Group II deficiencies can be corrected during the quality review process, obviating the need for return.¹⁹⁴ Decisions may also be returned for Technical Corrective Actions (TCAs) that would not affect the substantive outcome in a case.¹⁹⁵ As discussed further below, flawed subjective symptom evaluations identified in quality review would likely be categorized as a substantive Group I deficiency, and may be either decisional or documentation related. OQR tracks the numbers of Group I and Group II returns cited, but Conference staff are not aware of any structured data capture specific to deficiencies or errors in subjective symptom evaluation.¹⁹⁶ OQR provided the Office of the Chairman with the following summary of quality reviews and Group I Returns.¹⁹⁷ This summary includes information about reviews and returns that are not used to calculate performance accuracy statistics.

This data indicates that Group I returns are relatively infrequent—they occurred in less than four percent (4%) of the half a million reviews that took place across the initial, reconsideration, CDR and TDRs in FY 2013.

Division of Disability Quality												
Fiscal Year 2009												
National Total	QA (Initial)		QA (Recon)		QA (CDR)		PER Title II		PER Title XVI		TDR	
	Cases Reviewed	Group 1 Returns Cited	Cases Reviewed	Group 1 Returns Cited	Cases Reviewed	Group 1 Returns Cited	Cases Reviewed	Group 1 Returns Cited	Cases Reviewed	Group 1 Returns Cited	Cases Reviewed	Group 1 Returns Cited
510,147	32,638	1,691	7,721	350	25,281	706	329,862	7,369	114,645	1,900	0	0
Fiscal Year 2010												
National Total	QA (Initial)		QA (Recon)		QA (CDR)		PER Title II		PER Title XVI		TDR	
	Cases Reviewed	Group 1 Returns Cited	Cases Reviewed	Group 1 Returns Cited	Cases Reviewed	Group 1 Returns Cited	Cases Reviewed	Group 1 Returns Cited	Cases Reviewed	Group 1 Returns Cited	Cases Reviewed	Group 1 Returns Cited
542,495	33,399	1,106	7,874	291	24,073	620	357,745	8,489	115,437	1,986	3,967	356
Fiscal Year 2011												
National Total	QA (Initial)		QA (Recon)		QA (CDR)		PER Title II		PER Title XVI		TDR	
	Cases Reviewed	Group 1 Returns Cited	Cases Reviewed	Group 1 Returns Cited	Cases Reviewed	Group 1 Returns Cited	Cases Reviewed	Group 1 Returns Cited	Cases Reviewed	Group 1 Returns Cited	Cases Reviewed	Group 1 Returns Cited
590,086	35,017	1,542	7,657	275	25,145	692	369,414	10,252	115,550	2,567	37,303	3,831
Fiscal Year 2012												
National Total	QA (Initial)		QA (Recon)		QA (CDR)		PER Title II		PER Title XVI		TDR	
	Cases Reviewed	Group 1 Returns Cited	Cases Reviewed	Group 1 Returns Cited	Cases Reviewed	Group 1 Returns Cited	Cases Reviewed	Group 1 Returns Cited	Cases Reviewed	Group 1 Returns Cited	Cases Reviewed	Group 1 Returns Cited
590,280	31,943	1,136	7,770	276	24,817	633	341,457	9,413	108,140	2,384	76,153	6,922
Fiscal Year 2013												
National Total	QA (Initial)		QA (Recon)		QA (CDR)		PER Title II		PER Title XVI		TDR	
	Cases Reviewed	Group 1 Returns Cited	Cases Reviewed	Group 1 Returns Cited	Cases Reviewed	Group 1 Returns Cited	Cases Reviewed	Group 1 Returns Cited	Cases Reviewed	Group 1 Returns Cited	Cases Reviewed	Group 1 Returns Cited
522,176	31,661	1,195	7,583	313	23,505	694	312,296	9,538	101,669	2,501	45,462	4,808

If OQR returns a case to a DDS for a Group I or II deficiency, the adjudicating component may disagree with the quality review finding. When cases are processed electronically, disputes are filed and resolved through the Request for Program Consultation (RPC) process.¹⁹⁸ The Office of Policy Consultation within ODP is responsible for resolving disputes in order to identify trends or policy issues that require clarification or training. On receipt, disputes are ordinarily assigned to an RPC reviewer to thoroughly review the case, including all evidence of record, and to present the disagreement to a team of RPC staff.¹⁹⁹ The RPC process is not a “de novo” review. After a team vote, the RPC reviewer prepares a resolution that is sent to both DDS and OQR after RPC manager approval.²⁰⁰ The RPC resolution of the issue is the agency’s official and final response, and is binding on all components.²⁰¹ In FY 2014 there were 1,011 requests for RPC, whereas there were approximately 20,000 Group 1 returns per year in QA, PER, and TDR cases between FY 2011-2013.²⁰² Hence, it appears that in about ninety-five percent (95%) of cases, DDSs acquiesce to quality review findings.

Quality review, RPC resolution, and subjective symptom evaluation

SSA provided the Office of the Chairman with fifty illustrative RPC files. Review of these files generated some helpful insights into the RPC process, as well as quality review of subjective symptom evaluation. The following summary of the fifty RPC files is descriptive and should not be used as a basis for inferential analysis. It should also be noted that the Office of the Chairman did not review the full case file but rather reviewed for each case only 1) an OQR-edited DDE and 2) an ODP RPC Resolution document. Therefore we cannot comment on the strength of any particular adjudicator decision. The DDE was provided as an imaged (portable document format or PDF) file.²⁰³ The ODP RPC Resolution document for each case contains a *DDS Summary* of the case, prepared by the DDS; an *ODP Narrative*, a narrative explanation of the dispute, relevant case facts, evidence, etc., prepared by the RPC reviewer; and a *Resolution*, prepared by ODP. SSA notes on each ODP RPC Resolution document that it does not provide policy guidance (*i.e.*, is not precedential), but rather is based on consideration of the unique facts and discussion questions raised by each case.

In the fifty RPC files the initial determination was either disabled (35, fully or partially favorable) or not disabled (15). In each case, OQR identified a substantive Group I deficiency that was either decisional (33) or documentation related (16); there was also one Group II documentation deficiency. As a result of RPC, the OQR identified deficiency was either affirmed (22, 11 decisional/11 documentation) or rescinded (28, 22 decisional, 6 documentation). In these fifty files, decisional deficiencies were more likely to be rescinded (22/33 or 66%) than documentation deficiencies (6/17 or 35%). ODP was more likely to side with the DDS than OQR regarding whether there was a decisional deficiency.

In several files, a decisional deficiency was rescinded but ODP directed the DDS to obtain more information before making a determination (about potential substantial gainful earnings, about past work, medical evidence, etc.).²⁰⁴ In such instances, it is possible that a documentation deficiency should have been identified, rather than a decisional deficiency, and that the additional documentation would have the potential to impact the disability determination.²⁰⁵ Hence, ODP’s rescission of a decisional error identified by OQR does not necessarily mean that the DDS resolution of the case was policy compliant.

At least twelve files specifically referenced observations made by field officers as to a claimant's demeanor or presentation, highlighting the importance that these in-person observations can play in decisionmaking at the DDS level. Discussion of these observations in several ODP narratives indicates that they can also influence federal quality reviews.²⁰⁶

As noted above, the evaluation of subjective symptoms is not a coefficient in the algorithm used to select files for quality review. Nonetheless, SSA provided the Office of the Chairman with a number of RPC files that raised subjective symptom issues. Of fifty files reviewed, twenty-six contained substantive OQR or ODP discussion of the DDSs' subjective symptom evaluation. OQR specifically identified "Symptoms and Credibility" as a primary review issue in six files. Subjective symptom evaluation was substantively discussed by ODP in twenty-three files. In three of these files, both OQR and ODP identified or discussed subjective symptom evaluation as part of their review. A summary of these twenty-six files is presented in **Appendix D: Summary of Request for Program Consultation Files Discussing Subjective Symptom Evaluation**.

In each case, OQR identified a substantive Group I deficiency that was either decisional (12) or documentation related (14). As with the larger set of files, cases in which OQR identified deficiencies were not limited to those in which benefits were awarded—the initial determination was disabled in 15 files and not disabled in 10 files (in one file, the initial determination by DDS was indeterminable). As a result of the RPC process, the OQR identified deficiency was either affirmed (16: 6 decisional, 10 documentation) or rescinded (10: 6 decisional, 4 documentation).

In the twenty-three files in which ODP discussed subjective symptom evaluation, decisional deficiencies were again more likely to be rescinded (5 of 11, or 46%) than documentation deficiencies (2 of 12, or 17%). ODP was more likely to side with OQR on the question of whether a decisional or documentation deficiency occurred than in the set of all 50 files, but still rescinded nearly half of OQR-identified decisional deficiencies. In contrast, ODP almost always agreed with an OQR finding that additional record development was needed. A decisional deficiency was rescinded in two files where ODP directed the DDS to develop the record, perhaps indicating that the deficiency in these files was instead related to documentation.²⁰⁷ In one file, the DDS asked ODP to consider whether the decisional deficiency identified by ODP was actually a documentation deficiency.²⁰⁸

In most files in which ODP discussed subjective symptom evaluation (twenty-one of twenty-three), including in four files where an OQR-identified decisional deficiency was rescinded,²⁰⁹ ODP found that the DDSs' subjective symptom evaluation was not policy compliant. In fourteen files, DDSs were directed to further develop the record, such as by obtaining or verifying medical evidence and test results or up-to-date statements about activities of daily living.²¹⁰ In thirteen files, state DDSs were directed by ODP to provide detailed rationales and specific evidence-based explanations for their credibility determination.²¹¹ These ODP directives are similar to judicial admonishments at the hearing office level (discussed below), discouraging ALJs from using conclusory language in lieu of making specific findings.

In three files where decisional deficiencies were rescinded and in one file where it was affirmed, ODP found that OQR's discussion of subjective symptom evaluation was not policy compliant.²¹² In three of these four files, ODP found that the underlying analysis in the DDS decision was also not policy compliant.²¹³ In a few files, OQR raised issues regarding the DDS subjective symptom evaluation that were not addressed by ODP in the RPC resolution.²¹⁴ These

observations may evidence the complex nature of the determination and review process, and some difficulty even at the quality review and ODP dispute resolution levels in addressing all of the issues raised in a particular case.

As in the larger set of cases, field officer observations were sometimes significant.²¹⁵ For example, in file 0114-005, the field officer observed that the claimant used a cane and moved slowly and also commented that “Claimant did not appear to be embellishing her discomfort. Her movement and actions all seemed sincere.”²¹⁶ Since the disability determination in this case hinged on subjective symptoms that were alleged to be more disabling than indicated by the medical evidence of record, the field office characterization of the claimant’s credibility appeared to have a positive impact on the ODP decision to rescind the documentation deficiency identified by OQR, which had sought to require the DDS to obtain additional medical evidence of disability.²¹⁷

A number of files contained references to credibility or subjective symptom evaluations outside of the section of the DDE devoted to analysis of this policy issue. For example, some DDEs included subjective symptom evaluations by medical or psychological professionals or in the section of the DDE dedicated to additional information about the claimant’s RFC or in Case Analyses prepared by these individuals.²¹⁸

These fifty RPC files offer only a limited window into subjective symptom evaluation at the DDS level, as well as into the quality review process. This review indicates that problematic subjective symptom evaluation occurs in both favorable and unfavorable benefit determinations. These problems are similar to those identified in agency decision-making at other adjudicative levels and discussed later in the report. Specifically, subjective symptom evaluations were found to be improper in the cases where detailed rationales and specific evidence-based explanations were lacking or where additional record development was needed.

B. ODAR hearing office and Appeals Council levels

SSA’s ODAR administers federal adjudication of social security claims appealed after state DDSs have made an initial determination and, in non-Prototype states, resolved requests for reconsideration.²¹⁹ ODAR’s Office of the Chief Administrative Law Judge oversees SSA’s nationwide hearings process. If a claimant is dissatisfied with an ALJ’s adverse decision, he or she may appeal the hearing level decision within sixty days to the Appeals Council.²²⁰ Review or denial of review by the Appeals Council is the final step in the administrative process.²²¹ The Appeals Council and its staff are housed within ODAR’s Office of Appellate Operations. ODAR’s Office of Appellate Operations is also home to the Division of Civil Actions, under the Executive Director of the Office of Appellate Operations, and the Division of Quality. The Division of Civil Actions analyzes and recommends actions on cases remanded by the federal courts. The Division of Quality (which is distinct from OQR) aids the Appeals Council in the exercise of its quality review responsibilities.

Adjudication tools

At the hearing office level, SSA has its decisionmakers write decisions using the FIT electronic software program, whenever possible.²²² These templates provide a decisional shell for hearing office personnel (ALJs or decision writers) to draft decisions that adhere to applicable statutory and regulatory requirements. The FIT program provides more than 2,000 templates that cover the majority of decisional outcomes.²²³

According to former SSA Commissioner Michael J. Astrue, use of the FIT “improves the legal sufficiency of hearing decisions, conserves resources, and reduces average processing time.”²²⁴ For example, SSA’s present guidance to adjudicators using the FIT directs them to “evaluate each [subjective symptom] allegation in light of the objective medical evidence and other evidence regarding the relevant factors listed in the symptoms regulations and SSR 96-7p.”²²⁵ ALJs report that FIT use improves the quality of their decisionmaking and helps them to review and edit decisions more quickly.²²⁶ However, as discussed in-depth later in the report, use of these templates—and particularly their language with respect to subjective symptom evaluation—is not without criticism.

As it has done at the DDS level, SSA is presently developing a web-based electronic tool to guide agency decisionmaking at the hearing office level; this initiative is known as the Electronic Bench Book (eBB). According to Chief Information Officer Zielenski, “eBB aids in documenting, analyzing, and adjudicating disability cases at the hearings level in accordance with the Social Security Act and our regulations.”²²⁷ Adjudicators and other SSA personnel, such as decision writers, use eBB to “review the case file, take notes at the hearing, record analysis throughout the decisionmaking process, and prepare hearing instructions. eBB guides users through every step of the sequential evaluation process to ensure that each step is fully addressed.”²²⁸ A limited version of the program was deployed to three pilot sites in August of 2012, and in a 2013 estimate SSA expected that as many as fifty percent (50%) of ALJs would be using eBB by the end of 2014.²²⁹ Eventually, eBB is expected to fully replace the FIT program.²³⁰

Appeals Council pre-effectuation review of adjudicator decisionmaking

SSA’s Appeals Council has authority to review ALJ decisions where a claimant appeals²³¹ or on “own motion” review, which occurs prior to effectuation and on unappealed cases.²³² Own motion review of ALJ cases may include unfavorable cases and dismissals, though to date the Appeals Council has only selected those cases where the benefits determination was fully or partially favorable to the claimant for own motion review.²³³ Either type of review may result in a remand of an adjudicator’s decision for further action. As discussed below, flawed subjective symptom evaluation can be a basis for remand in cases appealed to the Appeals Council or on Appeals Council own motion review, including in cases where benefits would have been awarded.

SSA provided the Office of the Chairman with forty-five files illustrating Appeals Council review of ALJ decisionmaking involving subjective symptom evaluation. Each file provided by SSA consisted of (1) a hearing level disability determination made by an ALJ; and (2) an action by the Appeals Council, except that Unappealed (Own Motion) Effectuations did not include any documentation from the Appeals Council. As with the RPC files, the Office of the Chairman did not review supporting record materials and therefore cannot substantively comment on the strength

of any adjudicator's decision. Nonetheless, review of these files provided a number of descriptive insights relating to subjective symptom evaluation; results are described below by the type of review (appealed or unappealed (own motion)) and Appeals Council decision (denial, remand, or effectuation).

Denials of Appealed Unfavorable Decisions (11 files): In these files, a claimant requested review of an unfavorable decision by the Appeals Council and the Appeals Council denied review. In each file, the ALJ found the claimant to be only partially credible. In three files, ALJs used boilerplate template language statements finding that a claimant's subjective symptom complaints were not credible to the extent they were inconsistent with the assessment of residual functional capacity.²³⁴

Remands of Appealed Unfavorable Decisions (10 files): In these files, a claimant requested review of an unfavorable ALJ decision by the Appeals Council; the Appeals Council granted review and remanded for further consideration by the ALJ. Nine of ten remands were issued in part due to a flawed subjective symptom evaluation. In six of these remands, the Appeals Council did not believe that the ALJ had appropriately considered the regulatory factors.²³⁵ In three files, the Appeals Council cited the ALJ for failure to adequately consider the claimant's subjective complaints.²³⁶

Unappealed (Own Motion) Effectuations (10 files): On own motion review, the Appeals Council examined files favorable to the claimant and effectuated, rather than remanded, the ALJ decision. In eight files, the ALJ decision found the claimant to be generally credible and issued a favorable decision, even though none of the claimant's medically determinable impairments met or medically equaled listing severity.²³⁷ In each of these eight files, the ALJ gave the state agency medical and/or psychological consultants' opinions little weight.²³⁸ Specific reasons for finding the claimant credible included a strong work history by claimant²³⁹ and consistency between testimony and medical evidence.²⁴⁰ In the two remaining files, the ALJ conducted a more complicated and detailed subjective symptom evaluation, with mixed credibility findings.²⁴¹

Unappealed (Own Motion) Remands (13 files): In each of these files, an ALJ decision that was fully favorable to the claimant was selected for own motion review and remanded by the Appeals Council. In twelve remands, the Appeals Council directed the ALJs to re-evaluate the claimant's subjective symptoms and to provide a detailed rationale. More than half of these thirteen ALJ decisions were found to lack specific or sufficient support for the credibility determinations.²⁴² Additional reasons for remand included failure to discuss or reconcile inconsistencies in a claimant's testimony or between testimony and the medical record,²⁴³ or to address a claimant's noncompliance with prescribed medication or other treatment.²⁴⁴

Post-effectuation review of hearing level decisions by OQP

In addition to pre-effectuation review, SSA can conduct post-effectuation reviews of hearing level decisions, which do not impact the outcome of the case. These reviews may be undertaken by OQP, through random sampling.²⁴⁵ SSA provided the Office of the Chairman with fifty files illustrating OQP review of hearing level decisions. OQP review is normally not outcome determinative, but rather is used by ODAR to ensure policy compliance and to identify necessary training.²⁴⁶

If the OQP reviewer disagrees with the ALJ decision, then the cases are then referred to the Appeals Council for review by an Administrative Appeals Judge (AAJ).²⁴⁷ Each file contained three parts: (1) the ODAR Disability Adjudication decision, written by an ALJ; (2) a Hearing Level Disagreement Referral Form, in which the OQP reviewer evaluated the hearing level decision; (3) an AAJ Review Findings form, evaluating the quality reviewer's decision. With one exception, the AAJ's consistently agreed with the OQP reviewer.²⁴⁸

SSA indicated that about half of the files involved problematic subjective symptom evaluation.²⁴⁹ In general, evaluations were flawed due to the ALJ's failure to adequately follow the symptom evaluation regulations and policies. In these files, OQP reviewers cited ALJs for several errors in subjective symptom evaluation, including failure to: address inconsistency in the claimant's testimony or inconsistency between testimony and other evidence in favorable decisions;²⁵⁰ confront the claimant about inconsistent or incomplete evidence in favorable and unfavorable decisions;²⁵¹ address an external reason to believe the claimant was not credible in favorable decisions;²⁵² or hold a hearing of adequate length in favorable cases.²⁵³

Bias complaint redress procedures

The *Padro v. Colvin* class-action litigation demonstrates that some claimants are concerned that adverse credibility evaluations are sometimes premised on bias.²⁵⁴ All agency adjudicators, including ALJs, are obligated to fulfill their duties with fairness and impartiality.²⁵⁵ SSR 13-1p: *Titles II and XVI: Agency Processes for Addressing Allegations of Unfairness, Prejudice, Partiality, Bias, Misconduct, or Discrimination by Administrative Law Judges (ALJs)* identifies three separate processes for addressing such complaints when leveled at the federal hearing office level, including Appeals Council review, Division of Quality Service complaint investigation, and civil rights investigations.²⁵⁶

According to a recent report by SSA's Office of the Inspector General, in FY 2011, SSA's Division of Quality Service closed 1,490 bias complaints against 594 of the 1,500 ALJs hearing cases in FY 2011.²⁵⁷ While the number of complaints is less than one percent (1%) of the number of hearings conducted at the ALJ level in FY 2011, they involved about forty percent (40%) of the ALJ corps.²⁵⁸ Only four percent (4%) of these claims were substantiated after further review, but eleven percent (11%) were closed because the 75 ALJs against whom bias allegations were made left SSA before the complaint was reviewed.²⁵⁹ The status of five percent (5%) of the claims was not documented.²⁶⁰ Hence, at least four percent but perhaps as many as twenty percent (4-20%) of these claims may have been substantiated had they been fully reviewed or documented. However, it is unknown whether these complaints related to subjective symptom evaluation.

Additionally, SSA provided Administrative Conference staff with eighty-one sample bias referrals in individual cases both before and after adoption of SSR 13-1.²⁶¹ Seventeen of these complaints, all of which were made prior to issuance of SSR 13-1, contain allegations of bias that appear to be related to subjective symptom evaluation.²⁶² It is unknown whether any of these allegations were substantiated. Information about other processes for bias complaints was not readily available, though it is noteworthy that the Office of the Inspector General recommended that SSA share with the public information about the civil rights complaints process in agency literature explaining how to file unfair treatment complaints against ALJs.²⁶³ SSA appears to have incorporated this suggestion into SSR 13-1p.²⁶⁴

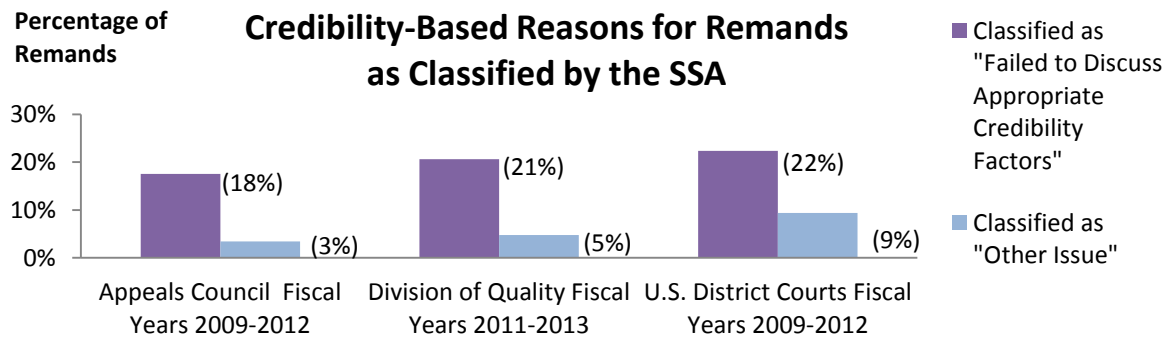
ODAR analysis of remand reasons

In an effort to improve its decisionmaking, ODAR has in recent years implemented a pioneering and laudable system of data collection and analysis designed to track the outcome of agency adjudications on review, both internally, by the Appeals Council (for both requests for review by claimants and on own motion review), and externally, by the federal courts. SSA’s efforts include a focus on cases where the agency’s final disability decision is returned to the agency for further evaluation. SSA personnel assess these cases and categorize the reason or reasons for remand.²⁶⁵ Up to three reasons for remand can be identified per decision, including a variety of remand reasons related to credibility evaluation. The relevant results of this data collection and analysis are reported below.

ODAR classifies remands on claimant credibility evaluation classification into five sub-categories, as follows:

- *Claimant credibility—failed to acknowledge unavailability of treatment*: the adjudicator considered the claimant’s failure to pursue treatment in the credibility evaluation, but the record evidence indicated (or perhaps would have indicated if the record were developed) that treatment was not available.
- *Claimant credibility—failed to apply two-step analysis*: the process that should be followed is: 1) establish the existence of a medically determinable impairment, 2) evaluate the intensity and persistence of the person's pain or any other symptoms and determine the extent to which the symptoms limit the person's capacity for work.²⁶⁶
- *Claimant credibility—failed to discuss appropriate credibility factors*: the credibility factors are set forth at 20 CFR §§ 404.1529(c)(3) and 416.929(c)(3).
- *Claimant credibility—finding not made*: the adjudicator failed to make a finding regarding the credibility of the claimant.
- *Claimant credibility—other issue*: this appears to be a catchall provision.

The sub-categories are not mutually exclusive. So, for example, a finding of *claimant credibility—other issue* could be a basis for remand with or without another more specific reasons for a credibility evaluation remand. As a result—and because some remands are evidently not coded—the number of remands and the total percentage of remands involving credibility evaluation may well be higher than reported.



As shown above and discussed in **Appendix E: SSA Data on Subjective Symptom-Related Remands**, *claimant credibility—failed to discuss the appropriate credibility factors* was the most frequent basis for a subjective symptom-related remand by the Appeals Council and

federal district courts.²⁶⁷ In these cases, adjudicators are making the required credibility/subjective symptom evaluation, but are not doing so appropriately.

Claimant credibility—failed to discuss the appropriate credibility factors was the basis for remand in a similar percentage (18-22%) of remanded cases at the Appeals Council and in the courts. As discussed in the next section of the report, adjudicator failure to discuss the regulatory credibility factors was also identified as a major reason for remand in an independent analysis of judicial remands conducted by the Conference staff.

Claimant credibility—other issue was the second most commonly cited subjective symptom-related remand reason. Notably, this remand reason was identified more frequently in judicial decisions (9% of cases) than in internal agency review decisions (fewer than 3% of cases). The types of “other issues” that appear in the case law are discussed further below. SSA’s analysis of remand data did not identify the failure to acknowledge the unavailability of treatment or to apply the two-step analysis as a common reason for remand.²⁶⁸

V. JUDICIAL REVIEW AND REMANDS OF SUBJECTIVE SYMPTOM EVALUATIONS

Judicial review of federal social security disability cases is exceptional by several measures.²⁶⁹ First, few social security claims are appealed to federal court relative to the total number of claims filed at the administrative level: 16,422 cases were filed in federal courts in FY 2012.²⁷⁰ In the same year, 3,158,421 applications for benefits were filed, and 849,869 appeals were made to ALJs.²⁷¹ It naturally takes some time for a claim to make its way through the administrative process to judicial review, but using these numbers to calculate a crude appeal rate indicates that only about one half of a percent (0.5%) of initial claims and only about two percent (2%) of ALJ decisions are appealed to federal court.

Second, the low appeal rate notwithstanding, social security cases impose a unique burden on the federal judicial system. In the 2013 calendar year, 19,977 social security appeals comprised about seven percent (7%) of all civil cases filed in district courts.²⁷² While the number of cases heard by the federal courts is only a minimal fraction of those heard by state and federal disability adjudicators, reducing the burden of these cases on the federal courts by identifying and proactively addressing bases for remand at the administrative level (and thereby reducing error) is a worthwhile endeavor.

Third, social security cases are unusual given the high frequency with which decisions, by consent, or reports and recommendations are issued by a magistrate judge.²⁷³ Social security cases excluded, much initial review of formal federal agency adjudication is in appellate rather than trial courts.²⁷⁴ Social security cases are an important exception to the traditional framework because the sheer volume of cases appealed to federal court would overwhelm courts of appeals.²⁷⁵ The reliance on magistrates to decide or to offer recommendations and reports in social security cases is perhaps reflective of a similar strain placed on district courts by the large disability caseload.

Finally, district court review of social security cases is appellate in nature.²⁷⁶ This congressional design choice is unsurprising given the massive volume of disability adjudications and the workload that de novo factual determinations would place on a judicial system already heavily burdened by social security cases. It is atypical, however, given the traditional role of

district court judges (and sometimes magistrate judges) as “finders of facts.”²⁷⁷ The deferential “substantial evidence” standard of review in social security cases, discussed further in the following section, places these judges in a relatively unusual operative role.²⁷⁸ This role is so unusual that it may not be universally recognized in cases heard by magistrate judges. A 2007 survey garnering responses from half of then-sitting magistrate judges indicated that nearly a third would characterize their review of social security cases as involving issues of fact.²⁷⁹ According to the retired magistrate judge who conducted the survey, this is “despite uniform appellate court description of the issue as one of law, demonstrat[ing] a clear disconnect between the district and circuit courts. . . .”²⁸⁰

The district court’s (or magistrate judge’s) appellate role is especially atypical in social security cases involving review of adjudicator credibility evaluation. This is an area of law in which the trial judge would ordinarily make the factual determination and would be the actor to whom deference would be afforded.²⁸¹ Even when a district court judge reviews a magistrate judge’s findings outside the social security disability context, it often must conduct a *de novo* evidentiary hearing, especially when credibility findings are at issue. Courts of appeals in six circuits require a new evidentiary hearing before a district court judge can “reject a magistrate’s proposed outcome-determinative credibility-based finding . . . when the result is likely to be conviction of a criminal defendant.”²⁸² Review of credibility determinations in social security cases is different than review of credibility findings in the criminal context in part because the magistrate or district court judge is reviewing rather than making the credibility findings at issue.²⁸³ It is also distinguishable because the rejection of an adverse credibility finding in the social security context would ordinarily benefit the claimant, rather than subject him or her to criminal punishment or loss of benefits. Finally, the ordinary response to a flawed credibility evaluation (if it is not harmless error, or where the credit-as-true rule discussed below is not applied) is to remand the case and to require SSA to conduct a new evidentiary hearing, thereby obviating due process concerns. It is not apparent whether judges distinguish between credibility evaluations made in different contexts. It is clear that credibility evaluation is a frequent basis for judicial remands in social security disability cases, which may indicate that review in this context is less deferential than judicial review of other types of credibility determinations or than one might expect given the court’s appellate function and the “substantial evidence” standard of review.²⁸⁴

As the statistics introducing this part of the report demonstrate, its focus on judicial review is somewhat myopic. The hope is that by identifying issues that commonly result in remands when cases are appealed to federal courts, and offering suggestions to address them, SSA can improve its own internal decisionmaking even in unappealed cases. Individual remands provide important feedback to adjudicators and the agency in particular cases, but as SSA has recognized, systemic analysis can help to identify widespread problems with subjective symptom evaluation.

A. Judicial review standards

42 U.S.C. Section 405(g) establishes the standard for review of the Commissioner’s decision by a district court: “The findings of the Commissioner of Social Security as to any fact, if supported by substantial evidence, shall be conclusive. . . .”²⁸⁵ Substantial evidence requires “more than a mere scintilla. It means such relevant evidence as a reasonable mind might accept as adequate to support a conclusion.”²⁸⁶ It need not rise to the level of preponderance.²⁸⁷ On appeal to a circuit court, the court applies the same substantial evidence standard as the district

court and otherwise reviews the district court's decision de novo.²⁸⁸ An administrative determination may be reversed if it is factually unsupported by substantial evidence or if the adjudicator did not apply the proper legal standards.

Review is on a certified copy of the transcript of the record, including the evidence on which the findings and decision complained of are based.²⁸⁹ The reviewing court is to evaluate the entire record—not just those parts of it that support the finding of SSA—and must take into account “whatever in the record fairly detracts from its weight.”²⁹⁰ The court should not, however, reweigh the evidence or substitute its judgment for the agency's.²⁹¹ SSA's failure to explain the rationale behind a decision is reversible error.²⁹²

B. Federal case law overview

As detailed above, the history of SSA's standards for subjective symptom evaluation is fraught with litigation. Judicial review of the agency's actions has long been searching.²⁹³ While SSA's compromise policy positions were ultimately endorsed by Congress and courts, the agency's early refusal to fully implement varied (or even conflicting) judicial directives on subjective symptom evaluation may have contributed to a judicial review climate in which the agency's activities continue to be closely scrutinized and earlier critical precedent relied upon.²⁹⁴

Today, the overall remand rate in social security cases heard in the federal courts is approximately forty-five percent (45%).²⁹⁵ Data provided by SSA indicate that between FYs 2009 and 2012 subjective symptom or credibility evaluation was an issue in at least one of five of these remands (or about 9% of all social security cases heard by the federal courts). In nearly one of ten remands (or about 5% of judicially reviewed social security cases), ODAR's data identify “other issues” pertaining to subjective symptom evaluation at play. The frequency with which remands due to subjective symptom evaluation occur may raise questions about the efficacy of the current process for evaluating the credibility of claimants who report that subjective symptoms contribute to their disability.²⁹⁶

In remanded cases, courts often do not believe that SSA adequately explained why it discredited a claimant's reports of subjective symptoms. They find insufficient discussion of the multiple factors SSA's regulations direct its adjudicators to consider in assessing a claimant's subjective symptoms.²⁹⁷ The courts have placed a high burden on the disability program's adjudicators to discuss and describe their findings. Specific findings are considered essential to ensuring the reviewability of administrative disability determinations, especially those based on credibility. It is important to note, however, that SSA adjudicators are not required to make a “formalistic factor-by-factor recitation of the evidence” when making a credibility assessment, so long as they set forth the specific evidence relied upon.²⁹⁸

Conference staff studied relevant federal case law at both the appellate and district court levels in order to ensure independent analysis and identification of common causes of credibility or symptom evaluation-related remands. We also sought to better understand SSA's data regarding such remands. For example, the subjective symptom-related remand reason most frequently identified by ODAR, *failed to discuss appropriate credibility factors*, could apply to one, two, some, several, or all of the seven regulatory factors adjudicators are directed to consider when symptoms suggest a greater severity of impairment than can be shown by objective medical

evidence alone.²⁹⁹ Improper consideration of even one factor might be a basis for a judicial remand where the factor was potentially dispositive. The number of combined possible problematic approaches to credibility evaluation based on a set of seven factors is 127, demonstrating the generality of this remand reason. (If one were to include the four “factors” discussed in SSR 96-7p, the agency’s zone of defense would be even larger, and the remand reason even more general.) Similarly, the second-most frequently identified remand reason, *other issue*, lacks specificity sufficient to produce a real understanding of these judicial and Appeals Council remands.

Conference staff developed a methodology to focus case law research on judicial opinions issued between January 1, 2009 and December 31, 2013 that specifically cite SSR 96-7p and also discuss credibility or pain or subjective symptoms.³⁰⁰ This methodology identified 105 relevant cases in the courts of appeals and 8,384 in the district courts citing SSR 96-7p between 2009 and 2013.³⁰¹ Results of staff review of appellate court and a sample of district court decisions are summarized in the following sections. An important caveat about the findings reported below is that, particularly at the district court level, many opinions identified by the methodology and available on LexisNexis® were not published in federal reporters and may not carry precedential weight or as much precedential weight as published opinions in some jurisdictions. Precedential appellate citations for common remand reasons are provided in **Appendix F: Appellate Case Law Citations** where possible.

C. Appellate review

Conference staff reviewed all 105 relevant cases in the courts of appeals to determine their disposition (affirm, remand to SSA, remand to district court, other). Problematic symptom or credibility evaluation led to remand (only once with a direct award) in twenty-nine cases (nearly 28%). There was substantial variance across circuits both in the number of cases heard and in case disposition. While several circuits heard only two or three cases citing SSR 96-7p and discussing credibility or subjective symptoms or pain, the Seventh Circuit heard thirty-four. It remanded seventeen cases (46%), which is a higher number than heard by any other appellate court. The Sixth Circuit remanded four of the twelve cases citing SSR 96-7p it considered (33%) because of problematic credibility evaluations, once with a direct award of benefits. All other circuits had remand rates below twenty-five percent (25%), with the exception of the Eighth Circuit, which heard only two cases and remanded one. Some circuits did not remand any cases.

Each judicial opinion in which the SSA’s decision to deny benefits was returned by a court of appeals to the agency was further analyzed to identify: other bases for remand, medical impairments providing the basis for the claim of disability, and the specific reasoning behind a remand related to credibility or subjective symptom evaluation. Credibility was rarely the exclusive basis for remand (five of twenty-nine subjective symptom-related remands); in the majority of cases, there was at least one other basis for remand. More than half of appellate remands in cases citing SSR 96-7p, sixteen of twenty-nine, were also returned due to problematic application of the treating physician rule. Approximately two-thirds of appellate remands involved a musculoskeletal impairment; one-third involved depression, anxiety, or another mental illness.³⁰²

Common bases for remand

Cases were reviewed to specifically identify bases for credibility or subjective symptom related reasons, and several common issues were identified as occurring in two or more circuits. Five common remand issues are described briefly below, alongside an italicized list of appellate courts with supporting precedent and with citation to exemplary precedent.³⁰³ A full set of supporting case citations, by appellate court, are provided in **Appendix F: Appellate Case Law Citations**. These common remand reasons are more specific than the remand reasons coded by SSA but are not necessarily mutually exclusive.

No First Circuit cases citing SSR 96-7p were identified by the methodology. Conference staff found case law addressing only one remand issue in each of the Fourth and Fifth Circuits. Both heard less than three of the 105 relevant cases identified by the methodology.

In comparison to other circuits, review of the agency's action in the Seventh Circuit appears to be somewhat anomalous. As noted above, the Seventh Circuit heard more than twice as many cases citing SSR 96-7p as any other appellate court.³⁰⁴ The court's remand rate on subjective symptom evaluation was comparable to the overall remand rate for social security disability cases, and was higher than other appellate courts hearing more than one case. Each of the common remand reasons arose in the Seventh Circuit. It may be that the Seventh Circuit gives disability cases involving credibility determinations a relatively hard look.³⁰⁵ But the issues the Seventh Circuit has identified as problematic are not unique. Each of the common bases for remand identified in the Seventh Circuit was also a basis for remand in at least two other circuits, and the Tenth Circuit remanded cases for four of the five common remand reasons identified below.

(1) Activities of daily living

The SSA federal adjudicator treated activities of daily living that were not comparable to full time employment or transferable to a work environment as evidence that the claimant was not disabled: *2nd, 6th, 7th, 8th, 9th, 10th, 11th Circuits*.³⁰⁶ SSA adjudicators are required to consider daily activities as a factor in evaluating subjective symptoms under the regulations.³⁰⁷ For instance, the Ninth Circuit in *Orn v. Astrue* rejected an adjudicator's adverse credibility determination because it was premised on a finding that the claimant read, watched television, and colored in coloring books.³⁰⁸ The court pointed out that the claimant's testimony regarding these activities was consistent with other testimony in the record and that the activities did not meet the threshold for transferable work skills necessary for an adverse credibility finding.³⁰⁹

(2) Absence of treatment

The SSA federal adjudicator found the claimant not credible because the adjudicator viewed an absence of treatment for subjective symptoms as evidence of non-disability: *3rd, 6th, 7th, 8th, 9th, 10th Circuits*.³¹⁰ Treatment via medication and other forms of treatment are two of the seven factors SSA's adjudicators are directed to consider under the regulations for subjective symptoms evaluation.³¹¹ Internal agency guidance also directs adjudicators to develop the record regarding failure to follow prescribed treatment.³¹²

ODAR identifies remands in which the adjudicator *failed to acknowledge unavailability of treatment* in its own analysis of Appeals Council and judicial opinions, but this issue is rarely flagged by SSA staff at the hearing office level. The remand reason identified by Conference staff

is broader in scope than the SSA remand code. For example, it was used to categorize cases where an adverse credibility determination was remanded because it was premised on the claimant's decision not to pursue treatment that was available but that was "aggressive," not recommended, or not "clearly expected" to work.³¹³ SSA's regulations and SSR 82-59 offer some examples of acceptable reasons for not following treatment that adjudicators should consider if presented.³¹⁴

(3) Boilerplate / conclusory language

The ALJ relied on "boilerplate" template language or conclusory language in lieu of specifying reasons for credibility conclusion or made a determination of the claimant's ability to work or RFC prior to analyzing his or her subjective symptoms and credibility (consistent with prior FIT language): *3rd, 5th, 7th, 9th, 10th Circuits*.³¹⁵ Use of the template language is not in and of itself an error that warrants remand; rather, some FIT-reliant ALJ opinions are rejected for conclusory language found to be unsupported by specific findings.³¹⁶ Courts have also taken issue with the formulated approach to credibility evaluation, which previously described a claimant's statements as "not credible to the extent they are inconsistent with the above residual functional capacity assessment."³¹⁷

Notably, ODAR updated FIT in May 2012 to remove language comparing the claimant's statements about his or her symptoms with the RFC assessment; the revised template language was deployed in December 2012.³¹⁸ Because SSA cases naturally take some time to wind their way through the system, some decisions relying on the prior FIT language may still be subject to judicial review. So far, this revision appears to have passed without comment, but courts have previously criticized variants of the template similar to the language applied today.³¹⁹ Judicial opinions have been consistently critical of template language that describes an adverse credibility finding as one in which the adjudicator determines that the claimant is "not entirely credible."³²⁰ According to Judge Posner of the Seventh Circuit, this language "is not only boilerplate; it is meaningless boilerplate. The statement by a trier of fact that a witness' testimony is 'not entirely credible' yields no clue [as] to what weight the trier of fact gave the testimony."³²¹

(4) Required objective medical evidence of subjective symptoms

The SSA federal adjudicator effectively required objective medical evidence of the subjective symptoms themselves after a medically determinable impairment was established: *2nd, 4th, 6th, 7th*, 9th Circuits*.³²² SSR 96-7p clearly states that "an individual's statements about the intensity and persistence of pain or other symptoms or about the effect the symptoms have on his or her ability to work may not be disregarded solely because they are not substantiated by objective medical evidence."³²³ One ALJ's opinion was rejected by the Second Circuit for requiring a claimant's allegations of pain to be "well supported" by medical evidence, which the court found to be an "undue burden."³²⁴

(5) Disregarded or rejected supporting medical evidence

The SSA federal adjudicator failed to consider or adequately explain rejection of contrary medical judgments or medical evidence in the record supporting claims of subjective symptoms: *2nd, 7th, 10th Circuits*.³²⁵ Consideration of medical evidence is required by the regulations.³²⁶ This basis for remand is particularly important in the Second Circuit, where "only allegations beyond what is substantiated by medical evidence are to be subjected to a credibility analysis."³²⁷

Circuit-specific findings

A few circuit-specific issues were identified as implicating the subjective symptom evaluation process.

Positive work history—The Second Circuit has held that a claimant with a positive work history is entitled to substantial credibility.³²⁸ This holding, which dates to 1980, was identified as an issue in the *Steinberger* litigation previously discussed. It is included in the *Manual of Second Circuit Disability Decisions*, which SSA’s adjudicators hearing claims from New York State residents are still directed to follow.³²⁹ Remands issued in reliance on this holding were not observed in the appellate case law identified by our methodology. This may be because the 1991 regulations and SSR 96-7p state that adjudicators will consider statements about a claimant’s “prior work record and efforts to work” in evaluating credibility.³³⁰

However, as discussed further below, consideration of work history continues to provide a basis for remand in district court opinions in the Second Circuit. Accordingly, Conference staff conducted follow-up research on the application of this holding at the circuit court level. We identified similar (and similarly dated) holdings in the Third and Eighth Circuits³³¹ A more recent Ninth Circuit case held that a claimant’s work record may be considered during a credibility evaluation, but did not specify how to weigh the work record relative to other considerations.³³² Most recently, in a 1998 opinion, the Second Circuit clarified that “work history is just one of many factors that the ALJ is instructed to consider in weighing the credibility of claimant testimony.”³³³ In the same opinion the Second Circuit explained that a poor work history may also be probative of credibility and, despite allegations of bias, declined to adopt a categorical rule prohibiting consideration of poor work history.³³⁴

Credit-as-true rule—The credit- (or accept-) as-true rule is an additional circuit-specific holding observed in the Ninth and Eleventh Circuits. This holding was not observed in the appellate case law identified by our methodology. We first identified the challenges of this rule for SSA in our report on the treating physician rule, which describes the application of the rule to certain medical evidence.³³⁵ As applied in the credibility context, the credit-as-true rule says that where an ALJ failed to articulate reasons for discrediting a claimant’s testimony, the court should hold as a matter of law that the adjudicator has accepted the testimony as true, and then determine whether to award benefits.³³⁶ This does not necessarily mean that benefits will be awarded.³³⁷ Moreover, there is authority to support the proposition that courts within the Ninth and Eleventh Circuits may apply the credit-as-true rule at their discretion.³³⁸ As a result, as well as due to dated information on comparative information on outcomes at SSA post-remand, it is difficult to determine the relative impact of this rule on actual case outcomes.³³⁹

Conference staff used LexisNexis[®] Shepard’s[®] Citation Service to identify judicial opinions in the Ninth and Eleventh Circuits citing the seminal credit-as-true cases, *Varney* in the Ninth Circuit and *Hale* in the Eleventh. This methodology identified nineteen appellate remands in the Ninth Circuit applying the credit-as-true rule, thirteen of which led to awards (68%). Only five remands applying the rule in cases citing *Hale* were found in the Eleventh Circuit, and only two of these cases were remanded for an award of benefits (40%). These award rates are comparable to or lower than the last known award rates by SSA on remand.³⁴⁰

D. District court review

Given the sheer volume of district court cases citing SSR 96-7p between 2009 and 2013 (8,384 opinions, or an average of 1,679 cases per year), it was not possible to analyze the full population over the study time period. After several conversations with statistical or empirical legal experts, we decided to conduct a simple random sample of ten percent (10%) of the population (839 cases) for purposes of analysis.³⁴¹ We selected the sample of cases using random numbers provided by Professor Jonah Gelbach, an empirical legal scholar at the University of Pennsylvania Law School whose expertise is federal-court litigation. Although the geographic distribution of cases in the sample at the circuit court level corresponded closely to the population distribution, findings should not be used to make comparisons or statistical inferences at either the circuit or district court levels. Accordingly, results are presented for the full sample, rather than by circuit or district.

We used our experience reviewing appellate case law to similarly analyze district court cases. The entire sample was initially coded for disposition (*e.g.*, affirm, remand, remand with award). Remanded cases were then further analyzed to determine whether one or more of the common bases for remand identified based on appellate court opinions were at issue, as well as to identify other bases for remand unrelated to subjective symptoms.³⁴² Staff also noted whether a magistrate judge made an initial recommended decision or decided the case on consent, as well as identified alleged impairments.³⁴³

The overall remand rate for the district court case sample was about thirty-five percent (35%).³⁴⁴ Twenty-six percent (26%) of sampled district court cases (222) were remanded due to problematic subjective symptom or credibility evaluation. This is similar to the appellate remand rate of twenty-eight percent (28%). As at the circuit court level, this is a higher remand rate than observed by SSA for the most common *claimant credibility* remand reason (21% for *claimant credibility—failed to discuss the appropriate credibility factors*).³⁴⁵ Two factors may help to explain this variance. First, it does not appear that all SSA remands are coded, and hence a particular remand reason may occur more frequently than reported. Second, no information was available about the co-occurrence of remand reasons in individual cases. The overall remand rate for reason of *claimant credibility* may be higher than the remand rate for any sub-category reason for remand if the sub-category remand reasons are not always observed together.

Flawed credibility or subjective symptom analysis was the sole basis for remand in fewer than twenty-five percent (25%) of sampled remanded cases, meaning that most cases also involved another basis for remand, such as misapplication of the treating physician rule. Nearly forty-five percent (45%) of the subjective symptom-related remands also involved treating physician rule issues. In twenty of these cases (9% of subjective symptom-related remands), the reviewing court expressly found that the credibility analysis was erroneous as a result of treating physician rule problems.³⁴⁶ Hence, while resolving treating physician rule problems has the clear potential to reduce subjective symptom-related remands, it will not likely eliminate them.

As at the appellate level, district court judges in the Tenth Circuit do not require SSA adjudicators to undertake a “formalistic” evaluation of each of the regulatory factors to be considered as part of the subjective symptom evaluation.³⁴⁷ While this approach has been adopted in at least one other district court opinion,³⁴⁸ not all courts agree. Three recent opinions from the Eastern District of New York hold that an adjudicator must consider each of the seven credibility

factors, although none of these cases rely on Second Circuit precedent for support.³⁴⁹ Most district courts do not explicitly require consideration of all seven factors, and our review of the case law indicates that this is not an implicit requirement except where each of the factors is relevant to an individual case. It may be that the Eastern District of New York is a special case.³⁵⁰

Magistrate judges initially decided the majority of subjective symptom-related remands (about 70%), and a magistrate's recommendations in these cases were rejected only twice (less than 1% of the time).³⁵¹ Notably, more than two-thirds of subjective symptom-related remands involved a musculoskeletal impairment, and nearly half involved some form of depression, anxiety, or similar mental health issue. Less than fifteen percent (15%) of sampled subjective symptom-related remands involved either headaches/migraines or specific pain disorders such as fibromyalgia.

Common bases for remand

Each of the common bases for remand identified at the appellate court level occurred in between nineteen and twenty-nine percent (19-29%) of subjective symptom-related remands. All but about fifteen percent (15%) of observed remands in the case sample were returned to SSA for one of the common remand reasons (thirty-two of 222).³⁵² In about half of subjective symptom-related remands, only one of the common remand reasons was observed; in the rest, more than one common remand reason was observed.

(1) Activities of daily living

About twenty-seven percent (27%) of subjective symptom-related remands in the district court cases (sixty-one of 223) were premised on the adjudicator's improper evaluation of the individual's activities of daily living. This remand reason was identified in at least one district court in every circuit other than the Fifth Circuit and was the second most frequently observed subjective symptom-related basis for remand at the district court level.

In some cases, the court found that the adjudicator mischaracterized the extent of the claimant's daily activities in finding his or her statements about subjective symptoms not to be credible or not entirely credible.³⁵³ In other cases, the adjudicator failed to consider some of the limitations on daily activities attested to by the claimant.³⁵⁴ Often, remands were attributable to overreliance on the claimant's ability to perform regular activities not comparable to substantial gainful activity.³⁵⁵ For example, one case was remanded because the "activities upon which the ALJ relies present no apparent inconsistencies with Plaintiff's allegations [of pain]" and hence should not have been relied upon in making an adverse credibility determination.³⁵⁶ Adjudicators were criticized for failure to explain the perceived inconsistencies they relied upon in discounting the credibility of claimants' statements about activities of daily living.³⁵⁷

(2) Absence of treatment

This remand reason was observed in at least one district court in every circuit, and was the most frequently observed subjective symptom-related basis for remand at the district court level. It was observed in twenty-nine percent (29%) of district court opinions with subjective symptom-related remands (sixty-four of 223).

As at the district court level, this remand reason was used to identify cases where an adjudicator premised an adverse credibility finding on the claimant's decision not to pursue available treatment. For example, one magistrate judge remanded a case in which the ALJ found that a claimant was not credible because he did not lose weight and quit smoking, both of which were necessary for him to undergo suggested surgery for his impairment.³⁵⁸ Among other findings, the magistrate judge distinguished between recommended, rather than prescribed, treatment.³⁵⁹ Other cases rejected adverse credibility determinations as penalizing claimants for undertaking conservative treatment, although at least one district court acknowledged Ninth Circuit precedent that would support discounting a claimant's testimony on such grounds.³⁶⁰

Still other opinions rejected ALJ decisions that did not show development of the record or that ignored evidence that would explain the absence of treatment.³⁶¹ In the words of one district court judge, "the burden of proof is on the Commissioner to establish unjustified noncompliance [with prescribed treatment] by substantial evidence."³⁶² Several remanded cases in the Ninth Circuit cautioned "it may be problematic to draw an adverse inference from a failure to seek mental health treatment."³⁶³ This remand reason was also used to identify cases where the adjudicator found an absence of treatment, but where there was record evidence of treatment.³⁶⁴

(3) Boilerplate / conclusory language

This issue was observed in at least one district court in every circuit other than the First, and in twenty-five percent (25%) of sampled district court remands for reason of erroneous credibility evaluation (fifty-six of 223).

A number of district court judges have adopted the Seventh Circuit's criticism of adjudicator reliance on language in the FIT. Nearly half of the more than fifty decisions rejecting conclusory credibility findings specifically discussed reliance on "boilerplate" FIT language.³⁶⁵ Judges within the Seventh Circuit issued many of these decisions,³⁶⁶ but this criticism has also percolated into some district courts in other circuits.³⁶⁷

As with appellate courts, district courts will not reject an opinion strictly for reliance on boilerplate FIT language.³⁶⁸ Opinions described by this common remand reason are focused on the paucity of analysis of subjective symptoms that this remand code represents.³⁶⁹ District courts remand these cases because a thorough credibility analysis is "necessary to allow a court on review to discharge its responsibility to ensure that the ALJ's opinion is supported by substantial evidence."³⁷⁰ Conference staff flagged this remand code whenever a reviewing court determined that the discrediting opinion constituted the "forbidden conclusory statement" that a claimant is not credible³⁷¹ or otherwise failed to document any consideration of the required credibility factors prior to determining the claimant's ability to work.³⁷²

Chief Judge Marcia S. Krieger of the U.S. District Court for the District of Colorado offers an articulate explanation of her concerns with describing the "specific evidentiary findings" the ALJ must make "with regard to the existence, severity, frequency, and effect of the subjective symptoms on the claimant's ability to work" as "credibility determinations."³⁷³

Technically, the credibility assessment is as to particular testimony or statements. But this characterization often improperly leads ALJs and claimants to focus upon whether the claimant is believable or "telling the truth". Such focus is reflected in ALJ references to the "claimant's credibility" and claimants' umbrage on appeal at findings that suggest that they were untruthful.

Greater precision in distinguishing between the credibility of particular testimony as compared to general credibility of a claimant is helpful for subsequent review. It is also worth recognizing that determining the ontological truth or falsity of a claimant's statements is rarely necessary. Indeed, the searching inquiry required of the ALJ assumes that the claimant experiences a symptom that cannot be objectively documented -- pain, confusion, ringing in the ears, tingling, nausea and the like. The focus of the inquiry need not be to determine whether the claimant is truthfully reporting his or her experience, but instead to determine whether such symptom corresponds to a severe impairment and whether its nature, intensity, frequency, and severity affects the claimant's ability to work. Careful analysis results in factual findings supported by substantial evidence.³⁷⁴

Her cogent concern helps also to explain why judges frequently invoke the next common reason for remand: where an ALJ requires objective medical evidence to document subjective symptoms.

(4) Required objective medical evidence of subjective symptoms

This reason for remand was identified in approximately nineteen percent (19%) of district court opinions with subjective symptom-related remands (forty-three of 222) and in at least one district court under all but the First, Eleventh, and Fifth Circuits.

District courts are clear that at step two of the credibility analysis, after it is found that a medically determinable impairment could reasonably be expected to produce a claimant's symptoms, it is inappropriate to reject a claimant's statements about the intensity and persistence of his symptoms "solely because they were not substantiated by objective medical evidence."³⁷⁵ As one court found, it is logically inconsistent to discount a claimant's testimony regarding the impact of symptoms of an identified impairment for lack of supporting medical evidence once the adjudicator has accepted that the underlying condition is a severe impairment.³⁷⁶

This remand code was also used to identify cases where the adjudicator failed to make findings regarding subjective symptoms beyond an unfavorable comparison of allegations to objective medical evidence.³⁷⁷ In some cases, an adjudicator may have an obligation to develop the record prior to discounting a claimant's subjective symptoms as being inconsistent with objective medical evidence.³⁷⁸ In other cases, the ALJ may have failed to consider supporting medical evidence (a remand reason on its own, as discussed further below).³⁷⁹ There are also cases in which a claimant's symptoms elude objective testing.³⁸⁰

A related but distinct reason for a remand identified at the district court level is the rejection of medical evidence because it is based primarily on subjective symptomology (and sometimes on an erroneous adverse credibility determination).³⁸¹ This issue was observed in approximately five percent (5%) of credibility-based remands, but may occur more or less frequently in cases that do not cite SSR 96-7p or are not challenged because of an adverse credibility determination.

(5) Disregarded or rejected supporting medical evidence

This remand reason was observed in at least one court within every judicial circuit. Reviewing district courts remanded cases for disregarding supporting medical evidence of subjective symptoms in twenty-four percent (24%, fifty-four of 222) of sampled district court credibility remands.

This remand reason was applied to cases in which medical or other evidence supporting subjective symptom allegations was not considered by the adjudicator.³⁸² Examples of the types

of supporting medical and other evidence that must be considered when present³⁸³ include: clinical findings,³⁸⁴ evidence of medical treatment or medication,³⁸⁵ and evidence of impediments to medical treatment.³⁸⁶ Courts may also remand ALJ decisions that do not adequately consider opinions on claimant credibility made by treating sources and consultative examiners.³⁸⁷ An adjudicator may not selectively rely on some medical evidence while rejecting or failing to consider other supporting medical evidence.³⁸⁸ Rejection of uncontroverted medical evidence must be supported by substantial evidence.³⁸⁹

This remand reason was also used to identify cases where symptom evaluation was flawed because supporting medical evidence should not have been rejected. For example, this remand reason was occasionally observed in cases that were also remanded because of problems in application of the treating physician rule and where the credibility evaluation was flawed as a result of improper weighting of medical evidence.³⁹⁰

Specific findings in district courts

Unsurprisingly, circuit-specific precedent has percolated down into the district courts in those jurisdictions. Analysis of cases with subjective symptom-related remands in the set of sampled cases did not identify district court opinions in other circuits applying the circuit-specific precedent previously identified.

Positive work history—Failure to consider a claimant’s positive work history when making a credibility determination may provide a basis for remand in district courts in the Second, Third, and Eighth Circuits.³⁹¹ However, district courts in the Fourth and Fifth Circuits have expressly declined to follow this view of the significance of a “good work record.”³⁹² Also as at the circuit court level, some district courts will consider a solid work history one of many factors in a credibility evaluation.³⁹³

Credit-as-true rule and remands with awards—District courts in the First and Tenth Circuits have declined to adopt the credit-as-true rule.³⁹⁴ It is applied by district courts in the Ninth and Eleventh Circuits. In courts whose decisions are appealed to the Ninth Circuit, the credit-as-true rule was addressed in about half of remanded cases (twenty-six of fifty-five total remands). In those whose decisions appealed to the Eleventh Circuit, the rule was addressed in less than a quarter of remanded cases (four of seventeen). Intercircuit comparisons are inappropriate given the sampling methodology, and differences in observed frequencies of cases applying the credit-as-true rule may be a result of limited sampling. However, review of the case law indicates that this discrepancy may be jurisprudential. In district courts in the Eleventh Circuit, the credit-as-true rule is not applied when the opinion below improperly discounts the credibility of statements but where the adjudicator “substantially complied with the regulations.”³⁹⁵ In district courts in the Ninth Circuit, the rule is applicable when the lower opinion fails to provide “specific, clear, and convincing reasons” for an adverse credibility determination.³⁹⁶ Notably, a number of cases in both jurisdictions identified a problematic subjective symptom evaluation but did not discuss the credit-as-true rule.

In the entire sample, only twenty-six remands were made with awards, twenty-three in cases attributable to problematic subjective symptom evaluation. The credit-as-true rule led to a subjective symptom-related remand with an award in eleven cases in district courts under the

jurisdiction of the Ninth Circuit, which is twenty percent (20%) of remands in that jurisdiction. No district court cases awarding benefits due to application of the credit-as-true rule were identified in sampled cases in the Eleventh Circuit, although several cases discussed the rule. Five awards were made by a single judge in the Western District of New York, which does not follow the credit-as-true rule.³⁹⁷

Bias—As noted above, SSA recently settled class-action litigation in the Eastern District of New York to address allegations of bias in credibility and disability determinations.³⁹⁸ Knowing of this alleged relationship, and also of bias complaints arising at the administrative level, Conference staff reviewed cases with subjective symptom-related remands with an eye towards identifying potential bias.³⁹⁹ Only one district court opinion in the sample remanded an ALJ opinion due to biased credibility evaluation, although a few other cases raised questions regarding the behavior of an ALJ, findings in this area were largely negative.⁴⁰⁰ Since we know allegations of bias to be an issue at the administrative level, this negative finding may indicate that the agency is successfully addressing bias concerns internally through an administrative process involving investigation of bias claims by ODAR’s Division of Quality Service.⁴⁰¹

E. Case law conclusions

SSA regulations require that an adjudicator, having determined that the claimant has one or more medically determinable impairment(s) that could reasonably be expected to produce pain or symptoms (step one of the symptom evaluation process), consider objective medical evidence and other evidence in evaluating the intensity and persistence of those subjective symptoms (step two of the process).⁴⁰² The common remand reasons identified through case law research arise because of ALJ analysis at step two of the symptom evaluation process.

In some cases, a claimant’s complaints of subjective symptoms may be fully substantiated by objective medical evidence. Consideration of objective medical evidence is central to determining whether this is the case, and courts have remanded ALJ decisions that disregard or inappropriately reject supporting medical evidence. An adjudicator’s failure to consider objective medical evidence is a clear example of regulatory implementation problems, because the regulations direct adjudicators to consider it in reaching a conclusion about whether a claimant is disabled.⁴⁰³ Purportedly inappropriate rejection of evidence is a thornier issue. It is worth highlighting that a significant number of remands by circuit and district court observed in our case law review—forty-five percent and more than half, respectively—occur because of problems in weighing medical evidence due to misapplication of the treating physician rule. In twenty percent of the sampled remanded cases, the court found that the subjective symptom evaluation was erroneous because of treating physician rule problems. We have previously offered SSA principles to guide its regulatory efforts to improve evaluation of medical evidence under the treating physician rule, and taking action on these prior recommendations may help SSA to improve adjudicator’s subjective symptom evaluations as well.⁴⁰⁴

In other cases, “symptoms sometimes suggest a greater severity of impairment than can be shown by objective medical evidence alone.”⁴⁰⁵ SSA “will not reject [a claimant’s] statements about the intensity and persistence of [] pain or other symptoms or about the effect [] symptoms have on [a claimant’s] ability to work (or if [] a child, to function independently, appropriately, and effectively in an age-appropriate manner) solely because the available objective medical

evidence does not substantiate [the claimant's] statements.”⁴⁰⁶ Requiring objective medical evidence of subjective symptoms was another commonly observed reason for remands at the district and circuit court levels of judicial review, and is another clear example of problematic application of existing regulations.

The remaining commonly observed remand reasons relate to the specific analysis that the courts and now SSA require the agency to consider in evaluating “other [non-objective medical] evidence” of subjective symptoms.⁴⁰⁷ In some cases, ALJs fail to adequately articulate the reasoning behind a credibility determination, and rely on boilerplate or conclusory language rather than explaining how they considered other evidence offered by the claimant in support of his or her claim. The common remand reasons also indicate that courts frequently take issue with the way ALJ's evaluate a claimant's 1) activities of daily living⁴⁰⁸ or 2) approach to treatment of symptoms.⁴⁰⁹ Here too, courts are concerned with ALJs' implementation (or lack thereof) of the agency's regulations. Taken together, these common remand reasons highlight specific areas in which the agency could improve adjudicator evaluations of subjective symptoms at step two of the regulatory symptom evaluation process.

VI. EXTERNAL PERSPECTIVES ON SSA'S EVALUATION OF CLAIMANTS' SYMPTOMS

Given the controversial history of subjective symptom evaluation, and the frequency with which this issue contributes to judicial and Appeals Council remands, one might expect to find healthy body of academic literature, congressional activity, and stakeholder engagement on the subject. The reality is that public attention to this topic in recent years has been relatively minimal.

A. Academic literature

Much of the academic literature focuses on specific disorders,⁴¹⁰ or pain generally,⁴¹¹ rather than how pain or subjective symptoms are considered in the disability adjudication context. An important exception is a 2001 article in *Journal of Health Law* by Elizabeth Schneider and Joseph Simeone discussing pain and disability under social security. It calls for new regulations for evaluating pain claims.⁴¹² The authors base their argument on a perceived inconsistency in treatment of pain claims amongst federal circuit courts regarding whether a claimant must “produce medical evidence of a relationship between the impairment and the severity of the pain.”⁴¹³ They distinguish between courts that do not require such evidence and those in which “there must be medical findings to support subjective complaints of pain.” The authors rely primarily on case law from the 1990s or earlier in drawing this distinction.⁴¹⁴ This question appears, however, to have been settled by SSR 96-7p, which clarifies that “an individual's statements about the intensity and persistence of pain or other symptoms or about the effect the symptoms have on his or her ability to work may not be disregarded solely because they are not substantiated by objective medical evidence.”⁴¹⁵ Although the authors briefly mention that recent case law has dealt with ALJ non-compliance with SSR 96-7p and conclusory credibility evaluation, they do not identify SSA's resolution of this issue. As discussed above, adjudicator failure to comply with SSR 96-7p's directive on objective medical evidence continues to be a common basis for remand in some appellate and district courts.

A few articles in the literature relate to bias in disability adjudications and identify credibility evaluation as an area where adjudicator bias may manifest. A recent article by Professor Pashler focuses on the stigma obese claimants face and suggests that implicit bias associated with this stigma can lead to inadequate record development. He suggested that involving adjudicators in the creation of objective protocols to question claimants and develop the record about whether stigmatized disorders are disabling “might minimize the risk that the ALJ’s implicit bias could surface when making the credibility findings.”⁴¹⁶ The late Clara Dworsky, former chair of the American Bar Association’s Social Security Law and Practice Committee, also suggested that bias can enter into credibility evaluations. She cited an example from her own practice experience in which an ALJ made an adverse credibility determination because the claimant was “‘an obese woman with AFDC and HUD as her sources of income’ and [because] her ‘primary motivation was to eat her way onto the disability rolls.’”⁴¹⁷ Ms. Dworsky explained that this violates SSR 96-7p, which prohibits adjudicators from making credibility determinations based on intangible, intuitive notions. She further cited judicial precedent clarifying that adjudicator speculation about a claimant’s financial motivation based on information about earning records, sporadic work history, or receipt of welfare payments “has no connection with testimony concerning the frequency and severity of subjective symptoms.”⁴¹⁸ As these examples show, bias can manifest in credibility evaluations through inadequate record development and inappropriate consideration of factors that are irrelevant to the limitations imposed by a claimant’s subjective symptoms.

Another extreme example of bias in the literature was identified in a student note in the *Cornell Law Review*. It describes litigation alleging bias by an individual ALJ who evidently viewed subjective symptom evaluation as an opportunity to identify “no-goodniks.”⁴¹⁹ The note documents both witness testimony as to biased credibility evaluations and statistical evidence indicating that this ALJ had, in at least sixty-nine individual cases, “unlawfully determined that the claimant was not credible.”⁴²⁰ After a complicated procedural history that culminated in class-action litigation by claimants to whom this judge had denied benefits, the U.S. District Court for the Middle District of Pennsylvania found that the ALJ “harbored biases which rendered him unable to fulfill his duty to develop the facts and to decide cases fairly” in violation of the plaintiffs’ rights to full and fair hearings and decisions based on substantial evidence.⁴²¹ In rendering this opinion, the court overruled an exculpatory inquiry of the issue undertaken by SSA, finding that it was not supported by substantial evidence and improperly discredited and disregarded corroborating testimony.⁴²² The allegations of bias described in this note, as well as in the Pashler and Dworsky articles, bring to mind those made in *Padro v. Colvin*, the recent class-action lawsuit settled in the Eastern District of New York.⁴²³

B. Congressional and oversight authorities

Congressional oversight of SSA takes many forms, in part due to jurisdiction over the agency by a number of different committees and subcommittees.⁴²⁴ SSA’s activities are also scrutinized by the Congressional Research Service, the Government Accountability Office, and SSA’s own Office of the Inspector General. A comprehensive review of publications by each of these oversight entities was not feasible. Rather, Conference staff conducted key word searches of the websites of: the House Ways and Means Committee’s Subcommittee on Social Security, the Senate Finance Committee, the Government Accountability Office, and the Social Security Office of Inspector General.⁴²⁵ Supplemental research was conducted on congressional hearings

relating to social security disability adjudication. This methodology identified only a few oversight materials or witness statements relevant to credibility or subjective symptom evaluation, almost all of which discussed subjective symptom evaluation descriptively or in passing.⁴²⁶ Since the 1984 amendments to the Social Security Act—which expired without adoption of a new statutory standard for the evaluation of subjective symptoms—the subject has not garnered much congressional attention.

The *Minority Staff Report of the U.S. Senate’s Permanent Subcommittee on Investigations on Social Security Disability Programs: Improving the Quality of Benefit Award Decisions* is perhaps the most notable of the identified congressional materials.⁴²⁷ Tellingly, its 2012 findings with respect to credibility evaluation are negative. The report is based on Committee staff review of 300 case files for disability beneficiaries. The report concluded that there were errors in about one in every four of these decisions and sought to identify repeat problems in decisionmaking. It examined the award of benefits bearing in mind SSA-identified common bases for remand of unappealed hearing decisions, including credibility evaluation.⁴²⁸ However, only two cases were identified (fewer than 3% of purportedly problematic decisions) in which benefits were awarded and credibility analysis was found to be erroneous—in both instances due to the ALJ’s failure to discuss evidence questioning credibility.⁴²⁹ As a result, and although the *Minority Staff Report* made several concrete recommendations for improving the social security disability determination process, such as focused training for ALJ’s, the report did not offer specific advice for improving subjective symptom evaluation. Former Senator Coburn and his staff continued to examine issues surrounding subjective symptom evaluation, such as the utility of symptom validity testing, and also called for focused training for ALJs regarding adequate articulation of legal determinations.⁴³⁰ In December 2014, just prior to leaving office, Senator Coburn introduced legislation that would permit ALJs to acquire and consider symptom validity tests and information from publicly available social media in evaluating the credibility of an individual’s medical evidence.⁴³¹

C. Stakeholder perspectives

While this report has focused on SSA’s decisionmaking process, a study of the evaluation of a claimant’s subjective symptoms would be incomplete if it did not also explore the perspectives of claimants (through their representatives) and adjudicators (including ALJs and disability examiners). A review of organizational websites did not identify analyses or advocacy pieces specific to subjective symptom or credibility evaluation.⁴³² To some extent, these perspectives can be inferred from positions taken in agency or judicial proceedings. However, such positions are offered within the existing framework for agency decisionmaking and may not present the full picture.

In order to better understand stakeholder views, including whether the existing process should be changed, Conference staff developed a short questionnaire soliciting feedback on SSA’s existing regulations and policy guidance for subjective symptoms and claimant credibility evaluation. This questionnaire was distributed to two prominent claimant representative organizations—the National Association of Disability Representatives (NADR) and the National Organization of Social Security Claimants’ Representatives (NOSSCR)—and two ALJ organizations—the Association of Administrative Law Judges (AALJ)⁴³³ and the Federal Administrative Law Judges Conference (FALJC)⁴³⁴—as well as the National Association of Disability Examiners (NADE) and the American Bar Association (ABA). Organizational

responses are included as an attachment to this report in **Appendix G: Stakeholder Questionnaire Responses**. We are grateful for the participation and feedback of each of these organizations.

Helpful feedback was also provided by the National Council of Disability Determination Directors (NCDDD) in the form of relevant prior testimony and responses to questions of record in Congress.⁴³⁵ The FALJC did not provide an official response to the questionnaire, but did transmit personal opinion responses from three individual judges. As FALJC noted in transmitting these materials, these responses do not reflect the views of the organization as a whole. Individual ALJ responses were at times divergent; hence they are discussed individually below. We are thankful for these resources and opinions as well.

In general, surveyed organizations did not believe that changes are required in SSA's existing regulations (20 C.F.R. §§404.1529, 416.929) or current sub-regulatory guidance in SSR 96-7p for the evaluation of a claimant's subjective symptoms.⁴³⁶ In the words of NOSSCR:

We believe that the current regulations and policies provide adequate detailed guidance for adjudicators and the public, allowing for accurate decision-making. They are measured and extensive, having been developed after years of comment and deliberation by SSA. The policies are sufficiently flexible to allow for application when a claimant's circumstances change.⁴³⁷

NADR commented that "[e]stablished rules provide a solid framework for evaluating pain," but also noted that the current rules and policy rulings "do not explicitly require specific findings" about claimant's symptoms.⁴³⁸ NADE observed that subjective symptom evaluation "is a challenging issue for adjudicators to address, considering the degree of subjectivity that is usually involved. The guidance does provide the tools for adjudicators to make a fair assessment."⁴³⁹

The AALJ, NOSSCR, and NADR agreed that opportunities exist to improve policy implementation and administration (the ABA did not offer specific comments on this subject).⁴⁴⁰ Implementation was of particular concern to the claimant representative organizations. NADR expressed concern that SSR 96-7p is not being followed and that resultant improper credibility evaluations deprive claimants of due process. NOSSCR suggested that "additional training or 'reminders' about the guidance provided in the regulations and SSRs would be useful.... It is critical that SSA provide adequate support and guidance to adjudicators regarding the application of its policies for evaluation of symptoms, including pain."⁴⁴¹ The AALJ and NADE urged SSA to ensure that adjudicators have sufficient time to review all of the evidence and to develop the record, where necessary. NADE commented that with "many adjudicators experiencing increased workload demands . . . claimant credibility may not [always] be given the due consideration it deserves."⁴⁴²

Both claimant representative organizations observed some of the common bases for remand that Conference staff independently identified through case law research. NADR and NOSSCR noted that adjudicator reliance on boilerplate or conclusory language in lieu of making specific findings is a problem, and NOSSCR also observed that the courts have taken issue with FIT language and the assessment of RFC before evaluation of subjective symptoms. NADR advised disallowing the use of the FIT language altogether and expressed concern that adjudicators "routinely discredit allegations of pain."⁴⁴³ Adjudicator evaluation of daily activities and treatment under the regulations and policy rulings also drew criticism. NADR suggested that SSA provide adjudicators with realistic scenarios to consider in assessing pain, such as those that recognize that because "someone goes out to eat, vacuums a small apartment, or does their own laundry does not

mean they do not have debilitating pain.”⁴⁴⁴ NOSSCR identified an example where an adjudicator drew an adverse credibility inference based on a claimant’s failure to seek regular medical treatment, without explicitly considering the claimant’s explanation that he was unable to afford treatment. NADR stated that limitations in access to medical treatment for some claimants—particularly the indigent, uninsured, or underinsured—may result in discredited allegations of pain. NOSSCR felt that record medical evidence was not always accounted for; according to its review of case law, “the most frequent reason for [] remands is the ALJ’s failure to articulate supported and valid reasons for rejecting or discounting medical evidence from treating sources.”⁴⁴⁵

While SSA data and staff research did not identify lay evidence or third party credibility issues as frequent reasons for remand, these issues were raised by both claimant organizations. NADR and NOSSCR expressed concern that lay or third person evidence and statements are given less weight than deserved. Each emphasized the value such evidence can provide, NADR where the claimant does not have access to healthcare and NOSSCR where it provides “key information needed to establish the individual’s functional limitations.”⁴⁴⁶ An individual ALJ expressed concern for potential abuse of third party evidence, when testimony by claimant’s family members or friends is not given under oath or, if written, is not provided as an affidavit.⁴⁴⁷

NADE, NADR, and the AALJ commented on the need for greater development of medical evidence in the evaluation of subjective symptoms. NADR suggested that SSA’s guidance on the use of pain specialists or pain centers as consultative examiners should be further explained to clarify when a consultative examination for pain is warranted. The AALJ thought that SSA should either require documentation of functional limitations by a claimant’s treating sources or pay for a complete physical/functional capacity evaluation. NADR stated that more time should be provided for consultative musculoskeletal and neurological consultative examinations and that more weight should be afforded to psychological evaluations identifying pain behavior. The AALJ and one individual ALJ suggested that SSA should permit adjudicators to order psychological tests that shed light on malingering or symptom exaggeration.⁴⁴⁸ NADR suggested that medical studies, such as one on the frequency of migraines, could provide greater insight on whether pain allegations are reasonable. At the DDS level, NADE said that “[s]ometimes additional clarification can make a difference in the outcome of the claim” but also expressed concerns about the extra time required to develop the record in such cases when “[m]any adjudicators are under high production demands.”⁴⁴⁹

Stakeholders provided some feedback on agency forms and decisionmaking tools. NADE offered feedback on the presentation of information regarding subjective symptom evaluation in the eCAT tool, discussed in greater depth in **Appendix C: The Electronic Claims Analysis Tool**. NADR provided a number of specific ideas relating to the use of forms or questionnaires in pain evaluation. It suggested that, at the DDS level, the existing pain questionnaire should include questions about how pain affects the claimant’s concentration, need to change positions, and sleep. More generally, NADR stated that SSA should require pain questionnaires and should consider asking about and evaluating pain early in the disability determination process. However, NADR recommended replacing or amending the existing form pain/function report used by SSA, due to the perception “that this report is constructed in a way that encourages people to give answers Social Security will later use against them.”⁴⁵⁰ The AALJ expressed concern that claimants do not complete pain questionnaires or forms that detail the nature, extent, and severity of subjective symptoms and the functional limitations that symptoms impose. NADE commented that claimant

statements on the agency’s disability and function report forms are at times “vague or misleading” and that additional clarification can sometimes “make a difference in the outcome of the claim.”⁴⁵¹ NADE also emphasized the evidentiary value of observations made by SSA Field Office personnel.

Finally, the AALJ suggested that providing ALJs and staff with access to social media sites and arrest and conviction records could aid judges in the assessment of subjective symptoms and resulting limitations by bringing to light “relevant information” on the alleged disability. This view was shared by one ALJ in a personal response that expressed concern of reprisal against an ALJ who attempts to obtain such information.⁴⁵² Another individual ALJ asserted that “[s]tatements by ex-cons, alcoholics, and drug addicts are inherently unreliable” but did not explicitly support access to external criminal or other records.⁴⁵³ The AALJ expressed its view that vigorous questioning of claimants and witnesses by adjudicators should be allowed “without threats of counseling or disciplinary action for being ‘biased’ or ‘impolite.’”⁴⁵⁴

Taken together, the substantive stakeholder responses indicate that: opportunities exist to improve implementation of subjective symptom evaluation, claimants have concerns with several of the common bases for remand, and diverse interests are advocates for additional resources and record development (especially of medical evidence), although supported approaches may vary.⁴⁵⁵

VII. RECOMMENDATIONS

The purpose of this effort is to advise SSA on how to best articulate the scope of symptom evaluation in its adjudication process, so as to: improve consistency in disability determinations, reduce complaints of bias and misconduct against SSA ALJs, and reduce the frequency of Appeals Council and judicial remands involving symptom evaluation. To this end, the report offers SSA the Office of the Chairman’s recommendations concerning potential improvements in the language SSR 96-7p and implementation of the regulatory standards.

A. Statutory and regulatory revisions

As the case law and stakeholder feedback illustrate, the existing subjective symptom regulations are generally well regarded.⁴⁵⁶ The major problem appears to be implementation of existing regulations. Hence, the Office of the Chairman is not recommending that SSA consider changes to the agency’s two-step approach to the evaluation of subjective symptoms or the regulations at this time. However, a few statutory and regulatory housekeeping changes are advisable.

1. SSA should seek the removal of the expired pain or other symptom provision, indicated in strikethrough text below, of the Social Security Disability Benefit Reform Act of 1984 from 42 U.S.C. Section 423(d)(5)(A).

As discussed above, this provision applied “only to determinations made prior to January 1, 1987.”⁴⁵⁷ The current codification contains no explanatory note identifying the sunset provision and might create confusion about the actual law even for sophisticated or legally trained code consumers. The Code should read:

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

...(d) “Disability Defined”

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

This problem is compounded when the statutory standard is incorporated by reference. For example, regulations of the U.S. Department of Housing and Urban Development for the Section 8 and Public Housing Assistance programs—funded by Congress at nearly thirty billion dollars for FY 2014⁴⁵⁸—define disability in part by reference to 42 U.S.C. Section 423.⁴⁵⁹

The expired statutory standard has been generally incorporated into SSA’s regulatory standards for the evaluation of subjective symptoms, which have been accepted by the courts and are well regarded by stakeholders. Nonetheless, the congressional standard is of historical interest and of guidance value, and so we encourage SSA to work with the Office of the Law Revision Counsel of the U.S. House of Representatives to include an appropriate editorial note containing the expired text.

2. SSA should consider clarifying a potential inconsistency in its regulations on *What is Needed to Show an Impairment*, at 20 C.F.R. §§ 404.1508, 416.908.

The regulations state:

If you are not doing substantial gainful activity, we always look first at your physical or mental impairment(s) to determine whether you are disabled or blind. Your impairment must result from anatomical, physiological, or psychological abnormalities which can be shown by medically acceptable clinical and laboratory diagnostic techniques. A physical or mental impairment must be established by medical evidence consisting of signs, symptoms, and laboratory findings, not only by your statement of symptoms (see § 404.1527). (See § 404.1528 for further information about what we mean by symptoms, signs, and laboratory findings.)⁴⁶⁰

These rules were adopted in 1980, prior to the 1991 codification of the current approach to subjective symptom evaluation.⁴⁶¹ In the 1980 Federal Register notice adopting the regulation, SSA recognized in response to comments that a “history of symptoms, recorded in a clinical setting, is important to the evaluation of disability.”⁴⁶² Also in response to comments, SSA included the cross-reference to the second regulatory provision containing more information, titled *Symptoms, Signs, and Laboratory Findings*. It states:

Symptoms are your own description of your physical or mental impairment. Your statements alone are not enough to establish that there is a physical or mental impairment.⁴⁶³

It is incongruous to define symptoms as a claimant's own description of his or her impairment while also identifying them as medical evidence, without further clarification.

The simplest regulatory fix would be to strike "symptoms" from the list of types of medical evidence that can be used to establish an impairment, but to keep the last clause stating that an impairment cannot be established "only by your statement of symptoms." This solution, however, would not explicitly honor SSA's recognition—both in responding to comments on the 1990 adoption of this rule and in the inclusion of pain as a diagnostic criterion in many of the impairments identified in the listing of impairments in Appendix I—that symptoms can contribute to the establishment of an impairment. Hence, a more nuanced approach might be warranted, but should be considered in light of the full set of regulations and policy rulings, including the rules for subjective symptom evaluation and SSRs 96-3p, 96-4p, and 96-7p. Any proposed regulatory fix to this perceived inconsistency would be subject to the notice-and-comment rulemaking procedures of the Administrative Procedure Act.⁴⁶⁴

B. Policy recommendations

- 1. SSA should consider amending SSR 96-7p to clarify that subjective symptom evaluation is not an examination of a claimant's character but rather is an evidence-based analysis of the administrative record to determine whether the nature, intensity, frequency, or severity of symptoms impact the claimant's ability to work.**

The evaluation of credibility undertaken by SSA's adjudicators at all levels of review is, to put it simply, quite unlike credibility evaluations often made and reviewed in many other judicial contexts. Courts are ordinarily highly deferential to credibility determinations made by finders of fact, to give "due regard" to the fact-finder's observations and judgment of a witness' credibility. In contrast, for every five appellate and district court cases remanded to the SSA, one is returned due to a judicial finding of problematic adjudicator analysis of a claimant's credibility in the context of subjective symptom evaluation. This raises questions about the level of deference federal judges actually afford to SSA's administrative credibility findings and the appropriateness of using the term "credibility" to describe the agency's or the court's evaluation of subjective symptoms.

One possible explanation for the frequency of credibility-related remands of social security disability cases is the ordinary remedy of returning the erroneous benefits determination to the agency for reconsideration. Subsequent administrative process to reassess credibility avoids due process concerns that might be raised, and indeed have been raised by six courts of appeals, where credibility determinations are overturned by federal courts without a new evidentiary hearing. (This is not to say that the availability of this remedy justifies a lack of deference to the Commissioner's decisions regarding subjective symptom complaints; the law is clear that Commissioner's decision is to be affirmed unless unsupported by "substantial evidence.")

Another possible explanation, offered by Chief Judge Krieger of the U.S. District Court for the District of Colorado, is that adjudicators are not actually being called upon to evaluate “credibility” in most social security cases. The administrative evaluation of subjective symptoms that the agency’s adjudicators often undertake in nonadversarial proceedings differs from the ordinary evaluation of a witness’s credibility—with its emphasis on the witness’s character for truthfulness and especially demeanor while testifying—that occur in other contexts. To offer a comparative example, the Federal Rules of Civil Procedure clearly place great weight on the fact finder’s personal observations about witnesses by requiring that they be upheld on appeal unless clearly erroneous.⁴⁶⁵

In contrast, at the initial and reconsideration levels of the administrative process, field officers rather than DDS decisionmakers make in-person observations, if any. Hearings allow adjudicators at the hearing office level to directly observe claimants, but nonetheless SSR 96-7p provides that credibility findings at all levels of review may not be based on “an intangible or intuitive notion” or personal observations alone. This aspect of administrative policy has clear and longstanding judicial origins, including in the *Polaski* class-action litigation over subjective symptom evaluation. Rather, subjective symptoms are to be evaluated after thorough consideration of record evidence in light of the *Polaski*-turned-regulatory factors. Judicial review of these findings involves close scrutiny of their evidentiary basis to determine whether the regulatory analysis was appropriate.

The description of subjective symptom evaluation as credibility evaluation may have judicial origins, but it is not anchored in the current regulations for the evaluation of subjective symptoms. The requirement for an evaluation of credibility is found in SSR 96-7p. It is not contained in the Social Security Act or in SSA’s implementing regulations, which require only an evaluation of the “intensity and persistence of your symptoms so that we can determine how your symptoms limit your capacity for work.”

Moreover, some commentators have raised serious concerns regarding the potential for bias in the evaluation of a claimant’s credibility, including in cases where an ALJ fails to develop the record (a common remand reason in sampled cases citing SSR 96-7p) or relies on extraneous information in decisionmaking. While administrative allegations of bias at the hearing office level appeared to be relatively rare based on FY 2011 data, when they were raised with the Division of Quality Service in less than one percent (1%) of ALJ adjudications, they nonetheless involved forty percent (40%) of SSA’s ALJ corps. Data suggest that between four and twenty percent (4-20%) of these claims (involving an unknown number of adjudicators) may have been capable of substantiation if fully analyzed and documented. Little is known about the connection between these complaints and credibility evaluation, but a handful of sample bias referrals provided by SSA, the academic literature, one sampled district court case, and the *Padro v. Colvin* class-action litigation demonstrate that there are examples in which such a relationship exists.

We are concerned that the current description of subjective symptom evaluation as credibility evaluation, though not wrong, may invite adjudicators to examine a claimant’s character or inquire into other matters that are not essential—and indeed may be irrelevant—to the evidentiary determination of whether the nature, intensity, frequency, or severity of these symptoms impacts the claimant’s ability to work, particularly where the evaluation is of symptoms that are unsubstantiated by objective medical evidence. As Judge Krieger points out, claimants are likely to “take umbrage” with adverse credibility determinations “that suggest that they were

untruthful.” The implementation of this recommendation may well reduce perceptions and complaints of bias arising from subjective symptom evaluation. It would also resolve judicial concerns with template language describing a claimant’s statements as “not entirely credible.” This is not to say that an evaluation of a claimant’s credibility—including those partially based on consideration of personal (or, at the DDS level, field office) observations or made by medical professionals—should play no role in the evaluation of subjective symptoms, but rather to clarify that credibility (as commonly understood) is not the central inquiry.

Accordingly, SSA should consider amending SSR 96-7p to clarify that subjective symptom evaluation is not an examination of a claimant’s character. We recommend that the agency instead more closely follow the regulatory language, which directs adjudicators to consider medical and other evidence to “evaluate the intensity and persistence of [an individual’s] symptoms so that [SSA] can determine how [the individual’s] symptoms limit [his or her] capacity for work or, if [he or she is] a child, [] functioning.” SSA could use this revision as an opportunity to offer guidance to its adjudicators on the specific regulatory implementation problems courts have identified.⁴⁶⁶

SSA should also consider revising related documentation, such as in POMS or HALLEX, and adjudicative tools including FIT, eCAT, and successor technologies, to avoid describing subjective symptom evaluation as a determination of the claimant’s credibility. Revising these tools may help to focus attention on the question of the extent to which the evidence indicates that a claimant’s subjective experience of symptoms contributes to his or her impairment or limits the capacity to work or function.

2. SSA should examine opportunities to improve administrative record development where evaluation of subjective symptoms is required for a disability determination.

Stakeholders, particularly disability examiners and ALJs, agreed that record evidence can help adjudicators to evaluate the limitations, if any, imposed by a claimant’s impairments and symptoms. The agency has a range of tools adjudicators could use to develop the record, such as: requests for additional information from treating sources, consultative examinations (including by pain specialists), and DDS form questionnaires about pain and functional limitations. However, stakeholders provided a number of specific comments raising concerns about the availability or application of these tools, and a number of quality review cases and remands cited inadequate record development, particularly with respect to treatment. It appears that these tools are insufficiently utilized in some cases. Agency adjudicators feel constrained by resource and record limitations, including those induced by production goals. SSA should evaluate whether changes in internal agency directives, procedures, or forms are needed in light of this stakeholder, quality review, and judicial feedback.

Some Members of Congress and the AALJ have questioned SSA’s decision to prohibit adjudicators from procuring symptom validity tests. We lack the expertise necessary to offer advice on this decision, and particularly on the weight such tests should be afforded or on the training that should be provided to adjudicators if the prohibition is lifted. We understand that SSA has engaged the Institute of Medicine at The National Academies to perform a critical review of symptom validity tests, as well as to offer guidance on their relevance and use in the context of disability determinations.⁴⁶⁷

Similarly, SSA may wish to engage experts to study and guide any revisions to its questionnaires or forms for gathering information about claimants' subjective symptoms and functional limitations.⁴⁶⁸ NADR in particular made a number of suggestions regarding the use of pain and function questionnaires, which typically occurs at the DDS level. The organization offered a potential explanation for why, as the AALJ noted, claimants may be reluctant to complete such forms, or, as NADE noted, to complete them with specificity—fear that their answers will later be used against them. NADR suggested that form construction contributes to this concern. If SSA is able to confirm this concern, addressing it may improve response rates. Ensuring that questionnaires and other tools available for record development are used early in the adjudication process has the potential to improve the quality of decisionmaking at the state and federal adjudicative levels, as well as to bolster the administrative record for decisionmaking.

The Office of the Chairman is not, at this time, recommending that SSA permit adjudicators to develop the record using social media, criminal record history, or other similarly extraneous tools. Although we understand that some individuals plausibly believe that these resources could provide valuable information about a claimant's credibility, we have already suggested that SSA should move away from treating subjective symptom evaluation as a character evaluation. We recognize that some tools may well provide adjudicators with information about the functional limitations a claimant suffers, but we share SSA's due process concerns where such information is potentially falsifiable, may be difficult to corroborate, or may be viewed out of context or with limited description.⁴⁶⁹ For example, it may be difficult to verify when photographs of a claimant were taken and hence to know whether they support or conflict with ongoing claims of functional limitation. Such evidence could counter a claim of limitations and hence be of probative value, but it would also be possible for a claimant to offer false or manipulated photographs or online postings to support a claim for benefits. While it is true that a claimant could be asked about such evidence where an in-person hearing is held at the hearing-office level of review, investigations into the veracity of such resources may be difficult at the DDS level or in the absence of an adversarial hearing process. Moreover, SSA's resources for record development are limited, and agency adjudicators already feel constrained by resource limitations.

3. OДАР should revise the Findings Integrated Template program, or successor technologies, to prompt hearing level adjudicators evaluating subjective symptoms to consider the applicability of each the regulatory factors as well as to explain the influence of applicable factors on the decision.

At the initial and reconsideration levels, the eCAT tool already prompts decisionmakers to consider each of the regulatory factors in evaluating subjective symptoms, where appropriate. Where symptom evaluation occurs, adjudicators are also required to provide a narrative explanation of their overall assessment, regardless of their conclusions about how subjective symptoms affect the individual's functional limitations and restrictions. Although data is not presently available to permit the Office of the Chairman to evaluate use of these tools by DDS decisionmakers, the agency's efforts to prompt consideration of the regulatory factors and articulation of the decision rationale at the initial and reconsideration levels are nevertheless a model for the hearing office level of administrative review.

At the hearing office level, as former Commissioner Astrue has testified, use of FIT software has not only improved the quality of written decisions but has also reduced processing

time for claims (and therefore claimants). ALJs have found that the templates improve the quality of their decisionmaking and help them to review and edit decisions more quickly. Despite these benefits, adjudicator reliance on the Findings Integrated Template language on credibility has drawn the criticism of federal judges. Judicial criticism centers on adjudicator failure to clearly articulate the reasoning underlying a finding that a claimant's statements regarding his or her subjective symptoms are not credible or not entirely credible.

We are reluctant to recommend that SSA forego the administrative benefits of FIT use in response to judicial feedback based on review of a marginal percentage of cases administered by the agency, but we agree that further revisions to template language are warranted. SSA's present FIT guidance to adjudicators and decision writers directs them to "evaluate each allegation in light of the objective medical evidence and other evidence regarding the relevant factors listed in the symptoms regulations and SSR 96-7p."⁴⁷⁰ Evidently, more specific direction is necessary.

ODAR should revise its FIT program to specifically enumerate each of the regulatory subjective symptom evaluation steps and factors, where applicable, and to prompt adjudicators and decision writers to select whether each regulatory factor is relevant to the evaluation. ODAR should capture this information as structured data. We recognize that requiring adjudicators to "check boxes" as part of the decisionmaking process could draw objections from critics who believe that SSA's ALJs are already overreliant on the agency's templates. Nonetheless, we believe that the benefits of structured data capture, including in the large volume of cases that are not appealed to federal court, outweigh this potential disadvantage.

At the hearing level, where an agency decisionmaker indicates that one of the enumerated regulatory factors factored into his or her subjective symptom evaluation, the adjudicator should be prompted to articulate his or her reasoning through specific reference to evidence of record. We make this suggestion bearing in mind the administrative burden that *requiring* detailed analysis of each of the regulatory factors in all cases would impose, particularly given the high volume of cases at the initial and reconsideration levels as well as in hearing office level cases where some may be inapposite. Consistent with the decisions of the Tenth and the Fourth Circuits—and Eastern District of New York precedent notwithstanding—we do not recommend a regulatory or policy change that would impose this burden on adjudicators for factors that are not relevant to the evaluation. Nonetheless, we think that requiring this specific articulation at the hearing office level for relevant factors would address concerns with inadequately explained decisions and with decision writing tools.

4. SSA should analyze structured data about subjective symptom evaluation.

Structuring information capture about subjective symptom evaluation, as SSA does at the initial and reconsideration levels through the eCAT tool, can permit the agency to better understand the frequency with which subjective symptoms contribute to a finding of disability, as well the basis for deciding claims involving subjective symptoms (*i.e.*, due to lack of a medically determinable impairment that could reasonably be expected to produce them, where they are substantiated by objective medical evidence, or after consideration of one or more applicable regulatory factors). To ensure that adequate data is available for review, and to permit the agency to identify and understand potential annual variance and trends over time, SSA should capture and

analyze information over several years prior to adopting any major regulatory changes based on its analysis.

This is not to say that the agency should wait several years to analyze existing data or to respond to information received. At the initial and reconsideration levels, SSA is already gathering a tremendous amount of information about subjective symptom evaluation. Useful insights are likely already obtainable from structured data contained in the more than ten million claims that have been decided using eCAT. Furthermore, beginning the analytical process now can help the agency to identify refinements to existing information technologies and structured data capture initiatives that would improve ongoing adjudications and future analyses.

For instance, eCAT presently captures structured data on subjective symptom evaluations, but review of fifty RPC files and interviews with SSA personnel indicate that occasionally narrative subjective symptom evaluations or direct observations about the claimant are located in other sections of eCAT. This insight might compel the agency to consider how best to consolidate all subjective symptom related information and to ensure that the structured response is consistent or reconciled with other evaluations in the record. In the same vein, SSA might also consider feedback from NADE urging it to locate the subjective symptom evaluation section of eCAT immediately following adjudicator analysis of whether a claimant has a medically determinable impairment so it can be considered also in determining whether a severe impairment exists.⁴⁷¹ To give a final example, if the agency found that “other” factors were important considerations in a large volume of subjective symptom evaluations, it could then explore ways to analyze the unstructured narrative information adjudicators provide and possibly to structure information capture about this catchall provision.

Analysis and review of structured subjective symptom evaluation data can help the agency to ensure that state DDS decisionmakers are complying with regulatory and policy requirements. This is also true at the hearing office level, where structured data on symptom evaluation is not presently captured, but where failure to adequately consider the regulatory factors is observed in eighteen to twenty-two percent (18-22%) of Appeals Council and judicial remands. The administrative burden of the subjective symptom regulations is significant in cases that require examination of seven regulatory factors, including the catch all “other” factors. This analysis appears to be something adjudicators struggle with at all levels of review.

Structuring information capture about this part of the process permits the agency not only to ensure consideration of the seven regulatory factors, but also to examine their continued empirical relevance. SSA’s regulations for subjective symptom evaluation were largely based on judicial directives from the 1980s, which are now three decades old. While the most prominent orders involved class-action litigation that was perhaps more broadly representative of past disability claimants than present-day judicial review (examining less than 2% of ALJ decisions and only about 0.5% of initial claims), their continued salience and applicability to modern day claimants is at least open to question and reconsideration. Structured data can provide the agency with an informed basis for such an inquiry.

When properly undertaken, structured data analysis and responsive policy actions can also promote the congressional goal of national uniform program administration.⁴⁷² For example, SSA might examine how frequently subjective symptoms selections (such as whether objective medical evidence substantiates subjective symptom complaints, or which regulatory factors were most

informative) are altered between the initial, reconsideration, and eventually hearing office levels of claim review. While DDS and ODAR-level comparisons might be complicated by additional record development at the hearing office level, SSA is capable of measuring the volume, type, and timing of evidentiary submissions at the hearing office level and can thus try to control for the impacts of new evidence received late in the administrative process.⁴⁷³ This may also help the agency to understand what types of records were determinative in cases where the subjective symptom evaluation changed on reconsideration or after a hearing. It might then consider ways to encourage development of determinative types of record information earlier in the adjudicative process so as to try and reduce the need for additional administrative review.

5. ODAR should provide targeted training to ALJs and should consider refining its remand reasons relating to subjective symptom evaluation.

ODAR's efforts to collect and analyze data about problematic decisionmaking at the hearing office level are remarkable and likely unparalleled within the federal government. They allow ODAR to identify recurring problem areas and to consider policy changes or offer direct feedback and additional training to adjudicators. This is a marked improvement from the past when, in the words of Judge Patricia Jonas, Executive Director of the Office of Appellate Operations in ODAR, SSA's "policy guidance and feedback to its ALJs was limited... [and] a remand order was the primary method of providing written feedback from the [Appeals Council] to ALJs."⁴⁷⁴ ODAR's data analytics have already helped it to recognize subjective symptom evaluation as a common basis for remand. ODAR is presently developing targeted training modules addressing each of the 170 reasons for remand it has identified.⁴⁷⁵ This training will be linked to ODAR's "How MI Doing" tool, which "gives adjudicators extensive information about the reasons their cases were subsequently remanded and allows them to view their performance in relation to the average of other ALJs in the office, region, and Nation."⁴⁷⁶

The major problem with credibility evaluation appears to be implementation of existing rules and policies. ALJ failure to discuss the appropriate credibility factors is the most frequently occurring credibility-related remand reason at the hearing office level identified through the agency's own analysis of Appeals Council and judicial remands of ALJ decisions. Conference staff analysis of appellate remands and sampled district court decisions in recent opinions citing SSR 96-7p also identified problems with the application of SSA's existing regulations and rules. More specifically, administrative decisions are remanded by federal courts due to:

- Problems in considering limitations in a claimant's daily activities imposed by symptoms, and in comparing these activities to those needed to sustain substantial gainful activity.
- Improper consideration of the absence of treatment, where treatment was unavailable, unadvisable, or occasionally even pursued, and in some cases where further record development was necessary.
- Reliance on conclusory or template language rather than specific analysis as required by SSR 96-7p.
- Requiring objective medical evidence of subjective symptoms.
- Unconsidered or inappropriately rejected medical evidence supporting subjective symptom complaints.

Stakeholders likewise raised concerns with some of these remand reasons and with policy implementation and administration more generally. The AALJ, NOSSCR, and NADR agree that there is room for improvement.

ODAR should ensure that the targeted training it provides to ALJs focuses on subjective symptom evaluation and addresses not only application of the regulatory factors but also the specific reasons for remand and implementation problem areas identified in federal case law. Training should offer adjudicators specific and, to quote NADR, “realistic” examples of each of the commonly identified problems in symptom evaluation, tied to the regulations and policy ruling. It should also illustrate proper application of the policies and guidance. (Due to the lack of systematic information regarding problematic subjective symptom evaluation at the DDS level, this recommendation is limited to the ODAR adjudicative level. SSA should consider ways to capture similar feedback at the DDS level, if any, such as through the quality review process.)

ODAR should also consider adding more specific remand reasons to those it uses in data collection and analysis. If the agency does implement more focused training, following this recommendation can help it to determine whether these issues continue to present problems for adjudicators, as well as to assess how training impacts performance in these areas.

Part I References:

¹ Factors contributing to the expectation of continued rising rates of chronic pain include: aging, obesity, medical advances, undermanagement of acute post-surgical pain, and increased understanding of chronic pain syndromes. PHILIP A. PIZZO, INST. OF MED., RELIEVING PAIN IN AMERICA 62-63 (2011).

² US\$2010, calculated using 2008 data. *Id.* at 91-92. In 2008, federal and state programs made \$99 billion in pain-related medical expenditures. The federal Medicare program bore \$65.3 billion of this financial burden, pain-related expenditures comprised fourteen percent (14%) of all Medicare costs in 2008. *Id.* at 93.

³ *Id.*

⁴ *Id.* at 86.

⁵ *Id.* at 86-87.

⁶ *Id.* at 87 (5.0-5.9 more days missed).

⁷ Social Security Act, Titles II and XVI. 42 U.S.C. §§ 401-34, 1381-85 (2014).

⁸ For the SSDI definition, *see* 42 U.S.C. § 416(i)(1) (“ . . . the term ‘disability’ means (A) inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or has lasted or can be expected to last for a continuous period of not less than 12 months, or (B) blindness . . . ”); 42 U.S.C. § 423; 20 C.F.R. § 404.1505(a). For the SSI definition, *see* 42 U.S.C. § 1382c(a)(3) (“an individual shall be considered to be disabled for purposes of this title if he is unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than twelve months”); 20 C.F.R. §§ 416.90, 416.906. Conceptually, however, “[t]here is no agreement on the definition and measurement of disability.” GOOLOO S. WUNDERLICH, INST. OF MED., THE DYNAMICS OF DISABILITY: MEASURING AND MONITORING DISABILITY FOR SOCIAL SECURITY PROGRAMS 4 (2002). In other government settings, such as for the purposes of preventing discrimination under the Americans with Disabilities Act of 1990, disability or handicap may have a very different definition. MARIAN OSTERWEIS ET AL., INST. OF MED., PAIN AND DISABILITY 34 (1987). Only the Social Security Act definition is used in this report.

⁹ Soc. Sec. Admin., SSA Fiscal Year Disability Claim Data, *available at* <http://www.ssa.gov/disability/data/ssa-sa-fywl.htm> (last visited July 7, 2014) (individuals may re-apply in consecutive years).

¹⁰ SOC. SEC. ADMIN., PROGRAM OPERATIONS MANUAL SYS., 12015.100, DISABILITY REDESIGN PROTOTYPE MODEL, *available at* <https://secure.ssa.gov/poms.nsf/lnx/0412015100> (last visited Feb. 02, 2015).

¹¹ *Id.*

¹² Soc. Sec. Admin., SSAR 99-4 (11), Titles II and XVI: Judicial Review of an Appeals Council Dismissal of a Request for Review of an Administrative Law Judge Decision, *Bloodsworth v. Heckler*, 703 F.2d 1233 (11th Cir. 1983), *available at* http://www.ssa.gov/OP_Home/rulings/ar/11/AR99-04-ar-11.html (last visited Feb. 2, 2015).

¹³ Tom Johns, Branch Chief, Disability Quality Branch, Office of Quality Performance, Presentation to the Occupational Information Development Advisory Panel, SSA’s Sequential Evaluation Process for Assessing Disability (2009), *available at* <https://www.socialsecurity.gov/oidap/Documents/Social%20Security%20Administration.%20%20SSAs%20Sequential%20Evaluation.pdf> (last visited Sept. 2, 2014). Disability determinations for children follow a different sequential evaluation process. 20 C.F.R. § 416.924.

¹⁴ *Id.* at 11.

¹⁵ 20 CFR §§ 404.1529, 416.929.

¹⁶ SSDI, 42 U.S.C. §§ 416(i)(1), 423(d)(3); 20 C.F.R. § 404.1505(a). SSI, 42 U.S.C. § 1382c(a)(3); 20 C.F.R. §§ 416.90, 416.906.

¹⁷ 20 C.F.R. pt. 404(P) app. 1 pt. A (musculoskeletal system: spinal arachnoiditis, lumbar spinal stenosis, herniated nucleus pulposus, osteoarthritis, degenerative disk disease, facet arthritis, and vertebral fracture; cardiovascular system: ischemic heart disease, peripheral vascular disease, and aneurysm).

¹⁸ 20 C.F.R. pt. 404(P) app. 1 pt. B.

¹⁹ 20 C.F.R. pt. 404(P) app. 1 pt. A. For example, spinal arachnoiditis “is a condition characterized by adhesive thickening of the arachnoid which may cause intermittent ill-defined burning pain and sensory dysesthesia. . . . Individuals with arachnoiditis, particularly when it involves the lumbosacral spine, are generally unable to sustain any given position or posture for more than a short period of time due to pain.” *Id.* at § 1.00 K 2(a)-(b).

²⁰ 20 C.F.R. §§ 404.1529(d)(2), 416.929(d)(2).

²¹ *Id.* at §§ 1.00, 4.00.

²² *Id.* at § 1.00 B 2(a).

²³ *Id.* at § 4.00 In comparison, chest pain is a common symptom of many respiratory disorders, but pain is not identified as medical criteria for any specific respiratory disorder. *Id.* at § 3.00.

²⁴ Musculoskeletal impairments: arachnoiditis, osteoarthritis, back disorders, vertebral fracture; cardiovascular impairments: chronic ischemic heart disease, peripheral vascular disease, aortic aneurysm; digestive impairments: inflammatory bowel disease (IBD); hematological impairments: hereditary hemotological anemia include sickle cell; immune system impairments: diffuse diseases of connective tissue (including polymyositis and dermatomyositis), symptomatic human immunodeficiency virus (HIV) infection.

²⁵ Pain may not occur in all claimants presenting with a particular impairment, even if pain could be used as a diagnostic tool if it were present. On the other hand, pain may be a symptom of a number of impairments for which it is not a primary diagnostic criterion.

²⁶ Soc. Sec. Admin., SSR 96-7p, Titles II and XVI: Evaluation of Symptoms in Disability Claims: Assessing the Credibility of an Individual's Statements, 61 Fed. Reg. 34,483, 34,484 (July 2, 1996) [hereinafter SSR 96-7p]. The focus of the report is on adjudicatory evaluation of a claimant's own statements about his or her symptoms under 20 C.F.R. §§ 404.1529 and 416.929. The scope of work excluded adjudicator examination of evidence or opinions from "acceptable medical sources" and "other sources" under 20 C.F.R. §§ 404.1513(a) and 416.913(a); 20 C.F.R. §§ 404.1513(d) and 416.913(d).

Part II References:

²⁷ See OSTERWEIS, *supra* note 8.

²⁸ Soc. Sec. Amendments of Aug. 1, 1956, Pub. L. No. 880 § 103(a), 70 Stat. 807) (codified as amended in scattered sections of 20 U.S.C.) (adding a new Section 223(c)(2) to Title II of the Social Security Act providing for disability insurance benefit payments with a definition of disability as follows: "The term 'disability' means inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment..."); see OSTERWEIS, *supra* note 8, at 22-28 (describing the early history of the Social Security program and the decisions that led to the program relying on a medical determination of disability, as well as physician opposition to such a standard). This policy remains in effect today for the social security disability insurance, and was also adopted for the supplemental security income assistance program. *Supra* notes 8 - 16.

²⁹ See OSTERWEIS, *supra* note 8.

³⁰ David Agastein, *Beyond the Threshold: Wincing at Social Security's Process of Evaluating Pain*, 17 J. NAT'L ASS'N ADMIN. L. JUDGES 231, 261 (1997).

³¹ *Ber v. Celebrezze*, 332 F.2d 293 (2d Cir. 1964); *Page v. Celebrezze*, 311 F.2d 757 (5th Cir. 1963).

³² *Simpson v. Schweiker*, 691 F.2d 966, 970 (11th Cir. 1982); *Marcus v. Califano*, 615 F. 2d 23, 27 (2d Cir. 1979) (citing, among other cases, *Celebrezze v. Warren*, 339 F.2d 833, 837-38 (10th Cir. 1964)); *Sayers v. Gardner*, 380 F.2d 940, 948 (6th Cir. 1967); *Page*, 311 F.2d at 757, 762-63.

³³ *Stark v. Weinberger*, 497 F.2d 1092, 1097 (7th Cir. 1974); *Bittel v. Richardson*, 441 F.2d 1193, 1194 (3d Cir. 1971).

³⁴ *Gold v. Secretary of Health, Educ. and Welfare*, 463 F.2d 38, 41 (2d Cir. 1972) (internal citation omitted); *Conklin v. Celebrezze*, 319 F.2d 569, 571 (7th Cir. 1963) (citing *Yeager v. Flemming*, 282 F.2d 779, 782 (5th Cir. 1960); *Folsom v. Poteet*, 235 F.2d 937 (9th Cir. 1956)).

³⁵ *E.g.*, *Sayers v. Gardner*, 380 F.2d 940, 948 (6th Cir. 1967); *Celebrezze*, 311 F.2d at 757, 763.

³⁶ Soc. Sec. Amendments of Jan. 2, 1968, Pub. L. No. 90-248 § 158(b), 81 Stat. 821 (codified as amended in scattered sections of 20 U.S.C.) (adding the definition of disability to Section 223 of the Social Security Act; defining a "physical or mental impairment" as "an impairment that results from anatomical, physiological, or psychological abnormalities which are demonstrable by medically acceptable clinical and laboratory diagnostic techniques.").

³⁷ *E.g.*, *Ware v. Schweiker*, 651 F.2d 408, 412 (5th Cir. 1981); *Marcus v. Califano*, 615 F. 2d 23, 27 (2d Cir. 1979).

³⁸ *E.g.*, *Bates v. Sullivan*, 894 F.2d 1059, 1068-70 (9th Cir. 1990) (discussing non-uniformity and inconsistency in the Ninth Circuit's own precedent); *Walker v. Bowen*, 834 F.2d 635, 641 (7th Cir. 1987) ("a claim of pain may be discounted if it is not borne out by objective medical evidence").

³⁹ See OSTERWEIS, *supra* note 8, at 56-57 ; Jon C. Dubin, *Poverty, Pain and Precedent*, 25 ST. MARY'S L.J. 81, 118 (1993) (describing public objection to 1980 regulations promulgated by SSA as in conflict with established judicial precedent recognizing that pain itself could be disabling).

⁴⁰ 45 Fed. Reg. 55,584 (Aug. 20, 1980) (codified at 20 C.F.R. 404.1529 (1980)).

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- ⁴¹ Soc. Sec. Admin., SSR 82-58, Titles II and XVI: Evaluation of Symptoms, 1982 WL 31378 (Jan. 1, 1982) (discussed in Dubin, *supra* note 39, at 119-20).
- ⁴² The Office of the Chairman was unable to review the prior POMS directive, which SSA no longer maintains a record of, and is relying on its analysis in *Samuels v. Heckler*, 668 F. Supp. 656, 660-64 (W.D. Tenn. 1986).
- ⁴³ Soc. Sec. Amendments of June 9, 1980, Pub. L. No. 96-265 § 311, 94 Stat. 441 (codified as amended in scattered sections of 20 U.S.C.).
- ⁴⁴ See OSTERWEIS, *supra* note 8.
- ⁴⁵ *Polaski v. Heckler*, 739 F.2d 1320, 1321-22 (8th Cir. 1984).
- ⁴⁶ *Id.*
- ⁴⁷ *Id.*
- ⁴⁸ *Id.* (emphasis in original).
- ⁴⁹ SOC. SEC. ADMIN., HEARINGS, APPEALS, AND LITIG. LAW MANUAL I-5-4-7 (Aug. 2, 1989), available at http://ssa.gov/OP_Home/hallex/I-05/I-5-4-7.html#i-5-4-7-v (last visited Sept. 2, 2014).
- ⁵⁰ See *Hyatt v. Heckler (Hyatt I)*, 757 F.2d 1455 (4th Cir. 1985). In this case, the Fourth Circuit rejected the district court's findings that claims relating to pain and subjective complaints were adjudicated improperly, but it later adopted those findings in *Hyatt v. Heckler (Hyatt II)*, 807 F.2d 376 (4th Cir. 1986). See also *Hyatt v. Sullivan (Hyatt III)*, 899 F.2d 329 (4th Cir. 1990).
- ⁵¹ *Hyatt v. Heckler (Hyatt II)*, 807 F.2d 376, 378 (4th Cir. 1986).
- ⁵² *Id.* at 380-81 (4th Cir. 1986) (citing *Bowen v. City of New York*, 476 U.S. 467 (1986)). The Supreme Court had remanded the Fourth Circuit's decision in *Heckler I* for reconsideration in light of *Bowen*. *Hyatt v. Bowen*, 476 U.S. 1167, 1167 (1986).
- ⁵³ *Hyatt II*, 807 F.2d at 381; *Bowen*, 476 U.S. at 1167; *Samuels v. Heckler*, 668 F. Supp. 656 (W.D. Tenn. 1986).
- ⁵⁴ Social Security Disability Benefit Reform Act of Oct. 9, 1984, Pub. L. No. 98-460 § 3, 98 Stat. 1794 (codified as amended in scattered sections of 20 U.S.C.) (amending the definition of disability in the Social Security Act's Section 223(d)(5)). The same law also required a more stringent legal standard for the conduct of continuing disability reviews—permitting disqualification only upon a showing of medical, therapeutic, or technological improvement related to his or her ability to work—and SSA implemented a temporary moratorium on disqualification. *Id.* at § 2; U.S. GEN. ACCOUNTING OFFICE, GAO/HEHS-98-198 SSA MAKING PROGRESS IN CONDUCTING DISABILITY REVIEWS 26 (1998), available at <http://www.gao.gov/assets/230/226195.pdf> (last visited Sept. 2, 2014).
- ⁵⁵ *E.g., Elam v. R.R. Ret. Bd.*, 921 F.2d 1210, 1213-1215 (11th Cir. 1991) (citing S. Rep. No. 466, 98th Cong., 2d Sess. 23-24 (1984), for its statement that “[i]f courts ignore the Secretary's regulatory authority and the expressed Congressional concerns for careful administration, national uniformity and verifiable evidence, the Committee has little choice but to draw the statute as narrowly as possible.”).
- ⁵⁶ *Id.* (describing the Ninth and Eleventh Circuits' prior decisions permitting a finding of disability based solely on subjective pain testimony, and the Eleventh Circuit's adoption of a new pain standard consistent with the Disability Benefit Reform Act of 1984); see also NANCY J. DAPPER ET AL., DEPT. OF HEALTH AND HUMAN SERVS., REPORT OF THE COMM'N ON THE EVALUATION OF PAIN 72 (1986) (“courts have deferred to the new statutory language and in some cases, gone so far as to find prior court rulings to be superseded”).
- ⁵⁷ *Samuels v. Heckler*, 668 F. Supp. 656, 665 (W.D. Tenn. 1986) (noting the mootness of the issue in light of the new statutory standard and subsequent implementing SSA directives).
- ⁵⁸ Unfortunately, the U.S. Code was never updated to remove the now defunct provision.
- ⁵⁹ Nancy J. Dapper ET AL., *Report of the Commission on the Evaluation of Pain*, 50:1 SOCIAL SECURITY BULLETIN 13, 39 (1987), available at <http://www.ssa.gov/policy/docs/ssb/v50n1/v50n1p13.pdf> (last visited Sept. 2, 2014).
- ⁶⁰ *Id.* (summarizing NANCY J. DAPPER ET AL., DEPT. OF HEALTH AND HUMAN SERVS., REPORT OF THE COMM'N ON THE EVALUATION OF PAIN xvii-xx (1986)).
- ⁶¹ See OSTERWEIS, *supra* note 8 at 265.
- ⁶² *Id.*
- ⁶³ *Id.* at 269.
- ⁶⁴ *Id.*
- ⁶⁵ *Id.*
- ⁶⁶ Soc. Sec. Admin., SSR 88-13, Titles II and XVI: Evaluation of Pain and Other Symptoms, 1988 WL 236011 (July 20, 1988).
- ⁶⁷ *Id.* at *2.
- ⁶⁸ A relatively discrete class action lawsuit in Colorado was settled by SSA in 1990 with an agreement to rehear certain denied claims in which pain was alleged to have been improperly evaluated. SSA agreed that on rehearing

its adjudicators would fully develop claims of pain using the six factors listed in SSR 88-13. SOC. SEC. ADMIN., HEARINGS, APPEALS, AND LITIG. LAW MANUAL I-5-4-24, *available at* http://www.ssa.gov/OP_Home/hallex/I-05/I-5-4-24.html (last visited Sept. 2, 2014).

⁶⁹ Soc. Sec. Admin., SSR 88-13, *supra* note 66; *Avery v. Sec’y of Health and Human Servs.*, 797 F.2d 19 (1st Cir. 1986) (publishing as an appendix POMS T00401.570, which the court found to commit SSA to consideration of what became known as the *Avery* regulatory factors and hence imposing a legal obligation in the First Circuit requiring SSA to consider treatment (other than medication) for relief of pain).

⁷⁰ *Howell v. Sullivan*, 950 F.2d 343, 347-48 (7th Cir. 1991); *Bunnell v. Sullivan*, 947 F.2d 341, 346 (9th Cir. 1991).

⁷¹ *Pope v. Shalala*, 998 F.2d 473, 483-86 (7th Cir. 1993) (discussing prior policy); *Walker v. Bowen*, 834 F.2d 635, 641 (7th Cir. 1987) (“a claim of pain may be discounted if it is not borne out by objective medical evidence”).

⁷² *Hyatt v. Heckler*, 711 F. Supp. 837, 844-48 (W.D.N.C. 1989).

⁷³ *Id.* at 841.

⁷⁴ *Hyatt v. Sullivan*, (*Hyatt III*), 899 F.2d 329, 336 (4th Cir. 1990).

⁷⁵ Soc. Sec. Admin., SSR 90-1p, Titles II and XVI: Evaluation of Pain and Other Symptoms, 55 Fed. Reg. 31898-02 (Aug. 6, 1990).

⁷⁶ U.S. GOV. ACCOUNTABILITY OFFICE, GAO-07-331, SSA HAS TAKEN STEPS TO ADDRESS CONFLICTING COURT DECISIONS, BUT NEEDS TO MANAGE DATA BETTER ON THE INCREASING NUMBER OF REMANDS 40 (Apr. 5, 2007).

⁷⁷ *Stieberger v. Sullivan*, 792 F. Supp. 1376 (S.D.N.Y. 1992).

⁷⁸ *Stieberger v. Sullivan*, 738 F. Supp. 716, 755 (S.D.N.Y. 1990).

⁷⁹ *Id.* at 741, 758-59.

⁸⁰ *Id.* at 741-44 (citing findings of the Social Security Acquiescence Task Force).

⁸¹ SOC. SEC. ADMIN., HEARINGS, APPEALS, AND LITIG. LAW MANUAL I-5-4-13, *available at* http://www.ssa.gov/OP_Home/hallex/I-05/I-5-4-13.html#i-5-4-13-att-a (last visited Sept. 2, 2014).

⁸² *Id.*

⁸³ Soc. Sec. Admin., *Evaluation of Symptoms, Including Pain*, 56 Fed. Reg. 57, 928 (Nov. 14, 1991).

⁸⁴ *Id.*

⁸⁵ Soc. Sec. Admin., SSR 95-5p, Titles II and XVI: Considering Allegations of Pain and Other Symptoms in Residual Functional Capacity and Individualized Functional Assessments and Explaining Conclusions Reached, 60 Fed. Reg. 55,405, 55,406 (Oct. 31, 1995).

⁸⁶ *Id.*

⁸⁷ U.S. GEN. ACCOUNTING OFFICE, GAO/HEHS-97-102, SSA MUST HOLD ITSELF ACCOUNTABLE FOR CONTINUED IMPROVEMENT IN DECISIONMAKING 19 (1997), *available at* <http://www.gao.gov/products/HEHS-97-102>.

⁸⁸ Dept. of Health and Human Servs., Soc. Sec. Admin., *The Bellmon Report*, 45:5 SOC. SEC. BULLETIN 3, 14-15 (1982) *available at* <http://www.ssa.gov/policy/docs/ssb/v45n5/v45n5p3.pdf> (last visited Sept. 2, 2014) (finding at the Appeals Council and ALJ level that severe pain could, combined with significant impairments, preclude performance of substantial gainful activity whereas pain is a factor in DDS consideration of disability but is not the basis for a separate finding of disability).

⁸⁹ U.S. GEN. ACCOUNTING OFFICE, *supra* note 87, at 4. *See also Social Security Disability Programs Challenges and Opportunities: Hearing before the Subcomm. on Soc. Sec. of the H. Comm. On Ways & Means*, 107th Cong. 89, 143 (2002) (statement of Jeffrey H. Price, President, Nat’l Assoc. of Disability Exam’rs) (“[DDS] decisions do take into consideration the subjective findings such as pain and fatigue and the impact the alleged impairment is said to have on a claimant’s daily activities. However, DDS decisions are influenced to a lesser extent than decisions made by administrative law judges by these subjective findings. Where the disability examiner in the DDS is unable to conclude that there is an objective medical basis to support the claimant’s allegations of pain or fatigue, the subjective complaints are often disregarded, as required by law.”).

⁹⁰ U.S. GEN. ACCOUNTING OFFICE, *supra* note 87, at 36 (citing SOC. SEC. ADMIN, OFFICE OF PROGRAM AND INTEGRITY REVIEWS, FINDINGS OF THE DISABILITY HEARINGS QUALITY REVIEW PROCESS (Sept. 1994 and Mar. 1995)).

⁹¹ *Id.*

⁹² *Id.*

⁹³ *Id.* at 67.

⁹⁴ *Id.* at 41; *see also* ADMIN. CONF. OF THE U.S., RECOMMENDATION 87-6, *State-Level Determinations in Social Security Disability Cases* ¶ 1, 52 Fed. Reg. 49,142 (Dec. 30, 1987) (encouraging additional experimentation with face-to-face hearings and interviews during state evaluations of social security disability claimants).

⁹⁵ U.S. GEN. ACCOUNTING OFFICE, *supra* note 87, at 41 (citing DEP’T OF HEALTH AND HUMAN SERVS., OFFICE OF

THE INSPECTOR GEN., THE DISABILITY APPEALS PROCESS: ADMINISTRATIVE LAW JUDGE PERSPECTIVES (May 1994)).

⁹⁶ *Id.*

⁹⁷ Letter from Carolyn W. Colvin, Acting Comm. Soc. Sec. Admin. to the Hon. Harold Rogers, Chairman, Comm. on Appropriations U.S. House of Representatives 10 (Apr. 29, 2013), *available at* <http://www.ssa.gov/budget/FY13Files/2013COPCombined.pdf> (last visited Sept. 02, 2014).

⁹⁸ *See infra*, at **Part IV, Subpart A: SSA's electronic disability (eDib) process.**

⁹⁹ Soc. Sec. Admin., SSR 97-2p, Title II and Title XVI: Prehearing Case Review by Disability Determination Services, 62 Fed. Reg. 42,850 (Aug. 8, 1997).

¹⁰⁰ U.S. GEN. ACCOUNTING OFFICE, *supra* note 87, at 37.

Part III References:

¹⁰¹ *E.g.*, *Craig v. Chater*, 76 F.3d 585, 593 (4th Cir. 1996) (discussing the legal history of subjective symptom evaluation and observing that the 1991 regulations “provide the authoritative standard for the evaluation of pain in disability determinations . . . and control all determinations made since their effective date”); *McCoy v. Chater*, 81 F.3d 44, 47 (6th Cir. 1996) (rejecting challenge to regulations and finding consistency with pre-1991 precedent); *Pope v. Shalala*, 998 F.2d 473, 483-84 (7th Cir. 1993) (stating “we believe that the new regulations are entirely in line with the previous interpretations respecting the evaluation of pain” and deferring to the regulations after observing that the approach taken therein is consistent with that taken by every other circuit).

¹⁰² *E.g.*, *Wagner v. Apfel*, No. 98-2260, 1999 U.S. App. LEXIS 29887, at *11 (4th Cir. 1999) (citing regulations and prior precedent for the same proposition); *Walters v. Comm'r of Soc. Sec.*, 127 F.3d 525, 531 (6th Cir. 1997) (citing regulations and prior precedent for the same proposition); *Smolen v. Chater*, 80 F.3d 1273, 1281 n.1 (9th Cir. 1996) (“[T]he new regulations are consistent with the Commissioner’s prior policies and with prior Ninth Circuit caselaw.”); *Knight v. Chater*, 55 F.3d 309, 314 (7th Cir. 1995) (same); *Siemers v. Shalala*, 47 F.3d 299, 301 (8th Cir. 1995) (citing the new regulations as consistent with *Polaski*); *Jones v. Shalala*, 10 F.3d 522, 525 (7th Cir. 1993) (“We have recently modified our position on evaluating a claimant’s subjective symptoms of pain in accordance with the Secretary’s recent clarifying regulations.”); *Williams v. Sullivan*, 970 F.2d 1178, 1186 (3rd Cir. 1992) (citing regulations and prior precedent for the same proposition); *Elam v. R.R. Ret. Bd.*, 921 F.2d 1210, 1213-15 (11th Cir. 1991) (discussing the evolution of the pain standard in the 11th Circuit and the validity of the 1991 regulations despite the lapse in the statutory standard).

¹⁰³ *Pope*, 998 F.2d at 473, 485-86.

¹⁰⁴ SSA recently settled a class-action lawsuit where a primary complaint was that certain administrative law judges were biased in their evaluation of claimant’s subjective complaints of pain. Complaint, *Padro v. Astrue*, CV11-1788 (E.D.N.Y. Apr. 12, 2011), *available at* http://www.aadpr.org/pdf_files/Padro_v_Astrue.pdf (last visited Sept. 4, 2014).

¹⁰⁵ SOC. SEC. ADMIN., HEARINGS, APPEALS, AND LITIG. LAW MANUAL I-5-4-71, PADRO ET AL. V. COLVIN (May 20, 2014), *available at* http://www.ssa.gov/OP_Home/hallex/I-05/I-5-4-71.html (last visited Sept. 4, 2014).

¹⁰⁶ 20 C.F.R. pt. 404(P) app. 1 pt. A § 12.07 (defining somatoform disorders as “[p]hysical symptoms for which there are no demonstrable organic findings or known physiological mechanisms” and requiring medically documented evidence to establish that the level of severity for the disorder is met under the listing); *Latham v. Shalala*, 36 F.3d 482, 484 (5th Cir. 1994) (somatoform disorders); *Carradine v. Barnhart*, 360 F.3d 754 (7th Cir. 2004); *Craig-Cook v. Colvin*, 2014 U.S. Dist. LEXIS 50594 (N.D. Tex. 2014); *Kent v. Apfel* 75 F. Supp. 2d 1170 (D. Kan. 1999).

¹⁰⁷ 42 U.S.C. § 423 (incorporated by reference into the SSI program at 42 U.S.C. § 1382(c)(3)(H)(i)).

¹⁰⁸ 42 U.S.C. § 423(d)(3).

¹⁰⁹ 42 U.S.C. §§ 423(d)(2)(a), 423(d)(3), 1382c(a)(3)(A), 1382c(a)(3)(D) (2013).

¹¹⁰ 20 C.F.R. §§ 404.1520(d), 416.929(d) (2013); *see also* Soc. Sec. Admin., SSR 96-4p, Titles II and XVI: Symptoms, Medically Determinable Physical and Mental Impairments, and Exertional and Nonexertional Limitations, 61 Fed. Reg. 34,488 (July 2, 1996) [hereinafter SSR 96-4p].

¹¹¹ 20 C.F.R. §§ 404.1569a(a), 416.969a(a) (2013).

¹¹² 20 C.F.R. §§ 404.1529(a)-(b), 416.929(a)-(b) (2013).

¹¹³ 20 C.F.R. §§ 404.1529(b), 416.929(b) (2013) (the intensity, persistence, or functionally limiting effects of symptoms may be considered in determining whether an impairment is severe or in assessing a claimant’s residual functional capacity at step two of the symptom evaluation process); Soc. Sec. Admin., SSR 96-3p, Titles II and XVI: Considering Allegations of Pain and Other Symptoms in Determining Whether a Medically Determinable

Impairment is Severe, 61 Fed. Reg. 34,468 (July 2, 1996) [hereinafter SSR 96-3p].

¹¹⁴ 20 C.F.R. §§ 404.1529(b), 416.929(b) (2013).

¹¹⁵ 20 C.F.R. §§ 404.1529(a), (c), 416.929(a), (c) (2013).

¹¹⁶ 20 C.F.R. §§ 404.1529(c)(2), 416.929(c)(2) (2013).

¹¹⁷ *Id.*, see also *Pope v. Shalala*, 998 F.2d 473, 483-86 (7th Cir. 1993).

¹¹⁸ 20 C.F.R. §§ 404.1529(c)(3)-(4), 416.929(c)(3)-(4) (2013).

¹¹⁹ 20 C.F.R. §§ 404.1545, 416.945 (2013).

¹²⁰ 20 C.F.R. §§ 404.1529(c)(3), 416.929(c)(3) (2013).

¹²¹ *Id.*

¹²² 20 C.F.R. §§ 404.1569a, 416.969a (2013).

¹²³ 20 C.F.R. § 402.35(b)(1) (“These rulings represent precedent final opinions and orders and statements of policy and interpretations that we have adopted.”).

¹²⁴ SSR 96-3p, *supra* note 113; see also 20 C.F.R. §§ 404.1529(d), 416.929(d) (2013).

¹²⁵ SSR 96-4p, *supra* note 110; see also 20 C.F.R. §§ 404.1569a, 416.969a (2013).

¹²⁶ *Heckler*, 739 F.2d at 1320.

¹²⁷ *E.g.*, *Lester v. Chater*, 81 F.3d 821, 833 (9th Cir. 1996) (amending 1995 decision referencing ALJ findings that “claimant’s testimony on his pain limitations was not fully credible”); *Mickels v. Shalala*, 29 F.3d 918, 921 (4th Cir. 1994); 35 F.3d 1027, 1034 (ALJ held that Rice “claimant’s pain testimony at the hearing was not fully credible”); *Bunnell v. Sullivan*, 947 F.2d 341, 342-43 (9th Cir. 1991); *Felisky v. Bowen*, 35 F.3d 1027, 1034 (6th Cir. 1994) (“claimant’s pain testimony at the hearing was not fully credible”); *Williams v. Bowen*, 844 F.2d 748, 754 (10th Cir. 1988) (citing Appeals Council opinion holding that the claimant’s subjective complaints were “not fully credible in light of the objective findings.”); *Morris v. Sec’y of Health & Human Servs.*, No. 86-5875, 1988 U.S. App. LEXIS 5113, at *7 (6th Cir. 1988) (citing 1985 ALJ decisions that found “claimant’s testimony is not fully credible”); *Beavers v. Sec’y of Health, Ed., & Welfare*, 577 F.2d 383, 386 (6th Cir. 1978).

¹²⁸ See FED. R. CIV. P. 52(a)(6) (“Findings of fact, whether based on oral or other evidence, must not be set aside unless clearly erroneous, and the reviewing court must give due regard to the trial court’s opportunity to judge the witnesses’ credibility.”); FED. R. BANKR. P. 8013 (“Findings of fact, whether based on oral or documentary evidence, shall not be set aside unless clearly erroneous, and due regard shall be given to the opportunity of the bankruptcy court to judge the credibility of the witnesses.”); FED. R. EVID. 104(e), 607-611, 806 (rules regarding witness and declarant credibility); see also Tania Galloni, *Keeping It Real: Judicial Review of Asylum Credibility Determinations in the Eleventh Circuit After the REAL ID Act*, 62 U MIAMI L. REV. 1037 (2008).

¹²⁹ See *Walden v. Schweiker*, 672 F.2d 835, 839 (11th Cir. 1982); see also *Mark v. Celebrezze*, 348 F.2d 289, 292 (9th Cir. 1965) (“it may be necessary . . . to determine the truthfulness of allegations of subjective pain”).

¹³⁰ SSR 96-7p, *supra* note 26, at 43,484 (July 2, 1996) (“The adjudicator must then make a finding on the credibility of the individual’s statements about symptoms and their functional effects.”).

¹³¹ See, *e.g.*, BLACK’S LAW DICTIONARY, POCKET EDITION 155-56 (1996) (defining credibility as the “quality that makes something (as a witness or some evidence) worthy of belief”).

¹³² FED. R. EVID. 608 (emphasis added); see also FED. R. EVID. 609 (setting forth circumstances under which a witness’s “character for truthfulness” may be attacked by introducing evidence of his or her conviction of a crime).

¹³³ Perhaps the best known example is the National Labor Relations Board, whose “established policy is not to overrule an administrative law judge’s credibility resolutions unless the clear preponderance of all the relevant evidence convinces us that they are incorrect.” *Don Chavas, LLC*, 361 NLRB No. 1 n. 1 (2014) (citations omitted). Another example is the Board of Immigration Appeals (BIA), which “accords deference” to an administrative judge’s findings concerning credibility . . . even when it reviews a case de novo. The BIA grants [such] deference . . . because the judge personally observes the petitioner’s testimony.” *Mayo v. Ashcroft*, 317 F.3d 867, 870-71 (8th Cir. 2003) (internal quotations marks and citations omitted).

¹³⁴ The APA does not require an agency to accord any deference to the decision of an administrative law judge in an intra-agency appeal of a hearing conducted “on the record,” even as to questions of fact, unless its own rules require otherwise. 5 U.S.C. § 557(b).

¹³⁵ See, *e.g.*, *United States v. Earnest*, 129 F.3d 906, 911 (7th Cir. 1997). The approach is reflected in the Federal Rules of Civil Procedure, which provide that “[f]indings of fact . . . must not be set aside unless clearly erroneous, and the reviewing court must give due regard to the trial court’s opportunity to judge the witness’s credibility.” FED. R. CIV. P. 52(a)(6). Early on, some appellate courts only accorded deference to those findings of fact by a district court involving credibility determinations. They reviewed all other findings of fact de novo. See *Anderson v. Bessemer City*, 470 U.S. 564, 574-75 (1985). Rule 52(a)(6) of course supplants that approach. See *id.* at 575-76.

¹³⁶ SSR 96-7p, *supra* note 26.

¹³⁷ *Id.*

¹³⁸ 20 C.F.R. § 404.1529(a), 416.929(a).

¹³⁹ SOC. SEC. ADMIN., PROGRAM OPERATIONS MANUAL SYS., DI 22510.011, USE OF PAIN SPECIALISTS AND/OR PAIN CENTERS (CLINICS) AS CE SOURCES (May 06, 2008).

¹⁴⁰ Letter from James Lankford, Chairman of the H. Subcomm. on Energy Policy, Healthcare, and Entitlements, and Jackie Spier, Ranking Member of the H. Subcomm. on Energy Policy, Healthcare and Entitlements, to Carolyn Colvin, Comm’r of Soc. Sec. 8 (Apr. 8, 2014), *available at* <http://oversight.house.gov/wp-content/uploads/2014/04/2014-04-08-Lankford-Speier-to-Colvin-SSA-SSDI-SSI-federal-disability-programs.pdf> (last visited Sept. 2, 2014).

¹⁴¹ Enclosure in Letter from Carolyn Colvin, Acting Comm’r of Soc. Sec., to the Honorable Darrell Issa, Chairman of the H. Comm. on Oversight and Gov’t Reform 3 (July 9, 2014).

¹⁴² *Id.* at 4.

¹⁴³ SOC. SEC. ADMIN., PROGRAM OPERATIONS MANUAL SYS., DI 22510.006, WHEN NOT TO PURCHASE A CONSULTATIVE EXAMINATION (CE) (“Do not purchase symptom validity tests (SVT) to address issues of credibility or malingering as part of a CE. Tests cannot prove whether a claimant is credible or malingering because there is no test that, when passed or failed, conclusively determines the presence of inaccurate self-reporting.”) [hereinafter POMS DI 22510.006]; SOC. SEC. ADMIN, DDS ADMIN. LETTER 866, CONSULTATIVE EXAMINATIONS MALINGERING & CREDIBILITY TESTS—INFORMATION 1-2 (Jan. 26, 2012).

¹⁴⁴ SOC. SEC. ADMIN., DDS ADMIN. LETTER 866, CONSULTATIVE EXAMINATIONS MALINGERING & CREDIBILITY TESTS—INFORMATION 1 (Jan. 26, 2012).

¹⁴⁵ SOC. SEC. ADMIN., OFFICE OF THE INSPECTOR GEN., A-08-13-23094, CONGRESSIONAL RESPONSE REPORT: THE SOCIAL SECURITY ADMINISTRATION’S POLICY ON SYMPTOM VALIDITY TESTING IN DETERMINING DISABILITY CLAIMS 3 (Sept. 2013) (citing SOC. SEC. ADMIN, CHIEF ADMIN. LAW JUDGE MEMORANDUM TO ALL ADMIN. LAW JUDGES, MALINGERING AND CREDIBILITY TESTS—INFORMATION (July 30, 2012)) [hereinafter OIG, SVT REPORT].

¹⁴⁶ POMS DI 22510.006, *supra* note 143 (“NOTE: When the results of SVT are part of the medical evidence of record, we consider them along with all of the relevant evidence in the case record.”).

¹⁴⁷ OIG, SVT REPORT, *supra* note 145, at Appx. D-1 (Sept. 2013) (response from SSA).

Part IV References:

¹⁴⁸ For example, federal regulations limit federal agency guidance and oversight of individual state agency employees, particularly with regard to selection, tenure, and compensation of individual employees. 20 C.F.R. §§ 404.1621(b), 416.1021(b).

¹⁴⁹ 42 U.S.C. § 421(a).

¹⁵⁰ 42 U.S.C. § 421 (a)(2).

¹⁵¹ 42 U.S.C. § 421(k).

¹⁵² 20 C.F.R. §§ 404.1603(a), 416.1003(a) et seq.

¹⁵³ 20 C.F.R. §§ 404.1615(e)-(f), 416.1015(e)-(f).

¹⁵⁴ SOC. SEC. ADMIN., PROGRAM OPERATIONS MANUAL SYS., DI 80850.001, OFFICE OF HEARINGS AND APPEALS (OHA) HEARING OFFICE (HO) ELECTRONIC DISABILITY (eDIB) PROCEDURES – CERTIFIED ELECTRONIC PROCESS, *available at* <https://secure.ssa.gov/poms.nsf/lnx/0480850001> (last visited Feb. 02, 2015) [hereinafter POMS DI 808.50.001].

¹⁵⁵ *Id.*

¹⁵⁶ *Id.*

¹⁵⁷ POMS DI 80850.001, *supra* note 154.

¹⁵⁸ See IT DASHBOARD, INTELLIGENT DISABILITY, *available at* <https://itdashboard.gov/investment?buscid=592> Operational Performance (last visited Feb. 02, 2015) (Investments: DDS Automation, Disability Case Processing System, Intelligent Disability, SSI Modernization).

¹⁵⁹ POMS DI 80850.001, *supra* note 154.

¹⁶⁰ Telephone interview with Jill Michels, eCAT Team Leader, Electronic Policy Applications Branch, Office of Disability Policy and Debra Gardiner, Electronic Services Division Director, Division of Electronic Services, Office of Disability Adjudication and Review (ODAR), Social Security Administration (Oct. 21, 2014) [hereinafter Oct. 21, 2014 telephone interview].

¹⁶¹ SOC. SEC. ADMIN., PROGRAM OPERATIONS MANUAL SYS., 11005.045, COMPLETING THE PAPER FORM SSA-3367-F5 (DISABILITY REPORT – FIELD OFFICE), *available at* <https://secure.ssa.gov/poms.nsf/lnx/0411005045> (last visited

Feb. 02, 2015). *See also* POMS DI 80850.001, *supra* note 154; SOC. SEC. ADMIN., PROGRAM OPERATIONS MANUAL SYS., 11005.001, Field Office Disability Interviews, *available at* <https://secure.ssa.gov/poms.nsf/lnx/0411005001> (last visited Feb. 02, 2015).

¹⁶² POMS DI 80850.001, *supra* note 155. Field Office personnel also input a claimant's information into the Modernized Claim System (MCS) for disability insurance claims and the Modernized SSI Claims System (MSSCIS) for SSI claims. *See* SOC. SEC. ADMIN., OFFICE OF THE INSPECTOR GEN., A-15-06-16109, PERFORMANCE INDICATOR AUDIT: CLAIMS PROCESSING (Mar. 2007), *available at* <http://oig.ssa.gov/sites/default/files/audit/full/html/A-15-06-16109.html> (last visited Feb. 02, 2015). Data entered into these three systems propagate into the Case Processing and Management System (CPMS), which has been used at the ODAR hearing office level to process cases since 2004. POMS DI 80850.001, *supra* note 155.

¹⁶³ *Id.*

¹⁶⁴ SOC. SEC. ADMIN., OFFICE OF THE INSPECTOR GEN., *supra* note 162.

¹⁶⁵ eCAT Demonstration with Chuck Wansor, Branch Chief, Electronic Policy Applications Branch (EPAB), Office of Disability Policy (ODP) and Jill Michels, eCAT Team Leader, EPAB, ODP, Ann Vollmer, Policy Analyst, eCAT Team, EPAB, OHITEP, ODP, Melany Froio, Policy Analyst, eCAT Team, EPAB, OHITEP, ODP, Heather Murr, Policy Analyst, eCAT Team, EPAB, OHITEP, ODP, Brandy Mershon, Policy Analyst, eCAT Team, EPAB, OHITEP, ODP, Mary Quotroche, Supervisor, Office of Vocational, Evaluation and Process Policy (OVEPP), ODP, Veronica Gales Short, Policy Analyst, OVEPP, ODP, and Nancy Schoenberg, Senior Advisor, ODP (Oct. 31, 2014) [hereinafter Oct. 31, 2013 eCAT demonstration].

¹⁶⁶ Oct. 21, 2014 telephone interview, *supra* note 160; *see also*

SOC. SEC. ADMIN., PROGRAM OPERATIONS MANUAL SYS., 26510.001, COMPLETING FORM SSA-831 (DISABILITY DETERMINATION AND TRANSMITTAL), *available at* <https://secure.ssa.gov/poms.nsf/lnx/0426510001> (last visited Feb. 02, 2015).

¹⁶⁷ *Id.*

¹⁶⁸ *Id.* DDSs' are also directed to discuss whether controlling weight was given to treating source medical opinions, another common basis for judicial remands. Oct. 31, 2013 eCAT demonstration, *supra* note 165; *see also* G. JACOBS ET AL., SSA DISABILITY BENEFITS PROGRAM: ASSESSING THE EFFICACY OF THE TREATING PHYSICIAN RULE, Report to the Admin. Conf. of the U.S. and the Soc. Sec. Admin. (2013), *available at* <http://www.acus.gov/report/treating-physician-rule-report-final>.

¹⁶⁹ SOC. SEC. ADMIN., OFFICE OF THE INSPECTOR GEN., A-01-10-11010, PERFORMANCE INDICATOR AUDIT: CLAIMS PROCESSING 5 (Jan. 2011), *available at* http://oig.ssa.gov/sites/default/files/audit/full/pdf/A-01-10-11010_7.pdf (last visited Feb. 2, 2015) [hereinafter OIG, PERFORMANCE INDICATOR AUDIT].

¹⁷⁰ A 2011 OIG report indicated that some eCAT users were using eCAT after making the disability determinations, essentially filling in the decision rationale after the fact. *Id.* More recently, a 2014 interview with SSA personnel indicate that, in their experience, the tool is now being used as intended during case processing to guide decisionmaking. *Preventing Disability Scams: Hearing Before the Subcomm. on Soc. Sec. of the H. Comm. on Ways and Means*, 113th Cong. (Feb. 26, 2014) (statement of William B. Zielinski, Deputy Commissioner of Systems and Chief Information Officer), *available at* http://www.ssa.gov/legislation/testimony_022614.html (last visited Feb. 02, 2015).

¹⁷¹ Telephone interview with Nancy Schoenberg, Senior Advisor, Office of Disability Policy (ODP), Melissa Spenser, Deputy Associate Commissioner ODP, Office of Retirement and Disability Policy and Art Cardenas, Acting Deputy Associate Commissioner, Office of Disability Determinations (ODD), Office of Operations (Oct. 22, 2014) [hereinafter Oct. 22, 2014 telephone interview].

¹⁷² *Id.*

¹⁷³ SOC. SEC. ADMIN., ECAT USER MANUAL 9.0, 10 (Aug. 08, 2014).

¹⁷⁴ *Id.* at 14.

¹⁷⁵ *Id.* at 162; email from Jill Michels, eCAT Team Leader, Electronic Policy Applications Branch, Office of Disability Policy to Stephanie Tatham, Att'y Advisor, ADMIN. CONF. OF THE U.S. (Nov. 19, 2014) (on file with author) [hereinafter Nov. 19, 2014 email].

¹⁷⁶ Nov. 19, 2014 email, *supra* note 175.

¹⁷⁷ Memorandum from Linda Dorn, Associate Commissioner for Disability Determinations, on eCAT Full Roll Out and Implementation for Initial/Reconsideration Claims (July 18, 2014) (on file with author).

¹⁷⁸ *Id.*

¹⁷⁹ IT DASHBOARD, *supra* note 158.

¹⁸⁰ SOC. SEC. ADMIN (ORDP/ODP/ODPMI), ECAT EMIS REPORT (Dec. 2014).

¹⁸¹ Email from Nancy Schoenberg, Senior Advisor Office of Disability Policy to Stephanie Tatham, Att'y Advisor,

ADMIN. CONF. OF THE U.S. (Dec. 23, 2014) (on file with author).

¹⁸² Oct. 22, 2014 telephone interview, *supra* note 171.

¹⁸³ *Id.*

¹⁸⁴ OIG, PERFORMANCE INDICATOR AUDIT, *supra* note 169.

¹⁸⁵ SOC. SEC. ADMIN., PROGRAM OPERATIONS MANUAL SYS., DI 30005.005, TYPES OF FEDERAL QUALITY REVIEWS, *available at* <https://secure.ssa.gov/apps10/poms.nsf/lrx/0430005005> (last visited Feb. 02, 2015) [hereinafter POMS DI 30005.005].

¹⁸⁶ *Id.* An initial calendar-quarter quality review is used to calculate quarterly performance accuracy statistics, but additional monthly reporting is provided on an informational basis.

¹⁸⁷ 42 U.S.C. § 221(c) (PER of at least fifty percent of Title II and concurrent Title II/Title XVI initial and reconsideration determinations); Social Security Act Section 1633(e)(1) (PER of at least fifty percent of Title XVI adult initial and reconsideration determinations).

¹⁸⁸ Oct. 22, 2014 telephone interview, *supra* note 171.

¹⁸⁹ *Id.*, *see also* POMS DI 30005.005, *supra* note 185.

¹⁹⁰ *Id.*

¹⁹¹ SOC. SEC. ADMIN., PROGRAM OPERATIONS MANUAL SYS., GN 04440.003, EXPLANATION OF QUALITY REVIEW (QR) TERMS, *available at* [HTTPS://secure.ssa.gov/apps10/poms.nsf/lrx/0204440003](https://secure.ssa.gov/apps10/poms.nsf/lrx/0204440003) (last visited Feb. 02, 2015).

¹⁹² The standard of review is not *de novo*, but rather is based on a preponderance of the evidence. SOC. SEC. ADMIN., PROGRAM OPERATIONS MANUAL SYS., GN 04440.007, QUALITY REVIEW (QR) STANDARD, *available at* <https://secure.ssa.gov/apps10/poms.nsf/lrx/0204440007> (last visited Feb. 02, 2015). Nonetheless, quality reviewers must take care to ensure that they do not substitute their own judgment for that of the adjudicating component where they would reach a different or opposite case determination, but where the evidence and documentation in a fully documented case equally support the adjudicating component's determination. *Id.*

¹⁹³ *Id.*

¹⁹⁴ SOC. SEC. ADMIN., PROGRAM OPERATIONS MANUAL SYS., GN 04440.201, GENERAL RULES FOR ROUTING AND CORRECTING DEFICIENT CASES, *available at* <https://secure.ssa.gov/apps10/poms.nsf/lrx/0204440201> (last visited Feb. 02, 2015).

¹⁹⁵ TCAs are issued where the quality reviewers determine, using a standard known as the Probability of Reversal Rule, that missing medical or vocational documentation is unlikely to reverse the disability determination or change the period of disability. *Id.*; *see also* SOC. SEC. ADMIN., PROGRAM OPERATIONS MANUAL SYS., DI 80850.010, WHEN YOU CANNOT USE THE PROBABILITY OF REVERSAL (POR), *available at* <https://secure.ssa.gov/apps10/poms.nsf/lrx> (last visited Feb. 3, 2015).

¹⁹⁶ SOC. SEC. ADMIN., PROGRAM OPERATIONS MANUAL SYS., DI 30005.121-127 (defining specific types of deficiencies and other technical corrective actions without reference to errors in credibility or subjective symptom evaluation); *see also* SOC. SEC. ADMIN., PROGRAM OPERATIONS MANUAL SYS., GN 04440.901, SSA-1774-U5 – REQUEST FOR CORRECTIVE ACTION (exhibiting the form filled out by quality reviewers in a request for corrective action, on which they may provide a narrative description about the action requested and rationale but which does not appear to capture structured data about subjective symptom evaluation), *available at* <https://secure.ssa.gov/apps10/poms/images/SSA1/G-SSA-1774-U5-1.pdf> (last visited Feb. 02, 2015).

¹⁹⁷ Email from Kathi Thompson, Disability Initial Director, Office of Quality Review, Office of Budget, Finance, Quality and Management, Soc. Sec. Admin. to Stephanie Tatham, Att'y Advisor, Admin. Conf. of the U.S. (Dec. 4, 2014) (on file with author).

¹⁹⁸ SOC. SEC. ADMIN., PROGRAM OPERATIONS MANUAL SYS., GN 04440.002, THE QUALITY REVIEW (QR) PROCESS, *available at* <https://secure.ssa.gov/apps10/poms.nsf/lrx/0204440002> (last visited Feb. 02, 2015).

¹⁹⁹ SOC. SEC. ADMIN., PROGRAM OPERATIONS MANUAL SYS., DI 30007.105, REQUEST FOR PROGRAM CONSULTATION (RPC) OVERVIEW, *available at* <https://secure.ssa.gov/apps10/poms.nsf/lrx/0430007105> (last visited Feb. 02, 2015).

²⁰⁰ *Id.*

²⁰¹ *Id.*

²⁰² Email from Nancy Schoenberg, Senior Advisor Office of Disability Policy to Stephanie Tatham, Att'y Advisor, Admin. Conf. of the U.S. (Nov. 4, 2014) (on file with author).

²⁰³ At times, it was difficult for Conference staff to distinguish between the original DDE, prepared by the DDS team or SDM, and the OQR-edited DDE, although sometimes OQR edits or comments were apparent. *See, e.g.*, SSA, *RPC Case—0913-062*, DDE at 5-6 (Sept. 6, 2013). With access to the full file, the RPC reviewer would be able to discern OQR edits to DDEs.

²⁰⁴ *E.g.*, SSA, *RPC Cases—0114-065, 0114-082, 0214-016, 0314-058, 0913-062, 1213-018*.

²⁰⁵ *I.e.*, there was a substantive Group I deficiency that would have produced a return, rather than a TCA.

²⁰⁶ *E.g.*, SSA, RPC Cases—0114-077 (RPC Resolution at 2 (Discussed by ODP in “Evidence” section)), 0214-016 (RPC Resolution at 1 (Discussed by ODP in “Case Facts” section)), 0314-058 (RPC Resolution at 1 (Discussed by ODP in “Case Facts” section)), 1113-018 (RPC Resolution at 2 (Discussed by ODP in “Evidence” section)).

²⁰⁷ SSA, RPC Cases—0214-016, 0314-058.

²⁰⁸ SSA, RPC Case—1213-071 (RPC Resolution at 1).

²⁰⁹ SSA, RPC Cases—0214-016, 0214-059, 0314-058, 1013-027.

²¹⁰ *E.g.*, SSA, RPC Cases—1213-041 (DDS must attempt to verify test results), 1213-049 (DDS must obtain additional ADL statements), 0114-0774 (updated ADLs needed).

²¹¹ *E.g.*, SSA, RPC Cases—0114-006, 0114-034, 0214-065, 0913-055, 1013-027, 1213-027.

²¹² SSA, RPC Cases—0214-059, 0314-007, 0314-058, 1013-028.

²¹³ *Id.*

²¹⁴ *E.g.*, SSA, RPC Cases—0114-065, 0913-102, 1213-021.

²¹⁵ *E.g.*, SSA, RPC Cases—0114-077 (RPC Resolution at 2 (discussed by ODP in “Evidence” section)), 0214-016 (RPC Resolution at 1 (discussed by ODP in “Case Facts” section)), 0314-058 (RPC Resolution at 1 (discussed by ODP in “Case Facts” section)), 1113-018 (RPC Resolution at 2 (Discussed by ODP in “Evidence” section)).

²¹⁶ SSA, RPC Cases—0114-005, DDE at 8-9 (Dec. 29, 2013).

²¹⁷ *Id.* ODP RPC Resolution at 2-3 (“The [claimant’s] ADLs are confirmed by a friend and the FO observation of the [claimant] lends credence to her alleged pain induced restrictions. The [claimant’s] alleged symptom related limitations are credible considering all of the evidence and the DDS RFC is reasonable. . . . The Group I Documentation Deficiency is rescinded.”).

²¹⁸ *E.g.*, SSA, RPC Cases—0214-065, 0913-108, 113-036 (Case Analyses) and 0114-065, 0214-016 (RFC). This observation was confirmed by SSA officials. Oct. 31, 2013 eCAT demonstration, *supra* note 165.

²¹⁹ For an overview of the ODAR, see SOC. SEC. ADMIN., ORGANIZATIONAL MANUAL, CHAPTER TL: OFFICE OF DISABILITY ADJUDICATION REVIEW, available at <http://www.ssa.gov/org/orgdcdar.htm> (last visited Aug. 26, 2014).

²²⁰ 20 C.F.R. §§ 404.968(a), 416.1468(a) (2013). Appeals Council review is discretionary, and limited to cases that meet the criteria set forth at 20 C.F.R. §§ 404.970, 416.1470.

²²¹ 20 C.F.R. §§ 404.981, 416.1481 (2013).

²²² Use of the FIT is encouraged but not required. Some decisions may be written outside of FIT if it is not applicable, such as where a decision is based on non-disability issues. Additionally, as recently as 2010, some ALJs reported a refusal to use the FIT to SSA’s Office of the Inspector General. SOC. SEC. ADMIN., OFFICE OF THE INSPECTOR GEN., 22A-02-09-19068, OFFICE OF DISABILITY ADJUDICATION AND REVIEW DECISION-WRITING PROCESS, AUDIT REPORT 2 (Nov. 2010), available at http://oig.ssa.gov/sites/default/files/audit/full/pdf/A-02-09-19068_7.pdf (last visited Feb. 4, 2015).

²²³ *Id.*

²²⁴ *Securing the Future of the Social Security Disability Insurance Program: Hearing Before the Subcomm. on Soc. Sec. of the H. Comm. on Ways and Means*, 112th Cong. 9 (June 27, 2012) (statement of Michael J. Astrue, Comm’r of Soc. Sec.), available at http://www.ssa.gov/legislation/testimony_062712.html (last visited Sept. 02, 2014).

²²⁵ Email from Rainbow Forbes, Appeals Officer, Office of Appellate Operations, Office of Disability Adjudication and Review, Soc. Security Admin. to Stephanie Tatham, Att’y Advisor, Admin. Conf. of the U.S. (Mar. 13, 2014) (on file with author) [hereinafter Mar. 13, 2014 email].

²²⁶ SOC. SEC. ADMIN., SSA FY 2007 PERFORMANCE AND ACCOUNTABILITY Report, Management’s Discussion and Analysis: Agency Challenges 23 (2007), available at http://www.ssa.gov/finance/2007/Agency_Challenges.pdf.

²²⁷ *Preventing Disability Scams: Hearing Before the Subcomm. on Soc. Sec. of the H. Comm. on Ways and Means*, 113th Cong. (Feb. 26, 2014) (statement of Carolyn W. Colvin, Acting Commissioner), available at http://www.ssa.gov/legislation/testimony_022614.html (last visited Feb. 02, 2015).

²²⁸ SOC. SEC. ADMIN., 2013 FISCAL YEAR AGENCY REPORT, Acting Comm’r of Soc. Sec., Carolyn W. Colvin, 14 (Dec 9, 2013), available at <http://www.ssa.gov/finance/2013/Full%20FY%202013%20AFR.pdf> (last visited Feb. 02, 2015).

²²⁹ SOC. SEC. ADMIN., 2013 SERVICE DELIVERY PLAN, (FEB. 20, 2013), available at http://www.ssa.gov/open/SDP/SDP_022013.pdf (last visited Feb. 5, 2015).

²³⁰ Oct. 22, 2014 telephone interview, *supra* note 171.

²³¹ 20 C.F.R. §§ 404.967, 404.968, 416.1467, 416.1468.

²³² 20 C.F.R. §§ 404.969(a)-(d), 416.1469(a)-(d) (2013) (setting current regulatory procedures for identification of own motion review cases). SSA has regulatory authority to conduct selective sampling. The Administrative Conference has encouraged SSA to expand and focus own motion review on cases with a higher likelihood of

containing errors. ADMIN. CONF. OF THE U.S, Recommendation 2013-1, *Improving Consistency in Social Security Disability Adjudications* ¶ 4 (June 13, 2013), available at <https://www.acus.gov/recommendation/improving-consistency-social-security-disability-adjudications>.

²³³ *Id.*; see also *Social Security Disability Programs: Improving the Quality of Benefit Award Decisions: Hearing before the Permanent Subcomm. on Investigations of the S. Comm. on Homeland Sec. and Gov't Affairs 2*, 112th Cong. 1 (2012) (statement of J. Patricia Jonas, Exec. Dir., Office of Appellate Operations, Office of Disability and Rev., Soc. Sec. Admin.).

²³⁴ Soc. Sec. Admin, *ODAR Sample Cases—Appealed Denials—AC Denial 2a*, ALJ Decision at 7 (Oct. 18, 2011); SSA, *ODAR Sample Cases—Appealed Denials—AC Denial 6a*, ALJ Decision at 5 (Sept. 22, 2011); SSA, *ODAR Sample Cases—Appealed Denials—AC Denial 11a*, ALJ Decision at 6 (Jan. 10, 2012).

²³⁵ Soc. Sec. Admin, *ODAR Sample Cases—Appealed Remands—AC Remand 3b*, Order of the Appeals Council at 1 (Feb. 21, 2013); SSA, *ODAR Sample Cases—Appealed Remands—AC Remand 5b*, Order of the Appeals Council at 2-3 (May 22, 2013); SSA, *ODAR Sample Cases—Appealed Remands—AC Remand 6b*, Order of the Appeals Council at 2 (July 8, 2013); SSA, *ODAR Sample Cases—Appealed Remands—AC Remand 7b*, Order of the Appeals Council at 1-2 (Aug. 14, 2013); SSA, *ODAR Sample Cases—Appealed Remands—AC 9b*, Order of the Appeals Council at 2 (Dec. 14, 2012); SSA, *ODAR Sample Cases—Appealed Remands—AC Remand 12b*, Order of the Appeals Council at 2 (Jan. 11, 2013).

²³⁶ Soc. Sec. Admin, *ODAR Sample Cases—Appealed Remands—AC Remand 5b*, Order of the Appeals Council at 1-2 (May 22, 2013); SSA, *ODAR Sample Cases—Appealed Remands—AC Remand 9b*, Order of the Appeals Council at 1 (Dec. 14, 2012); SSA, *ODAR Sample Cases—Appealed Remands—AC Remand 11b*, Order of the Appeals Council at 2 (Sept. 6, 2013).

²³⁷ Soc. Sec. Admin, *ODAR Sample Cases—Unappealed Effectuated—AC Unappealed Effectuated 1*, ALJ Decision at 5 (May 15, 2013); SSA, *ODAR Sample Cases—Unappealed Effectuated—AC Unappealed Effectuated 3*, ALJ Decision at 4 (Feb. 22, 2013); SSA, *ODAR Sample Cases—Unappealed Effectuated—AC Unappealed Effectuated 4*, ALJ Decision at 4 (Nov. 19, 2012); SSA, *ODAR Sample Cases—Unappealed Effectuated—AC Unappealed Effectuated 5*, ALJ Decision at 4 (Oct. 9, 2012); SSA, *ODAR Sample Cases—Unappealed Effectuated—AC Unappealed Effectuated 7*, ALJ Decision at 5 (Oct. 12, 2012); SSA, *ODAR Sample Cases—Unappealed Effectuated—AC Unappealed Effectuated 8*, ALJ Decision at 5 (Mar. 22, 2012); SSA, *ODAR Sample Cases—Unappealed Effectuated—AC Unappealed Effectuated 9*, ALJ Decision at 6 (Sept. 13, 2013); SSA, *ODAR Sample Cases—Unappealed Effectuated—AC Unappealed Effectuated 12*, ALJ Decision at 4 (July 26, 2013).

²³⁸ Soc. Sec. Admin, *ODAR Sample Cases—Unappealed Effectuated—AC Unappealed Effectuated 1*, ALJ Decision at 5 (May 15, 2013); SSA, *ODAR Sample Cases—Unappealed Effectuated—AC Unappealed Effectuated 3*, ALJ Decision at 4 (Feb. 22, 2013); SSA, *ODAR Sample Cases—Unappealed Effectuated—AC Unappealed Effectuated 4*, ALJ Decision at 4 (Nov. 19, 2012); SSA, *ODAR Sample Cases—Unappealed Effectuated—AC Unappealed Effectuated 5*, ALJ Decision at 4-5 (Oct. 9, 2012); SSA, *ODAR Sample Cases—Unappealed Effectuated—AC Unappealed Effectuated 7*, ALJ Decision at 5 (Oct. 12, 2012); SSA, *ODAR Sample Cases—Unappealed Effectuated—AC Unappealed Effectuated 8*, ALJ Decision at 5 (Mar. 22, 2012); SSA, *ODAR Sample Cases—Unappealed Effectuated—AC Unappealed Effectuated 9*, ALJ Decision at 6-7 (Sept. 13, 2013); SSA, *ODAR Sample Cases—Unappealed Effectuated—AC Unappealed Effectuated 12*, ALJ Decision at 5 (July 26, 2013).

²³⁹ SSA, *ODAR Sample Cases—Unappealed Effectuated—AC Unappealed Effectuated 1*, ALJ Decision at 6 (May 15, 2013); SSA, *ODAR Sample Cases—Unappealed Effectuated—AC Unappealed Effectuated 7*, ALJ Decision at 5 (Oct. 12, 2012).

²⁴⁰ Soc. Sec. Admin, *ODAR Sample Cases—Unappealed Effectuated—AC Unappealed Effectuated 3*, ALJ Decision at 4 (Feb. 22, 2013); SSA, *ODAR Sample Cases—Unappealed Effectuated—AC Unappealed Effectuated 7*, ALJ Decision at 4 (Oct. 12, 2012).

²⁴¹ Soc. Sec. Admin, *ODAR Sample Cases—Unappealed Effectuated—AC Unappealed Effectuated 10*, ALJ Decision at 6 (Mar. 5, 2013); SSA, *ODAR Sample Cases—Unappealed Effectuated—AC Unappealed Effectuated 11*, ALJ Decision at 4 (June 26, 2013).

²⁴² Soc. Sec. Admin, *ODAR Sample Cases—Unappealed Remands—Unappealed AC Remand 2b*, Order of the Appeals Council at 3 (Mar. 29, 2013); SSA, *ODAR Sample Cases—Unappealed Remands—Unappealed AC Remand 4b*, Order of the Appeals Council at 3-4 (Sept. 20, 2013); SSA, *ODAR Sample Cases—Unappealed AC Remands—Unappealed AC Remand 6b*, Order of the Appeals Council at 4 (Dec. 18, 2013); SSA, *ODAR Sample Cases—Unappealed AC Remands—Unappealed AC Remand 8b*, Order of the Appeals Council at 2 (Aug. 9, 2013); SSA, *ODAR Sample Cases—Unappealed AC Remands—Unappealed AC Remand 9b*, Order of the Appeals Council at 4-5 (Feb. 19, 2013); SSA, *ODAR Sample Cases—Unappealed AC Remands—Unappealed AC Remand 12b*, Order of the Appeals Council at 3 (Aug. 21, 2013); SSA, *ODAR Sample Cases—Unappealed AC Remands—Unappealed AC Remand 14b*, Order

of the Appeals Council at 3 (Dec. 11, 2013).

²⁴³ Soc. Sec. Admin, *ODAR Sample Cases—Unappealed Remands—Unappealed AC Remand 2b*, Order of the Appeals Council at 3 (Mar. 29 2013) (on file with author); SSA, *ODAR Sample Cases—Unappealed Remands—Unappealed AC Remand 5b*, Order of the Appeals Council at 3 (Oct. 23, 2013); SSA, *ODAR Sample Cases—Unappealed Remands—Unappealed AC Remand 12b*, Order of the Appeals Council at 3 (Aug. 21, 2013); SSA, *ODAR Sample Cases—Unappealed Remands—Unappealed AC Remand 13b*, Order of the Appeals Council at 3 (Sept. 5, 2013); SSA, *ODAR Sample Cases—Unappealed Remands—Unappealed AC Remand 14b*, Order of the Appeals Council at 2-3 (Dec. 11, 2013).

²⁴⁴ Soc. Sec. Admin, *ODAR Sample Cases—Unappealed Remands—Unappealed AC Remand 3b*, Order of the Appeals Council at 3 (July 12, 2013); SSA, *ODAR Sample Cases—Unappealed Remands—Unappealed AC Remand 9b*, Order of the Appeals Council at 2 (Feb. 19 2013).

²⁴⁵ SOC. SEC. ADMIN., OFFICE OF THE INSPECTOR GEN. REVIEW OF ADMIN. LAW JUDGES' DECISIONS, A-07-12-21234, 3-4 (Mar. 2012), available at <http://oig.ssa.gov/sites/default/files/audit/full/pdf/A-07-12-21234.pdf> (last visited Feb. 5, 2014) [hereinafter OIG, REVIEW OF ALJ DECISIONS].

²⁴⁶ *Id.* at 4.

²⁴⁷ *Id.* at 9.

²⁴⁸ Soc. Sec. Admin., *DCBFQM OQR DDA Cases: Unfavorable without Credibility Issues—Case 41*, Hearing Level Disagreement Referral at 2 (Feb. 2013).

²⁴⁹ Quality reviewers also identified some errors in subjective symptom evaluation even in files SSA did not indicate had issues in this area (see below).

²⁵⁰ Soc. Sec. Admin, *DCBFQM OQR DDA Cases: Favorable—Case 1*, Hearing Level Disagreement Referral at 1 (Oct. 2012); *Favorable—Case 2*, Hearing Level Disagreement Referral at 1-2 (Oct. 2012); *Favorable—Case 5*, Hearing Level Disagreement Referral at 1 (Dec. 2012); *Favorable—Case 7*, Hearing Level Disagreement Referral at 2-3 (Oct. 2012); *Favorable—Case 8*, Hearing Level Disagreement Referral at 2 (Nov. 2012); *Favorable—Case 9*, Hearing Level Disagreement Referral at 1-2 (Nov. 2012); *Favorable—Case 10*, Hearing Level Disagreement Referral at 1 (Feb. 2013); *Favorable—Case 11*, Hearing Level Disagreement Referral at 1 (Jan. 2013); *Favorable—Case 12*, Hearing Level Disagreement Referral at 1 (Nov. 2012); *Favorable—Case 13*, Hearing Level Disagreement Referral at 2 (Feb. 2013); *Favorable—Case 21*, Hearing Level Disagreement Referral at 1 (Dec. 2011).

²⁵¹ Soc. Sec. Admin, *DCBFQM OQR DDA Cases: Favorable without Credibility Issues—Case 19*, Hearing Level Disagreement Referral at 2 (Oct. 2011); *Unfavorable without Credibility Issues—Case 39*, Hearing Level Disagreement Referral at 1 (Apr. 2013); *Unfavorable without Credibility Issues—Case 41*, Hearing Level Disagreement Referral at 2 (Feb. 2013).

²⁵² Soc. Sec. Admin, *DCBFQM OQR DDA Cases: Favorable—Case 7*, Hearing Level Disagreement Referral at 2 (Oct. 2012); *Favorable—Case 8*, Hearing Level Disagreement Referral at 1-3 (Nov. 2012); *Favorable—Case 12*, Hearing Level Disagreement Referral at 2 (Nov. 2012).

²⁵³ Soc. Sec. Admin, *DCBFQM OQR DDA Cases: Favorable—Case 10*, Hearing Level Disagreement Referral at 2 (Feb. 2013); *Favorable—Case 11*, Hearing Level Disagreement Referral at 1 (Jan. 2013); *Favorable—Case 13*, Hearing Level Disagreement Referral at 2 (Feb. 2013).

²⁵⁴ *Supra* notes 104-105 and accompanying text.

²⁵⁵ SSR 13-1p, Titles II and XVI: Agency Processes for Addressing Allegations of Unfairness, Prejudice, Partiality, Bias, Misconduct, or Discrimination by Administrative Law Judges (ALJs) 78 FR 6168 (Jan. 29, 2013) [hereinafter SSR 13-1p].

²⁵⁶ *Id.*

²⁵⁷ OIG, REVIEW OF ALJ DECISIONS, *supra* note 245, at 3.

²⁵⁸ *Id.*

²⁵⁹ *Id.* at 2.

²⁶⁰ *Id.*

²⁶¹ Soc. Sec. Admin., Sample Bias Referrals from the Office of Appellate Operations to ODAR's Division of Quality Service (2014) (on file with author). It would be inappropriate to draw general inferences about bias complaints from this description of individual complaints.

²⁶² For example, one claimant representative wrote: "The ALJ paints a rosier picture of my client's abilities around the house and around routine activities than [the client] actually presented. This is an improper and less than faithful use of the exhibit that results in bias against the claimant." Another representative alleged that the "ALJ erred by approaching this case with an admitted bias against claimant's testimony regarding subjective complaints associated with the physical, mental and side effects of medications as they effect the claimant's activities of daily living and work restrictions." One attorney accused the ALJ of "turn[ing] the hearing quickly into an 'adversarial' hearing

upon his questioning of the claimant on his past earnings.” (ALJ XXX). Several alleged bias due to consideration of a claimant’s prior criminal history and past or present use of substances, including alcohol. An evidently unrepresented claimant stated that “The [ALJ] demonstrated a bias toward me due to a felony record evident in the body of the decision . . . The ALJ also stated I am manipulative, a liar, and persistent criminal.” Another thought “[The ALJ] is bias [sic] towards people that have been incarcerated or use of have possibly sold illegal drugs.” *Id.*²⁶³ *Id.* at 13.

²⁶⁴ SSR 13-1p, *supra* note 255.

²⁶⁵ Remands are categorized or coded at three levels: a) by Appeals Council personnel in the Division of Civil Actions when they are received from courts, b) by Appeals Council personnel after remand by the Appeals Council, and c) at the hearing office level for both judicial and Appeals Council remands.

²⁶⁶ 20 C.F.R. §§ 404.1529(a)-(c), 416.929(a)-(c) (2013).

²⁶⁷ SSA has identified similar bases for remand in the evaluation of a third party’s credibility.

²⁶⁸ Third party credibility issues were slightly more common—they were identified in as many as three percent (3%) of remanded cases at some levels of review—but were still relatively rare.

Part V References:

²⁶⁹ For a full elaboration see PAUL VERKUIL & JEFFREY LUBBERS, ALTERNATIVE APPROACHES TO JUDICIAL REVIEW OF SOCIAL SECURITY DISABILITY CASES, SSAB NO. SSA-RFG-02-0026 (2002), *available at* <http://www.ssab.gov/Publications/Disability/VerkuilLubbers.pdf> (last visited Sept. 02, 2014).

²⁷⁰ Letter from Carolyn W. Colvin, *supra* note 97.

²⁷¹ *Id.*

²⁷² ADMIN. OFFICE OF THE U.S. COURTS, JUDICIAL BUSINESS OF THE UNITED STATES COURTS (2013), *available at* <http://www.uscourts.gov/Statistics/JudicialBusiness/2013.aspx> (last visited Sept. 02, 2014) [hereinafter JUDICIAL BUSINESS 2013].

²⁷³ In 2013, U.S. Magistrate Judges issued reports and recommendations in nearly 5,000 social security cases; U.S. District Courts terminated 16,283 SSDI and SSI actions in the same time period. *Id.* at Table M-4B 1, Table C-4 2. *See also* text accompanying note 351; S. Rep. No. 96-74, at 5 (1979), reprinted in 1979 U.S.C.C.A.N. 1469, 1473 (noting in the Senate Committee Report for the 1979 Amendments to the Federal Magistrate Act that “the fact that magistrates presently handle social security appeals and that this procedure has worked well for all parties concerned. Many litigants feel they have indeed received justice if they are given their ‘day in court’”); *Mathews v. Weber*, 423 U.S. 261 (1976) (upholding a district court rule referring all Social Security cases to magistrate judges for preliminary review).

²⁷⁴ VERKUIL ET AL., *supra* note 269, at 8-9.(describing direct review of agency formal adjudications in the courts of appeals as “the usual practice”). *But see* Joseph Mead & Nicholas A. Fromherz, *Choosing a Court to Review the Executive* 67 ADMIN. L. REV. 1 (at 10 in SSRN version), *available at* http://papers.ssrn.com/sol3/papers.cfm?abstract_id=2409944 (forthcoming Mar. 2015) (raising questions about this common conception). *See also* ADMIN. CONF. OF THE U.S., Recommendation 75-3, *The Choice of Forum for Judicial Review of Agency Action*, 40 Fed. Reg. 27,926 (July 2, 1975) (urging direct review of a number of agency actions in courts of appeals, but recommending that SSA’s order continue to be reviewable in the first instance in district courts).

²⁷⁵ The volume of social security cases filed in district courts in 2013 was more than double the volume of all administrative appeals filed in the courts of appeals in the same period. JUDICIAL BUSINESS 2013, *supra* note 272; *see also* VERKUIL ET AL., *supra* note 269, at 9-10.

²⁷⁶ *Id.* at 8.

²⁷⁷ *See* Richard A. Pierce, *District Court Review of Findings of Fact Proposed by Magistrates: Reality Versus Fiction*, 81 GEO. WASH. L. REV. 1236, 1237 (2013) (“District judges can assign to magistrates the tasks of conducting hearings and making proposed findings with respect to a wide variety of civil and criminal matters.”).

²⁷⁸ *See* VERKUIL ET AL., *supra* note 269, at 12 (suggesting that the unusual statutory relationship between judges and the agency may contribute to the judicial remand rate of one out of every two disability cases).

²⁷⁹ Morton Denlow, *Substantial Evidence Review in Social Security Cases as an Issue of Fact*, 28 J. NAT’L ASS’N ADMIN. L. JUDICIARY 28, 40 (2008) (describing the self-reported factual nature of some magistrate judge review and reporting that in a survey of all U.S. magistrate judges with a fifty percent (50%) response rate, thirty percent (30%) characterized their experience of “reviewing the record in a social security case to determine whether substantial evidence supports the decision of the ALJ” as “deciding a question of fact”).

²⁸⁰ *Id.*

²⁸¹ *E.g.*, FED. R. CIV. P. 52(a)(6) (“Findings of fact, whether based on oral or other evidence, must not be set aside unless clearly erroneous, and the reviewing court must give due regard to the trial court’s opportunity to judge the witnesses’ credibility.”); *see also United States v. Raddatz*, 447 U.S. 667, 681 n.7 (1980) (observing in the criminal context “we assume it is unlikely that a district judge would reject a magistrate judge’s findings on credibility when those findings are dispositive and substitute the judge’s own appraisal; to do so without seeing and hearing the witnesses whose credibility is in question could well give rise to serious questions which we do not reach”).

²⁸² *Pierce*, *supra* note 277, at 1236. Bearing in mind, however, that the power of magistrate judges is statutorily conferred “subject to the district judge’s duty to ‘make a de novo determination of those portions of the report or specified proposed findings or recommendations to which objection is made.’” *Id.* at 1237.

²⁸³ *Carradine v. Barnhart*, 360 F.3d 751, 753 (7th Cir. 2003) (“Appellate review of credibility determinations, especially when made by specialists such as the administrative law judges of the Social Security Administration, is highly limited because the reviewing court lacks direct access to the witnesses . . . , lacks the trier’s immersion in the case as a whole, and when reviewing decisions by specialized tribunals also lacks the trier’s experience with the type of case under review.”).

²⁸⁴ *Id.*; *see also* Paul R. Verkuil, *An Outcomes Analysis of Scope of Review Standards*, 44 WM. & MARY L. REV. 679, 708-09 (2002).

²⁸⁵ 42 U.S.C. § 405(g). At least one magistrate judge has described the process of record review as “fact-finding” that is “no different than a bench trial” and a question in a survey of U.S. magistrate judges yielding over 220 responses indicated that thirty percent (30%) would characterize their review of the record in social security cases as answering a question of fact. Denlow, *supra* note 279, at 28, 40.

²⁸⁶ *Richardson v. Perales*, 402 U.S. 389 (1971) (internal quotations and citations omitted).

²⁸⁷ *Slusser v. Astrue*, 557 F.3d 923, 925 (8th Cir. 2009); *Newell v. Comm’r of Soc. Sec.*, 347 F.3d 541, 545 (3d Cir. 2003).

²⁸⁸ *E.g.*, *Pichette v. Barnhart*, 2006 WL 1697524, at *2 (11th Cir. 2006); *Lounsbury v. Barnhart*, 464 F.3d 944, 947 (9th Cir. 2006); *Choate v. Barnhart*, 457 F.3d 865, 869 (8th Cir. 2006); *Butts v. Barnhart*, 388 F.3d 377, 384 (2d Cir. 2004).

²⁸⁹ 42 U.S.C. § 405(g).

²⁹⁰ *Cox v. Apfel*, 160 F.3d 1203, 1207 (9th Cir. 1998); *Casias v. Sec’y of Health & Human Serv.’s*, 933 F.2d 799, 800-801 (10th Cir. 1991); *Gavin v. Heckler*, 811 F.2d 1195, 1199 (9th Cir. 1987) (quoting *Universal Camera Corp. v. National Labor Relations Bd.*, 340 U.S. 474, 488 (1951)); *Garner v. Heckler*, 745 F.2d 383, 388 (6th Cir. 1984). If good cause exists for new evidence is to be taken, it is to be before the Commissioner of Social Security. 42 U.S.C. § 1316(a)(4).

²⁹¹ *Casias*, 933 F.2d at 800-801.

²⁹² *E.g.*, *Murphy v. Colvin*, 2014 U.S. App. LEXIS 14035, at *9 (7th Cir. 2014) (insufficiently specific reasoning in evaluating credibility is reversible error). *See also* discussion of adjudicator reliance on the findings integrated template and conclusory analysis. This is true at the administrative level as well. SSR 96-7p places a high evidentiary burden on social security adjudicators to explain their findings about a claimant’s subjective symptoms. *See* SSR 96-7p, *supra* note 26 (“The reasons for the credibility finding must be grounded in the evidence and articulated in the determination or decision. It is not sufficient to make a conclusory statement that ‘the individual’s allegations have been considered’ or that ‘the allegations are (or are not) credible.’ It is also not enough for the adjudicator simply to recite the factors that are described in the regulations for evaluating symptoms. The determination or decision must contain specific reasons for the finding on credibility, supported by the evidence in the case record, and must be sufficiently specific to make clear to the individual and to any subsequent reviewers the weight the adjudicator gave to the individual’s statements and the reasons for that weight. This documentation is necessary in order to give the individual a full and fair review of his or her claim, and in order to ensure a well-reasoned determination or decision.”).

²⁹³ *Sayers v. Gardner*, 380 F. 2d 940, 943 (6th Cir. 1967) (describing “searching” review in social security cases given a “great number of reversals” and cases “where the same errors have repeatedly pointed out” and describing multiple tallies of remand rates of social security cases in excess of fifty percent (50%)).

²⁹⁴ Verkuil, *supra* note 284 at 708-709.

²⁹⁵ Letter from Carolyn W. Colvin, *supra* note 97.

²⁹⁶ On the other hand, it is worth noting, that the federal courts see only a miniscule percentage of social security disability claims adjudicated at the state and federal levels. Additionally, judicial review is focused on a limited set of decisions that discredit, rather than credit, a claimant’s subjective symptoms. *See supra* text accompanying note 94 (describing data indicating the positive influence claimant testimony has on benefit awards at the administrative level).

²⁹⁷ 20 CFR §§ 404.1529(c)(3) and 416.929(c)(3).

²⁹⁸ *Keyes-Zachary v. Astrue*, 695 F.3d 1156, 1167 (10th Cir. 2012) (quotations omitted); *see also Spruill v. Astrue*, 299 Fed. Appx. 356, 358 (5th Cir. 2008) (“This explanation need not follow formalistic rules.”). *But see Mickles v. Shalala*, 29 F.3d 918, 921 (4th Cir. 1994) (applauding an ALJ’s subjective symptom evaluation comprehensively considering each of the factors as “a refreshing mode of analysis [that] is precisely what I believe our cases have been striving for.”)

²⁹⁹ 20 U.S.C. §§ 404.1529(c)(3), 416.929(c)(3).

³⁰⁰ Search engine: LEXISAdvance; terms and connectors: social security and 96-7 or 96-7p; search within results: pain! or credib! or subj!. An implicit assumption of this study is that this search string accurately describes the population of cases involving SSR 96-7p. It may be that additional cases discuss credibility or subjective symptom evaluation but do not cite the SSR 96-7p, and hence were not identified by this methodology.

³⁰¹ Two results were excluded from the courts of appeals dataset because they were false positives, containing the search terms but not referencing SSR 96-7p. One court of appeals result was a duplicate, from a case that was initially unpublished but subsequently published. The list of district court cases was finalized in the first few days of June. Some unpublished 2013 opinions were still being added to Lexis throughout 2014, so some 2013 cases were likely not identified by this methodology.

³⁰² Three remands were in cases with fibromyalgia. One fibromyalgia claim also involved chronic fatigue syndrome, and one case involved a complex regional pain syndrome. Five cases involved headaches or migraines.

³⁰³ Remand reasons were identified using case law from the courts of appeals, since precedential appellate cases are binding on all district courts within an appellate jurisdiction. The identified remand reasons are presented in the report starting first with the remand reason identified in the most courts of appeals (seven circuits) and ending with the remand reason identified in the fewest number of courts of appeals (three). Remand reasons occurring more than twice were researched in all Circuits, an examination that extended to cases not identified through the case selection methodology. After this review, only remand issues identified in more than three circuits were included. Because a number of these decisions were unpublished, a remand reason was included only where it had precedential value in at least one Court of Appeals. Note was made of other reasons for remand that occurred occasionally but not in more than three Courts of Appeals or that occurred only in non-precedential cases. *E.g.*, *White*, 312 Fed. Appx. 779, 786-87 (6th Cir. 2009) (holding that claimant’s temporary relief was not necessarily inconsistent with disabling pain, and that therefore ALJ’s determination that claimant could work was in error; also finding error in the ALJ’s determination that the claimant had no trouble walking because the cane he used had not been medically prescribed). These additional potential remand reasons were discarded after a preliminary review of district court cases indicated that they did not commonly occur at that level of judicial review.

³⁰⁴ Judge Posner authored only three of the 34 Seventh Circuit opinions, resulting in three remands. His reasoning is often endorsed in subsequent Seventh Circuit opinions. *E.g.*, *Perkins v. Astrue*, 498 Fed. Appx. 641, 644 (7th Cir. 2012) (per curiam order before Judges Manion, Kanne, and Tinder citing prior precedent on “meaningless boilerplate”); *Parker v. Astrue*, 597 F.3d 920 (7th Cir. 2010) (Posner, J.) (describing “meaningless boilerplate” in FIT template used by SSA adjudicator).

³⁰⁵ *But see Carradine v. Barnhart*, 360 F.3d 751, 753 (7th Cir. 2003).

³⁰⁶ *E.g.*, *Mueller v. Astrue*, 493 Fed. Appx. 772, 777 (7th Cir. 2012); *Orn v. Astrue*, 495 F.3d 625, 639 (9th Cir. 2007); *Balsamo v. Chater*, 142 F.3d 75, 81 (2d Cir. N.Y. 1998) (“a claimant need not be an invalid to be found disabled’ under the Social Security Act”); *Baumgarten v. Chater*, 75 F.3d 366, 369 (8th Cir. 1996) (finding making bed, preparing food, performing light housekeeping, grocery shopping, and visiting friends, unpersuasive reasons to deny benefits).

³⁰⁷ 20 C.F.R. §§ 404.1529(c)(3)(i), 416.929(c)(3)(i) (2014) (“[f]actors relevant to your symptoms, such as pain, which we will consider include: (i) Your daily activities”); SSR 96-7p, *supra* note 26 (“the adjudicator must consider . . . daily activities”).

³⁰⁸ *Orn v. Astrue*, 495 F.3d 625, 639 (9th Cir. 2007).

³⁰⁹ *Id.*

³¹⁰ *E.g.*, *Orn*, 495 F.3d at 625, 638; *Thompson v. Sullivan*, 987 F.2d 1482, 1490 (10th Cir. 1993).

³¹¹ 20 C.F.R. §§ 404.1529(c)(3)(iv)-(v), 416.929(c)(3)(iv)-(v); *see also* SSR 82-59, Titles II and XVI: Failure to Follow Prescribed Treatment, *available at* http://www.ssa.gov/OP_Home/rulings/di/02/SSR82-59-di-02.html.

³¹² SOC. SEC. ADMIN., PROGRAM OPERATIONS MANUAL SYS., DI 23010.005(A)(2)(d), FAILURE TO FOLLOW PRESCRIBED TREATMENT – POLICIES (July 10, 2012) (“[a] failure to follow prescribed treatment determination may be made only where . . . evidence of record discloses that there has been refusal to follow prescribed treatment”).

³¹³ *E.g.*, *Kalmbach v. Comm’r of Soc. Sec.*, 409 Fed. Appx. 852, 863-64 (6th Cir. 2011) (holding claimant’s reluctance to pursue “aggressive” treatment not recommended for her condition should not have led the ALJ to

discount her credibility); *Eakin v. Astrue*, 432 Fed. Appx. 607, 612 (7th Cir. 2011) (finding that adverse credibility determination should not have been based on claimant's decision to treat arthritis with medication rather than surgery, because there was no evidence suggesting that a medically recommended hip replacement would be "clearly expected" to work and because the adjudicator did not develop the record regarding the claimant's failure to follow prescribed treatment).

³¹⁴ 20 C.F.R. §§ 404.1530(c), 416.930(c).

³¹⁵ E.g., *Bjornson v. Astrue*, 671 F.3d 640, 645 (7th Cir. 2012); *Penson v. Barnhart*, 103 Fed. Appx. 843, 844 (5th Cir. 2004); *Hardman v. Barnhart*, 362 F.3d 676, 679 (10th Cir. 2004).

³¹⁶ See, e.g., *Schomas v. Colvin*, 732 F.3d 702, 708 (7th Cir. 2013) (describing the FIT language as "innocuous when, as here, the language is followed by an explanation for rejecting the claimant's testimony"); *Romero v. Colvin*, 563 Fed. Appx. 618, at *5 (10th Cir. 2014) (citing prior precedent for the proposition that "boilerplate is problematic only when it appears 'in the absence of a more thorough analysis'").

³¹⁷ *Orn v. Astrue*, 495 F.3d 625, 645 (9th Cir. 2007).

³¹⁸ Email from Rainbow Forbes, Appeals Officer, Office of Appellate Operations, Office of Disability Adjudication and Review, Soc. Security Admin. to Stephanie Tatham, Att'y Advisor, Admin. Conf. of the U.S. (July 31, 2014) (on file with author).

³¹⁹ *Bjornson*, 671 F.3d at 640, 645 ("This 'template' is a variant of one that this court (and not only this court) had criticized previously—that 'after considering the evidence of record, the undersigned finds that claimant's medically determinable impairments would reasonably be expected to produce the alleged symptoms, but that the claimant's statements concerning the intensity, persistence and limiting effects of these symptoms are not entirely credible'").

³²⁰ *Punzio v. Astrue*, 630 F.3d 704, 709 (7th Cir. 2011); *Martinez v. Astrue*, 630 F.3d 693, 696-97 (7th Cir. 2011); *Spiva v. Astrue*, 628 F.3d 346, 348 (7th Cir. 2010); *Parker v. Astrue*, 597 F.3d 920, 922 (7th Cir. 2010).

³²¹ *Parker et. al. v. Astrue*, 597 F.3d 920, 922 (7th Cir. 2010).

³²² E.g., *Meadors v. Astrue*, 370 Fed. Appx. 179, 183-84 (2d Cir. 2010); *Nazzal v. Astrue*, 316 Fed. Appx. 591, 592 (9th Cir. 2009); **Bjornson v. Astrue*, 671 F.3d 640, 646 (7th Cir. 2012) (dicta noting potential tension between SSR 96-7p and a consultative examiner's skepticism about a claimant's pain).

³²³ SSR 96-7p, *supra* note 26

³²⁴ *Nazzal*, 316 Fed. Appx. at 591, 592

³²⁵ E.g. *Burgess v. Astrue*, 537 F.3d 117, 130 (2d Cir 2008).

³²⁶ 20 C.F.R. §§ 404.1529(c)(2), 416.929(c)(2).

³²⁷ *Meadors*, 370 Fed. Appx. at 183-84 (citation and quotation, including brackets, omitted).

³²⁸ *Singletary v. Sec'y of Health, Educ. & Welfare*, 623 F.2d 217, 219 (2d Cir. 1980).

³²⁹ SOC. SEC. ADMIN., HEARINGS, APPEALS, AND LITIG. LAW MANUAL I-5-4-13, STIEBERGER V. SULLIVAN att. a (Feb. 21, 1997), available at http://www.ssa.gov/OP_Home/halex/I-05/I-5-4-13.html#i-5-4-13-att-a; SOC. SEC. ADMIN, PROGRAM OPERATIONS MANUAL SYS., DI 42586.081, SECOND CIRCUIT DISABILITY DECISIONS MANUAL - STIEBERGER (Mar. 9, 2013); SOC. SEC. ADMIN, PROGRAM OPERATIONS MANUAL SYS., DI 42586.080, STIEBERGER DISABILITY ADJUDICATION (Mar. 9, 2013).

³³⁰ 20 C.F.R. §§ 404.1529(c)(3), 416.929(c)(3); SSR 96-7p, *supra* note 26.

³³¹ *Nunn v. Heckler*, 732 F.2d 645, 648 (8th Cir. 1984) (citing *Rivera v. Schweiker*, 717 F.2d 719, 725 (2d Cir. 1983), for the proposition that a "claimant with a good work record is entitled to substantial credibility when claiming an inability to work because of a disability."); *Dobrowolsky v. Califano*, 606 F.2d 403, 409 (3d Cir. 1979) ("when the claimant has a work record like Dobrowolsky's twenty-nine years of continuous work, fifteen with the same employer his testimony as to his capabilities is entitled to substantial credibility.").

³³² *Light v. SSA*, 119 F.3d 789, 792 (9th Cir. 1997) ("ALJ may consider [claimant's] reputation for truthfulness, inconsistencies either in his testimony or between his testimony and his conduct, his daily activities, his *work record*, and testimony from physicians and third parties concerning the nature, severity, and effect of the symptoms of which he complains").

³³³ *Schall v. Apfel*, 134 F.3d 496, 502 (2d Cir. 1998).

³³⁴ *Id.* at 502-503.

³³⁵ G. JACOBS ET AL., *supra* note 168 at 20-23.

³³⁶ *Vasquez v. Astrue*, 572 F.3d 586 (9th Cir. 2008); *Varney v. Sec'y of Health & Human Serv's*, 859 F.2d 1396, 1398 (9th Cir. 1988); *Hale v. Bowen*, 831 F.2d 1007, 1012 (11th Cir. 1987); *MacGregor v. Bowen*, 786 F.2d 1050, 1054 (11th Cir. 1986) ("If the secretary refuses to credit [a claimant's subjective pain] testimony he must do so explicitly and give reasons for that decision. . . . Where he fails to do so we hold as a matter of law that he has accepted the testimony as true.").

³³⁷ *Vasquez*, 572 F.2d at 586, 593 (citing *Hammock v. Bowen*, 879 F.2d 498 (9th Cir. 1989)—which applied the

credit-as-true rule and was remanded to SSA for further consideration—as support for its holding that the credit-as-true rule may be applied “even where application of the rule would not result in the immediate payment of benefits”).

³³⁸ *Id.*; *Connett v. Barnhart*, 340 F.3d 871, 876 (9th Cir. 2003); *Foote v. Chater*, 67 F.3d 1553, 1562-63 (11th Cir. 1995); *Holt v. Sullivan*, 921 F.2d 1221, 1224 (11th Cir. 1991); *Gonzalez v. Sullivan*, 914 F.2d 1197, 1203 (9th Cir. 1990); *Cannon v. Bowen*, 858 F.2d 1541, 1545 (11th Cir. 1988).

³³⁹ Data on the outcome of remanded cases is nearly a decade old, but between 1995 and 2005 sixty-six percent (66%) of the 57,000 cases returned to SSA by district courts resulted in an award of benefits. U.S. GOV'T ACCOUNTABILITY OFFICE, GAO-07-331, SSA HAS TAKEN STEPS TO ADDRESS CONFLICTING COURT DECISIONS, BUT NEEDS TO MANAGE DATA BETTER ON THE INCREASING NUMBER OF REMANDS 16 (2007).

³⁴⁰ *Id.*

³⁴¹ We are very grateful for the time and advice of Professor Jonah Gelbach of the University of Pennsylvania Law School, as well as Professors Alan Izenman of Temple University, Deborah Hensler of Stanford Law School, and Joshua Fischman of Northwestern University School of Law.

³⁴² Staff also sought to identify additional common reasons for remand, but none rose to the level of commonality observed for issues identified through review of appellate decisions.

³⁴³ Many, but not all, of the analyzed remanded decisions were reviewed by a second Conference staffer for quality control purposes. Findings are conservatively described in approximate percentages below to account for reasonable subjectivity in interpretation and the potential for human error in cases we did not review a second time.

³⁴⁴ About twenty-five percent (25%) of remanded cases citing SSR 96-7p were returned to SSA for reasons other than subjective symptom or credibility evaluation.

³⁴⁵ *Supra* **Part IV, Subpart B: ODAR analysis of remand reasons.**

³⁴⁶ *E.g.*, *Dygert v. Astrue*, No. 09-CV-325, 2010 U.S. Dist. LEXIS 109954, at *20-21 (N.D.N.Y. Sept. 7, 2010) (finding the credibility “assessment is tainted by the ALJ's failure to develop the record with regard to [the treating physician's] opinion”); *Cooper v. Astrue*, 7-09-0062, 2010 U.S. Dist. LEXIS 75726, at *22 (N.D.N.Y. May 27, 2010) (“Because the Court has already concluded that the treating physician's opinions and the consultative physician's opinions were improperly assessed, the ALJ's analysis of [the] subjective allegations is necessarily flawed.”); *Latchum v. Astrue*, 2011 U.S. Dist. LEXIS 81795, at *8-9 (remanding because the treating source rule problem “had a ripple effect on [the ALJ's] determination of [claimant's] credibility”).

³⁴⁷ *Horne v. Astrue*, 2012 U.S. Dist. LEXIS 137317, at *15-16 (E.D. Okla. Sept. 7, 2012).

³⁴⁸ *Beck v. Astrue*, Civ. No. 6:11-714, 2012 U.S. Dist. LEXIS 72636, at *21 (D.S.C. May 2, 2012).

³⁴⁹ *Felder v. Astrue*, 2012 U.S. Dist. LEXIS 129384, at *40 (E.D.N.Y. Sept. 11, 2012); *Valet v. Astrue*, 2012 U.S. Dist. LEXIS 7315, at *65 (E.D.N.Y. Jan. 23, 2012) (“Social Security Ruling (“S.S.R.”) 96-7p, 1996 SSR LEXIS 4 sets forth seven factors that an ALJ must consider in determining the credibility of a claimant's statements about his or her symptoms and the effects of his or her impairments.”); *Grosse v. Comm'r of Soc. Sec.*, No. 08-CV-4137 (NGG), 2011 U.S. Dist. LEXIS 3869, at *12-13 (E.D.N.Y. Jan. 14, 2011) (finding that ALJ committed legal error by failing to apply factors two through seven).

³⁵⁰ Based on the *Padro v. Colvin* class-action litigation in the Eastern District of New York, we speculate that subjective-symptom evaluation by some adjudicators whose actions are regularly reviewed by this court may have prompted the application of a more stringent standard in that particular jurisdiction. We are hopeful that the review and training agreed to by SSA in settling this litigation will obviate the need for special treatment in this jurisdiction beyond the agreed upon period for prospective relief.

³⁵¹ Magistrate recommendations in remanded cases were rejected six times but SSA's decision was upheld in only three of those cases. In the three remanded cases the magistrate judge's recommendations were partially rejected, and two were remanded due to flawed subjective symptom evaluation.

³⁵² The high percentage of cases that eluded common categorization but still led to remand indicates the difficult SSA faces in its data analysis endeavors.

³⁵³ *E.g.*, *Charon v. Astrue*, 2011 U.S. Dist. LEXIS 59995, at *26-27 (D. Mass. June 6, 2011) (“The ALJ's conclusion is not a fair characterization of Charon's daily activities.”); *Young v. Astrue*, 2010 U.S. Dist. LEXIS 143218, at *25 (N.D. Ohio Oct. 5, 2010) (“the ALJ's assertions that Plaintiff's daily activities of maintaining a residence and failing to seek physical therapy for his pain are directly contradicted by the record.”).

³⁵⁴ *E.g.*, *Felder v. Astrue*, 2012 U.S. Dist. LEXIS 129384, at *41-42 (E.D.N.Y. Sept. 11, 2012); *Charon v. Astrue*, 2011 U.S. Dist. LEXIS 59995, at *26-27 (D. Mass. June 6, 2011); *MacKinley v. Astrue*, 2011 DNH 86 (D.N.H. May 31, 2011).

³⁵⁵ *E.g.*, *Mecklenburg v. Astrue*, 2009 U.S. Dist. LEXIS 108111, at *21-23 (W.D.N.Y. Nov. 19, 2009); *Floyd v. Astrue*, 2010 U.S. Dist. LEXIS 54305, at *20 (S.D. Cal. Apr. 19, 2010) (“Plaintiff's ability to complete these simple

activities does not amount to clear and convincing evidence that the Plaintiff's testimony regarding his fatigue and functional limitation is not credible.”).

³⁵⁶ *Carroll v. Astrue*, 2010 U.S. Dist. LEXIS 140643, at *27-28 (N.D. Ohio Jan. 28, 2010).

³⁵⁷ *E.g.*, *Hill v. Colvin*, 2013 U.S. Dist. LEXIS 104629, at *20 (C.D. Cal. July 25, 2013) (“[T]he ALJ found that plaintiff's daily activities are consistent with an RFC for medium work The ALJ in the instant case failed to make any specific findings relating to plaintiff's daily activities or their transferability to the work place.”); *Herman v. Astrue*, 2013 U.S. Dist. LEXIS 20256, at *53-55 (D.S.D. Jan. 8, 2013); *Hollister v. Colvin*, 2013 U.S. Dist. LEXIS 26522, at *23 (N.D. Ind. Feb. 26, 2013) (rejecting third part testimony after unexplained adverse credibility determination).

³⁵⁸ *Calhoun v. Astrue*, 821 F. Supp. 2d 435 (D. Mass. Oct. 28, 2011).

³⁵⁹ *Id.*

³⁶⁰ *Rinaldi-Mishka v. Astrue*, 2013 U.S. Dist. LEXIS 98512, at *36-37 (N.D. Ill. July 8, 2013); *Valet v. Astrue*, 2012 U.S. Dist. LEXIS 7315, *66 (E.D.N.Y. Jan. 23, 2012). *But see Hill v. Colvin*, 2013 U.S. Dist. LEXIS 104629, at *18-19 (C.D. Cal. July 25, 2013) (citing *Parra v. Astrue*, 481 F.3d 742, 751 (9th Cir. 2007) for the proposition that “Evidence of ‘conservative treatment’ is sufficient to discount a claimant's testimony regarding severity of an impairment.”).

³⁶¹ *E.g.*, *O’Neal v. Comm’r of Soc. Sec.*, 2013 U.S. Dist. LEXIS 122742, at *14-16 (E.D. Mich. Aug. 5, 2013) (“while the ALJ acknowledged Plaintiff's financial constraints, he did not appear to factor them into the credibility determination as required by SSR 96-7p”); *Wieland v. Astrue*, 2012 U.S. Dist. LEXIS 135259, at *6 (E.D. Wis. Sept. 21, 2012) (“An ALJ may not rely on lack of treatment without exploring why treatment was infrequent.”); *Eschmann v. Astrue*, 2011 U.S. Dist. LEXIS 52061, at *43-44 (E.D.N.Y. May 16, 2011) (failed to consider adverse side effects of prescribed medication).

³⁶² *Dickens v. Astrue*, 2011 U.S. Dist. LEXIS 84359, at *8 (E.D.N.C. July 28, 2011) (citing *Preston v. Heckler*, 769 F.2d 988, 990-991 (4th Cir. 1985)).

³⁶³ *Sindt v. Colvin*, 2013 U.S. Dist. LEXIS 154472, at *13 (W.D. Wash. Sept. 27, 2013) (citing to *Regennitter v. Comm’r Soc. Sec. Admin.*, 166 F.3d 1294, 1299-1300 (9th Cir. 1999) for the proposition that “we have particularly criticized the use of a lack of treatment to reject mental complaints both because mental illness is notoriously underreported and because ‘it is a questionable practice to chastise one with a mental impairment for the exercise of poor judgment in seeking rehabilitation.’”); *Williams v. Astrue*, 2011 U.S. Dist. LEXIS 90111, at *13-14 (W.D. Wash. July 20, 2011).

³⁶⁴ *E.g.*, *Neal v. Colvin*, 2013 U.S. Dist. LEXIS 116789, at *15-16 (S.D. Ind. Aug. 19, 2013); *Royal v. Astrue*, 2012 U.S. Dist. LEXIS 160366, Civ. 5:11-456, at *24-26 (N.D.N.Y. Oct. 2, 2012).

³⁶⁵ *E.g.*, *Little v. Colvin*, 2013 U.S. Dist. LEXIS 82741, *19-23 (E.D. Va. Mar. 12, 2013); *Horne v. Astrue*, 2012 U.S. Dist. LEXIS 137317, at *15-16 (E.D. Okla. Sept. 7, 2012) (“The problem with the ALJ's analysis of the claimant's credibility (apart from vagueness) is that he should have *first* evaluated the claimant's testimony (along with all the other evidence) according to the guidelines *and only then* formulated an appropriate RFC, not the other way around, *i.e.*, the ALJ apparently judged the credibility of the claimant's testimony by comparing it to a pre-determined RFC.” (emphasis in original)); *Smith v. Comm’r of Soc. Sec.*, 2011 U.S. Dist. LEXIS 147025, at *27-28 (D. Vt. Dec. 20, 2011).

³⁶⁶ *E.g.*, *Vujnovich v. Astrue*, No. 2-10-43, 2011 U.S. Dist. LEXIS 32606, at *30-31 (N.D. Ind. Mar. 28, 2011) (remanding because the “ALJ's credibility determination consists entirely of one sentence of boiler-plate analysis”).

³⁶⁷ *E.g.*, *Little v. Colvin*, No. 2-12-300, 2013 U.S. Dist. LEXIS 82741, at *18-20 (E.D. Va. Mar. 12, 2013) (citing *Bjornson*, 671 F.3d at 644-645); *Alvarez v. Colvin*, No. 12-6205, 2013 U.S. Dist. LEXIS 181287, at *20-21 (D.N.J. Dec. 27, 2013); *Smith v. Comm’r of Soc. Sec.*, No. 2-10-176, 2011 U.S. Dist. LEXIS 147025, at *28 (D. Vt. Dec. 20, 2011).

³⁶⁸ *E.g.*, *Rich v. Comm’r of Soc. Sec.*, No. 1-12-255, 2013 U.S. Dist. LEXIS 135232, at *15-16 (W.D. Mich. Sept 23, 2013) (remanding for unrelated reasons, but rejecting claimant’s boilerplate argument); *Dante v. Colvin*, No. 12-4381, 2013 U.S. Dist. LEXIS 116076, at *37-39 (N.D. Ill. Aug. 16, 2013) (rejecting claimant’s boilerplate argument).

³⁶⁹ *E.g.*, *Parton v. Astrue*, No. 10-294, 2011 U.S. Dist. LEXIS 110966, at *15-16 (E.D. Okla. Sept. 28, 2011) (remanding and criticizing the discrediting opinion for listing the credibility factors set forth in SSR 96-7p and the symptom evaluation regulations and then failing to document their application to the evidence).

³⁷⁰ *Folino v. Astrue*, No. 11-3556, 2013 U.S. Dist. LEXIS 18437, at *21-22 (N.D. Ill. Feb 11, 2013); *see also, e.g.*, *Morrison v. Astrue*, No. 08-2048, 2010 U.S. Dist. LEXIS 115190, at *13 (E.D.N.Y. Oct. 27, 2010); *Horton v. Astrue*, No. 2-09-2055, 2010 U.S. Dist. LEXIS 121663, at *11-12 (D.S.C. Oct. 26, 2010) (“this court has nothing to review”).

³⁷¹ *Kiely v. Astrue*, No. 3-10-1079, 2011 U.S. Dist. LEXIS 123015, at *3 (D. Conn. Oct. 25, 2011).

³⁷² *E.g.*, *Skillman v. Astrue*, No. 08-6481, 2010 U.S. Dist. LEXIS 61349, at *19-20 (W.D.N.Y. June 18, 2010) (remanding because the discrediting opinion did not elaborate on the stock FIT language).

³⁷³ *Clauss v. Astrue*, Civ No. 11-cv-03330-MSK, 2013 U.S. Dist. LEXIS 45513, at *23 (D. Colo. Mar. 29, 2013).

³⁷⁴ *Id.* at *24.

³⁷⁵ *Caffrey v. Astrue*, 2009 U.S. Dist. LEXIS 57428, at *16, *19 (S.D.N.Y. June 30, 2009) (rejecting adverse credibility finding premised on determination by ALJ that the claimant's allegations "are not found to be corroborated by *objective medical evidence* to the degree purported") (emphasis in original); *see also Ramirez v. Astrue*, 2012 U.S. Dist. LEXIS 153862, at *12-13 (C.D. Cal. 2012); *Kemp v. Astrue*, 2011 U.S. Dist. LEXIS 107497, at *30-32 (D.S.C. Sept. 22, 2011) (remanding for a second time an ALJ's opinion for relying on a lack of objective medical evidence in discrediting claimant, noting limited revision to prior opinion and verbatim replacement of some portions of the prior decision).

³⁷⁶ *Bates v. Comm'r of Soc. Sec.*, 2010 U.S. Dist. LEXIS 141005, at *12-13 (N.D. Ohio Dec. 14, 2010).

³⁷⁷ *Small v. Astrue*, 2010 U.S. Dist. LEXIS 116632, at *33 (E.D. Pa. Sept. 30, 2010) (remanding in part because the ALJ "failed to discuss which subjective complaints he was rejecting and on what basis and, instead, summarily stated that the objective evidence did not support plaintiff's subjective complaints").

³⁷⁸ *Herman v. Astrue*, 2013 U.S. Dist. LEXIS 20256, at *56 (D.S.D. Jan. 8, 2013) (finding the credibility determination to be unsupported by substantial evidence because "the ALJ also discounted Herman's credibility because of the lack of objective medical evidence. . . but these shortcomings are the result of the ALJ's own failure to develop the record.").

³⁷⁹ *Sims v. Astrue*, 2012 U.S. Dist. LEXIS 29710, at *7-10 (C.D. Cal. Mar. 6, 2012)

³⁸⁰ *Jones v. Astrue*, 2011 U.S. Dist. LEXIS 28187, at *23, 21-24 (W.D. Wash. Feb. 25, 2011) (noting that "fibromyalgia is disease that is notable for its lack of objective diagnostic techniques" and quoting *Green-Younger v. Barnhart*, 335 F.3d 99, 109 (2d Cir. 2003), for the proposition that "'the absence of swelling joints or other orthopedic and neurologic deficits is no more indicative that the patient's fibromyalgia is not disabling than the absence of a headache is an indication that a patient's prostate cancer is not advanced'").

³⁸¹ *Baker v. Colvin*, 2013 U.S. Dist. LEXIS 150876, at *26-27 (W.D. Va. Sept. 24, 2013) ("In point of fact, the Law Judge assigned little weight to Dr. Aaron's opinion in large part because he believed it was based on plaintiff's subjective complaints, which he found were not entirely credible, rather than the objective evidence of record. (R. 26-27.) It is on this point, and on the Law Judge's examination of the VE, that the undersigned has concerns."); *Davis v. Astrue*, No. 2-08-01101, 2010 U.S. Dist. LEXIS 59826, at *17-18 (S.D.W.V. May 20, 2010) (questioning ALJ's disregarding physician's reports based on symptoms and substituting his own judgment). *But see Williams v. Astrue*, 2012 U.S. Dist. LEXIS 48682 (W.D. Wash. Mar. 14, 2012) (holding "the ALJ did not err in rejecting at least in part Dr. Brown's findings based on the ALJ's determination that plaintiff was not fully credible regarding her subjective complaint").

³⁸² *E.g.*, *Kiely v. Astrue*, 2011 U.S. Dist. LEXIS 123015, at *3-4 (D. Conn. Oct. 25, 2011) (discussing the "mountain of doctor's reports recording Ms. Kiely's consistent complaints of gastrointestinal problems").

³⁸³ 20 C.F.R. §§ 404.1529(c), 416.929(c).

³⁸⁴ *E.g.*, *Satterfield v. Astrue*, 2011 U.S. Dist. LEXIS 125541, at *13 (D. Utah Oct. 31, 2011) (finding the adjudicator's pain analysis to be flawed in part due to failure to consider two Global Assessment of Functioning scores given by a physician); *Osborn v. Astrue*, 2010 U.S. Dist. LEXIS 115139, at *33-35 (W.D. Wash. Oct. 6, 2010) (noting clinical findings of knee swelling and locking that should have been considered prior to rejecting the plaintiff's testimony regarding the same).

³⁸⁵ *E.g.*, *Beier v. Colvin*, 2013 U.S. Dist. LEXIS 36724, *29 (N.D. Ind. Mar. 18, 2013) ("Because the ALJ fails to discuss the numerous, favorable treatment records in support of Plaintiff's ongoing allegations, the ALJ has not built a logical bridge between the evidence and his decision."); *Brown v. Astrue*, 2012 U.S. Dist. LEXIS 179240, at * 26-27 (N.D. Ill. Dec. 19, 2012) (finding that the "ALJ's review of the record shows a significant oversight of Brown's treatment records. The ALJ claimed that no evidence supported Brown's testimony that she had sought chiropractic care for cervical spine pain. (R. 23). In reality, the record contains eighty-one pages of treatment notes by chiropractor Dr. Timothy Hammer for treatments extending from March 2009 through July 2010."); *Hua v. Astrue*, 2009 U.S. Dist. LEXIS 20345, at *23 (D. Colo. Mar. 2, 2009) (finding "the ALJ's decision makes no reference to . . . all the different medications the Plaintiff has tried to relieve her migraines. In fact, Plaintiff has been prescribed Ultram, Tylenol # 3, Darvocet, Fioricet, Propoxyphene and Disalsid (Tr. 187, 194, 199, 203, 209, 220). The ALJ also did not address. . . the frequency of Plaintiff's medical contacts for her migraines. The record discloses 29 visits by Plaintiff to Dr. Tran for treatment of her headaches from May 2002 to March 2007 (Tr. 194-95, 199, 202-04, 205-06, 209-12, 219-25, 227). This oversight by the ALJ was substantial, as the agency has recognized that

‘[p]ersistent attempts by the individual to obtain relief of pain or other symptoms ... may be a strong indication that the symptoms are a source of distress to the individual and generally lend support to an individual's allegations of intense and persistent symptoms.’ Soc. Sec. Ruling 96-7p...”).

³⁸⁶ *E.g.*, *Gutierrez v. Astrue*, 2013 U.S. Dist. LEXIS 316, at *13-14 (D. Or. Jan. 2, 2013) (“Mr. Gutierrez cites numerous instances in the medical record addressing his inability to understand diabetic diet instructions.”)

³⁸⁷ *E.g.*, *Jones v. Astrue*, 2011 U.S. Dist. LEXIS 89366, *27 (E.D. Tenn. July 20, 2011) (concluding that “this case should be remanded so that the ALJ can properly evaluate Plaintiff's credibility by (1) explaining his reasoning, and (2) appropriately addressing the credibility findings made by Mr. Porter, Dr. Sachs, and Dr. Walwyn.”) *But see* SSR 96-7p, *supra* note 26 (stating that findings by State agency consultants and other program physicians and psychologists on the credibility of the individual's statements about limitations or restrictions due to symptoms are findings of fact that should be weighed under the applicable regulations and policy rulings governing nonexamining sources).

³⁸⁸ *E.g.*, *Alexander v. Astrue*, 2011 U.S. Dist. LEXIS 7924, at *15-16 (W.D. La. Jan. 6, 2011) (stating that an ALJ may not “pick and choose” only the evidence that supports his or her opinion and finding that the ALJ “failed ignored multiple diagnoses and medications for management of neuropathy, and instead relied on a single medical opinion that was itself issued without the benefit of reviewing any other medical records.”); *Damm v. Comm'r of Soc. Sec.*, 2010 U.S. Dist. LEXIS 84996, at *21-26 (D.N.J. Aug. 18, 2010).

³⁸⁹ *E.g.*, *Penland v. Astrue*, 2011 U.S. Dist. LEXIS 144616, at *17 (W.D.N.C. Sept. 19, 2011) (credibility finding strongly contraindicated by uncontroverted objective medical evidence); *Gol v. Comm'r of Soc. Sec.*, 2010 U.S. Dist. LEXIS 22787, at *39-51 (M.D. Fla. Mar. 11, 2010).

³⁹⁰ *Dygert v. Astrue*, 2010 U.S. Dist. LEXIS 109954, at *20-21 (N.D.N.Y. Sept. 7, 2010) (noting “tainted” credibility assessment as a result of flawed application of treating physician rule); *Cooper v. Astrue*, 2010 U.S. Dist. LEXIS 75726, at *22 (N.D.N.Y. May 27, 2010) (“Because the Court has already concluded that the treating physician's opinions and the consultative physician's opinions were improperly assessed, the ALJ's analysis of Plaintiff's subjective allegations is necessarily flawed.”). In one case the court made it clear that an adjudicator may not disregard a treating source's medical opinion because he or she makes an adverse credibility determination about the claimant. *Peters v. Astrue*, 2010 U.S. Dist. LEXIS 101044, at *22 (N.D. Ga. Sept. 23, 2010).

³⁹¹ *E.g.*, *Felder*, 2012 U.S. Dist. LEXIS 129384, at *44 (E.D.N.Y. Sept. 11, 2012); *Andrews v. Astrue*, No. 7-10-1202, 2012 U.S. Dist. LEXIS 117956, at *36-37 (N.D.N.Y. Aug 21, 2012); *Sopher v. Astrue*, No. 10-184, 2011 U.S. Dist. LEXIS 87381, at *34-36 (W.D. Pa. Aug. 8, 2011); *McKnight v. Astrue*, No. 4-10-02126, 2011 U.S. Dist. LEXIS 122349, at *102 (M.D. Pa. Oct. 21, 2011); *Deweese v. Astrue*, No. 10-3483, 2011 U.S. Dist. LEXIS 145548, at *5 (W.D. Mo. Dec. 19, 2011); *Jefferson v. Astrue*, No. 4-11-921, 2012 U.S. Dist. LEXIS 145988, at *42 (E.D. Mo. Oct. 10, 2012).

³⁹² *E.g.*, *Jeffries v. Astrue*, No. 3-10-1405, 2012 U.S. Dist. LEXIS 11995, at *76-77 (S.D.W. Va. Feb. 1, 2012) (“Although Claimant's work history is commendable, it is not sufficient in and of itself to entitle Claimant to ‘substantial credibility’ given the lack of evidence corroborating Claimant's testimony.”); *Melancon v. Astrue*, No. 6-11-01389, 2012 U.S. Dist. LEXIS 106882, at *19 (W.D. La. June 6, 2012) (declining to follow the Second, Third and Eighth Circuits).

³⁹³ *E.g.*, *Poe v. Astrue*, 2009 U.S. Dist. LEXIS 94036, at *38-39 (D. Ariz. 2009) (“As an initial matter, Plaintiff has a solid forty-five-year work record, which bolsters his credibility regarding his inability to work.”).

³⁹⁴ *Bazile v. Apfel*, 113 F. Supp. 2d 181, 190 (D. Mass. 2000) (finding the First Circuit “explicitly stopped short” of adopting the credit-as-true rule, citing *Nguyen v. Chater*, 172 F.3d 31, 36 (1st Cir. 1999) and *Corchado v. Shalala*, 953 F. Supp. 12, 16 (1st Cir. 1996)); *Hoffman v. Chater*, No. 94-4183, 1995 U.S. Dist. LEXIS 12992, at *5-6 (D. Kan. Aug. 14, 1995) (finding no Tenth Circuit authority for the credit-as-true rule, declining to follow Eleventh Circuit precedent).

³⁹⁵ *E.g.*, *Byrd v. Astrue*, No. 09-781, 2010 U.S. Dist. LEXIS 99489, at *33-34 (S.D. Ala. Sept. 21, 2010) (finding that the credit-as-true rule is applicable when statements are ignored, but not when statements are improperly discounted).

³⁹⁶ *Iniguez v. Astrue*, No. 09-1902, 2010 U.S. Dist. LEXIS 78750, at *12-13 (C.D. Cal. Aug. 3, 2010) (citing *Reddick v. Chater*, 157 F.3d 715, 722 (9th Cir. 1998) and *Smolen v. Chater*, 80 F.3d 1273, 1283 (9th Cir. 1996), characterizing “specific, clear, and convincing reasons” as a “high standard”).

³⁹⁷ In five W.D.N.Y. cases in the sample, nearly twenty percent (20%) of remands with awards, U.S. District Judge Telesca entered a direct award of benefits.

³⁹⁸ SOC. SEC. ADMIN., HEARINGS, APPEALS, AND LITIG. LAW MANUAL I-5-4-71, PADRO ET AL. V. COLVIN (May 20, 2014), available at http://www.ssa.gov/OP_Home/hallex/I-05/I-5-4-71.html.

³⁹⁹ *Supra* notes 254-264 and accompanying text.

⁴⁰⁰ *Fluker v. Comm'r of Soc. Sec.*, No. 12-10612, 2013 U.S. Dist. LEXIS 41722, at *46-47 (E.D. Mich. Feb. 11, 2013) (magistrate judge recommending remand for further proceedings due to bias), *rejected, in part, adopted, in part*, No. 12-10612, 2013 U.S. Dist. LEXIS 36695, at *11-12 (E.D. Mich. Mar. 18, 2013) (adopting finding of bias, remanding for the sole purpose of calculating benefits award). *See also Nix v. Astrue*, No. 07-CV-344, 2009 U.S. Dist. LEXIS 98356, at *18-19 (W.D.N.Y. Oct. 22, 2009) (finding “the ALJ was curt” and unfairly labeled the claimant “histrionic”); *Rodriguez v. Astrue*, No. 09-1810, 2010 U.S. Dist. LEXIS 51979, at *37 (N.D. Ill. May 26, 2010) (criticizing ALJ for characterizing claimant as “dramatic” and “exaggerating”).

⁴⁰¹ *See* Hearings, Appeals, and Litig. Law Manual I-3-1-71, ALLEGATIONS OF UNFAIRNESS, PREJUDICE, PARTIALITY, BIAS, MISCONDUCT, OR DISCRIMINATION BY ADMINISTRATIVE LAW JUDGES (ALJ) (June 17, 2014) (authorizing the Appeals Council to refer cases alleging bias to the Division of Quality Service for handling), *available at* http://www.socialsecurity.gov/OP_Home/hallex/I-03/I-3-1-25.html (last visited Sept. 02, 2014); Hearings, Appeals, and Litig. Law Manual I-1-8, DIVISION OF QUALITY SERVICE (varying dates) (discussing the Division of Quality Service’s role in reviewing such allegations of bias), *available at* http://www.socialsecurity.gov/OP_Home/hallex/I-01/I-1-8.html (last visited Sept. 02, 2014).

⁴⁰² 20 C.F.R. §§ 404.1529, 416.929.

⁴⁰³ 20 C.F.R. §§ 404.1529(c)(2), 416.929(c)(2).

⁴⁰⁴ *See* G. JACOBS ET AL., *supra* note 168.

⁴⁰⁵ 20 C.F.R. §§ 404.1529(c)(3), 416.929(c)(3).

⁴⁰⁶ 20 C.F.R. §§ 404.1529(c)(2), 416.929(c)(2).

⁴⁰⁷ *Polaski v. Heckler*, 739 F.2d 1320, 1321-22 (8th Cir. 1984); 20 C.F.R. §§ 404.1529(c)(3), 416.929(c)(3).

⁴⁰⁸ 20 C.F.R. §§ 404.1529(c)(3)(i), 416.929(c)(3)(i).

⁴⁰⁹ 20 C.F.R. §§ 404.1529(c)(3)(v)-(vi), 416.929(c)(3)(v)-(vi).

Part VI References:

⁴¹⁰ *E.g.*, Gregory C. Flatt, *All in Your Head: A Comprehensive Approach to Somatoform Disorders in Adult Disability Claims*, 87 WASH. U. L. REV. 1397 (2009-10).

⁴¹¹ *E.g.*, Lawrence T. King and Traci Reid-Miodrag, “*I Feel Your Pain*”: *Visible Evidence of Invisible Phenomena and Other Tales of Round Pegs and Square Holes*, 32 AM. J. TRIAL ADVOC. 235 (2008); Adam J. Kolber, *Pain Detection and the Privacy of Subjective Experience*, 33 AM. J.L. & MED. 433 (2007); Michael Finch, *Law and the Problem of Pain*, 74 U. CIN. L. REV. 285 (2005-2006).

⁴¹² Elizabeth Schneider and Joseph Simeone, *Pain and Disability Under Social Security: Time for a New Standard*, 34 J. OF HEALTH L. 459 (2001) [pincite unavailable on LexisNexis].

⁴¹³ *Id.* at [pincite unavailable on LexisNexis].

⁴¹⁴ Earlier academic literature also describes a history of inconsistent case law and Professor Dubin’s four-part framework for categorizing approaches to subjective symptom evaluation is particularly helpful for understanding the potential for conflict. *See* Jon C. Dubin, *Poverty, Pain, and Precedent: The Fifth Circuit’s Social Security Jurisprudence*, 25 St. Mary’s L.J. 81, 111-12 (1993-1994).

⁴¹⁵ SSR 96-7p, *supra* note 26.

⁴¹⁶ Christopher E. Pashler, *Mirror, Mirror on the Wall: Stigma and Denial in Social Security Disability Hearings*, 43 U. MEM. L. REV. 419, 576-76 (2012).

⁴¹⁷ Clara W. Dworsky, *What to Do about Bias: Social Security Q&A*, 12 EXPERIENCE 44 (2002).

⁴¹⁸ *Id.* at 45 (citing *Miller v. Shalala*, 953 F.2d 417 (8th Cir. 1992) and *Sarcher v. Chater*, 78 F.3d 305 (7th Cir. 1996)).

⁴¹⁹ Jason D. Vendel, Note, *General Bias and Administrative Law Judges: Is There a Remedy For Social Security Claimants?*, 90 CORNELL L. REV. 769, 778 (2005).

⁴²⁰ *Id.* at 780 (quoting *Grant v. Comm'r*, 111 F.Supp. 2d 556, 558-59 (M.D. Pa. 2000)).

⁴²¹ *Grant v. Comm'r*, 111 F.Supp. 2d 556, 570 (M.D. Pa. 2000) (citing *Ventura v. Shalala*, 55 F.3d 900, 904 (3d Cir. 1995) and *Hummel v. Heckler*, 736 F.2d 91, 92 (3d Cir. 1984) for the proposition that “even if the record was totally devoid of evidence supporting a finding of disability, ‘the bias of the adjudicator might still be a ground for setting aside a determination adverse to the claimant, for we have repeatedly held that in Social Security disability claim hearings the administrative law judge has an affirmative obligation to assist the claimant in developing the facts.’”).

⁴²² *Id.* at 566-69.

⁴²³ *Supra* notes 104-105 and accompanying text.

⁴²⁴ In a non-comprehensive review Conference staff identified 11 congressional hearings on social security disability issues in 2011, 10 in 2012, and 11 in 2013, and 6 in the first half of 2014.

⁴²⁵ Congressional Research Service reports are generally not available to the public on the agency's website. Government Accountability Office and SSA's OIG publications provided general background information, including on the history of subjective symptom evaluation at SSA, and major findings reported by these agencies have been incorporated throughout the report.

⁴²⁶ E.g., *The Challenges of Achieving Fair and Consistent Disability Decisions: Hearing Before the Subcomm. on Soc. Sec. of the H. Comm. on Ways and Means*, 113th Cong. 4 (2013) (statement of Trudy Lyon-Hart, President of the Nat'l Council of Disability Determination Dirs., describing the complexity of symptom evaluation); *The Challenges of Achieving Fair and Consistent Disability Decisions: Hearing Before the Subcomm. on Soc. Sec. of the H. Comm. on Ways and Means*, 113th Cong. 6 (2013) (statement of David G. Hatfield, A.L.J. (ret.) describing the subjective nature of aspects of social security decisionmaking, including symptom evaluation); *Social Security Disability Claims Backlogs: Joint Hearing Before the Subcomm. on Income Sec. and Family Support and Subcomm. on Soc. Sec. of the H. Comm. on Ways and Means*, 111th Cong. 16 (2010) (statement of Nancy Shor, Exec. Dir., Nat'l Org. of Soc. Sec. Claimants' Representatives, recommending training on the evaluation of subjective symptoms); *Soc. Sec. Disability Backlogs: Hearing Before the Subcomm. on Soc. Sec. of the H. Comm. on Ways and Means*, 110th Cong. 44 (2007) (statement of Nancy Shor, Exec. Dir., Nat'l Org. of Soc. Sec. Claimants' Representatives commenting that pain evaluation at the state disability determination services level is insufficient).

⁴²⁷ MINORITY STAFF OF PERMANENT SUBCOMM. ON INVESTIGATIONS OF THE S. COMM. ON HOMELAND SEC. AND GOV'T AFFAIRS, 112TH CONG., SOCIAL SECURITY DISABILITY PROGRAMS: IMPROVING THE QUALITY OF BENEFIT AWARD DECISIONS 14-15 (Comm. Print 2012).

⁴²⁸ *Id.* at 4, 22.

⁴²⁹ *Id.* at 65-67.

⁴³⁰ See *Social Security Disability Programs: Improving the Quality of Benefit Award Decisions: Hearing Before the Permanent Subcomm. on Investigations of the S. Comm. on Homeland Sec. and Gov't Affairs*, 112th Cong. 50-51, 900 (2012) (statements of Sen. Coburn, Member, Permanent Subcomm. on Investigations, questions from Subcomm. Staff); SOC. SEC. ADMIN., OFFICE OF THE INSPECTOR GEN., CONGRESSIONAL RESPONSE REPORT: THE SOCIAL SECURITY ADMINISTRATION'S POLICY ON SYMPTOM VALIDITY TESTING IN DETERMINING DISABILITY CLAIMS, A-08-13-23094, app. at D-1 (Sept. 2013) (responding to an inquiry by Sen. Coburn); STAFF OF S. COMM. ON HOMELAND SEC. AND GOV'T AFFAIRS, 113TH CONG., HOW SOME LEGAL, MEDICAL, AND JUDICIAL PROFESSIONALS ABUSED SOCIAL SECURITY DISABILITY PROGRAMS FOR THE COUNTRY'S MOST VULNERABLE: A CASE STUDY OF THE CONN LAW FIRM 8 (Comm. Print 2013) ("The Office of Appellate Operations, Quality Division, should provide training to all ALJs regarding adequate articulation in opinions of legal determinations. This training should emphasize the proper way to analyze and address these issues as required by law, regulation and agency guidance, including how to address obesity and drug and alcohol abuse.").

⁴³¹ Protecting Social Security Disability Act of 2014, S. 3003, 113th Cong. § 207(d)-(e) (2014).

⁴³² Staff also searched the websites of claimant and administrative law judge organizations for relevant materials; none were identified.

⁴³³ The AALJ was founded in 1971 as a professional organization. It became the SSA ALJ union in 1999; currently its membership includes eighty percent (80%) of SSA ALJs. See AALJ, Mission & History, <http://www.aalj.org/mission-history> (last visited July 30, 2014).

⁴³⁴ The FALJC is a professional organization that represents the interests of the federal administrative judiciary across the federal government; membership is limited to current or retired administrative law judges. See FALJC, Membership, <http://www.faljc.org/membership/> (last visited July 30, 2014).

⁴³⁵ Statement of Trudy Lyon-Hart, President of the Nat'l Council of Disability Determination Dirs. *supra* note 426; Letter from Trudy Lyon-Hart, President of the Nat'l Council of Disability Determination Dirs., to Rep. Sam Johnson, Chairman of the Subcomm. on Soc. Sec. of the H. Comm. on Ways and Means (May 23, 2013) (on file with the author).

⁴³⁶ However, two individual ALJs recommended that disability decisions be made exclusively on the basis of objective medical evidence alone, rather than after consideration of subjective symptoms. Letter from Admin. L. J. Member One, to Stephanie Tatham, Att'y Advisor Admin. Conf. of the U.S. (June 9, 2014) [hereinafter ALJ Member One]; Letter from Admin. L. J. Member Two to Stephanie Tatham, Att'y Advisor Admin. Conf. of the U.S. (June 9, 2014) [hereinafter ALJ Member Two]. One ALJ felt that the existing regulations and rulings place "an unreasonable burden on the ALJs adjudicating the case." ALJ Member One at 1-2.

⁴³⁷ Letter from Cynthia Berger, President, Bd. Of Dirs., Nat'l Org. of Soc. Sec Claimants' Reps. and Barbara Silverstone, Exec. Dir. Nat'l Org. of Soc. Sec. Claimants' Reps., to Stephanie Tatham, Att'y Advisor Admin. Conf. of the U.S., at 2 (June 9, 2014) [hereinafter NOSSCR Response].

⁴³⁸ Letter from Nat'l Ass'n of Disability Reps., to Stephanie Tatham, Att'y Advisor Admin. Conf. of the U.S., at 1

(June 9, 2014) [hereinafter NADR Response].

⁴³⁹ Letter from Jeffrey Price, President, National Association of Disability Examiners, to Stephanie Tatham, Attorney Advisor, Admin. Conf. of the U.S., at 1 (Nov. 4, 2014) [hereinafter NADE Response].

⁴⁴⁰ Letter from Thomas M. Susman, Director, Governmental Affairs Office, American Bar Association, to Paul R. Verkuil, Chairman, Admin. Conf. of the U.S (July 2, 2014).

⁴⁴¹ NOSSCR Response at 9.

⁴⁴² NADE Response at 3.

⁴⁴³ NADR Response at 3.

⁴⁴⁴ *Id.* at 4.

⁴⁴⁵ NOSSCR Response at 12.

⁴⁴⁶ *Id.*

⁴⁴⁷ Letter from Admin. L. J. Member Three, to Stephanie Tatham, Att’y Advisor Admin. Conf. of the U.S. (June 9, 2014) [hereinafter ALJ Member Three].

⁴⁴⁸ *Id.*

⁴⁴⁹ NADE Response at 2.

⁴⁵⁰ NADR Response at 3.

⁴⁵¹ NADE Response at 2.

⁴⁵² ALJ Member Three at 5.

⁴⁵³ ALJ Member Two at 1.

⁴⁵⁴ Ass’n of Admin. L. J. National Executive Board, Suggested Responses to ACUS Questionnaire 2 (June 15, 2014).

⁴⁵⁵ A number of additional suggestions for improving disability adjudication were outside the limited focus of this report but may be reviewed in the responses at **Appendix G: Stakeholder Questionnaire Responses**. NOSSCR supports retention of the treating physician rule, but urged SSA to expand its definition of “acceptable medical source” to include other primary treating sources. The AALJ and an individual ALJ urged SSA to either provide advocates for the government during disability hearings or permit more vigorous questioning of claimants. NADR suggested that SSA consider a new musculoskeletal medical listing given evidence of three or more spinal surgeries. NADE urged SSA to reconsider its policy on acceptable medical sources in determining whether a Medically Determinable Impairment exists. [*Note: this footnote has been amended to accurately reflect NOSSCR’s views.]

Part VII References:

⁴⁵⁶ Of course, any policy is unlikely to garner universal acceptance. *See* note 436 identifying contrary personal opinions of two individual ALJ’s.

⁴⁵⁷ Social Security Disability Benefit Reform Act of Oct. 9, 1984, Pub. L. No. 98-460 § 3(a)(3), 98 Stat. 1794 (codified as amended in scattered sections of 20 U.S.C.).

⁴⁵⁸ National Council of State Housing Agencies, Congress Passes FY 2014 Omnibus Appropriations Bill, <http://www.ncsha.org/blog/congress-passes-fy-2014-omnibus-appropriations-bill> (Jan. 17, 2014) (describing funding of \$9.9 billion for Project-based Section 8 programs and \$29.2 billion for vouchers). Of course, only a percentage of these benefits accrue to persons with disabilities.

⁴⁵⁹ 24 CFR 5.403 Person with disabilities (1)(i).

⁴⁶⁰ 20 C.F.R. §§ 404.1508, 416.908. For the sake of clarity, the Section 404 regulations are cited in text. It is notable that SSA has adopted two separate—three if you count the Railroad Retirement Board—sets of regulations on symptom evaluation that are identical. The separate sets of citations lead to duplicative case law research and create the potential for conflicting regulatory interpretations. This is particularly true for the identical regulations of the Railroad Retirement Board, which is a separate independent federal agency that presumably is entitled to deference in the interpretation of its own regulations. A better approach might be to incorporate identical regulatory provisions by reference rather than repetition.

⁴⁶¹ 45 Fed. Reg. 55,566 (Aug. 20, 1980), *amended by* 56 Fed. Reg. 36,954 (Aug. 1, 1991).

⁴⁶² 45 Fed. Reg. 55,566, 55,571 (Aug. 20, 1980).

⁴⁶³ 20 C.F.R. §§ 404.1528, 416.928.

⁴⁶⁴ 5 U.S.C. § 553.

⁴⁶⁵ *See supra* notes 281-284 and accompanying text.

⁴⁶⁶ *See Part V, Subpart E: Case law conclusions.*

⁴⁶⁷ The National Academies, Current Projects System: Project Information, Project Title Psychological Testing, Including Symptom Validity Testing, for Social Security Administration Disability Determinations, IOM-BSP-13-

09, <http://www8.nationalacademies.org/cp/projectview.aspx?key=49622> (last accessed Aug. 1, 2014).

⁴⁶⁸ This was recommended also by the 1986 Commission on the Evaluation of Pain regarding initial development of these materials. DAPPER, *supra* note 56.

⁴⁶⁹ *Supra* notes 140-142 and accompanying text.

⁴⁷⁰ Mar. 13, 2014 email, *supra* note 225.

⁴⁷¹ See **Appendix C: The Electronic Claims Analysis Tool.**

⁴⁷² *Supra* notes 149-151.

⁴⁷³ See, e.g., G. JACOBS ET AL., ASSESSING THE IMPACT OF THE REGION I PILOT PROGRAM, Report to the Soc. Sec. Admin. (2013) (examining the volume and timing of evidentiary submissions relative to hearing dates), *available at* <https://www.acus.gov/report/assessing-impact-region-i-pilot-program>.

⁴⁷⁴ *Social Security Disability Programs: Improving the Quality of Benefit Award Decisions: Hearing before the Permanent Subcomm. on Investigations of the S. Comm. on Homeland Sec. and Gov't Affairs*, 112th Cong. 1, 2 (2012) (statement of J. Patricia Jonas, Exec. Dir., Office of Appellate Operations, Office of Disability and Rev., Soc. Sec. Admin.).

⁴⁷⁵ *Id.* at 1.

⁴⁷⁶ *Id.*