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1320-1

Medical opinions are statements from acceptable medical sources that reflect judgments about the nature and severity of a claimant's impairment(s), including symptoms, diagnosis and prognosis, what the claimant can still do despite impairment(s), and physical or mental restrictions. Medical opinions may be received from treating sources, nontreating sources who have examined the claimant (e.g., consulting physicians or psychologists), and nonexamining sources (e.g., physicians and psychologists who work for insurance companies, disability determination services) other than those who work for the disability determination services (DDS) or SSA. (For treatment of DDS or SSA physicians, consult POMS DI 24515.007.) In addition to considering medical opinions, evidence from other sources (e.g., chiropractors) may be used to help understand how the claimant's impairment affects his or her ability to work. (POMS DI 24515.002A.)

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When the case record contains an opinion from a claimant's treating source, it may be given controlling weight or more weight than an opinion from a nontreating source. Give controlling weight to a treating source's medical opinion regarding the nature and severity of the claimant's impairment(s) if the opinion is well supported by medically acceptable clinical and laboratory diagnostic techniques and it is not inconsistent with the other substantial medical or nonmedical evidence in the case record. (POMS DI 24515.003A.2.) Generally, give more weight to:

- (1) Medical opinions from sources who have examined the claimant than from sources which have not examined the claimant.
- (2) Treating source opinions than nontreating source opinions. (POMS DI 24515.005)
- (3) An opinion from a medical source who provides relevant supporting evidence (e.g., medical signs, laboratory findings) and a better explanation for the opinion.
- (4) An opinion consistent with other evidence of record.
- (5) The opinion of a specialist about medical issues related to the source's specialty.

(POMS DI 24515.003A.4.)

1320-3

The opinions of state agency medical and psychological consultants, and other program physicians and psychologists, are generally given less weight than the opinions of treating sources. (20 CFR §416.927(f); POMS DI 24515.003) In appropriate circumstances, opinions from these state agency sources may be entitled to greater weight (but only when they are supported by evidence in the case record) than that accorded to treating or examining sources. For example, greater weight may be given to the state source when the medical or psychologist's opinion is based "...on a review of a complete case record that includes a medical report from a specialist in the individual's particular impairment which provides more detailed and comprehensive information than what was available to the individual's treating source." (POMS DI 24515.013B.; Social Security Ruling 96-6p)

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An ALJ is not bound by the uncontroverted opinions of the applicant's physicians on the ultimate issue of disability, but cannot reject them without presenting clear and convincing reasons for doing so. Neither personal observations by the ALJ at the hearing nor the inability of the reporting physicians to support their opinions with objective findings constitutes the required clear and convincing reasons to reject uncontroverted opinions. The ALJ's personal observations are especially inadequate to rebut expert opinions in a case involving psychiatric impairment. (*Montijo v. Secretary* (1984) 729 F.2d 599, 601-602)

1320-5

When resolving a conflict between the opinions of a treating physician and an examining physician, the opinion of the treating physician is entitled to greater weight, and may be rejected only on the basis of findings setting forth specific, legitimate reasons based on substantial evidence in the record. (*Sprague v. Bowen* (1987) 812 F.2d 1226, 1230) The opinions of treating physicians are entitled to greater weight than "one-shot" consultants since the treating doctor is "employed to cure" and has a greater opportunity to observe and know the applicant as an individual. (*Murray v. Heckler* (1983) 722 P.2d 499, 502)

1320-6

Where a treating physician states an opinion which is uncontradicted and which rests on substantial medical evidence, such opinion shall not be disregarded by an Administrative Law Judge (ALJ) unless clear and convincing reasons for doing so are set forth. An ALJ must accept the treating physician's opinion in the absence of clear and convincing reasons to reject it. (*Davis v. Heckler*, (1989) 868 F.2d 323; *Lester v. Chater* (1996) 81 F. 3d 821; *Magallanes v. Bowen* (1989) 881 F. 2d 747)

When the ALJ had pointed to specific examples where the treating physician's reported level of the claimant's impairment was not consistent with the claimant's described symptoms, and the ALJ had also pointed to inconsistencies between the reports of the treating physicians, his detailed and thorough summary of the facts and conflicting clinical evidence entitled him to reject the treating physicians' opinions. (*Morgan v. Commisioner* (1999) 169 F. 3d 595)

1320-7

In evaluating medical source opinions under 20 CFR §416.927, the Social Security Rulings (SSRs) give the following guidance.

1. Opinions About Whether an Individual's Impairment Meets the Requirements of a Listed Impairment

Whether the findings for an individual's impairment meet the requirements of an impairment in the listings is usually more a question of medical fact than a question of medical opinion. Many of the criteria in the listings relate to the nature and severity of impairments; e.g., diagnosis, prognosis and, for those listings that include such criteria, symptoms and functional limitations. In most instances, the requirements of listed impairments are objective, and whether an individual's impairment manifests these requirements is simply a matter of documentation. To the extent that a treating source is usually the best source of

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this documentation, the adjudicator looks to the treating source for medical evidence with which he or she can determine whether an individual's impairment meets a listing. When a treating source provides medical evidence that demonstrates that an individual has an impairment that meets a listing, and the treating source offers an opinion that is consistent with this evidence, the adjudicator's administrative finding about whether the individual's impairment(s) meets the requirements of a listing will generally agree with the treating source's opinion.

2. Opinions on Whether an Individual's Impairment(s) Is Equivalent In Severity to the Requirements of a Listed Impairment

In 20 CFR §416.926, equivalence is addressed as a "decision *** on medical evidence only" because this finding does not consider the vocational factors of age, education, and work experience. A finding of equivalence involves more than findings about the nature and severity of medical impairments. It also requires a judgment that the medical findings equal a level of severity set forth in 20 CFR §416.925(a); i.e., that the impairment(s) is "...severe enough to prevent a person from doing any gainful activity." This finding requires familiarity with the regulations and legal standard of severity set forth in 20 CFR §§416.925(a) and 416.926.

3. Residual Functional Capacity Assessments and Medical Source Statements

The regulations describe two distinct kinds of assessments of what an individual can do despite the presence of a severe impairment(s). The first is described in 20 CFR §416.913(b) and (c) as a "statement about what you can still do despite your impairment(s)" made by an individual's medical source and based on that source's own medical findings. This "medical source statement" is an opinion submitted by a medical source as part of a medical report. The second category of assessments is the RFC assessment described in 20 CFR §§416.945, and 416.946 which is the adjudicator's ultimate finding of "what you can still do despite your limitations." Even though the adjudicator's RFC assessment may adopt the opinions in a medical source statement, they are not the same thing: A medical source statement is evidence that is submitted to SSA by an individual's medical source reflecting the source's opinion based on his or her own knowledge, while an RFC assessment is the adjudicator's ultimate finding based on a consideration of this opinion and all the other evidence in the case record about what an individual can do despite his or her impairment(s).

a. Medical Source Statements

Medical source statements are medical opinions submitted by acceptable medical sources, including treating sources and consultative examiners, about what an individual can still do despite a severe impairment(s), in particular about an individual's physical or mental abilities to perform work-related activities on a sustained basis. (The term "acceptable medical sources" is defined in 20 CFR §416.913(a)) Adjudicators are generally required to request that acceptable medical sources provide these statements with their medical reports. Medical source statements

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are to be based on the medical sources' records and examination of the individual; i.e., their personal knowledge of the individual. Therefore, because there will frequently be medical and other evidence in the case record that will not be known to a particular medical source, a medical source statement may provide an incomplete picture of the individual's abilities.

Medical source statements submitted by treating sources provide medical opinions which are entitled to special significance and may be entitled to controlling weight on issues concerning the nature and severity of an individual's impairment(s). Adjudicators must remember, however, that medical source statements may actually comprise separate medical opinions regarding diverse physical and mental functions, such as walking, lifting, seeing, and remembering instructions, and that it may be necessary to decide whether to adopt or not adopt each one.

b. RFC Assessment

The term "residual functional capacity assessment" describes an adjudicator's finding about the ability of an individual to perform work-related activities. The assessment is based upon consideration of all relevant evidence in the case record, including medical evidence and relevant nonmedical evidence, such as observations of lay witnesses of an individual's apparent symptomatology, an individual's own statement of what he or she is able or unable to do, and many other factors that could help the adjudicator determine the most reasonable findings in light of all the evidence.

c. Medical Source Statement vs. RFC Assessment

A medical source's statement about what an individual can still do is medical opinion evidence that an adjudicator must consider together with all of the other relevant evidence when assessing an individual's RFC. Although an adjudicator may decide to adopt all of the opinions expressed in a medical source statement, a medical source statement must not be equated with the administrative finding known as the RFC assessment. Adjudicators must weigh medical source statements under the rules set out in 20 CFR §416.927, providing appropriate explanations for accepting or rejecting such opinions.

From time-to-time, medical sources may provide opinions that an individual is limited to "sedentary work," "sedentary activity," "light work," or similar statements that appear to use the terms set out in our regulations and Rulings to describe exertional levels of maximum sustained work capability. Adjudicators must not assume that a medical source using terms such as "sedentary" and "light" is aware of our definitions of these terms. The judgment regarding the extent to which an individual is able to perform exertional ranges of work goes beyond medical judgment regarding what an individual can still do and is a finding that may be dispositive of the issue of disability.

At Steps 4 and 5 of the sequential evaluation process in 20 CFR §416.920, the adjudicator's assessment of an individual's RFC may be the most critical finding

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contributing to the final determination or decision about disability. Although the overall RFC assessment is an administrative finding on an issue reserved to the Commissioner, the adjudicator must nevertheless adopt in that assessment any treating source medical opinion (i.e., opinion on the nature and severity of the individual's impairment(s)) to which the adjudicator has given controlling weight under the rules in 20 CFR §416.927(d)(2).

4. Opinions on Whether an Individual Is Disabled

Medical sources often offer opinions about whether an individual who has applied for Title II or Title XVI disability benefits is "disabled" or "unable to work," or make similar statements of opinions. In addition, they sometimes offer opinions in other work-related terms; for example, about an individual's ability to do past relevant work or any other type of work. Because these are administrative findings that may determine whether an individual is disabled, they are reserved to the Commissioner. Such opinions on these issues must not be disregarded. However, even when offered by a treating source, they can never be entitled to controlling weight or given special significance.

5. Findings of State Agency Medical and Psychological Consultants

Medical and psychological consultants in the State agencies are adjudicators at the initial and reconsideration determination levels (except in disability hearings - see 20 CFR §416.1414 ff.). As such, they do not express opinions; they make findings of fact that become part of the determination. However, 20 CFR §416.927(f) provides that, at the administrative law judge and Appeals Council levels of the administrative review process, medical and psychological consultant findings about the nature and severity of an individual's impairment(s), including any RFC assessments, become opinion evidence. Adjudicators at these levels, including administrative law judges and the Appeals Council, must consider these opinions as expert opinion evidence of nonexamining physicians and psychologists and must address the opinions in their decisions. In addition, under 20 CFR §416.926, adjudicators at the administrative law judge and Appeals Council levels must consider and address State agency medical or psychological consultant findings regarding equivalence to a listed impairment.

At the administrative law judge and Appeals Council levels, adjudicators must evaluate opinion evidence from medical or psychological consultants using all of the applicable rules in 20 CFR §416.927 to determine the weight to be given to the opinion.

(SSR 96-5p, referring also to SSR 96-6p which deals with ALJ responsibilities; POMS DI 24515.009B., revised February 2001)

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Acceptable medical sources are:

- (1) Licensed physicians;
- (2) Licensed osteopaths;

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- (3) Licensed or certified psychologists;
- (4) Licensed optometrists for the measurement of visual acuity and visual fields; and
- (5) Persons authorized to send us a copy or summary of the medical records of a hospital, clinic, sanitarium, medical institution, or health care facility;
- (6) A report of an interdisciplinary team that contains the evaluation and signature of an acceptable medical sources is also considered acceptable medical evidence.

(20 CFR 416.913 (a))

The CFR goes on to state that information from other sources may also help us to understand how your impairment(s) affects your ability to work. Other sources may include, and are not limited to:

- (1) Public and private social welfare agencies and social workers;
- (2) Observations by people who know you;
- (3) Other practitioners (for example, nurse practitioners and physicians' assistants, naturopaths, and chiropractors);
- (4) Therapists (for example, physical, occupational, or speech and language therapists); and
- (5) Educational agencies and personnel.

(20 CFR 416.913(e))

1320-9

The 9th Circuit Court of Appeals reviewed an ALJ's denial of an applicant's claim for Social Security disability (SSD) benefits after the Department of Veteran Affairs (VA) had determined the applicant was 80% disabled due to depression and lower back injury. The ALJ had not mentioned the VA determination in his opinion.

The Court, following the approach of the Fourth, Fifth and Eleventh Circuits, held that in "... an SSD case an ALJ must ordinarily give great weight to a VA determination of disability."

Based on the record before it and the VA finding of disability, the Court found the applicant disabled throughout the relevant period.

(*McCartey v. Massanari*, 2002 Daily Journal DAR 8870, August 6, 2002)

1321-1

When the extent of erosion of the unskilled sedentary occupational base is not clear, the adjudicator may consult the DOT, the Selected Characteristics of Occupations (SCO), the Occupational Outlook Handbook, or County Business Patterns.

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In more complex cases, a vocational expert (VE) or specialist may be consulted. VEs are vocational professionals who provide impartial expert opinions during all phases of the hearing process. The opinions of VEs are evidence, but are not binding on the adjudicator. Whenever a VE is used, the individual has the right to review and respond to the VE evidence prior to the issuance of a decision.

(POMS DI 25015.020B.8)

1321-2

The 9th Circuit Court of Appeals, in the *Burkhart* case, dealt with the individual who does not fall within the Grids:

“Once a claimant establishes a prima facie case of disability by demonstrating the claimant cannot return to his or her former employment, the burden then shifts to the Secretary to show that the claimant can perform other types of work in the national economy, given the claimant's age, education and work experience.” (*Burkhart v. Bowen* (1988) 856 F.2d at 1335, 1340)

The Secretary can use the Grids “only when the grids accurately and completely describe the claimant's abilities and limitations.” *Jones v. Heckler* (9th Circuit 1985) 760 F.2d 993, 998. Where there are significant nonexertional limitations (“significant” meaning “sufficiently severe”) then the Secretary must take the testimony of a vocational expert.

“Nonexertional limitations” are limitations that do not directly affect a claimant's strength. They include mental, sensory, postural, manipulative or environmental limitations that affect a claimant's ability to work.

When the ALJ found that the claimant could not return to his former work as a truck driver, and could not perform a full range of sedentary and light work, it was reversible error for the ALJ to find that there were hundreds of jobs the claimant could do. The matter was remanded to the Secretary to take the testimony of a vocational expert.

(*Burkhart v. Bowen* (1988) 856 F.2d 1335)

1321-3

If a vocational expert's hypothetical does not reflect all the claimant's limitations, then the expert's testimony has no evidentiary value to support a finding that the claimant can perform jobs in the national economy. (*Delorme v. Sullivan* (1991) 924 F. 2d 841, cited in *Matthews v. Shalala* (1993) 10 F. 3d 687; *Light v. Social Security Administration* (1997) 119 F. 3d 789)

1321-4

Vocational conclusions reached by an ALJ, without testimony or evidence from a vocational expert, represented an improper reliance upon information outside the record, deprived the applicant of an opportunity to cross-examine or rebut, and lacked sufficient support to constitute substantial evidence. *Burkhart v. Bowen* (1988) 856 F.2d 1335.

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When it has been determined that a person has a severe medically determinable impairment which, though not meeting or equaling the criteria in the Listing of Impairments (Regulations No. 4, Subpart P, Appendix 1), prevents the person from performing past relevant work, a decision must be made whether he or she can do other work. The Medical-Vocational Guidelines which follow Appendix 1 as Appendix 2 contain numbered table rules which direct conclusions of "Disabled" or "Not disabled" where all of the individual findings coincide with those of a numbered rule. The table rules do not direct such conclusions when an individual's exertional RFC does not coincide with the exertional criteria of any one of the external ranges, i.e., sedentary, light, medium, as defined in 20 Code of Federal Regulations (CFR) §416.967. In some instances, an individual can do a little more or less than the exertion specified for a particular range of work; e.g., the person is considered to be physically capable of meeting the exertional demands of light work except that he or she can lift no more than 15 pounds at a time rather than 20 pounds, or he or she can fully meet the exertional demands of light work and can also perform part of the greater lifting requirement of medium work (such as up to 30 pounds at a time rather than 50 pounds at a time).

Where an individual exertional RFC does not coincide with the definitions of any one of the ranges of work as defined in 20 CFR §416.967, the occupational base is affected and may or may not represent a significant number of jobs in terms of the rules directing a conclusion as to disability. The adjudicator will consider the extent of any erosion of the occupational base and determine its significance. In some instances, the restriction will be so slight that it would clearly have little effect on the occupational base. In cases of considerably greater restriction(s), the occupational base will obviously be affected. In still other instances, the restrictions of the occupational base will be less obvious.

Where the extent of erosion of the occupational base is not clear, the adjudicator will need to consult a vocational resource. The publications listed in 20 CFR §416.966 of the regulations will be sufficient for relatively simple issues. In more complex cases, a person or persons with specialized knowledge would be helpful. State agencies may use personnel termed vocational consultants or specialists, or they may purchase the services of vocational evaluation workshops.

(Social Security Ruling 83-12)

1321-6

The Code of Federal Regulations (CFR) provides that, "where an individual has an impairment or combination of impairments resulting in both strength limitations and nonexertional limitations, the rules in this subpart are considered in determining first whether a finding of disabled may be possible based on the strength limitations alone and, if not, the rule(s) reflecting the individual's maximum residual strength capabilities, age, education, and work experience provide a framework for consideration of how much the individual's work capability is further diminished in terms of any types of jobs that would be contraindicated by the nonexertional limitations. Also, in these combinations of nonexertional and exertional limitations which cannot be wholly determined under the rules in Appendix 2, full consideration must be given to all of the relevant facts in the case in accordance with the definitions and discussions of each factor in the appropriate sections of the regulations, which will provide insight into the adjudicative weight to be accorded each factor." (20 CFR, Appendix 2, §200.00(e)(2))

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Disabled Based on Strength Limitations Alone

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

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

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

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

Use of a vocational resource may be helpful in the evaluation of what appear to be "obvious" types of cases. In more complex situations, the assistance of a vocational resource may be necessary. The publications listed in 20 CFR §416.966 of the regulations will be sufficient for relatively simple issues. In more complex cases, a person or persons with specialized knowledge would be helpful. State agencies may use personnel termed vocational consultants or specialists, or they may purchase the services of vocational evaluation workshops.

Examples of Evaluation Involving Combinations of Exertional and Nonexertional Limitations

1. Sedentary exertion combined with a nonexertional impairment. Example 1 of Section 201.00(h) in Appendix 2 illustrates a limitation to unskilled sedentary work with an additional loss of bilateral manual dexterity that is significant and, thus, warrants a conclusion of "Disabled." (The bulk of unskilled sedentary jobs require bilateral manual dexterity.) An example of nonexertional impairment which ordinarily has an insignificant effect on a person's ability to work is an allergy to ragweed pollen. Many individuals who have this allergy experience no more discomfort during the ragweed season than someone who has a common

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cold. However, others are more affected by the condition. Assuming that an individual has a severe impairment of the low back which limits that person to sedentary work, and that the assessment of RFC also restricts him or her from workplaces which involve exposure to ragweed pollen, the implications for adjustment to sedentary work are relatively clear. Ragweed grows outdoors and its pollen is carried in the air, but the overwhelming majority of sedentary jobs are performed indoors. Therefore, with the possible exclusion of some outdoor sedentary occupations which would require exposure to ragweed pollen, the unskilled sedentary occupational base is not significantly compromised. The decisionmaker may need the assistance of a VS in determining the significance of the remaining occupational base of unskilled sedentary work in more difficult cases.

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

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

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

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

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

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

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

As in light work, inability to use the finger tips to sense the temperature or texture of an object is an example of a nonexertional limitation which would have very little effect on the potential unskilled medium occupational base. The need to avoid environments which contain objects or substances commonly known not to exist in most workplaces would be an obvious example of a restriction which does not significantly affect the medium occupational base.

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

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

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

In reaching judgments as to the sufficiency of the remaining exertional job base (approximately 2,500 unskilled medium, light, and sedentary occupations, approximately 1,600 unskilled light and sedentary occupations, and approximately 200 unskilled sedentary occupations), there are three possible situations to consider:

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

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2. Where it is clear that additional limitations or restrictions have significantly eroded the exertional job base set by the exertional limitations alone, the remaining portion of the job base will guide the decision.
3. Where the adjudicator does not have a clear understanding of the effects of additional limitations on the job base, the services of a VS will be necessary.

(Social Security Ruling No. 83-14)

1322-1

A request for retroactive Medi-Cal may be made in conjunction with, or after, application for public assistance or Medi-Cal. The application must be submitted within one year of the month for which retroactive coverage is requested. (§50148) An application for SSI/SSP benefits is an application for public assistance. (§50078) Example: An individual who is approved for SSI/SSP effective April 1994, and who requests retroactive coverage in February 1995 may be entitled to coverage in February and March 1994, but not in January 1994 because more than one year has elapsed between February 1995 and January 1994. (All-County Welfare Directors Letter No. 95-81, December 8, 1995, Situation 2)

1322-2

The POMS sets forth criteria for establishing onset dates in disabilities of nontraumatic origin. Since medical evidence establishing a precise onset date is often difficult to obtain, it will be necessary to infer the onset from the medical and other evidence that describe the history and symptomatology of the disease process. In some cases it may be possible to reasonably infer that the onset occurred some time prior to the date of the first recorded medical examination. How long the disease may be determined to have existed to a disabling level of severity depends on an informed judgment of the facts in the particular case. This judgment, however, must have a legitimate medical basis and should be made by or at least concurred in by a physician. The available medical evidence should be considered in view of the nature of the impairment and the onset date set when it is most reasonable to conclude from the evidence that the impairment was sufficiently severe to prevent the individual from engaging in SGA. In the cases of slowly progressive impairments it is not necessary for an impairment to have reached listing severity (i.e., be decided on medical grounds alone) before onset can be established. In such cases, consideration of vocational factors can contribute to the determination of when the disability began. (POMS DI 25501.015)

1322-2A

The Social Security Administration has developed guidelines for determining the onset date for Title XVI purposes in disabilities of nontraumatic origin. The determination of onset involves consideration of the applicant's allegations, work history, if any, and the medical and other evidence concerning impairment severity.

1. Applicant Allegations

The starting point in determining the date of onset of disability is the individual's statement as to when disability began.

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2. Work History

The day the impairment caused the individual to stop work is frequently of great significance in selecting the proper onset date.

3. Medical and Other Evidence

Medical reports containing descriptions of examinations or treatment of the individual are basic to the determination of the onset of disability. The medical evidence serves as the primary element in the onset determination. Reports from all medical sources (e.g., physicians, hospitals, and government agencies) which bear upon the onset date should be obtained to assist in determining when the impairment(s) became disabling.

With slowly progressive impairments, it is sometimes impossible to obtain medical evidence establishing the precise date an impairment became disabling. Determining the proper onset date is particularly difficult, when for example, the alleged onset and the date last worked are far in the past and adequate medical records are not available. In such cases, it will be necessary to infer the onset date from the medical and other evidence that describe the history and symptomatology of the disease process.

Particularly in the case of slowly progressive impairments, it is not necessary for an impairment to have reached listing severity (i.e., be decided on medical grounds alone) before onset can be established. In such cases, consideration of vocational factors can contribute to the determination of when the disability began.

In determining the date of onset of disability, the date alleged by the individual should be used if it is consistent with all the evidence available. When the medical or work evidence is not consistent with the allegation, additional development may be needed to reconcile the discrepancy. However, the established onset date must be fixed based on the facts and can never be inconsistent with the medical evidence of record.

Precise Evidence Not Available -- Need for Inferences

In some cases, it may be possible, based on the medical evidence to reasonably infer that the onset of a disabling impairment(s) occurred some time prior to the date of the first recorded medical examination, e.g., the date the claimant stopped working. How long the disease may be determined to have existed at a disabling level of severity depends on an informed judgment of the facts in the particular case. This judgment, however, must have a legitimate medical basis. At the hearing, the administrative law judge (ALJ) should call on the services of a medical advisor when onset must be inferred. If there is information in the file indicating that additional medical evidence concerning onset is available, such evidence should be secured before inferences are made.

If reasonable inferences about the progression of the impairment cannot be made on the basis of the evidence in the file and additional relevant medical evidence is not available, it may be necessary to explore other sources of documentation. Information may be

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obtained from family members, friends, and former employers to ascertain why medical evidence is not available for the pertinent period and to furnish additional evidence regarding the course of the individual's condition. The impact of lay evidence on the decision of onset will be limited to the degree it is not contrary to the medical evidence of record. (In mental impairment cases, see SSR 83-15.)

The available medical evidence should be considered in view of the nature of the impairment (i.e., what medical presumptions can reasonably be made about the course of the condition). The onset date should be set on the date when it is most reasonable to conclude from the evidence that the impairment was sufficiently severe to prevent the individual from engaging in SGA (or gainful activity) for a continuous period of at least 12 months or result in death. Convincing rationale must be given for the date selected.

(SSR 83-20)

1322-3

Based upon psychiatric and psychological examinations in May 1983, it was appropriate to set disability onset in May 1982, when there was historical evidence to establish disability one year prior to the examinations. *Villa v. Heckler* (1986) 797 F.2d 794.

1322-4

For disabilities of traumatic origin, onset is described in the Social Security Rulings (SSRs) as the day of the injury if the individual is thereafter expected to die as a result or is expected to be unable to engage in substantial gainful activity (SGA) (or gainful activity) for a continuous period of at least 12 months (see SSR 82-52). The fact that the claimant worked on the day of onset is not relevant, irrespective of the hours worked and money earned.

(SSR 83-20)

1323-1

Federal law provides, in pertinent part, that in determining whether disability continues (once established) different rules are used. It must be determined whether there has been any medical improvement in a recipient's impairments and if so, whether the medical improvement is related to the recipient's ability to work. If there is no such improvement, it must be determined whether certain exceptions to medical improvement apply. If medical improvement related to the ability to work has not occurred and no exception applies, then benefits will continue. It must also be shown that the recipient is currently able to engage in Substantial Gainful Activity (SGA) before it can be found that a recipient is no longer disabled. This section then continues to define and discuss the criteria which are used in determining medical improvement and in determining whether disability continues under the regulations. Medical improvement is any decrease in the medical severity of the recipient's impairments and any determination of such a decrease must be based on changes (improvement) in the symptoms, signs and/or laboratory findings associated with the improvements. (20 CFR §416.994)

1323-2

If an individual is found eligible based on an ALJ decision a continuing disability review will generally not be conducted earlier than 3 years after that decision unless the case should be scheduled for a medical improvement expected (MIE) diary review or a

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question of continuing disability is raised pursuant to Subsection (b). (20 CFR §416.990(f))

Mandatory MIE criteria describe medical conditions which will usually medically improve or go into remission. Optimal MIE criteria under Section C.(1) permit an earlier review when the evidence strongly suggests the disability will not continue. (POMS DI 26525.005B.1)

Generally the MIE diary will be set for two years or less. If medical improvement is not expected (MINE), the diary is set for 7 years. (POMS DI 26525.001)

1323-3

When Listing 9.09 was deleted, it did not affect the entitlement or eligibility of individuals receiving benefits because their impairment(s) met or equaled that listing. Their disabilities did not end just because Listing 9.09 was deleted.

There must be a periodical review of all claims to determine whether the individual's disability continues. When SSA conducts a periodic continuing disability review (CDR), it will not find that an individual's disability has ended based on a change in a listing. For individuals receiving disability benefits under Title II and adults receiving payments under Title XVI, apply the medical improvement review standard described in 20 CFR 404.1594 and 416.994.

First evaluate whether the individual's impairment(s) has medically improved and, if so, whether any medical improvement is related to the ability to work. If the individual's impairment(s) has not medically improved, he or she is still disabled, unless there is an exception to the medical improvement standard which applies. Even if the impairment(s) has medically improved, one must find that the improvement is not related to the ability to work if the impairment(s) continues to meet or equal the same listing section used to make the most recent favorable decision. This is true even if SSA has deleted the listing section that was used to make the most recent favorable decision. See 20 CFR §416.994(b)(2)(iv)(A).

Even if the individual's impairment(s) has medically improved and no longer meets or equals prior Listing 9.09, it must still be determined whether he or she is currently disabled, considering all the impairments.

What amount of weight loss would represent "medical improvement"?

Because an individual's weight may fluctuate over time and minor weight changes are of little significance to an individual's ability to function, it is not appropriate to conclude that an individual with obesity has medically improved because of a minor weight loss. A loss of less than 10 percent of initial body weight is too minor to result in a finding that there has been medical improvement in the obesity. However, obesity has medically improved if an individual maintains a consistent loss of at least 10 percent of body weight for at least 12 months. One does not count minor, short-term changes in weight when deciding whether an individual has maintained the loss consistently.

If there is a coexisting or related condition(s) and the obesity has not improved, consider whether the coexisting or related condition(s) has medically improved.

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If there has been medical improvement in obesity or in any coexisting or related condition(s), decide whether the medical improvement is related to the ability to work. If necessary, decide whether any exceptions to the medical improvement review standard apply and, if appropriate, whether the individual is currently disabled.

(Social Security Ruling No. 00-3p; POMS DI 24570.001B.)