12-2432

To Be Argued By:
ANN M. NEVINS

United States Court of Appeals

FOR THE SECOND CIRCUIT

Docket No. 12-2432

SANDRA JONES-REID,
Plaintiff-Appellant,

-vs-

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

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

BRIEF FOR THE UNITED STATES OF AMERICA

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

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Statement of Jurisdiction

The district court (Warren W. Eginton, J.) had subject matter jurisdiction over this civil case pursuant to 42 U.S.C. §§ 405(g) and 1383(c). Judgment entered on May 16, 2012. Doc. #37-4. On June 12, 2012, the plaintiff, Sandra Jones-Reid ("Jones-Reid"), filed a timely notice of appeal pursuant to Fed. R. App. P. 4(a). Government's Appendix ("GA")820. This Court has appellate jurisdiction pursuant to 28 U.S.C. § 1291.

Statement of Issues Presented for Review

1. Was the decision by the Administrative Law Judge ("ALJ") that Jones-Reid was not disabled supported by substantial evidence?

   A. Did the ALJ properly consider the medical opinions of record?

   B. Did the ALJ consider Jones-Reid's subjective statements of pain and alleged limitations and properly weigh her credibility?

   C. Was the ALJ's Residual Functional Capacity ("RFC") determination supported by substantial evidence?

   D. Did the ALJ err in not including Jones-Reid's alleged mental limitations in its RFC determination?

   E. Was the ALJ's finding that there were other jobs that Jones-Reid could perform supported by substantial evidence?

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Preliminary Statement

A claimant seeking disability benefits under the Social Security Act ("the Act") must demonstrate that her impairments are severe and prevent her from working. Appellant Jones-Reid applied for Social Security Disability Insurance Benefits ("DIB") and Supplemental Security Income ("SSI") benefits. After careful review, the Commissioner of Social Security ("the Commis-

sioner") found that Jones-Reid could perform certain jobs despite her impairments and denied both her applications. The Decision Review Board, a United States Magistrate Judge and a United States District Judge all agreed with this decision.

Jones-Reid now appeals, raising many of the same arguments she raised below. In particular, she claims that (1) the ALJ did not give proper weight to the opinions of two different treating physicians and one nurse practitioner; (2) the ALJ issued an unsupported credibility finding as to Jones-Reid's testimony; (3) the ALJ's RFC finding was not based on substantial evidence; (4) the ALJ erred in failing to include Jones-Reid's mental limitations in its RFC; and (5) the ALJ's conclusion that Jones-Reid could perform other jobs in the economy was not supported by substantial evidence. For the reasons set forth below, none of these arguments has merit.

Statement of the Case

On June 27, 2008, Jones-Reid filed applications for DIB and SSI. GA230-GA35. The application was denied initially and on reconsideration, and Jones-Reid requested a hearing before an ALJ, which was held on July 30, 2009. GA27-GA110. The ALJ issued a decision finding that Jones-Reid was not disabled on May 21, 2010. GA7-GA20. The Decision Review Board ("DRB") selected the case for review and affirmed the ALJ's decision on August 24, 2010. GA1-GA6.

On September 21, 2010, Jones-Reid commenced a civil action for review of the Commissioner's decision. GA815. On February 16, 2012, United States Magistrate Judge Holly B. Fitzsimmons issued a recommended ruling granting the government's motion to affirm the ALJ's decision and denying Jones-Reid's motion to reverse and remand the ALJ's decision. Doc. #37-2.[1] On April 9, 2012, Jones-Reid filed an objection to the recommended ruling, GA819, and on May 14, 2012, the district court (Warren W. Eginton, J.) issued an order adopting the recommended ruling and affirming the decision of the ALJ. GA820. Judgment entered on May 16, 2012. GA820. On June 12, 2012, Jones-Reid filed a timely notice of appeal. GA820.

[1] Jones-Reid filed this written decision as an attachment to her opening brief, and it has been docketed as document #37-2. The government will refer to the recommended ruling as "RR" and the page number.

Statement of Facts and Proceedings Relevant to this Appeal

A. The administrative proceedings

Jones-Reid filed applications for DIB and SSI on June 27, 2008. GA230-GA235. In both applications, Jones-Reid alleged that she became disabled on April 1, 2008. GA230-GA235. Her applications were denied initially and upon reconsideration, and she requested a hearing before an ALJ. GA65-GA110. Prior to the hearing, Jones-Reid amended her alleged onset date to December 1, 2007. GA10. ALJ Marlene W. Heiser held a hearing on July 30, 2009, at which Jones-Reid, who was represented by counsel, a friend of Jones-Reid's, and a vocational expert appeared and testified. GA27-GA64. On May 21, 2010, the ALJ issued a decision in which she found that Jones-Reid was not disabled at any time from December 1, 2007, the amended alleged onset date, through the date of the ruling because she could perform work that existed in significant numbers in the national economy. GA7-GA20. The DRB selected Jones-Reid's claim for review, and affirmed the ALJ's decision on August 24, 2010. GA1-GA6.

B. The testimonial and non-medical evidence

Jones-Reid was born in June 1957. GA31. She has an eighth grade education. GA31. From 1992 to 2007, Jones-Reid held jobs in the restau-

rant industry, the manufacturing and assembly industry, and as a lifeguard. GA270. The last job she held was as a restaurant prep cook at Bugaboo Creek restaurant. GA32, GA270. Her duties at that job included preparing vegetables, making dressings, stocking, and cleaning. GA32-GA33. Those duties required her to lift and carry items weighing up to ninety pounds. GA33.

According to Jones-Reid, she became unable to work on December 1, 2007, due to mental and physical impairments. GA32, GA158. She testified that she was depressed, causing her to cry a lot and stay to herself, but that medication helped. GA40. She also testified that her knees bothered her when it was rainy and humid, and sometimes swelled; that she had back pain at least three times per week, lasting for one to two days or longer, which she treated with Robaxin or ibuprofen in conjunction with Trazodone; and that she had shoulder pain, which she controlled with the same medication, saying "[t]he same medication works for it all." GA33-GA36. She said that, on a typical day, her pain was an eight on a scale of one to ten, with ten being the worst. GA46.

She said she got dizzy at times; had sleep apnea, for which she used a machine; had a blocked heart valve; and had a seventy percent blockage in her liver. GA42. She had trouble concentrating, could no longer make good judg-

ments with respect to problems at work, felt guilty all the time, and could not complete a full workweek because of her psychological problems. GA43. Due to her physical problems, she could walk "maybe two blocks," and could not sit or lie down for too long. GA36. She could sit or stand for twenty minutes. GA38. She used a cane to walk, which she was prescribed following a visit to Hartford Hospital, where she was treated for a swollen knee. GA37. She could lift a maximum of about ten pounds and had trouble reaching above her head with her left arm, and bending at the waist. GA38, GA46.

Regarding daily activities, Jones-Reid testified that she lived alone, did all of her own cooking and cleaning, and had no problems taking care of her personal hygiene, doing her laundry, or shopping for food. GA39. She said she drove about six hours per week to see her mother, but preferred to stay home because she got agitated when she was out. GA39. Jones-Reid said that reading frustrated her, she did not care for television, and had no hobbies other than listening to jazz on the radio. GA40-GA41. She had no close friends except her mother and talked to her sister and brother occasionally. GA41.

Ms. Johnny Grice also testified. She had known Jones-Reid for over twelve years. GA49. Grice said that Jones-Reid had changed over the last two to three years. She said Jones-Reid had problems with walking, sitting, and bending at

the waist; struggled with lifting heavy objects; and avoided using her left arm to reach. GA50-GA52. She also said that Jones-Reid had memory issues, trouble making simple decisions, and was irritable when tired. GA50-GA52.

C. The medical evidence

1. Physical impairments

On May 2, 2007, Jones-Reid underwent an electrocardiogram ("EKG") at Hartford Hospital that indicated abnormalities. GA349.

On June 6, 2007, Jones-Reid went to Hartford Hospital after falling down the stairs. GA324. She complained of back pain, which was diagnosed as a muscle spasm, and was treated with ibuprofen and Robaxin. GA324.

On October 23, 2007, Jones-Reid went to St. Francis Hospital with complaints of numbness and pain in her left arm, and mild chest pain. GA563. She underwent an EKG that indicated left ventricular hypertrophy ("LVH") and normal sinus rhythm. GA571. A chest x-ray was normal. GA573. A stress EKG performed on October 24, 2007, demonstrated no changes. GA585.

On April 16, 2008, Jones-Reid was admitted to Hartford Hospital after experiencing an episode of syncope. GA366-GA368. She admitted that she had not been taking her antihypertensive medications. GA366-GA367. Her hypertension was controlled once she resumed

medication. GA366-GA367. An April 17, 2008, EKG revealed mild aortic root dilatation, moderate concentric LVH, and normal left ventricular systolic and diastolic function. GA369. On April 17, 2008, Jones-Reid also underwent lumbar spine radiological readings, and the impression was "facet arthropathy of the lower lumbar spine" with "no evidence" of "acute injury." GA394. Cardiac catheterization performed on April 18, 2008, showed mild disease in the left anterior descending artery, circumflex and right coronary artery, which was treated. GA370-GA371. Jones-Reid was discharged from the hospital on April 19, 2008, with a thirty-day loop monitor to detect any ventricular arrhythmia or supraventricular arrhythmia to explain her syncope. GA366-GA368.

On June 4, 2008, Jones-Reid went to Hartford Hospital for complaints of chest pain, as well as back and shoulder pain. GA373-GA374. An EKG showed some abnormalities. GA400.

On June 12, 2008 and again on June 26, 2008, Jones-Reid presented to Community Health Services, Inc. ("Community Health") for complaints of neck and back pain. GA413-GA414.

On August 9, 2008, Jones-Reid was admitted to Hartford Hospital for complaints of upper back pain and atypical chest pain of two to three days' duration. GA550-GA557. Testing revealed no significant changes from studies conducted in

April 2008, and Jones-Reid's cardiac enzymes were completely normal. Jones-Reid was kept for observation and discharged on August 11, 2008. GA550-GA557. On exam, Jones-Reid's severe upper back pain was determined to be consistent with muscle spasm of the spinal muscles. GA551. Jones-Reid also underwent a CT angio scan that did not show any significant findings. GA551. The discharge notes indicated that, following cardiac catheterization, which showed "mild disease and no evidence of acute coronary syndrome, the plan was made to discharge the patient" with follow-up by a cardiology clinic. GA551.

On August 26, 2008, Dr. James Menzoian of the University of Connecticut Health Center examined Jones-Reid and noted that she was morbidly obese and that several procedures were planned, including an arteriogram, a possible right renal angioplasty, and a stent replacement. GA427.

On September 15, 2008, Jones-Reid presented to St. Francis Hospital for complaints of left shoulder pain. GA598. X-rays indicated no fracture, no dislocation, and no degenerative changes. GA599. Jones-Reid was discharged with after-care instructions for a rotator cuff injury. GA600.

Jones-Reid underwent a sleep study in September 2008, which showed mild obstructive

sleep apnea with symptoms of daytime sleepiness and fatigue. GA447-GA448.

On October 13, 2008, Jones-Reid underwent angiography on her renal arteries and angioplasty and stenting on her right renal artery to normalize the luminal diameter. GA528.

Jones-Reid underwent a sleep study on October 24, 2008, which confirmed mild obstructive sleep apnea with associated daytime fatigue. GA604-GA605.

Jones-Reid underwent blood work on November 4, 2008, which indicated the presence of Hepatitis C antibodies. GA457. A subsequent blood specimen collected on November 26, 2008, indicated a Hepatitis C infection. GA454.

Jones-Reid underwent a sleep study on November 25, 2008, which revealed only the presence of poor sleep quality with a reduced sleep efficiency. GA447. The study concluded that Jones-Reid's obstructive sleep apnea was well-controlled with the use of continuous positive airway pressure ("CPAP"). GA447.

On December 4, 2008, Jones-Reid presented to Community Health for complaints of left side pain and dizziness following a fall one week prior. GA470. She was diagnosed with a left shoulder contusion. GA470.

On December 18, 2008, Jones-Reid was treated at Community Health and found to have controlled hypertension. GA469.

On December 29, 2008, an abdominal ultrasound indicated that Jones-Reid had an enlarged liver. GA446.

On January 5, 2009, a progress note from Community Health indicated diagnoses of cirrhosis, Hepatitis C, hypertension, and tobacco use. GA468.

On January 8, 2009, Jones-Reid underwent an abdominal CT scan with and without contrast, which showed mild hepatomegaly and no suspicious masses. GA657.

In January 2009, Jones-Reid was prescribed outpatient rehabilitation therapy for left shoulder tendonitis. GA612. She received outpatient therapy at the St. Francis Center for Rehab and Sports Medicine on January 27, February 5, February 9, February 11, February 16, and February 19, 2009. GA618-GA620.

On March 5, 2009, Jones-Reid presented to Community Health for complaints of back pain. GA672.

On March 16, 2009, Jones-Reid presented to St. Francis Hospital for left-sided back pain, but left before being treated. GA625.

On two occasions in April 2009, Jones-Reid was treated at Community Health for lower back and arm pain. GA677, GA686.

On April 15, 2009, an x-ray of Jones-Reid's right hip showed early degenerative arthritic changes, and an x-ray of her right hand revealed early degenerative arthritic changes in the interphalengeal joints to the digits. GA721-GA722.

On April 16, 2009, Jones-Reid underwent an EKG, which showed abnormalities. GA640.

On May 3, 2009, Jones-Reid presented to Hartford Hospital for complaints of right knee pain and swelling, and was diagnosed with pain and effusion of the right knee. GA786.

On May 12, 2009, a magnetic resonance imaging ("MRI") of Jones-Reid's left shoulder showed a partial distal bursal tear. GA694.

On July 15, 2009, Jones-Reid underwent a liver biopsy, which confirmed chronic Hepatitis C. GA789-GA790.

2. Mental impairments

Beginning on June 22, 2008, Jones-Reid was treated by a licensed social worker at Community Health. GA438-GA440, GA442-GA444. On September 4, 2008, Jones-Reid was referred for a psychiatric evaluation (GA440), which took place on September 23, 2008. GA428. Dr. Julia Volpe diagnosed Jones-Reid with recurrent major de-

pression and noted that she had passive suicidality. GA429. She indicated that Jones-Reid had a Global Assessment of Functioning ("GAF") score of 48.[2] Dr. Volpe prescribed Jones-Reid a daily regimen of Cymbalta to control her depression. GA429.

On October 2, 2008, Dr. Volpe switched Jones-Reid's medication from Cymbalta to Celexa because of adverse side effects. GA436. On October 20, November 17, and December 11, 2008, Dr. Volpe indicated that Jones-Reid showed improvement on her current medication and showed no evidence of suicidality. GA435, GA459, GA461.

On February 5, 2009, Dr. Volpe found Jones-Reid to have increasing symptoms of depression and prescribed her an increased dose of Celexa. GA661.

On February 28, 2009, Jones-Reid went to Eastern Maine Medical Center following acute mental status changes. GA695. The impression of the treating physician's assistant, Paul Spencer, was that Jones-Reid perhaps inadvertently took her sedating medications to excess or at an unusual time. GA696.

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[2] A GAF of 41-50 indicates serious symptoms or serious impairments in social, occupational or school functioning. *Diagnostic and Statistical Manual of Mental Disorders* 34-35 (4th ed. 2000).

On March 5, April 6, April 28, and May 8, 2009, Jones-Reid again saw Dr. Volpe, who noted no significant changes in her mental status. GA674, GA683, GA685, GA693.

3. Limitation on work activities

On June 13, 2008, Nurse Practitioner Phyllis Schling and Dr. Dennis Morgan completed a form for the Connecticut Department of Social Services and opined that Jones-Reid's heart condition and arthritis restricted her to sitting for one hour per eight-hour workday, never standing or walking, never lifting anything weighing more than five pounds, and not performing fine manipulation. GA700-GA713. They opined that Jones-Reid could not use her feet to push or pull leg controls; could never bend, squat, crawl, climb, or reach; should not be around unprotected heights, machinery, marked changes in temperature and humidity, or dust and fumes; and could not drive a car. GA702-GA703. They opined that Jones-Reid would be unable to work for a period of twelve months or more. GA700.

On August 28, 2008, Dr. Arthur Waldman reviewed all of the available evidence of record and opined that Jones-Reid could occasionally lift twenty pounds; frequently lift ten pounds; stand and/or walk for about six hours in an eight-hour day; sit with breaks for six hours per eight-hour day; perform unlimited pushing and/or pulling of hand/foot controls; occasionally climb, stoop, kneel, crouch, and crawl; and never balance; and

should avoid concentrated exposure to extreme cold and hazards such as machinery and heights. GA419-GA426.

On July 16, 2009, Dr. Volpe completed two forms, characterizing Jones-Reid as having moderate impairment. GA766-GA777. She specifically stated that Jones-Reid tended to experience an increase in depressive symptoms during periods of stress. GA771. She opined that Jones-Reid had no limitations in the areas of: remembering locations and work-like procedures; understanding, remembering, and carrying out very short, simple instructions; maintaining regular attendance and being punctual; sustaining an ordinary routine without special supervision; making simple work-related decisions; asking simple questions or requesting assistance; getting along with co-workers or peers without distracting them; maintaining socially appropriate behavior; being aware of normal hazards and taking appropriate precautions; and traveling in unfamiliar places or using public transportation. GA773-GA775. Dr. Volpe opined that Jones-Reid had level 2 functional limitations, described as being able to perform designated tasks or functions and having noticeable difficulty no more than ten percent of the workday or workweek, in the areas of: understanding, remembering and carrying out detailed instructions; maintaining attention and concentration for extended periods of time; performing activities within a

schedule; working in coordination with or proximity to others without being distracted by them; completing a normal workday or workweek without interruptions from psychologically-based symptoms and performing at a consistent pace without an unreasonable number and length of rest periods; interacting appropriately with the general public; accepting instructions and responding appropriately to criticism from supervisors; responding appropriately to changes in the work setting; and setting realistic goals or making plans independently of others. GA773-GA775.

On July 24, 2009, Nurse Practitioner Kathleen Tummillo completed a Physical Residual Functional Capacity Questionnaire regarding Jones-Reid in which she noted that she first saw Jones-Reid on February 12, 2009, after a referral for a Hepatitis C consult. GA778. Tummillo listed Jones-Reid's symptoms as left shoulder pain, hypertension, depression, and right knee swelling. Without citing any objective findings or treatment notes, Tummillo opined that Jones-Reid's pain and other symptoms would frequently interfere with the concentration and attention needed to perform even simple work tasks. GA779. She further opined that Jones-Reid could only walk a single city block, sit for no more than two hours consecutively, stand for no more than twenty minutes consecutively, and stand/walk for fewer than two hours total in an

eight-hour workday. GA779. She concluded that Jones-Reid needed periods of walking approximately every twenty minutes during an eight-hour workday. GA779. She also stated that Jones-Reid could never lift or carry anything weighing ten pounds or more; or stoop, crouch, or climb ladders; could occasionally look down, turn head to left and right, look up, and hold head in a static position; could rarely twist; and could occasionally climb stairs. GA780. She thought that Jones-Reid had no significant limitations on reaching, handling, or fingering. GA780. Finally, she concluded that Jones-Reid would likely have good days and bad days, and would likely miss an average of more than five days per month from work. GA781.

On April 10, 2010, Dr. Joseph Gaeta opined that Jones-Reid had coronary artery disease and hypertensive heart disease, which did not meet or equal any of the impairments listed in the Listing of Impairments. GA800-GA802. Dr. Gaeta thought that Jones-Reid's impairments limited her to lifting or carrying ten pounds frequently and twenty pounds occasionally, and walking for twenty-minute stretches, with no limit on sitting or standing. GA802. He also thought that Jones-Reid should avoid extremes of cold or heat and had no limitations concerning manipulative functions. GA802.

D. The vocational expert testimony

At the hearing, vocational expert ("VE") Renee Jubrey testified that Jones-Reid's past job as a "cook helper" was classified as medium, unskilled work according to *Dictionary of Occupational Titles* ("*DOT*") title 317.687-010. GA53-GA54.

The ALJ asked the VE whether a hypothetical individual with the exertional capacity for light work; who could occasionally bend, climb stairs, balance, stoop, kneel, crouch, and crawl; who could not climb ropes, ladders, scaffolds, or be exposed to hazards like moving machinery or unprotected heights; who could not reach above the shoulder with the left arm; who could only receive short, simple instructions; and who could only work in an environment with few workplace changes and no public contact, could perform Jones-Reid's past work as a cook helper. GA54. The VE opined that this individual could not work as a cook helper. GA54.

The ALJ then amended the hypothetical slightly to allow the individual to have some contact with the public, provided there was no regular contact with the public. GA54. The VE opined that there were jobs in the national economy that the individual could do, including "marker" (*DOT* title 209.587-034, a light, unskilled job with 628,000 positions nationally and 370 positions in Connecticut); "mail clerk" (*DOT* title 209.687-026, a light, unskilled job with

1,500,000 positions nationally and 500 positions in Connecticut); and "routing clerk" (*DOT* title 222.687-022, a light, unskilled job with 751,000 positions nationally and 400 positions in Connecticut). GA54-GA55.

The ALJ again amended the hypothetical to add the requirement that the individual be permitted to sit or stand at will. GA55. In response, the VE opined that the individual could perform the mail clerk job with the additional limitation, but not the other positions. GA55.

On cross examination, Jones-Reid's attorney asked the VE to amend the hypothetical to include that the individual would be off-task for four and one-half hours per week, and the VE opined that there were no unskilled jobs where the individual could be off-task more than ten percent of the time. GA57.

Jones-Reid's attorney then asked the VE whether an individual with the same age, education, and experience as Jones-Reid, who could sit one hour; never stand or walk at work; occasionally lift or carry up to five pounds; never lift or carry six or more pounds; could not use his or her arms to push or pull arm controls; could not use his or her hands for fine manipulation; could not use his or her feet for repetitive pushing or pulling of leg controls; could never bend, squat, crawl, climb, or reach with his or her left hand; could never be around unprotected heights, moving machinery, marked changes in temperature

or humidity, or dust or fumes, or drive an automobile, could work. GA60. The VE opined that no jobs existed for the individual. GA60.

E. The ALJ's decision

In making her determination, the ALJ used the regulatory sequential evaluation process set forth at 20 C.F.R. §§ 404.1520 and 416.920. At step one of the process, the ALJ found that Jones-Reid had not engaged in substantial gainful activity since December 1, 2007, her amended alleged onset date. GA12. At step two, the ALJ determined that Jones-Reid had the following severe impairments: hypertensive heart disease, depression, obesity, renal artery stenosis, arthritis, chronic hepatitis, and a partial bursal tear of the left shoulder. GA13. The ALJ went on to find at step three that none of Jones-Reid's impairments, either singly or in combination, met or equaled the criteria of any of the impairments listed in Appendix 1, Subpart P of Regulation No. 4 ("the Listings"). GA13.

Before proceeding to step four, the ALJ determined that Jones-Reid had the RFC to perform light work as defined in 20 C.F.R. §§ 404.1567(b) and 416.967(b),[3] with the following

[3]Light work involves lifting no more than twenty pounds at a time with frequent lifting or carrying of objects weighing up to ten pounds. 20 C.F.R. §§ 404.1567(b), 416.967(b). A job is in this category when it requires a good deal of walking or standing,

limitations: occasional bending, climbing stairs, balancing, stooping, kneeling, crouching, and crawling; no climbing ladders or frequent reaching above shoulder level with the left arm; no exposure to moving machinery, unprotected heights, or extreme cold or heat; and only tasks involving short, simple instructions in an environment with few workplace changes and no public contact. GA14.

Based on her RFC determination, the ALJ found at step four that Jones-Reid was unable to perform her past relevant work, since that job entailed duties beyond her functional capacity. GA18. However, at step five of the sequential evaluation process, relying on the VE testimony, and considering Jones-Reid's age, education, past work experience, and RFC, the ALJ determined that there were jobs that existed in significant numbers in the national economy that Jones-Reid could perform. GA19. Accordingly, the ALJ concluded that Jones-Reid was not under a disability, as defined in the Act, at any time from December 1, 2007 through the date of her decision. GA20.

F. The DRB's ruling

The DRB affirmed the ALJ's decision. GA1-GA6. The DRB first addressed Jones-Reid's con-

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or when it involves sitting most of the time with some pushing and pulling of arm or leg controls. *Id.*

tention that the ALJ did not consider all of her impairments at step two, specifically, her lower back pain, chronic abdominal pain, cirrhosis, sleep apnea, and bilateral arm pain. GA1. The DRB found that Jones-Reid did not explain how those impairments resulted in functional limitations that were not reflected in the impairments identified by the ALJ, which included obesity, arthritis, and chronic hepatitis. GA1. As the DRB noted, the ALJ specifically considered Jones-Reid's arthritis, which entailed limitations with her knee, back, hands, and hips. Furthermore, the ALJ considered Jones-Reid's chronic hepatitis, which included limitations from abdominal pain and cirrhosis. The DRB also pointed out that, while the ALJ did not identify sleep apnea as an impairment, she specifically considered fatigue as a limitation. GA1.

The DRB next addressed Jones-Reid's argument that the ALJ should have afforded controlling weight to the treating source opinions of Drs. Morgan and Volpe. GA2. The DRB iterated that a treating source opinion can only be afforded controlling weight if it is well-supported and not inconsistent with other substantial evidence in the record. Here, the ALJ attributed little weight to Dr. Morgan's opinion that Jones-Reid was limited to sedentary work with no pushing or pulling, no fine manipulation, and no reaching, since it was not supported by the record. GA2. The DRB also pointed out that the

ALJ gave great weight to Dr. Volpe's opinion that Jones-Reid had moderate limitations in social functioning and sustaining tasks despite an examination in September 2008, in which she assessed Jones-Reid with a GAF of 48, reflecting serious symptoms. GA2. It was apparent from Dr. Volpe's subsequent evaluation in July 2009, showing only moderate impairment, that the earlier assessment reflected only a temporary increase in Jones-Reid's symptoms, and did not represent her overall long-term functioning. For that reason, the DRB determined that there was no need for medical expert testimony to further address Jones-Reid's mental functioning. GA2.

The DRB next found that the ALJ gave good rationale for assessing Jones-Reid's credibility and her functional limitations based on a thorough review of the record as a whole. GA2.

Finally, the DRB addressed Jones-Reid's argument that the hypothetical presented to VE did not reflect all of her limitations. GA2. The DRB noted that the hypothetical reflected all of the credible limitations found by the ALJ, but did not include those that were not supported by the evidence.

The DRB concluded that substantial evidence supported the ALJ's decision that Jones-Reid was not disabled because significant numbers of jobs existed that she could still do despite her limitations. GA3.

G. The district court action

On September 21, 2010, Jones-Reid filed a complaint in the district court seeking review of the Commissioner's denial of her application. GA815. Jones-Reid claimed that the ALJ had erred in numerous respects, including by improperly: (1) weighing the opinions of Jones-Reid's treating physicians; (2) determining whether Jones-Reid's impairments were severe; (3) determining the credibility of Jones-Reid's testimony; (4) determining Jones-Reid's RFC; (5) considering Jones-Reid's combined impairments; and (6) propounding an incomplete hypothetical to the VE and relying on the resulting testimony. RR37-RR64.

On February 16, 2010, United States Magistrate Judge Holly B. Fitzsimmons issued a ruling recommending that the district court affirm the ALJ's decision. RR1-RR65. The court determined that the ALJ thoroughly examined the record, afforded appropriate weight to all of the medical evidence, including the opinions of Jones-Reid's treating physicians, determined an appropriate RFC, afforded Jones-Reid's subjective claims of pain and other limitations an appropriate weight, and properly considered vocational testimony regarding the existence of jobs that Jones-Reid could perform despite her impairments. RR37-RR64.

With respect to Jones-Reid's treating physicians, the court found that the ALJ properly

gave great weight to the opinions of Dr. Volpe, and had no duty to re-contact her as there was no inconsistency between her opinion and previous treatment, and her evaluation did not appear to be incomplete. RR39-RR40.

Regarding Dr. Morgan, whose entire record before the ALJ consisted of a 7 page form dated June 13, 2008 showing that Dr. Morgan first saw Jones-Reid in April 2008 and last saw her in June 2008, the court found that the ALJ properly gave little weight to his opinions since they were not well-supported by the record. RR40-RR42.

As to Dr. Gaeta, the court found that the ALJ properly gave no weight to his opinion regarding Jones-Reid's limitations related to arthritis, back pain, sleep apnea, and Hepatitis C because Dr. Gaeta was retained only for an opinion on Jones-Reid's heart condition. RR42.

The court also agreed that Nurse Practitioner Tummillo's opinion was entitled to little weight because she offered no explanation for her conclusions, cited no relevant evidence in support of her opinion, had a relatively short treatment history with Jones-Reid, and was referred to treat Jones-Reid only for Hepatitis C. RR43-RR44.

And as to the weight the ALJ afforded to Dr. Waldman's opinion, the court agreed that the ALJ properly considered the opinion and did not

err by failing to obtain an updated medical expert opinion pursuant to Social Security Ruling ("SSR") 96-6p. Noting that SSR 96-6p requires an updated medical opinion when the additional medical evidence "may change the State agency medical or psychological consultant's finding that the impairment(s) is not equivalent in severity to any impairment in the Listing of Impairments," the court upheld the weight given to Dr. Waldman's opinion since later medical evidence was consistent with the evidence considered by Dr. Waldman. RR46.

In response to Jones-Reid's argument that the ALJ had erred at step two of the analysis by not properly considering all alleged impairments, the court found that any such error was harmless. RR46-RR49. Here, the ALJ did find that Jones-Reid had several severe impairments, including coronary artery disease, hypertensive heart disease, depression, obesity, renal artery stenosis, arthritis, chronic hepatitis, and a partial bursal tear in the left shoulder. RR48.

The court also found that the ALJ's credibility determinations regarding the testimony of Jones-Reid and her friend, Ms. Grice, were properly supported by the record. RR49-RR51. Applying SSR 96-7, the court concluded that the ALJ made specific citations to record evidence, including Jones-Reid's reports of activities of daily living and objective medical records indicating that her limitations were not as severe as

reported by Jones-Reid. With respect to Grice, the court noted that her testimony was duplicative and provided no additional information that had not already been considered by the ALJ. RR51.

The court next found that the ALJ properly considered all of the objective medical evidence and medical opinion evidence of record in making her RFC determination. RR51-RR54. As to the ALJ's failure to call a medical expert to testify as to whether Jones-Reid's combined impairments met or equaled a listing, the court found that the two situations in which a medical expert might be required were not present here. RR54-RR55. The court found that it was not necessary for the ALJ to call a medical expert for an updated opinion regarding Jones-Reid's GAF score because the score was incorporated into Dr. Volpe's Psychiatric Evaluation Forms. RR54-RR56. Since it was not new evidence, it would not have changed Dr. Volpe's opinion, and no additional medical expert opinion was required under the SSR 96-6p.

Finally, the court concluded that the ALJ's step five determination was supported by substantial evidence. RR56-RR64. The court found that the characteristics of the hypothetical claimant the ALJ posed to the VE were supported by substantial evidence. RR56-RR58. The court also found that the jobs identified by the VE were consistent with the hypothetical limita-

tions presented by the VE. RR62-RR64. Specifically, the court found that the jobs identified by the VE accommodated both the limitations regarding reaching with the left arm and "short, simple instructions." RR62-RR64.

On May 14, 2012, the district court issued an order approving and adopting the recommended ruling over Jones-Reid's objection, and affirming the decision of the ALJ. GA820.

Summary of Argument

Substantial evidence supports the Commissioner's decision that Jones-Reid was not disabled. Jones-Reid attacks this conclusion based on five arguments, none of which has merit. First, the ALJ correctly evaluated the medical evidence and accorded the appropriate amount of weight to the opinions of the treating and examining sources. Second, the ALJ properly weighed Jones-Reid's subjective statements of pain and limitation and reasonably determined that she was not entirely credible because her testimony was inconsistent with both the medical record and her reported daily activities. Third, the ALJ's RFC determination that Jones-Reid could perform light, unskilled work was based on the expert opinions of the various doctors who examined her. Fourth, the ALJ did account for Jones-Reid's alleged mental limitations in its RFC determination. Fifth, the ALJ properly relied on the VE's opinion that there were jobs that Jones-Reid could perform. The VE's opinion

was based on a hypothetical that included all of the limitations that the ALJ reasonably found to be present, and accounted for Dr. Volpe's opinion that Jones-Reid could understand, remember, and carry out very short, simple instructions.

Argument

I. The decision by the ALJ that Jones-Reid was not disabled was supported by substantial evidence

A. Governing law and standard of review

1. Determining disability under the Act

The Act defines "disability" in relevant part as the inability

> to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment . . . which has lasted or can be expected to last for a continuous period of not less than twelve months.

Shaw v. Chater, 221 F.3d 126, 131 (2d Cir. 2000) (quoting 42 U.S.C. § 423(d)(1)(A)). To qualify for disability benefits, any such impairment must have resulted from "anatomical, physiological, or psychological abnormalities which are demonstrable by medically acceptable clinical and laboratory diagnostic techniques." 42 U.S.C. §§ 423(d)(3), 1382(a)(3)(c). Further, a claimant can

be found to be under a disability within the meaning of the Act

> only if [her] physical or mental impairment or impairments are of such severity that [s]he is not only unable to do [her] previous work but cannot, considering [her] age, education, and work experience, engage in any other kind of substantial gainful work which exists in the national economy . . .

Shaw, 221 F.3d at 131-32 (internal quotation marks omitted).

In light of the foregoing standards, the Commissioner has issued regulations prescribing a five-step analysis for the consideration of disability claims. *See* 20 C.F.R. §§ 404.1520, 416.920.

At the first step, the Commissioner will find non-disability unless the claimant shows that she is not working at "substantial gainful activity." 20 C.F.R. §§ 404.1520(b), 416.920(b). At step two, the Commissioner will find non-disability unless the claimant shows that she has a "severe impairment," defined as "any impairment or combination of impairments which significantly limits [the claimant's] physical or mental ability to do basic work activities." *Id.*, §§ 404.1520(c), 416.920(c). At step three, the Commissioner determines whether the impairment which has enabled the claimant to survive step two is on the list of impairments presumed

severe enough to render one disabled; if so, the claimant qualifies. *Id.*, §§ 404.1520(d), 416.920(d). If the claimant's impairment is not on the list, the inquiry proceeds to step four, at which the Commissioner assesses whether the claimant can do her previous work; unless she shows that she cannot, she is determined not to be disabled. If the claimant survives the fourth stage, the fifth, and final, step requires the Commissioner to consider so-called "vocational factors" (the claimant's age, education, and past work experience), and to determine whether the claimant is capable of performing other jobs existing in significant numbers in the national economy. *Barnhart v. Thomas*, 540 U.S. 20, 24-25 (2003) (footnote omitted).

Through step four of the sequential evaluation process, the claimant has the dual burdens of production of evidence and persuasion about what the evidence shows. *Bowen v. Yuckert*, 482 U.S. 137, 146 n.5 (1987); *see Perez v. Chater*, 77 F.3d 41, 46 (2d Cir. 1996). In short, a claimant must demonstrate the existence of a severe impairment that results in an RFC that prevents the performance of past relevant work. If a claimant is able to meet her burden of proof at the first four steps, the sequential evaluation process proceeds to the fifth step, where there is a limited shift in the burden of proof. *Bowen*, 482 U.S. at 146 n.5. The same RFC used to determine whether a claimant can perform her

past relevant work at step four is used to determine whether she can adjust to any other work at step five. *See* 20 C.F.R. §§ 404.1560(c)(2), 416.960(c)(2). Specifically, at step five, the Commissioner is required to provide evidence demonstrating that jobs exist in significant numbers in the national economy that the claimant can do, given her RFC and vocational profile of age, education, and work experience. *See Berry v. Schweiker*, 675 F.2d 464, 467 (2d Cir. 1982). This is a burden of production of evidence only. As directed by the Act, the ultimate burden of persuasion to prove disability remains with the claimant. *See* 42 U.S.C. § 423(d)(5)(A).

In determining whether a claimant is disabled, the Commissioner must consider the objective medical facts, any diagnoses or medical opinions based on those facts, subjective evidence of the claimant's pain or disability, and the requirements of the claimant's past work. *See, e.g., Mongeur v. Heckler*, 722 F.2d 1033 (2d Cir. 1983). The relative weight that the Commissioner is to accord these factors in determining whether the claimant is capable of doing work is a matter entrusted to the Commissioner's sound discretion. *Mongeur*, 722 F.2d at 1037.

In considering opinions by a claimant's treating physician on the issue of disability, the Commissioner will afford controlling weight if the opinion is supported by medical tests and

clinical evidence found to be consistent with other substantial evidence in the record. *Schisler v. Sullivan*, 3 F.3d 563, 567 (2d Cir. 1993). "[S]ome kinds of findings," however, "including the ultimate finding of whether a claimant is disabled and cannot work—are reserved to the Commissioner . . ." *Snell v. Apfel*, 177 F.3d 128, 133 (2d Cir. 1999) (internal quotation marks omitted). Accordingly, "[a] treating physician's statement that the claimant is disabled cannot itself be determinative." *Id.*

The factors an ALJ should consider when deciding how much weight a treating physician's opinion should be given are articulated in 20 C.F.R. §§ 404.1527(c), 416.927(c). The regulations provide that the ALJ will evaluate every medical opinion received, regardless of its source. Unless a treating source's opinion is given controlling weight under 20 C.F.R. §§ 404.1527(c)(2) or 416.927(c)(2), the ALJ considers all of the following factors in deciding the weight to give to any medical opinion: (1) examining relationship; (2) treatment relationship including (i) length of the treatment relationship and the frequency of examination; and, (ii) nature and extent of the treatment relationship; (3) supportability; (4) consistency; (5) specialization; and (6) any factors the claimant or others bring to the attention of the ALJ, or of which the ALJ is aware, which tend to support or contradict the opinion. *Id.*

After considering the factors for determining how much weight the treating physician's opinion should receive in social security disability proceedings, the ALJ "must comprehensively set forth her reasons for the weight assigned to a treating physician's opinion." *Burgess v. Astrue*, 537 F.3d 117, 129 (2d Cir. 2008) (internal quotation marks omitted). "Failure to provide . . . good reasons for not crediting the opinion of a treating physician is a ground for remand." *Id.*

The ALJ must also consider opinions from sources that are not "acceptable medical sources." SSR 06-03p. SSR 06-03p clarifies, however, that only an "acceptable medical source" can provide evidence of a medically determinable impairment, give medical opinions, and act as treating sources whose medical opinions can be afforded controlling weight. *Id.* The weight accorded to evidence that is not an acceptable medical source varies based on the following factors: length and frequency of treatment relationship, consistency with other evidence, degree to which relevant evidence is offered in support of an opinion, how well the source explains the opinion, whether the source has expertise related to the impairment, and other relevant information. *Id.*

The ALJ is also required to consider the claimant's own allegations of her symptoms, including pain, and the extent to which the symptoms are consistent with objective medical evi-

dence, 20 C.F.R. §§ 404.1529(a), 416.929(a), but is not bound by the claimant's subjective complaints and is entitled to make an independent judgment regarding the degree of impairment caused by the claimant's condition. *Aponte v. Secretary of Health and Human Services*, 728 F.2d 588, 591-91 (2d Cir. 1984); *Parker v. Harris*, 626 F.2d 225, 231 (2d Cir. 1980). A finding that a claimant "is not credible must . . . be set forth with sufficient specificity to permit intelligible plenary review of the record." *Carroll v. Sec'y of Health and Human Servs.*, 705 F.2d 638, 643 (2d Cir. 1983).

At step two, the ALJ considers whether the evidence shows that the claimant has a severe impairment, *i.e.*, one which significantly limits the claimant's ability to do basic work activities. 20 C.F.R. §§ 404.1520(c), 416.920(c). Impairments having only a minimal effect on basic work activities are not severe. *See* SSR 85-28**.** When the ALJ finds one severe impairment, all impairments, both severe and non-severe, are considered in assessing a claimant's RFC. 20 C.F.R. §§ 404.1520(e), 404.1545(a)(2), 416.920 (e), 416.925(a)(2); SSR 96-8p.

A claimant's RFC is an administrative determination of the most that she can do despite her impairments. 20 C.F.R. §§ 404.1527(e)(2), 404.1545(a), 416.927(e)(2), 416.945(a). In assessing RFC, the ALJ must consider all of a claimant's functional limitations, including pain,

caused by medically determinable impairments. SSR 96-8p. The RFC assessment must include a narrative discussion describing how the evidence supports each conclusion, citing specific medical facts and non-medical evidence, and must explain how any material inconsistencies or ambiguities in the evidence were considered and resolved. *Id.* A claimant bears the burden of establishing her RFC and of establishing that under her RFC, she was unable to perform her past relevant work. *Diaz v. Shalala*, 59 F.3d 307, 312 n. 2 (2d Cir. 1995).

If the claimant is unable to perform her past relevant work, the burden shifts to the Commissioner who must determine, at step five, whether, given her RFC and vocational factors including age, education, and past work experience, the claimant can do other work that exists in the national economy in significant numbers. 20 C.F.R. §§ 404.1520(a)(4)(v), (g), 416.920(a)(4)(v), (g). If there are a significant number of jobs that the claimant can perform, she will be found not "disabled." *Id*. §§ 404.1520(f), 416.920(f).

When the claimant has only exertional limitations, the Commissioner may utilize the Medical-Vocational Guidelines found in 20 C.F.R. Part 404, subpart P, Appendix 2 to meet the burden of establishing the existence of jobs in the national economy. These guidelines direct a finding of "disabled" or "not disabled" according to combinations of factors including age, educa-

tion level, work history, and residual functional capacity. The guidelines also reflect the administrative notice taken of the numbers of jobs in the national economy that exist for different combinations of these factors. 20 C.F.R. § 404(P), app. 2, § 200.00(b). When a claimant's vocational factors, as determined in the preceding steps of the evaluation process, coincide with a combination listed in Appendix 2, the guidelines direct a conclusion as to whether a claimant is disabled. 20 C.F.R. §§ 404.1569, 416.969. The claimant may rebut any finding of fact as to a vocational factor. *Id.* § 404(P), app. 2, § 200.00(a).

If the claimant's impairments include exertional and non-exertional restrictions, exclusive reliance on the guidelines is improper, and vocational testimony or similar evidence is necessary to consider the combined effect of the claimant's exertional and non-exertional limitations. 20 C.F.R. §§ 404.1566(e), 416.966(e).

2. The standard of review

The Act provides that "[t]he findings of the Commissioner of Social Security as to any fact, if supported by substantial evidence, shall be conclusive." 42 U.S.C. § 405(g). It follows from this statutory directive that "[i]t is not the function of the reviewing court to try the case *de novo* but, assuming the [Commissioner] has applied the correct legal standards, to decide whether the [Commissioner's] decision is supported by sub-

stantial evidence." *Mongeur*, 722 F.2d at 1038; *see Anderson v. Bessemer City*, 470 U.S. 564, 573-75 (1985) (substantial evidence standard "plainly does not entitle a reviewing court to reverse . . . simply because it is convinced that it would have decided the case differently").

Substantial evidence is evidence that is "more than a mere scintilla. It means such relevant evidence as a reasonable mind might accept as adequate to support a conclusion." *Richardson v. Perales*, 402 U.S. 389, 401 (1971) (internal quotation marks omitted); *accord Schaal v. Apfel*, 134 F.3d 496, 501 (2d Cir. 1998). Even where the administrative record may also adequately support contrary findings on particular factual issues, the Commissioner's factual determinations "must be given conclusive effect by the courts," as long as those determinations are supported by substantial evidence. *Schauer v. Schweiker*, 675 F.2d 55, 57 (2d Cir. 1982); *see American Textile Mfrs. Inst. v. Donovan*, 452 U.S. 490, 523 (1981) ("the possibility of drawing two inconsistent conclusions from the evidence does not prevent an administrative agency's finding from being supported by substantial evidence"); *DeChirico v. Callahan*, 134 F.3d 1177, 1182 (2d Cir. 1998) (Commissioner's decision affirmed where substantial evidence exists for both sides). Thus, a court may set aside the Commissioner's decision only if it is based upon legal error or his factual findings are not sup-

ported by substantial evidence in the record as a whole. 42 U.S.C. § 405(g); *Schaal*, 134 F.3d at 501.

B. The ALJ properly considered the various medical opinions.

Jones-Reid first argues that the ALJ erred by not according "controlling weight" to the opinions of several of her treating physicians. Appellant's Brief ("App. Br.") at 17-27. The standard for evaluating medical opinions in Social Security disability cases is found in the regulations at 20 C.F.R. §§ 404.1527 and 416.927. Under the regulations, when evaluating the medical opinion of a treating physician, the ALJ must determine whether that opinion should be given controlling weight. *Id.* In order to be granted controlling weight, the ALJ must find that the opinion is from a treating source, it is a medical opinion concerning the nature and severity of the claimant's impairment, and it is well-supported by medically acceptable clinical and laboratory diagnostic techniques and is not inconsistent with other substantial evidence in the case record. *Id.* If a treating source's opinion is not granted controlling weight, the ALJ will apply the following factors in determining the weight to be assigned: length of treatment relationship and frequency of examination; nature and extent of the treatment relationship; the degree to which the opinion is supported by relevant evidence; the consistency of the opinion with the

record as a whole; and, the specialization of the treating source. *Id*.

1. Dr. Volpe

Here, Dr. Volpe opined that Jones-Reid had no limitations in the areas of remembering locations and work-like procedures; understanding, remembering, and carrying out very short, simple instructions; maintaining regular attendance and being punctual; sustaining an ordinary routine without special supervision; making simple work-related decisions; asking simple questions or requesting assistance; getting along with coworkers or peers without distracting them; maintaining socially appropriate behavior; being aware of normal hazards and taking appropriate precautions; and traveling in unfamiliar places or using public transportation. GA773-GA775. She further opined that Jones-Reid would have difficulty no more than ten percent of the workday or workweek in the areas of understanding, remembering and carrying out detailed instructions; maintaining attention and concentration for extended periods of time; performing activities within a schedule; working in coordination with or proximity to others without being distracted by them; completing a normal workday or workweek without interruptions from psychologically-based symptoms and performing at a consistent pace without an unreasonable number and length of rest periods; interacting appropriately with the general public; accepting

instructions and responding appropriately to criticism from supervisors; responding appropriately to changes in the work setting; and setting realistic goals or making plans independently of others. GA773-GA775. The ALJ considered this opinion and accorded it "great weight." GA18.

Jones-Reid alleges that, although the ALJ asserted in her decision that she afforded Dr. Volpe's opinion "great weight," she actually did not because she did not incorporate all of Dr. Volpe's opined limitations into her RFC. App. Br. at 19-21. Jones-Reid is incorrect. The ALJ found Jones-Reid to have an RFC for tasks involving short, simple instructions in an environment with few workplace changes and no public contact. GA14. Such limitations specifically accounted for Dr. Volpe's opinion. Although the ALJ did not specifically include all of the limitations discussed by Dr. Volpe, these limitations, according to Dr. Volpe, would only impact *no more than* 10% of the workday, *i.e.*, less than one hour per day. Indeed, based on Dr. Volpe's opinion, Jones-Reid could have those limitations for fewer than five minutes per workday. Thus, the ALJ's RFC was not necessarily inconsistent with Dr. Volpe's opinion of Jones-Reid's limitations since nothing in Dr. Volpe's opinion suggests that, even considering those limitations, Jones-Reid was unable to perform work involving short, simple instructions in an

environment with few workplace changes and no public contact.

Jones-Reid further points out that the ALJ failed to incorporate all of Dr. Volpe's opinion into her hypothetical to the VE. App. Br. at 20. Based on her RFC assessment, the ALJ asked the VE to consider a person who, mentally, was limited to tasks involving short, simple instructions in an environment with few workplace changes and no public contact. GA54. This hypothetical was based on the RFC, and the RFC was based on Dr. Volpe's opinion. As with the RFC, the hypothetical limitations presented by the ALJ specifically accounted for Dr. Volpe's opinion that Jones-Reid had no limitations in her ability to understand, remember, and carry out very short, simple instructions, and would only be distracted "for up to 10% of the work day or work week" in the areas of understanding, remembering, and carrying out detailed instructions; maintaining attention and concentration for extended periods of time, interacting appropriately with the general public; and responding appropriately to changes in the workplace. *See* GA773-GA775. Although the ALJ did not specifically include all of Dr. Volpe's opined limitations in her hypothetical, as noted by the district court, "[t]here is nothing logically inconsistent between the ALJ's posed hypothetical and the limitations alleged to have been improperly excluded." RR57.

Jones-Reid also alleges that the ALJ erred in failing to discuss the GAF score of 48 that Dr. Volpe assessed on September 23, 2008. App. Br. at 20-21. The ALJ's failure to mention this GAF score does not in and of itself mean that she did not attribute great weight to Dr. Volpe's opinion. Since the ALJ considered Dr. Volpe's September 23, 2008 assessment, she necessarily considered the GAF score as well. *See Bradley v. Astrue*, 528 F.3d 1113, 1115 n.3 (8th Cir. 2008) (noting that, since the GAF score was part of doctor's assessment, the ALJ necessarily considered it when considering the overall evidence from the doctor). "When, as here, the evidence of record permits us to glean the rationale of an ALJ's decision, we do not require that he have mentioned every item of testimony presented to him or have explained why he considered particular evidence unpersuasive or insufficient to lead him to a conclusion of disability." *Mongeur*, 722 F.2d at 1040.

As part of this argument, Jones-Reid claims that the GAF score assessed by Dr. Volpe was inconsistent with her July 16, 2009 opinion, and the ALJ was therefore required to re-contact Dr. Volpe for clarification under SSR 85-15. App. Br. at 21. As noted by the district court, however, Dr. Volpe's July 16, 2009 opinion was not inconsistent with the GAF score of 48. Indeed, in the July 16, 2009 Psychiatric Evaluation, which was completed ten months after the GAF was

assessed, Dr. Volpe opined that Jones-Reid had experienced repeated episodes of decompensation (GA771), which would be consistent with her exacerbated depression on September 23, 2008 and GAF of 48, but that the episodes of decompensation were not of extended duration. GA767-GA771. Because Dr. Volpe's July 2009 opinion was consistent with Jones-Reid's treatment history, the ALJ was not required to re-contact Dr. Volpe for clarification under SSR 85-15. SSR 85-15 only requires that a treating source physician be re-contacted where the source's notes are incomplete, and there is a need for more detailed information. SSR 85-15. As there is no inconsistency between Dr. Volpe's July 16, 2009 opinion and her previous treatment, and the evaluation was not incomplete, the ALJ was under no duty to re-contact Dr. Volpe.

Lastly, as to Dr. Volpe, Jones-Reid maintains the opinion compels a finding of disability pursuant to SSR 85-15. App. Br. at 21-24. SSR 85-15 emphasizes:

> (1) that the potential job base for mentally ill claimants without adverse vocational factors is not necessarily large even for individuals who have no other impairments, unless their remaining mental capacities are sufficient to meet the intellectual and emotional demands of at least unskilled, competitive, remu-

> nerative work on a sustained basis; and, (2) that a finding of disability can be appropriate for an individual who has a severe mental impairment which does not meet or equal the Listing of Impairments, even where he or she does not have adversities in age, education, or work experience.

SSR 85-15. But the ALJ did not "assume" that, because Jones-Reid's severe depression did not meet or equal a listed impairment, "she had essentially no limitations in her mental capacity to do unskilled work." App. Br. at 22-23. She also did not find that all of Jones-Reid's mental limitations "were essentially 'normal." App. Br. at 23. Rather, the ALJ properly considered all of the evidence regarding Jones-Reid's depression (noting, among other things, that her examinations at Community Health had "generally been normal"), and reasonably concluded that the record showed that she was able to perform tasks involving short, simple instructions in an environment with few workplace changes and no public contact *despite* her depression and accompanying limitations. GA14-GA18. Thus, although the ALJ did not specifically discuss SSR 85-15, her analysis was consistent with the intent of the ruling, which is that a claimant with a severe impairment that does not meet the Listings should not be presumed to retain the RFC to perform at least unskilled work.

2. Dr. Morgan

Jones-Reid next alleges that the ALJ erred by not giving "controlling weight" to Dr. Morgan's opinion that Jones-Reid was restricted with regard to sitting, standing, walking, lifting, and fine manipulation. App. Br. at 24-27. Dr. Morgan opined that Jones-Reid's impairments restricted her to sitting for one hour per eight-hour workday, never standing or walking, occasionally lifting up to five pounds, and no fine manipulation. GA700-GA713. The ALJ considered this opinion and declined to give it controlling weight as it was not supported by the evidence of record. GA18.

According to SSR 96-2p, a treating source's opinion is given controlling weight when it is "well-supported" by medically acceptable clinical and laboratory diagnostic techniques, and is "not inconsistent" with other medical evidence of record. SSR 96-2p. While "the ALJ cannot arbitrarily substitute his own judgment for competent medical opinion," *Rosa v. Callahan*, 168 F.3d 72, 79 (2d Cir. 1999), "[w]hen other substantial evidence in the record conflicts with the treating physician's opinion . . . that opinion will not be deemed controlling." *Snell*, 177 F.3d at 133. Here, the ALJ stated that she afforded Dr. Morgan's opinion "little weight" since there was no support for the opined exertional restrictions. GA18. Indeed, as also articulated by the DRB, Dr. Morgan's opinion was not accompanied by

any objective findings, and did not point to evidence that adequately supported his extremely restrictive opinion. GA2, GA700-GA713. *See Poupore v. Astrue*, 566 F.3d 303, 307 (2d Cir. 2009) (stating that, if the treating physician's opinion is not supported by objective medical evidence or is inconsistent with other substantial evidence in the record, the ALJ need not give the opinion significant weight). Although Dr. Morgan cited the April 2008 lumbar spine x-ray that showed facet arthropathy as support of his opinion that Jones-Reid could never stand or walk and could only sit for one hour per day (GA701), such evidence on its own is not indicative of an impairment requiring an individual to seemingly lie down all but one hour per day.

Nor does other evidence of record provide objective support for restrictions of sitting for only one hour of an eight-hour workday, never standing or walking, never lifting more than five pounds, and no fine manipulation. To the contrary, as cited by the ALJ, x-rays of the right hip and hand showed only early degenerative changes. GA721-GA722. Even assuming such evidence is consistent with Dr. Morgan's opinion, these x-rays were obtained ten months after Dr. Morgan issued his opinion and, thus, could not be the evidentiary basis for the opinion.

Additionally, as the ALJ noted, medical expert Dr. Gaeta opined that Jones-Reid had no restrictions with sitting or standing, could walk

for twenty minutes at a time, could lift up to twenty pounds, and had no manipulative limitations. GA802. Dr. Waldman also opined that Jones-Reid could occasionally lift twenty pounds, frequently lift ten pounds, stand and/or walk for about six hours in an eight-hour day, sit with breaks for six hours per eight-hour day, and perform unlimited pushing and/or pulling of hand/foot controls. GA419-GA426. "Although the treating physician rule generally requires deference to the medical opinion of a claimant's treating physician, the opinion of the treating physician is not afforded controlling weight where, as here, the treating physician issued opinions that are not consistent with other substantial evidence in the record, such as the opinions of other medical experts." *Halloran*, 362 F.3d at 32. If a treating physician's opinion is inconsistent with other evidence in the record, then the conflict is to be resolved by the Commissioner and not the courts. *Rodriguez v. Sec'y of Health and Human Servs.,* 647 F.2d 218, 222 (1st Cir. 1981). Here, the ALJ reasonably concluded, and the district court agreed, that Dr. Morgan's restrictive opinion was not well-supported by either his own objective findings or other substantial evidence of record. GA18, RR40-RR42.

3. Nurse practitioner Tummillo

Jones-Reid asserts that the ALJ erred when she attributed "limited weight" to Nurse Practi-

tioner Tummillo's opinion. App. Br. at 27-32. Ms. Tummillo completed a functional capacity questionnaire and opined that Jones-Reid's pain and other symptoms rendered her unable to perform even simple tasks on a frequent basis. She further found that Jones-Reid could only walk one block without rest or severe pain, and could stand less than two hours in a workday. GA778-GA781. The ALJ afforded Tummillo's opinion little weight because she was not an acceptable medical source, *see* 20 C.F.R. §§ 404.1513, 416.913, and because she gave no basis for her opinion of severe restrictions. GA18.

The weight accorded the evidence varies based on the following factors: length and frequency of treatment relationship, consistency with other evidence, degree to which relevant evidence is offered in support of an opinion, how well the source explains the opinion, whether the source has expertise related to the impairment, and other relevant information. SSR 06-03p. Here, Tummillo "offered no explanation for her opinion, and cited no relevant evidence in support of it." GA18, RR44. Furthermore, Jones-Reid was referred to Tummillo for treatment for Hepatitis C, and "[n]othing in the record indicates that [she] had any expertise as to [Jones-Reid's] limitations with regard to anything other than Hepatitis C." RR44. Thus, since Tummillo offered no explanation for her opinion and did not have expertise related to the

impairments at issue, it was proper for the ALJ to accord little weight to her opinion under SSR 06-03p.

Jones-Reid maintains that, although the ALJ stated she gave "little weight" to Tummillo's opinion, in reality, she gave the opinion no weight because she did not include all of Tummillo's opined limitations in her RFC. App. Br. at 31-32. First, Tummillo's opinion was not a medical opinion that the ALJ was required to weigh and explain if rejected, per 20 C.F.R. §§ 404.1527(c), 416.927(c). Second, an ALJ need not adopt a provider's opinion in its entirety and is entitled "to piece together the relevant medical facts from the findings and opinion of multiple physicians." *Evangelista v. Sec'y of Health and Human Servs.*, 826 F.2d 136, 144 (1st Cir. 1987).

4. Dr. Waldman

Jones-Reid finally argues that the ALJ committed two errors by relying on the opinion of State agency medical consultant, Dr. Arthur Waldman. Jones-Reid first argues the ALJ erred because Dr. Waldman did not review the evidence submitted after his August 2008 opinion. App. Br. at 32-33. Second, Jones-Reid argues that, because Dr. Waldman did not examine Jones-Reid, the ALJ should not have relied on his August 2008 opinion. Id. at 33-34.

The first argument relies, in part, on an erroneous reading of *Pratts v. Chater*, 94 F.3d 34 (2d Cir. 1996), and a selective reading of SSR 96-6p. Jones-Reid relies on this Court's decision in Pratts to argue that a non-examining source's opinion based on incomplete medical records cannot constitute substantial evidence to uphold an ALJ's decision. In Pratts, however, the consulting medical opinion was provided through a doctor who appeared at the hearing before the ALJ and testified; the doctor's testimony was not fully transcribed and therefore was not fully before the reviewing court; the medical record that was before the court indicated that "[m]uch of Pratts's medical history [was] missing," including records indicating an initial diagnosis of HIV, treatment notes, lab results, and identification of medications; and those medical reports that were in the record were incomplete or illegible. Id. at 37-38. But here, Dr. Waldman's opinion was based on the records available to him as of August 2008.

The circumstance in this case – where new records become available after a medical opinion is rendered -- is contemplated by SSR 96-6p which only requires an ALJ to obtain an updated medical expert opinion when, as relevant here, "additional medical evidence is received that in the opinion of the administrative law judge or the Appeals Council may change the State agency medical or psychological consultant's finding

that the impairment(s) is not equivalent in severity to any impairment in the Listing of Impairments." SSR 96-6p at *4. But Dr. Waldman's opinion is consistent with the evidence submitted after his opinion was issued, including a report dated August 26, 2008 from UConn Health Center (GA427); laboratory results from Hartford Hospital in October 2008 (GA431); laboratory reports from November and December 2008 (GA445-GA457); treatment records of Hartford Hospital from August 2008 through March 2009 (GA550-GA561); cardiology records from Hartford Hospital dated June 2008 through April 2009 (GA637-GA641); laboratory results from Community Health Services dated October 2009 (GA 797-799); and the April 2010 opinion of medical expert, Dr. Gaeta (GA800-GA802). Jones-Reid fails to identify any evidence after August 2008 that would have changed Dr. Waldman's opinion. Moreover, the records Jones-Reid complains Dr. Waldman did not review were before the ALJ herself, so the ALJ could evaluate Dr. Waldman's opinion in light of those later records. Thus, the ALJ acted in accordance with SSR 96-6p in not seeking an updated medical expert opinion.

As to the claim that the ALJ should not have relied on Dr. Waldman because he never examined Jones-Reid, this Court has held that the opinions of non-examining physicians can override even a treating source's opinion where, as

here, they are supported by evidence in the record. *Diaz*, 59 F.3d at 313 n. 5; *Schisler*, 3 F.3d at 567. Here, the ALJ reasonably found that Dr. Waldman's opinion was consistent with the medical record as a whole, which evidenced mild findings and improvement with treatment, and accordingly afforded it great weight. GA18.

C. The ALJ did not err in her credibility determinations.

Jones-Reid next avers that the ALJ erred in her credibility evaluation. App. Br. at 34-39. A review of the ALJ's decision and the record, however, demonstrates that the ALJ properly explained her assessment of Jones-Reid's credibility, and this assessment was based on substantial objective and subjective evidence.

An individual's symptoms and subjective allegations cannot form the basis for a finding of disability unless there are medical signs and laboratory findings demonstrating the existence of a medically determinable impairment that could reasonably be expected to produce the symptoms alleged. 20 C.F.R. §§ 404.1529(a)-(b), 416.929(a)-(b); SSR 96-7p. The regulations recognize, however, that symptoms may suggest a more severe impairment than can be shown by objective medical evidence. 20 C.F.R. §§ 404.1529(c)(3), 416.929(c)(3). Once it is determined that an individual has an impairment that could reasonably produce the symptoms alleged, the ALJ must

determine the extent to which the subjective symptoms affect the individual's capacity to perform basic work activities. 20 C.F.R. §§ 404.1529(c)(1), 416.929(c)(1); SSR 96-7p. Accordingly, the ALJ is directed to analyze an individual's complaints of pain under the following factors:

> (1) The nature, location, onset, duration, frequency, radiation and intensity of any pain; (2) Precipitating and aggravating factors; (3) Type, dosage, effectiveness and adverse side-effects of any pain medication; (4) Treatment, other than medication, for relief of pain; (5) Functional restrictions; and, (6) The individual's daily activities.

See 20 C.F.R. § 404.1529(c)(3); SSR 96-7p.

The ALJ, however, is not obligated to accept without question the credibility of subjective evidence. *Marcus v. Califano*, 615 F.2d 23, 27 (2d Cir. 1979). The ALJ has the discretion to evaluate the credibility of an individual and to arrive at an independent judgment regarding subjective symptoms in light of medical findings and other evidence. *Mimms v. Heckler*, 750 F.2d 180, 186 (2d Cir. 1984). While the ALJ may not reject an individual's subjective symptoms because objective, clinical findings do not establish a cause for such symptoms, it is well within the province of the ALJ to discredit an individual's claims after consideration of the objective medi-

cal evidence, the individual's demeanor, and other indicia of credibility. *Marcus*, 615 F.2d at 27-28. Where the ALJ's findings are supported by substantial evidence, the decision to discount subjective testimony may not be disturbed on review. *Aponte*, 728 F.2d at 591.

Here, the ALJ determined that the objective and subjective evidence of record was inconsistent with Jones-Reid's allegations of severely disabling pain and mental impairment. GA14-GA18. Contrary to Jones-Reid's assertion, the ALJ discussed with specificity why her testimony about the extent of her limitations was not fully supported by the objective evidence. GA14-GA18. For example, the ALJ noted that, with regard to Jones-Reid's allegations of knee pain, she had not undergone x-rays on her knees. GA14, GA36. As to her testimony about back pain, the x-rays showed only mild degenerative changes in Jones-Reid's hip, examinations of Jones-Reid's back were often normal, and medication helped to relieve her pain. GA15-GA16. And as to her heart condition, testing showed normal results or, at most, mild disease. GA16. For her mental condition, according to Dr. Volpe, she could perform simple work despite the impairment. GA17, GA773-GA775. Based on these medical findings, the ALJ reasonably determined that the objective evidence of record was not entirely consistent with Jones-Reid's testimony. GA14-GA18.

The ALJ also considered Jones-Reid's reported daily activities and noted that they were inconsistent with a finding of total disability. GA15-GA18. Jones-Reid testified that she did the dishes, did laundry, went food shopping, drove about six hours per week, visited her mother, and had no problems taking care of herself. GA15, GA17-GA18. On March 5, 2009, Jones-Reid told Tummillo that she had taken a bus trip to Maine for the weekend and talked about playing bingo. GA17, GA672. Similarly, on March 10, 2009, Jones-Reid described having a nice weekend after doing a lot of cooking for her family for a birthday celebration. GA675. A claimant's daily activities are a factor to be considered when assessing the veracity of his subjective complaints, and the ALJ correctly considered Jones-Reid's activities in determining that her complaints were not entirely credible. Jones-Reid's ability to perform such wide and varied activities is consistent with an ability to perform a range of light work, just as the ALJ found.

Finally, contrary to Jones-Reid's allegation, the ALJ properly considered the testimony of Ms. Grice and reasonably concluded that it was not persuasive because it simply regurgitated Jones-Reid's own complaints, which the ALJ had heard at the hearing and considered. GA16-GA17. The ALJ further noted that Grice only saw Jones-Reid once per month, indicating that

her observations on such a limited basis would not change her determination. GA17.

In support of her argument, Jones-Reid alleges that the ALJ erred by not discussing the State agency physician's opinion that Jones-Reid's statements were fully credible based upon objective medical evidence. App. Br. at 37-38; GA92. But here the State agency physician (Dr. Golkar) opined that Jones-Reid's statements were credible based on the objective medical evidence, which showed that Jones-Reid was able to perform light work. GA92-GA95. Thus, although the ALJ did not discuss Dr. Golkar's opinion, Dr. Golkar agreed with the ALJ in that he found Jones-Reid could perform light work.[4]

In sum, the ALJ thoroughly explained her credibility finding. As explained in detail above, the ALJ cited the evidence that belied Jones-Reid's complaints of disabling pain and mental limitations, including the objective medical evidence as well as her own reports of her daily ac-

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[4] Jones-Reid also alleges that the ALJ failed to consider her longitudinal attempts to seek medical treatment as supporting her subjective statements of pain and enhancing her credibility. App. Br. at 38. But the ALJ considered all of Jones-Reid's treatment and attempts to alleviate pain with medication, and specifically found that the record showed primarily mild findings and well-controlled symptoms. GA16-GA18.

tivities. GA14-GA18; *Williams v. Bowen*, 859 F.2d 255, 260-61 (2d Cir. 1988) (holding that an ALJ must set forth her reasons for finding a claimant not credible with sufficient specificity to permit intelligible plenary review).

D. Substantial evidence supports the ALJ's RFC determination.

The RFC finding is an administrative determination of the most that a claimant can do despite her impairments. 20 C.F.R. §§ 404.1527(e)(2), 416.927(e)(2), 404.1545(a), 416.945(a). Based on a review of the objective and subjective evidence of record, the ALJ determined that Jones-Reid had an RFC to perform light work except that she could only occasionally bend, climb stairs, balance, stoop, kneel, crouch and crawl; could not climb ladders or frequently reach above shoulder level with the left arm; could not be exposed to moving machinery, unprotected heights, or extreme cold or heat; and was limited to tasks involving short, simple instructions in an environment with few workplace changes and no public contact. GA14. In so finding, the ALJ relied on the opinions of Drs. Waldman and Gaeta, who concluded that Jones-Reid could perform a range of light work, and Dr. Volpe, who concluded that she was able to perform simple work. GA18, GA419-GA426, GA773-775, GA800-GA802.

Jones-Reid first argues that the ALJ erred in not discussing whether her low back pain, hand

pain, knee pain, cirrhosis, and sleep apnea were severe impairments at step two. App. Br. at 40-43. She alleges that this is not harmless error because the impairments caused limitations that would affect her RFC. *Id.* A severe impairment is one which significantly limits an individual's ability to do basic work activities. 20 C.F.R. §§ 404.1520(c), 416.920(c). Impairments having only a minimal effect on basic work activities are not severe. *See* SSR 85-28; *Munoz v. Sec'y of Health and Human Servs.*, 788 F.2d 822, 823 (1st Cir. 1986). A claimant has the burden to establish the existence of an impairment by objective medical evidence and to establish that any medically determined impairment is severe. 20 C.F.R. §§ 404.1508, 404.1512, 416.908, 416.912. Evidence that merely shows the diagnosis of an ailment is not sufficient to prove that it is severe or disabling. *See Williams*, 859 F.2d at 260-61; *Higgs v. Bowen*, 880 F.2d 860, 863 (6th Cir. 1988).

Here, the ALJ specifically found that Jones-Reid's arthritis was a severe impairment. GA13. In so finding, she implicitly considered Jones-Reid's allegations of low back and hand pain. As noted, when Jones-Reid presented for hand and hip pain, x-rays revealed degenerative arthritic changes in both the interphalangeal joints to the digits and the superlateral acetabular rim of the hip. GA721-GA722. In discussing Jones-Reid's arthritis and noting that it was a severe im-

pairment, the ALJ specifically cited to not only these x-rays, but also to examination findings including tenderness and spasm related to Jones-Reid's back. GA16. Thus, the ALJ accounted for Jones-Reid's symptoms of severe low back and hand pain.

With regard to Jones-Reid's cirrhosis, the ALJ specifically discussed the evidence regarding Jones-Reid's liver disease and chronic hepatitis and noted that the only manifestation of Jones-Reid's cirrhosis appeared to be some fatigue that would not prevent working. GA17. Jones-Reid does not point to any evidence of record indicating that her cirrhosis significantly limited her ability to perform basic work activities.

Similarly, with regard to Jones-Reid's sleep apnea, the record has only one mention of the impairment at a more than mild level. As noted, a sleep study conducted in September 2008 showed mild obstructive sleep apnea with symptoms of daytime sleepiness and fatigue. GA447-GA448. Although a sleep study conducted in October 2008 confirmed obstructive sleep apnea with associated daytime fatigue, by November 25, 2008, a sleep study revealed only the presence of poor sleep quality with a reduced sleep efficiency. GA604-GA605. Again, Jones-Reid points to no evidence of how her sleep apnea significantly limited her ability to perform basic work activities.

And even assuming the ALJ erred in not finding Jones-Reid's low back pain, hand pain, cirrhosis, and sleep apnea to be severe impairments, this error was harmless. The ALJ did as she was required and considered all impairments, both severe and non-severe, throughout the remaining steps of the sequential evaluation process, and in assessing Jones-Reid's RFC. *See* 20 C.F.R. §§ 404.1520(e), 404.1545(a)(2), 416.920(e), 416.925(a)(2); SSR 96-8p; *see Carpenter v. Astrue*, 537 F.3d 1264, 1266 (10th Cir. 2008); *Jamison v. Bowen*, 814 F.2d 585, 588 (11th Cir. 1987). Although Jones-Reid maintains that the ALJ did not consider the effects of her non-severe impairments when assessing her RFC, App. Br. at 43-44, she does not cite any evidence in support of her contention. In fact, the ALJ specifically noted that Jones-Reid's cirrhosis only limited her by causing some fatigue, which was not inconsistent with the ability to perform a range of unskilled, light work. GA17.

E. The ALJ did include Jones-Reid's mental limitations in its RFC determination

Jones-Reid next argues that the ALJ erred in translating Dr. Volpe's opinion regarding Jones-Reid's mental limitations into a finding that she could perform unskilled work. App. Br. at 45-49. First, the ALJ did not, as Jones-Reid states, find that Jones-Reid was limited to unskilled work. Rather, the ALJ determined, as part of her RFC

assessment, that Jones-Reid was "limited to tasks involving short, simple instructions in an environment with few workplace changes and no public contact." GA14.

Jones-Reid, relying on a district court case, argues that "[c]ourts" have admonished ALJs for translating mental limitations into "unskilled, simple, repetitive, routine, one-or two-step, or any similar characterization, because these descriptions may not account for all the limitations a doctor meant to convey." App. Br. at 45 (citing *Tune v. Astrue*, 760 F. Supp.2d 555 (E.D.N.C. 2011)). Jones-Reid's reliance on *Tune* is misplaced because, here, unlike in *Tune*, Dr. Volpe specifically concluded that Jones-Reid could understand, remember, and carry out very short, simple instructions. Thus, the ALJ was simply relying on Dr. Volpe's opinion.

Jones-Reid similarly relies on cases that find error where an ALJ equates limitations as to concentration and pace with unskilled work. App. Br. at 46-49. These cases are also distinguishable because the ALJ here did not assume, without support, that moderate difficulties with concentration and pace could be accommodated by limiting the claimant to unskilled work. The ALJ's limitation was specifically based on Dr. Volpe's opinion, and was, therefore, clearly supported by the medical record. Courts will uphold a limitation to simple tasks or instructions as long as the record supports that assessment. *See*

Johansen v. Barnhart, 314 F.3d 283, 288-89 (7th Cir. 2002).

Moreover, Dr. Volpe's opinion of Jones-Reid's mental limitations *is* consistent with the ALJ's finding that Jones-Reid could perform unskilled jobs. Contrary to Jones-Reid's assertion, Dr. Volpe did not conclude that Jones-Reid was unable to concentrate or pay attention. Rather, she opined that Jones-Reid would have no limitation in performing short, simple tasks. GA773-GA775. The concept of "unskilled work" essentially aligns with the "simple tasks" term of art common to non-exertional RFC findings. Unskilled work is described as "work which needs little or no judgment to do simple duties that can be learned on the job in a short period of time." 20 C.F.R. §§ 404.1567, 416.967. Further, SSR 85-15 states: "The basic mental demands of competitive, remunerative, unskilled work include the abilities (on a sustained basis) to understand, carry out, and remember simple instructions . . . ." SSR 85-15. Thus, Dr. Volpe's opinion that Jones-Reid could follow short, simple instructions was not inconsistent with a finding that she could perform the unskilled jobs presented by the VE.

F. Substantial evidence supports the ALJ's step five finding that there were other jobs that Jones-Reid could perform.

Lastly, Jones-Reid alleges that the ALJ's step five determination that she could perform other work that existed in significant numbers in the economy is not supported by substantial evidence since the hypothetical the ALJ presented to the VE failed to include all of Jones-Reid's limitations. The ALJ asked the VE to consider an individual who was limited to tasks involving short, simple instructions in an environment with few workplace changes and no public contact. GA54.

Jones-Reid first points to the fact that the ALJ did not include Dr. Volpe's opined limitations regarding concentration, persistence and pace in her hypothetical to the VE. As discussed above, however, ALJ's hypothetical did account for Dr. Volpe's opinion that Jones-Reid had *no* limitations in her ability to understand, remember, and carry out very short, simple instructions, and would only be distracted "for up to 10% of the work day or work week" in the areas of understanding, remembering, and carrying out detailed instructions, and maintaining attention and concentration for extended periods of time. GA773-775. Although the ALJ did not specifically include all of Dr. Volpe's limitations in her hypothetical, as noted by the district

court, "[t]here is nothing logically inconsistent between the ALJ's posed hypothetical and the limitations alleged to have been improperly excluded." RR57. Dr. Volpe opined that Jones-Reid would be "able to" perform activities within a schedule and perform at a consistent pace without an unreasonable number and length of rest periods, and would only have "noticeable difficulty" with them less than 10% of the workday. GA773-775. Although these specific limitations were not included in the ALJ's hypothetical, "[t]he hypothetical claimant's limitations seem adequate to accommodate any of [Jones-Reid's] limitations in this regard, especially considering that the maximum severity of [Jones-Reid's] limitations is only up to 10 percent of a workday." RR57-RR58. Thus, the ALJ's hypothetical was proper.

Jones-Reid next argues that the *DOT* jobs identified by the VE did not meet the limitations set forth in the ALJ's hypothetical. App. Br. at 49-50. Specifically, she argues that the mail clerk job requires frequent reaching, and the hypothetical provided for no reaching above shoulder level. *Id.* As the ALJ stated, however, frequent reaching does not imply reaching above shoulder level. GA20. Therefore, the two limitations were not mutually exclusive. Jones-Reid maintains that the ALJ "ignored the Social Security definition of 'reaching' found in SSR 85-15—reaching is defined as, 'extending the hands

and arms in any direction.'" App. Br. at 50. As noted by the district court, however, there is no evidence that Jones-Reid would not be able to perform any reaching tasks required without exceeding the limitation on her left arm. RR62.

Jones-Reid also argues that the limitation of "short, simple instructions with few workplace changes" would preclude the routing clerk and marker jobs, which both involve a reasoning level of 2, and the mail clerk job, which involves a reasoning level of 3. App. Br. at 50-52. Contrary to Jones-Reid's allegation, and as held by the district court, jobs with a reasoning level of 2 or 3 are consistent with a limitation to short, simple instructions. *See Terry v. Astrue*, 580 F.3d 471, 478 (7th Cir. 2009) (holding that GED level 3 reasoning was not inconsistent with ability to perform "simple" work); *Renfrew v. Astrue*, 469 F.3d 918, 921 (8th Cir. 2007) (finding that two unskilled GED level 3 reasoning jobs were not "complex" and not inconsistent with the claimant's limitations); *Hackett v. Barnhart*, 395 F3d. 1168, 1176 (10th Cir. 2005) (stating that an RFC's limitation for "simple and routine work tasks" was consistent with the demands of level 2 reasoning). There is nothing in the record to suggest that Jones-Reid cannot satisfy the requirements of GED levels 2 or 3 reasoning. Therefore, Jones-Reid's assertion that the ALJ's hypothetical for short, simple instructions is in-

consistent with the GED reasoning level 2 and 3 of the jobs presented by the VE is incorrect.

Based on the above, substantial evidence supports the ALJ's step five finding that there were other jobs that Jones-Reid could perform.

Conclusion

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

Dated: January 2, 2013

Respectfully submitted,

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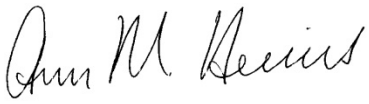

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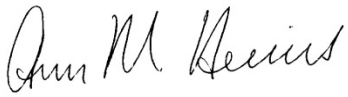
Federal Rule of Appellate Procedure 32(a)(7)(C) Certification

This is to certify that the foregoing brief complies with the 14,000 word limitation of Fed. R. App. P. 32(a)(7)(B), in that the brief is calculated by the word processing program to contain approximately 13,863 words, exclusive of the Table of Contents, Table of Authorities, Addendum, and this Certification.



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ADDENDUM

20 C.F.R. § 404.1513

Medical and other evidence of your impairment(s).

(a) Sources who can provide evidence to establish an impairment. We need evidence from acceptable medical sources to establish whether you have a medically determinable impairment(s). See § 404.1508. Acceptable medical sources are--

> (1) Licensed physicians (medical or osteopathic doctors);
>
> (2) Licensed or certified psychologists. Included are school psychologists, or other licensed or certified individuals with other titles who perform the same function as a school psychologist in a school setting, for purposes of establishing mental retardation, learning disabilities, and borderline intellectual functioning only;
>
> (3) Licensed optometrists, for purposes of establishing visual disorders only (except, in the U.S. Virgin Islands, licensed optometrists, for the measurement of visual acuity and visual fields only);
>
> (4) Licensed podiatrists, for purposes of establishing impairments of the foot, or foot and ankle only, depending on whether the State in which the podiatrist practices per-

mits the practice of podiatry on the foot only, or the foot and ankle; and

(5) Qualified speech-language pathologists, for purposes of establishing speech or language impairments only. For this source, "qualified" means that the speech-language pathologist must be licensed by the State professional licensing agency, or be fully certified by the State education agency in the State in which he or she practices, or hold a Certificate of Clinical Competence from the American Speech–Language–Hearing Association.

(b) Medical reports. Medical reports should include--

(1) Medical history;

(2) Clinical findings (such as the results of physical or mental status examinations);

(3) Laboratory findings (such as blood pressure, x-rays);

(4) Diagnosis (statement of disease or injury based on its signs and symptoms);

(5) Treatment prescribed with response, and prognosis; and

(6) A statement about what you can still do despite your impairment(s) based on the acceptable medical source's findings on the

> factors under paragraphs (b)(1) through (b)(5) of this section (except in statutory blindness claims). Although we will request a medical source statement about what you can still do despite your impairment(s), the lack of the medical source statement will not make the report incomplete. See § 404.1527.

(c) Statements about what you can still do. At the administrative law judge and Appeals Council levels, we will consider residual functional capacity assessments made by State agency medical and psychological consultants, and other program physicians and psychologists to be "statements about what you can still do" made by nonexamining physicians and psychologists based on their review of the evidence in the case record. Statements about what you can still do (based on the acceptable medical source's findings on the factors under paragraphs (b)(1) through (b)(5) of this section) should describe, but are not limited to, the kinds of physical and mental capabilities listed as follows (See §§ 404.1527 and 404.1545(c)):

> (1) The acceptable medical source's opinion about your ability, despite your impairment(s), to do work-related activities such as sitting, standing, walking, lifting, carrying, handling objects, hearing, speaking, and traveling; and

(2) In cases of mental impairment(s), the acceptable medical source's opinion about your ability to understand, to carry out and remember instructions, and to respond appropriately to supervision, coworkers, and work pressures in a work setting.

(d) Other sources. In addition to evidence from the acceptable medical sources listed in paragraph (a) of this section, we may also use evidence from other sources to show the severity of your impairment(s) and how it affects your ability to work. Other sources include, but are not limited to--

(1) Medical sources not listed in paragraph (a) of this section (for example, nurse-practitioners, physicians' assistants, naturopaths, chiropractors, audiologists, and therapists);

(2) Educational personnel (for example, school teachers, counselors, early intervention team members, developmental center workers, and daycare center workers);

(3) Public and private social welfare agency personnel; and

(4) Other non-medical sources (for example, spouses, parents and other caregivers, siblings, other relatives, friends, neighbors, and clergy).

(e) Completeness. The evidence in your case record, including the medical evidence from acceptable medical sources (containing the clinical and laboratory findings) and other medical sources not listed in paragraph (a) of this section, information you give us about your medical condition(s) and how it affects you, and other evidence from other sources, must be complete and detailed enough to allow us to make a determination or decision about whether you are disabled or blind. It must allow us to determine--

(1) The nature and severity of your impairment(s) for any period in question;

(2) Whether the duration requirement described in § 404.1509 is met; and

(3) Your residual functional capacity to do work-related physical and mental activities, when the evaluation steps described in § 404.1520(e) or (f)(1) apply.

20 C.F.R. § 404.1520

Evaluation of disability in general.

(a) General--

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

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

(3) Evidence considered. We will consider all evidence in your case record when we make a determination or decision whether you are disabled. See § 404.1520b.

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

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

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

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

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

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

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

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

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

possible for you to have a period of disability for a time in the past even though you do not now have a severe impairment.

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

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

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

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

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

(1) If we find that you cannot do your past relevant work because you have a severe impairment(s) (or you do not have any past relevant work), we will consider the same residual functional capacity assessment we made under paragraph (e) of this section, together with your vocational factors (your age, education, and work experience) to determine if you can make an adjustment to other work. (See § 404.1560(c).) If you can make an adjustment to other work, we will find you not disabled. If you cannot, we will find you disabled.

(2) We use different rules if you meet one of the two special medical-vocational profiles described in § 404.1562. If you meet one of those profiles, we will find that you cannot make an adjustment to other work, and that you are disabled.

(h) Expedited process. If we do not find you disabled at the third step, and we do not have sufficient evidence about your past relevant work to make a finding at the fourth step, we may proceed to the fifth step of the sequential evaluation process. If we find that you can adjust to other work based solely on your age, education, and the same residual functional capacity assessment we made under paragraph (e) of this section, we will find that you are not disabled and will not make a finding about whether you can do your past relevant work at the fourth step. If we find that you may be unable to adjust to other work or if § 404.1562 may apply, we will assess your claim at the fourth step and make a finding about whether you can perform your past relevant work. See paragraph (g) of this section and § 404.1560(c).

20 C.F.R. § 404.1527

Evaluating opinion evidence.

(a) General.

(1) You can only be found disabled if you are unable to do any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a con-

tinuous period of not less than 12 months. See § 404.1505. Your impairment must result from anatomical, physiological, or psychological abnormalities which are demonstrable by medically acceptable clinical and laboratory diagnostic techniques. See § 404.1508.

(2) Evidence that you submit or that we obtain may contain medical opinions. Medical opinions are statements from physicians and psychologists or other acceptable medical sources that reflect judgments about the nature and severity of your impairment(s), including your symptoms, diagnosis and prognosis, what you can still do despite impairment(s), and your physical or mental restrictions.

(b) How we consider medical opinions. In determining whether you are disabled, we will always consider the medical opinions in your case record together with the rest of the relevant evidence we receive. See § 404.1520b.

(c) How we weigh medical opinions. Regardless of its source, we will evaluate every medical opinion we receive. Unless we give a treating source's opinion controlling weight under paragraph (c)(2) of this section, we consider all of the following factors in deciding the weight we give to any medical opinion.

(1) Examining relationship. Generally, we give more weight to the opinion of a source who has examined you than to the opinion of a source who has not examined you.

(2) Treatment relationship. Generally, we give more weight to opinions from your treating sources, since these sources are likely to be the medical professionals most able to provide a detailed, longitudinal picture of your medical impairment(s) and may bring a unique perspective to the medical evidence that cannot be obtained from the objective medical findings alone or from reports of individual examinations, such as consultative examinations or brief hospitalizations. If we find that a treating source's opinion on the issue(s) of the nature and severity of your impairment(s) is well-supported by medically acceptable clinical and laboratory diagnostic techniques and is not inconsistent with the other substantial evidence in your case record, we will give it controlling weight. When we do not give the treating source's opinion controlling weight, we apply the factors listed in paragraphs (c)(2)(i) and (c)(2)(ii) of this section, as well as the factors in paragraphs (c)(3) through (c)(6) of this section in determining the weight to give the opinion. We will always give good reasons in our notice of determi-

nation or decision for the weight we give your treating source's opinion.

(i) Length of the treatment relationship and the frequency of examination. Generally, the longer a treating source has treated you and the more times you have been seen by a treating source, the more weight we will give to the source's medical opinion. When the treating source has seen you a number of times and long enough to have obtained a longitudinal picture of your impairment, we will give the source's opinion more weight than we would give it if it were from a nontreating source.

(ii) Nature and extent of the treatment relationship. Generally, the more knowledge a treating source has about your impairment(s) the more weight we will give to the source's medical opinion. We will look at the treatment the source has provided and at the kinds and extent of examinations and testing the source has performed or ordered from specialists and independent laboratories. For example, if your ophthalmologist notices that you have complained of neck pain during your eye examinations, we will consider his or her opinion with respect to your neck pain, but we will give it less weight

than that of another physician who has treated you for the neck pain. When the treating source has reasonable knowledge of your impairment(s), we will give the source's opinion more weight than we would give it if it were from a nontreating source.

(3) Supportability. The more a medical source presents relevant evidence to support an opinion, particularly medical signs and laboratory findings, the more weight we will give that opinion. The better an explanation a source provides for an opinion, the more weight we will give that opinion. Furthermore, because nonexamining sources have no examining or treating relationship with you, the weight we will give their opinions will depend on the degree to which they provide supporting explanations for their opinions. We will evaluate the degree to which these opinions consider all of the pertinent evidence in your claim, including opinions of treating and other examining sources.

(4) Consistency. Generally, the more consistent an opinion is with the record as a whole, the more weight we will give to that opinion.

(5) Specialization. We generally give more weight to the opinion of a specialist about

medical issues related to his or her area of specialty than to the opinion of a source who is not a specialist.

(6) Other factors. When we consider how much weight to give to a medical opinion, we will also consider any factors you or others bring to our attention, or of which we are aware, which tend to support or contradict the opinion. For example, the amount of understanding of our disability programs and their evidentiary requirements that an acceptable medical source has, regardless of the source of that understanding, and the extent to which an acceptable medical source is familiar with the other information in your case record are relevant factors that we will consider in deciding the weight to give to a medical opinion.

(d) Medical source opinions on issues reserved to the Commissioner. Opinions on some issues, such as the examples that follow, are not medical opinions, as described in paragraph (a)(2) of this section, but are, instead, opinions on issues reserved to the Commissioner because they are administrative findings that are dispositive of a case; i.e., that would direct the determination or decision of disability.

(1) Opinions that you are disabled. We are responsible for making the determination or

decision about whether you meet the statutory definition of disability. In so doing, we review all of the medical findings and other evidence that support a medical source's statement that you are disabled. A statement by a medical source that you are "disabled" or "unable to work" does not mean that we will determine that you are disabled.

(2) Other opinions on issues reserved to the Commissioner. We use medical sources, including your treating source, to provide evidence, including opinions, on the nature and severity of your impairment(s). Although we consider opinions from medical sources on issues such as whether your impairment(s) meets or equals the requirements of any impairment(s) in the Listing of Impairments in appendix 1 to this subpart, your residual functional capacity (see §§ 404.1545 and 404.1546), or the application of vocational factors, the final responsibility for deciding these issues is reserved to the Commissioner.

(3) We will not give any special significance to the source of an opinion on issues reserved to the Commissioner described in paragraphs (d)(1) and (d)(2) of this section.

(e) Opinions of nonexamining sources. We consider all evidence from nonexamining sources

to be opinion evidence. When we consider the opinions of nonexamining sources, we apply the rules in paragraphs (a) through (d) of this section. In addition, the following rules apply to State agency medical and psychological consultants, other program physicians and psychologists, and medical experts we consult in connection with administrative law judge hearings and Appeals Council review:

(1) In claims adjudicated by the State agency, a State agency medical or psychological consultant may make the determination of disability together with a State agency disability examiner or provide one or more medical opinions to a State agency disability examiner when the disability examiner makes the initial or reconsideration determination alone (see § 404.1615(c) of this part). The following rules apply:

(i) When a State agency medical or psychological consultant makes the determination together with a State agency disability examiner at the initial or reconsideration level of the administrative review process as provided in § 404.1615(c)(1), he or she will consider the evidence in your case record and make findings of fact about the medical issues, including, but not limited to, the existence and severity of your impairment(s),

the existence and severity of your symptoms, whether your impairment(s) meets or medically equals the requirements for any impairment listed in appendix 1 to this subpart, and your residual functional capacity. These administrative findings of fact are based on the evidence in your case but are not in themselves evidence at the level of the administrative review process at which they are made.

(ii) When a State agency disability examiner makes the initial determination alone as provided in § 404.1615(c)(3), he or she may obtain the opinion of a State agency medical or psychological consultant about one or more of the medical issues listed in paragraph (e)(1)(i) of this section. In these cases, the State agency disability examiner will consider the opinion of the State agency medical or psychological consultant as opinion evidence and weigh this evidence using the relevant factors in paragraphs (a) through (e) of this section.

(iii) When a State agency disability examiner makes a reconsideration determination alone as provided in § 404.1615(c)(3), he or she will consider findings made by a State agency medical or psychological consultant at the initial

level of the administrative review process and any opinions provided by such consultants at the initial and reconsideration levels as opinion evidence and weigh this evidence using the relevant factors in paragraphs (a) through (e) of this section.

(2) Administrative law judges are responsible for reviewing the evidence and making findings of fact and conclusions of law. They will consider opinions of State agency medical or psychological consultants, other program physicians and psychologists, and medical experts as follows:

(i) Administrative law judges are not bound by any findings made by State agency medical or psychological consultants, or other program physicians or psychologists. State agency medical and psychological consultants and other program physicians, psychologists, and other medical specialists are highly qualified physicians, psychologists, and other medical specialists who are also experts in Social Security disability evaluation. Therefore, administrative law judges must consider findings and other opinions of State agency medical and psychological consultants and other program physicians, psychologists, and other medical special-

ists as opinion evidence, except for the ultimate determination about whether you are disabled (see § 404.1512(b)(8)).

(ii) When an administrative law judge considers findings of a State agency medical or psychological consultant or other program physician, psychologist, or other medical specialist, the administrative law judge will evaluate the findings using the relevant factors in paragraphs (a) through (d) of this section, such as the consultant's medical specialty and expertise in our rules, the supporting evidence in the case record, supporting explanations the medical or psychological consultant provides, and any other factors relevant to the weighing of the opinions. Unless a treating source's opinion is given controlling weight, the administrative law judge must explain in the decision the weight given to the opinions of a State agency medical or psychological consultant or other program physician, psychologist, or other medical specialist, as the administrative law judge must do for any opinions from treating sources, nontreating sources, and other nonexamining sources who do not work for us.

(iii) Administrative law judges may also ask for and consider opinions from medi-

cal experts on the nature and severity of your impairment(s) and on whether your impairment(s) equals the requirements of any impairment listed in appendix 1 to this subpart. When administrative law judges consider these opinions, they will evaluate them using the rules in paragraphs (a) through (d) of this section.

(3) When the Appeals Council makes a decision, it will follow the same rules for considering opinion evidence as administrative law judges follow.

(f) [Redesignated as subsection (e) by 77 FR 10656]

20 C.F.R. § 404.1566

Work which exists in the national economy.

(a) General. We consider that work exists in the national economy when it exists in significant numbers either in the region where you live or in several other regions of the country. It does not matter whether--

(1) Work exists in the immediate area in which you live;

(2) A specific job vacancy exists for you; or

(3) You would be hired if you applied for work.

(b) How we determine the existence of work. Work exists in the national economy when there is a significant number of jobs (in one or more occupations) having requirements which you are able to meet with your physical or mental abilities and vocational qualifications. Isolated jobs that exist only in very limited numbers in relatively few locations outside of the region where you live are not considered "work which exists in the national economy". We will not deny you disability benefits on the basis of the existence of these kinds of jobs. If work that you can do does not exist in the national economy, we will determine that you are disabled. However, if work that you can do does exist in the national economy, we will determine that you are not disabled.

(c) Inability to obtain work. We will determine that you are not disabled if your residual functional capacity and vocational abilities make it possible for you to do work which exists in the national economy, but you remain unemployed because of--

(1) Your inability to get work;

(2) Lack of work in your local area;

(3) The hiring practices of employers;

(4) Technological changes in the industry in which you have worked;

(5) Cyclical economic conditions;

(6) No job openings for you;

(7) You would not actually be hired to do work you could otherwise do; or

(8) You do not wish to do a particular type of work.

(d) Administrative notice of job data. When we determine that unskilled, sedentary, light, and medium jobs exist in the national economy (in significant numbers either in the region where you live or in several regions of the country), we will take administrative notice of reliable job information available from various governmental and other publications. For example, we will take notice of--

(1) Dictionary of Occupational Titles, published by the Department of Labor;

(2) County Business Patterns, published by the Bureau of the Census;

(3) Census Reports, also published by the Bureau of the Census;

(4) Occupational Analyses, prepared for the Social Security Administration by various State employment agencies; and

(5) Occupational Outlook Handbook, published by the Bureau of Labor Statistics.

(e) Use of vocational experts and other specialists. If the issue in determining whether you are disabled is whether your work skills can be used in other work and the specific occupations in which they can be used, or there is a similarly complex issue, we may use the services of a vocational expert or other specialist. We will decide whether to use a vocational expert or other specialist.

20 C.F.R. § 404.1567

Physical exertion requirements.

To determine the physical exertion requirements of work in the national economy, we classify jobs as sedentary, light, medium, heavy, and very heavy. These terms have the same meaning as they have in the Dictionary of Occupational Titles, published by the Department of Labor. In making disability determinations under this subpart, we use the following definitions:

(a) Sedentary work. Sedentary work involves lifting no more than 10 pounds at a time and occasionally lifting or carrying articles like docket files, ledgers, and small tools. Although a sedentary job is defined as one which

involves sitting, a certain amount of walking and standing is often necessary in carrying out job duties. Jobs are sedentary if walking and standing are required occasionally and other sedentary criteria are met.

(b) Light work. Light work involves lifting no more than 20 pounds at a time with frequent lifting or carrying of objects weighing up to 10 pounds. Even though the weight lifted may be very little, a job is in this category when it requires a good deal of walking or standing, or when it involves sitting most of the time with some pushing and pulling of arm or leg controls. To be considered capable of performing a full or wide range of light work, you must have the ability to do substantially all of these activities. If someone can do light work, we determine that he or she can also do sedentary work, unless there are additional limiting factors such as loss of fine dexterity or inability to sit for long periods of time.

(c) Medium work. Medium work involves lifting no more than 50 pounds at a time with frequent lifting or carrying of objects weighing up to 25 pounds. If someone can do medium work, we determine that he or she can also do sedentary and light work.

(d) Heavy work. Heavy work involves lifting no more than 100 pounds at a time with frequent lifting or carrying of objects weighing

up to 50 pounds. If someone can do heavy work, we determine that he or she can also do medium, light, and sedentary work.

(e) Very heavy work. Very heavy work involves lifting objects weighing more than 100 pounds at a time with frequent lifting or carrying of objects weighing 50 pounds or more. If someone can do very heavy work, we determine that he or she can also do heavy, medium, light and sedentary work.

20 C.F.R. § 404.1569

Listing of Medical–Vocational Guidelines in appendix 2.

The Dictionary of Occupational Titles includes information about jobs (classified by their exertional and skill requirements) that exist in the national economy. Appendix 2 provides rules using this data reflecting major functional and vocational patterns. We apply these rules in cases where a person is not doing substantial gainful activity and is prevented by a severe medically determinable impairment from doing vocationally relevant past work. (See § 404.1520(h) for an exception to this rule.). The rules in appendix 2 do not cover all possible variations of factors. Also, as we explain in § 200.00 of appendix 2, we do not apply these rules if one of the findings of

fact about the person's vocational factors and residual functional capacity is not the same as the corresponding criterion of a rule. In these instances, we give full consideration to all relevant facts in accordance with the definitions and discussions under vocational considerations. However, if the findings of fact made about all factors are the same as the rule, we use that rule to decide whether a person is disabled.

20 C.F.R. § 416.913

Medical and other evidence of your impairment(s).

(a) Sources who can provide evidence to establish an impairment. We need evidence from acceptable medical sources to establish whether you have a medically determinable impairment(s). See § 416.908. Acceptable medical sources are--

(1) Licensed physicians (medical or osteopathic doctors);

(2) Licensed or certified psychologists. Included are school psychologists, or other licensed or certified individuals with other titles who perform the same function as a school psychologist in a school setting, for purposes of establishing mental retardation,

learning disabilities, and borderline intellectual functioning only;

(3) Licensed optometrists, for purposes of establishing visual disorders only (except, in the U.S. Virgin Islands, licensed optometrists, for the measurement of visual acuity and visual fields only);

(4) Licensed podiatrists, for purposes of establishing impairments of the foot, or foot and ankle only, depending on whether the State in which the podiatrist practices permits the practice of podiatry on the foot only, or the foot and ankle; and

(5) Qualified speech-language pathologists, for purposes of establishing speech or language impairments only. For this source, "qualified" means that the speech-language pathologist must be licensed by the State professional licensing agency, or be fully certified by the State education agency in the State in which he or she practices, or hold a Certificate of Clinical Competence from the American Speech–Language–Hearing Association.

(b) Medical reports. Medical reports should include--

(1) Medical history;

(2) Clinical findings (such as the results of physical or mental status examinations);

(3) Laboratory findings (such as blood pressure, x-rays);

(4) Diagnosis (statement of disease or injury based on its signs and symptoms);

(5) Treatment prescribed with response, and prognosis; and

(6) A statement about what you can still do despite your impairment(s) based on the acceptable medical source's findings on the factors under paragraphs (b)(1) through (b)(5) of this section (except in statutory blindness claims). Although we will request a medical source statement about what you can still do despite your impairment(s), the lack of the medical source statement will not make the report incomplete. See § 416.927.

(c) Statements about what you can still do. At the administrative law judge and Appeals Council levels, we will consider residual functional capacity assessments made by State agency medical and psychological consultants, and other program physicians and psychologists to be "statements about what you can still do" made by nonexamining physicians and psychologists based on their review of the evidence in the case record. Statements about what you can still do

(based on the acceptable medical source's findings on the factors under paragraphs (b)(1) through (b)(5) of this section) should describe, but are not limited to, the kinds of physical and mental capabilities listed as follows (See §§ 416.927 and 416.945(c)):

> (1) The acceptable medical source's opinion about your ability, despite your impairment(s), to do work-related activities such as sitting, standing, walking, lifting, carrying, handling objects, hearing, speaking, and traveling; and
>
> (2) In cases of mental impairment(s), the acceptable medical source's opinion about your ability to understand, to carry out and remember instructions, and to respond appropriately to supervision, coworkers, and work pressures in a work setting.

(d) Other sources. In addition to evidence from the acceptable medical sources listed in paragraph (a) of this section, we may also use evidence from other sources to show the severity of your impairment(s) and how it affects your ability to work. Other sources include, but are not limited to--

> (1) Medical sources not listed in paragraph (a) of this section (for example, nurse-practitioners, physicians' assistants, natur-

opaths, chiropractors, audiologists, and therapists);

(2) Educational personnel (for example, school teachers, counselors, early intervention team members, developmental center workers, and daycare center workers);

(3) Public and private social welfare agency personnel; and

(4) Other non-medical sources (for example, spouses, parents and other caregivers, siblings, other relatives, friends, neighbors, and clergy).

(e) Completeness. The evidence in your case record, including the medical evidence from acceptable medical sources (containing the clinical and laboratory findings) and other medical sources not listed in paragraph (a) of this section, information you give us about your medical condition(s) and how it affects you, and other evidence from other sources, must be complete and detailed enough to allow us to make a determination or decision about whether you are disabled or blind. It must allow us to determine--

(1) The nature and severity of your impairment(s) for any period in question;

(2) Whether the duration requirement described in § 416.909 is met; and

(3) Your residual functional capacity to do work-related physical and mental activities, when the evaluation steps described in § 416.920(e) or (f)(1) apply.

20 C.F.R. § 416.927

Evaluating opinion evidence.

(a) General.

(1) If you are an adult, you can only be found disabled if you are unable to do any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months. (See § 416.905.) If you are a child, you can be found disabled only if you have a medically determinable physical or mental impairment(s) that causes marked and severe functional limitations and that can be expected to result in death or that has lasted or can be expected to last for a continuous period of not less than 12 months. (See § 416.906.) Your impairment must result from anatomical, physiological, or psychological abnormalities which are demonstrable by medically acceptable clinical and laboratory diagnostic techniques. (See § 416.908.)

(2) Evidence that you submit or that we obtain may contain medical opinions. Medical opinions are statements from physicians and psychologists or other acceptable medical sources that reflect judgments about the

nature and severity of your impairment(s), including your symptoms, diagnosis and prognosis, what you can still do despite impairment(s), and your physical or mental restrictions.

(b) How we consider medical opinions. In determining whether you are disabled, we will always consider the medical opinions in your case record together with the rest of the relevant evidence we receive. See § 416.920b.

(c) How we weigh medical opinions. Regardless of its source, we will evaluate every medical opinion we receive. Unless we give a treating source's opinion controlling weight under paragraph (c)(2) of this section, we consider all of the following factors in deciding the weight we give to any medical opinion.

(1) Examining relationship. Generally, we give more weight to the opinion of a source who has examined you than to the opinion of a source who has not examined you.

(2) Treatment relationship. Generally, we give more weight to opinions from your treating sources, since these sources are likely to be the medical professionals most able to provide a detailed, longitudinal picture of your medical impairment(s) and may bring a unique perspective to the medical evidence that cannot be obtained from the

objective medical findings alone or from reports of individual examinations, such as consultative examinations or brief hospitalizations. If we find that a treating source's opinion on the issue(s) of the nature and severity of your impairment(s) is well-supported by medically acceptable clinical and laboratory diagnostic techniques and is not inconsistent with the other substantial evidence in your case record, we will give it controlling weight. When we do not give the treating source's opinion controlling weight, we apply the factors listed in paragraphs (c)(2)(i) and (c)(2)(ii) of this section, as well as the factors in paragraphs (c)(3) through (c)(6) of this section in determining the weight to give the opinion. We will always give good reasons in our notice of determination or decision for the weight we give your treating source's opinion.

> (i) Length of the treatment relationship and the frequency of examination. Generally, the longer a treating source has treated you and the more times you have been seen by a treating source, the more weight we will give to the source's medical opinion. When the treating source has seen you a number of times and long enough to have obtained a longitudinal picture of your impairment, we will give the source's opinion more weight than we

would give it if it were from a nontreating source.

(ii) Nature and extent of the treatment relationship. Generally, the more knowledge a treating source has about your impairment(s) the more weight we will give to the source's medical opinion. We will look at the treatment the source has provided and at the kinds and extent of examinations and testing the source has performed or ordered from specialists and independent laboratories. For example, if your ophthalmologist notices that you have complained of neck pain during your eye examinations, we will consider his or her opinion with respect to your neck pain, but we will give it less weight than that of another physician who has treated you for the neck pain. When the treating source has reasonable knowledge of your impairment(s), we will give the source's opinion more weight than we would give it if it were from a nontreating source.

(3) Supportability. The more a medical source presents relevant evidence to support an opinion, particularly medical signs and laboratory findings, the more weight we will give that opinion. The better an explanation a source provides for an opinion, the more

weight we will give that opinion. Furthermore, because nonexamining sources have no examining or treating relationship with you, the weight we will give their opinions will depend on the degree to which they provide supporting explanations for their opinions. We will evaluate the degree to which these opinions consider all of the pertinent evidence in your claim, including opinions of treating and other examining sources.

(4) Consistency. Generally, the more consistent an opinion is with the record as a whole, the more weight we will give to that opinion.

(5) Specialization. We generally give more weight to the opinion of a specialist about medical issues related to his or her area of specialty than to the opinion of a source who is not a specialist.

(6) Other factors. When we consider how much weight to give to a medical opinion, we will also consider any factors you or others bring to our attention, or of which we are aware, which tend to support or contradict the opinion. For example, the amount of understanding of our disability programs and their evidentiary requirements that an acceptable medical source has, regardless of the source of that understanding, and the

extent to which an acceptable medical source is familiar with the other information in your case record are relevant factors that we will consider in deciding the weight to give to a medical opinion.

(d) Medical source opinions on issues reserved to the Commissioner. Opinions on some issues, such as the examples that follow, are not medical opinions, as described in paragraph (a)(2) of this section, but are, instead, opinions on issues reserved to the Commissioner because they are administrative findings that are dispositive of a case; i.e., that would direct the determination or decision of disability.

(1) Opinions that you are disabled. We are responsible for making the determination or decision about whether you meet the statutory definition of disability. In so doing, we review all of the medical findings and other evidence that support a medical source's statement that you are disabled. A statement by a medical source that you are "disabled" or "unable to work" does not mean that we will determine that you are disabled.

(2) Other opinions on issues reserved to the Commissioner. We use medical sources, including your treating source, to provide evidence, including opinions, on the nature and

severity of your impairment(s). Although we consider opinions from medical sources on issues such as whether your impairment(s) meets or equals the requirements of any impairment(s) in the Listing of Impairments in appendix 1 to subpart P of part 404 of this chapter, your residual functional capacity (see §§ 416.945 and 416.946), or the application of vocational factors, the final responsibility for deciding these issues is reserved to the Commissioner.

(3) We will not give any special significance to the source of an opinion on issues reserved to the Commissioner described in paragraphs (d)(1) and (d)(2) of this section.

(e) Opinions of nonexamining sources. We consider all evidence from nonexamining sources to be opinion evidence. When we consider the opinions of nonexamining sources, we apply the rules in paragraphs (a) through (d) of this section. In addition, the following rules apply to State agency medical and psychological consultants, other program physicians and psychologists, and medical experts we consult in connection with administrative law judge hearings and Appeals Council review:

(1) In claims adjudicated by the State agency, a State agency medical or psychological consultant may make the determination of disability together with a State agency dis-

ability examiner or provide one or more medical opinions to a State agency disability examiner when the disability examiner makes the initial or reconsideration determination alone (See § 416.1015(c) of this part). The following rules apply:

(i) When a State agency medical or psychological consultant makes the determination together with a State agency disability examiner at the initial or reconsideration level of the administrative review process as provided in § 416.1015(c)(1), he or she will consider the evidence in your case record and make findings of fact about the medical issues, including, but not limited to, the existence and severity of your impairment(s), the existence and severity of your symptoms, whether your impairment(s) meets or medically equals the requirements for any impairment listed in appendix 1 to subpart P of part 404 of this chapter, and your residual functional capacity. These administrative findings of fact are based on the evidence in your case but are not in themselves evidence at the level of the administrative review process at which they are made.

(ii) When a State agency disability examiner makes the initial determination

alone as provided in § 416.1015(c)(3), he or she may obtain the opinion of a State agency medical or psychological consultant about one or more of the medical issues listed in paragraph (e)(1)(i) of this section. In these cases, the State agency disability examiner will consider the opinion of the State agency medical or psychological consultant as opinion evidence and weigh this evidence using the relevant factors in paragraphs (a) through (e) of this section.

(iii) When a State agency disability examiner makes a reconsideration determination alone as provided in § 416.1015(c)(3), he or she will consider findings made by a State agency medical or psychological consultant at the initial level of the administrative review process and any opinions provided by such consultants at the initial and reconsideration levels as opinion evidence and weigh this evidence using the relevant factors in paragraphs (a) through (e) of this section.

(2) Administrative law judges are responsible for reviewing the evidence and making findings of fact and conclusions of law. They will consider opinions of State agency medical or psychological consultants, other pro-

gram physicians and psychologists, and medical experts as follows:

> (i) Administrative law judges are not bound by any findings made by State agency medical or psychological consultants, or other program physicians or psychologists. State agency medical and psychological consultants and other program physicians, psychologists, and other medical specialists are highly qualified physicians, psychologists, and other medical specialists who are also experts in Social Security disability evaluation. Therefore, administrative law judges must consider findings and other opinions of State agency medical and psychological consultants and other program physicians, psychologists, and other medical specialists as opinion evidence, except for the ultimate determination about whether you are disabled (see § 416.912(b)(8)).
>
> (ii) When an administrative law judge considers findings of a State agency medical or psychological consultant or other program physician, psychologist, or other medical specialist, the administrative law judge will evaluate the findings using the relevant factors in paragraphs (a) through (d) of this section, such as the consultant's medical specialty and exper-

tise in our rules, the supporting evidence in the case record, supporting explanations the medical or psychological consultant provides, and any other factors relevant to the weighing of the opinions. Unless a treating source's opinion is given controlling weight, the administrative law judge must explain in the decision the weight given to the opinions of a State agency medical or psychological consultant or other program physician, psychologist, or other medical specialist, as the administrative law judge must do for any opinions from treating sources, nontreating sources, and other nonexamining sources who do not work for us.

(iii) Administrative law judges may also ask for and consider opinions from medical experts on the nature and severity of your impairment(s) and on whether your impairment(s) equals the requirements of any impairment listed in appendix 1 to subpart P of part 404 of this chapter. When administrative law judges consider these opinions, they will evaluate them using the rules in paragraphs (a) through (d) of this section.

(3) When the Appeals Council makes a decision, it will follow the same rules for consid-

ering opinion evidence as administrative law judges follow.

(f) [Redesignated as subsection (e) by 77 FR 10657]

20 C.F.R. § 416.966

Work which exists in the national economy.

(a) General. We consider that work exists in the national economy when it exists in significant numbers either in the region where you live or in several other regions of the country. It does not matter whether--

(1) Work exists in the immediate area in which you live;

(2) A specific job vacancy exists for you; or

(3) You would be hired if you applied for work.

(b) How we determine the existence of work. Work exists in the national economy when there is a significant number of jobs (in one or more occupations) having requirements which you are able to meet with your physical or mental abilities and vocational qualifications. Isolated jobs that exist only in very limited numbers in relatively few locations outside of the region where you live are not con-

sidered work which exists in the national economy. We will not deny you disability benefits on the basis of the existence of these kinds of jobs. If work that you can do does not exist in the national economy, we will determine that you are disabled. However, if work that you can do does exist in the national economy, we will determine that you are not disabled.

(c) Inability to obtain work. We will determine that you are not disabled if your residual functional capacity and vocational abilities make it possible for you to do work which exists in the national economy, but you remain unemployed because of--

(1) Your inability to get work;

(2) Lack of work in your local area;

(3) The hiring practices of employers;

(4) Technological changes in the industry in which you have worked;

(5) Cyclical economic conditions;

(6) No job openings for you;

(7) You would not actually be hired to do work you could otherwise do, or;

(8) You do not wish to do a particular type of work.

(d) Administrative notice of job data. When we determine that unskilled, sedentary, light, and medium jobs exist in the national economy (in significant numbers either in the region where you live or in several regions of the country), we will take administrative notice of reliable job information available from various governmental and other publications. For example, we will take notice of--

(1) Dictionary of Occupational Titles, published by the Department of Labor;

(2) County Business Patterns, published by the Bureau of the Census;

(3) Census Reports, also published by the Bureau of the Census;

(4) Occupational Analyses prepared for the Social Security Administration by various State employment agencies; and

(5) Occupational Outlook Handbook, published by the Bureau of Labor Statistics.

(e) Use of vocational experts and other specialists. If the issue in determining whether you are disabled is whether your work skills can be used in other work and the specific occupations in which they can be used, or there is a similarly complex issue, we may use the services of a vocational expert or other specialist.

We will decide whether to use a vocational expert or other specialist.

20 C.F.R. § 416.969

Listing of Medical–Vocational Guidelines in appendix 2 of subpart P of part 404 of this chapter.

The Dictionary of Occupational Titles includes information about jobs (classified by their exertional and skill requirements) that exist in the national economy. Appendix 2 provides rules using this data reflecting major functional and vocational patterns. We apply these rules in cases where a person is not doing substantial gainful activity and is prevented by a severe medically determinable impairment from doing vocationally relevant past work. (See § 416.920(h) for an exception to this rule.) The rules in appendix 2 do not cover all possible variations of factors. Also, as we explain in § 200.00 of appendix 2, we do not apply these rules if one of the findings of fact about the person's vocational factors and residual functional capacity is not the same as the corresponding criterion of a rule. In these instances, we give full consideration to all relevant facts in accordance with the definitions and discussions under vocational considerations. However, if the findings of fact made about all factors are the same as the rule, we use that rule to decide whether a person is disabled.

SSR 85-15

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

This supersedes Program Policy Statement No. 116 (SSR 85-7) with the same title (which superseded Program Policy Statement No. 104 (SSR 83-13) and is in accord with an order of the U.S. District Court for the District of Minnesota.

PURPOSE: The original purpose of SSR 83-13 was to clarify how the regulations and the exertionally based numbered decisional rules in Appendix 2, Subpart P, Regulations No. 4, provide a framework for decisions concerning persons who have only a nonexertional limitation(s) of function or an environmental restriction(s). The purpose of this revision to SSR 83-13 and SSR 85-7 is to emphasize, in the sections relating to mental impairments: (1) that the potential job base for mentally ill claimants without adverse vocational factors is not necessarily large even for individuals who have no other impairments, unless their remaining mental capacities are sufficient to meet the intellectual and emotional demands of at least unskilled, competitive, remunerative work on a sustained basis; and (2) that a finding of disability can be appropriate for an individual who has a severe mental impair-

ment which does not meet or equal the Listing of Impairments, even where he or she does not have adversities in age, education, or work experience.

CITATIONS (AUTHORITY): Sections 223(d)(2)(A) and 1614(a)(3)(E) of the Social Security Act; Regulations No. 4, Subpart P, sections 404.1505(a), 404.1520(f)(1), 404.1521(b), 404.1545, and 404.1560 through 404.1569; Appendix 2 of Subpart P, sections 200.00(c), 200.00(e)(1), and 204.00; and Regulations No. 16, Subpart 1, sections 416.905(a), 416.920(f)(1), 416.921(b), 416.945, and 416.960 through 416.969.

PERTINENT HISTORY: If a person has a severe medically determinable impairment which, though not meeting or equaling the criteria in the Listing of Impairments, prevents the person from doing past relevant work, it must be determined whether the person can do other work. This involves consideration of the person's RFC and the vocational factors of age, education, and work experience.

The Medical-Vocational Guidelines (Regulations No. 4, Subpart P, Appendix 2) discuss the relative adjudicative weights which are assigned to a person's age, education, and work experience. Three tables in Appendix 2 illustrate the interaction of these vocational factors with his or her RFC. RFC is expressed in terms of sedentary, light, and medium work exertion. The table

rules reflect the potential occupational base of unskilled jobs for individuals who have severe impairments which limit their exertional capacities: approximately 2,500 medium, light, and sedentary occupations; 1,600 light and sedentary occupations; and 200 sedentary occupations--each occupation representing numerous jobs in the national economy. (See the text and glossary in SSR 83-10, PPS-101, Determining Capability to Do Other Work--the Medical-Vocational Rules of Appendix 2.) Where individuals also have nonexertional limitations of function or environmental restrictions, the table rules provide a framework for consideration of how much the individual's work capability is further diminished in terms of any types of jobs within these exertional ranges that would be contraindicated by the additional limitations or restrictions. However, where a person has solely a nonexertional impairment(s), the table rules do not direct conclusions of disabled or not disabled. Conclusions must, instead, be based on the principles in the appropriate sections of the regulations, giving consideration to the rules for specific case situations in Appendix 2.

*2 This PPS clarifies policies applicable in cases involving the evaluation of solely nonexertional impairments.

POLICY STATEMENT: Given that no medically determinable impairment limits exertion, the RFC reflecting the severity of the particular

nonexertional impairment(s) with its limiting effects on the broad world of work is the first issue. The individual's relative advantages or adversities in terms of age, education, and work experience is the second. Section 204.00 of Appendix 2 provides an example of one type of nonexertional impairment-environmental restrictions--and states that environmental restrictions ordinarily would not significantly affect the range of work existing in the national economy for individuals with the physical capability for heavy work (or very heavy work); i.e., with no medically determinable impairment which limits exertion. However, numerous environmental restrictions might lead to a different conclusion, as might one or more severe losses of nonexertional functional capacities. The medical and vocational factors of the individual case determine whether exclusion of particular occupations or kinds of work so reduces the person's vocational opportunity that a work adjustment could not be made.

Nonexertional Impairments Contrasted With Exertional Impairments

The term "exertional" has the same meaning in the regulations as it has in the U.S. Department of Labor's classifications of occupations by strength levels. (See SSR 83-10, PPS-101, Determining Capability to Do Other Work--The Medical-Vocational Rules of Appendix 2.) Any job requirement which is not exertional is con-

sidered to be nonexertional. A nonexertional impairment is one which is medically determinable and causes a nonexertional limitation of function or an environmental restriction. Nonexertional impairments may or may not affect a person's capacity to carry out the primary strength requirements of jobs, and they may or may not significantly narrow the range of work a person can do.

Nonexertional limitations can affect the abilities to reach; to seize, hold, grasp, or turn an object (handle); to bend the legs alone (kneel); to bend the spine alone (stoop) or bend both the spine and legs (crouch). Fine movements of small objects, such as done in much sedentary work and in certain types of more demanding work (e.g., surgery), require use of the fingers to pick, pinch, etc. Impairments of vision, speech, and hearing are nonexertional. Mental impairments are generally considered to be nonexertional, but depressions and conversion disorders may limit exertion. Although some impairments may cause both exertional limitations and environmental restrictions (e.g., a respiratory impairment may limit a person to light work exertion as well as contraindicate exposure to excessive dust or fumes), other impairments may result in only environmental restrictions (e.g., skin allergies may only contraindicate contact with certain liquids). What is a nonexertional and extremely rare factor in one range of work (e.g., crawling in

sedentary work) may become an important element in arduous work like coal mining.

*3 Where a person's exertional capacity is compromised by a nonexertional impairment(s), see SSR 83-14, PPS-105, Capability to Do Other Work--The Medical-Vocational Rules as a Framework for Evaluating a Combination of Exertional and Nonexertional Impairments.

Jobs which can possibly be performed by persons with solely nonexertional impairments are not limited to the approximately 2,500 unskilled sedentary, light and medium occupations which pertain to the table rules in Appendix 2. The occupational base cuts across exertional categories through heavy (and very heavy) work and will include occupations above the unskilled level if a person has skills transferable to skilled or semiskilled occupations within his or her RFC. (Note the examples in item 4.b of SSR 82-41, PPS-67, Work Skills and Their Transferability as Intended by the Expanded Vocational Factors Regulations effective February 26, 1979, where medical factors prevent not only the performance of past work but also the transferability of skills.)

Given no medically determinable impairment which limits exertion, the first issue is how much the person's occupational base--the entire exertional span from sedentary work through heavy (or very heavy) work--is reduced by the effects of the nonexertional impairment(s). This may range from very little to very much, depend-

ing on the nature and extent of the impairment(s). In many cases, a decisionmaker will need to consult a vocational resource.

The publications listed in sections 404.1566 and 416.966 of the regulations will be sufficient vocational resources for relatively simple issues. In more complex cases, a person or persons with specialized knowledge would be helpful. State agencies may use personnel termed vocational consultants or specialists, or they may purchase the services of vocational evaluation workshops. Vocational experts may testify for this purpose at the hearing and appeals levels. In this PPS, the term vocational specialist (VS) describes all vocational resource personnel.

The second issue is whether the person can be expected to make a vocational adjustment considering the interaction of his or her remaining occupational base with his or her age, education, and work experience. A decisionmaker must consider sections 404.1562-404.1568 and 416.962-416.968 of the regulations, section 204.00 of Appendix 2, and the table rules for specific case situations in Appendix 2. If, despite the nonexertional impairment(s), an individual has a large potential occupational base, he or she would ordinarily not be found disabled in the absence of extreme adversities in age, education, and work experience. (This principle is illustrated in rules 203.01, 203.02, and 203.10 and is set out in SSR 82-63, PPS-79, Medical- Vocational

Profiles Showing an Inability to Make an Adjustment to Other Work.) The assistance of a vocational resource may be helpful. Whenever vocational resources are used and the decision is adverse to the claimant, 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.

Examples of Nonexertional Impairments and Their Effects on the Occupational Base

*4 1. Mental Impairments

There has been some misunderstanding in the evaluation of mental impairments. Unless the claimant or beneficiary is a widow, widower, surviving divorced spouse or a disabled child under the Supplemental Security Income program, the sequential evaluation process mandated by the regulations does not end with the finding that the impairment, though severe, does not meet or equal an impairment listed in Appendix 1 of the regulations. The process must go on to consider whether the individual can meet the mental demands of past relevant work in spite of the limiting effects of his or her impairment and, if not, whether the person can do other work, considering his or her remaining mental capacities reflected in terms of the occupational base, age, education, and work experience.

The decisionmaker must not assume that failure to meet or equal a listed mental impairment equates with capacity to do at least unskilled work. This decision requires careful consideration of the assessment of RFC.

In the world of work, losses of intellectual and emotional capacities are generally more serious when the job is complex. Mental impairments may or may not prevent the performance of a person's past jobs. They may or may not prevent an individual from transferring work skills. (See SSR 82-41, PPS-67, Work Skills and Their Transferability as Intended by the Expanded Vocational Factors Regulations effective February 26, 1979.)

Where a person's only impairment is mental, is not of listing severity, but does prevent the person from meeting the mental demands of past relevant work and prevents the transferability of acquired work skills, the final consideration is whether the person can be expected to perform unskilled work. The basic mental demands of competitive, remunerative, unskilled work include the abilities (on a sustained basis) to understand, carry out, and remember simple instructions; to respond appropriately to supervision, coworkers, and usual work situations; and to deal with changes in a routine work setting. A substantial loss of ability to meet any of these basic work-related activities would severely limit the potential occupational base. This, in turn,

would justify a finding of disability because even favorable age, education, or work experience will not offset such a severely limited occupational base.

Example 1: A person whose vocational factors of age, education, and work experience would ordinarily be considered favorable (i.e., very young age, university education, and highly skilled work experience) would have a severely limited occupational base if he or she has a mental impairment which causes a substantial loss of ability to respond appropriately to supervision, coworkers, and usual work situations. A finding of disability would be appropriate.

Where there is no exertional impairment, unskilled jobs at all levels of exertion constitute the potential occupational base for persons who can meet the mental demands of unskilled work. These jobs ordinarily involve dealing primarily with objects, rather than with data or people, and they generally provide substantial vocational opportunity for persons with solely mental impairments who retain the capacity to meet the intellectual and emotional demands of such jobs on a sustained basis. However, persons with this large job base may be found disabled because of adversities in age, education, and work experience. (This is illustrated in examples 2 and 3 immediately following.)

*5 Example 2: Someone who is of advanced age, has a limited education, has no relevant work

experience, and has more than a nonsevere mental impairment will generally be found disabled. (See SSR 82-63, PPS-79, Medical-Vocational Profiles Showing an Inability to Make an Adjustment to Other Work.)

Example 3: Someone who is closely approaching retirement age, has a limited education or less, worked for 30 years in a cafeteria doing an unskilled job as a "server," almost constantly dealing with the public, and now cannot, because of a severe mental impairment, frequently deal with the public. In light of the narrowed vocational opportunity in conjunction with the person's age, education, lack of skills, and long commitment to the particular type of work, a finding of disabled would be appropriate; but the decision would not necessarily be the same for a younger, better-educated, or skilled person. (Compare sections 404.1562 and 416.962 of the regulations and rule 203.01 of Appendix 2.)

Where a person has only a mental impairment but does not have extreme adversities in age, education, and work experience, and does not lack the capacity to do basic work-related activities, the potential occupational base would be reduced by his or her inability to perform certain complexities or particular kinds of work. These limitations would affect the occupational base in various ways.

Example 4: Someone who is of advanced age, has a high school education, and did skilled work as

manager of a housing project can no longer, because of a severe mental impairment, develop and implement plans and procedures, prepare budget requests, schedule repairs or otherwise deal with complexities of this level and nature. Assuming that, in this case, all types of related skilled jobs are precluded but the individual can do work which is not detailed and does not require lengthy planning, the remaining related semiskilled jobs to which skills can be transferred and varied unskilled jobs, at all levels of exertion, constitute a significant vocational opportunity. A conclusion of "not disabled" would be appropriate. (Compare rules 201.07, 202.07, and 203.13 of Appendix 2.)

Example 5: Someone who is of advanced age, has a limited education, and did semiskilled work as a first-aid attendant no longer has the mental capacity to work with people who are in emergency situations and require immediate attention to cuts, burns, suffocation, etc. Although there may be very few related semiskilled occupations to which this person could transfer work skills, the large occupational base of unskilled work at all levels of exertion generally would justify a finding of not under a disability. (This is consistent with rules 203.11-203.17 of Appendix 2.)

Stress and Mental Illness--Since mental illness is defined and characterized by maladaptive behavior, it is not unusual that the mentally im-

paired have difficulty accommodating to the demands of work and work-like settings. Determining whether these individuals will be able to adapt to the demands or "stress" of the workplace is often extremely difficult. This section is not intended to set out any presumptive limitations for disorders, but to emphasize the importance of thoroughness in evaluation on an individualized basis.

*6 Individuals with mental disorders often adopt a highly restricted and/or inflexible lifestyle within which they appear to function well. Good mental health services and care may enable chronic patients to function adequately in the community by lowering psychological pressures, by medication, and by support from services such as outpatient facilities, day-care programs, social work programs and similar assistance.

The reaction to the demands of work (stress) is highly individualized, and mental illness is characterized by adverse responses to seemingly trivial circumstances. The mentally impaired may cease to function effectively when facing such demands as getting to work regularly, having their performance supervised, and remaining in the workplace for a full day. A person may become panicked and develop palpitations, shortness of breath, or feel faint while riding in an elevator; another may experience terror and begin to hallucinate when approached by a stranger asking a question. Thus, the mentally impaired

may have difficulty meeting the requirements of even so-called "low-stress" jobs.

Because response to the demands of work is highly individualized, the skill level of a position is not necessarily related to the difficulty an individual will have in meeting the demands of the job. A claimant's condition may make performance of an unskilled job as difficult as an objectively more demanding job. for example, a busboy need only clear dishes from tables. But an individual with a severe mental disorder may find unmanageable the demands of making sure that he removes all the dishes, does not drop them, and gets the table cleared promptly for the waiter or waitress. Similarly, an individual who cannot tolerate being supervised may not be able to work even in the absence of close supervision; the knowledge that one's work is being judged and evaluated, even when the supervision is remote or indirect, can be intolerable for some mentally impaired persons. Any impairment-related limitations created by an individual's response to demands of work, however, must be reflected in the RFC assessment.

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SSR 96-6p

POLICY INTERPRETATION RULING TITLES II AND XVI: CONSIDERATION OF ADMINISTRATIVE FINDINGS OF FACT BY STATE AGENCY MEDICAL AND PSYCHOLOGICAL CONSULTANTS AND OTHER PROGRAM PHYSICIANS AND PSYCHOLOGISTS AT THE ADMINISTRATIVE LAW JUDGE AND APPEALS COUNCIL LEVELS OF ADMINISTRATIVE REVIEW; MEDICAL EQUIVALENCE

PURPOSE: To clarify Social Security Administration policy regarding the consideration of findings of fact by State agency medical and psychological consultants and other program physicians and psychologists by adjudicators at the administrative law judge and Appeals Council levels. Also, to restore to the Rulings and clarify policy interpretations regarding administrative law judge and Appeals Council responsibility for obtaining opinions of physicians or psychologists designated by the Commissioner regarding equivalence to listings in the Listing of Impairments (appendix 1, subpart P of 20 CFR part 404) formerly in SSR 83-19. In particular, to emphasize the following longstanding policies and policy interpretations:

1. Findings of fact made by State agency medical and psychological consultants and other program physicians and psychologists regarding the nature and severity of an individual's impairment(s) must be treated as expert opinion evi-

dence of nonexamining sources at the administrative law judge and Appeals Council levels of administrative review.

2. Administrative law judges and the Appeals Council may not ignore these opinions and must explain the weight given to these opinions in their decisions.

3. An updated medical expert opinion must be obtained by the administrative law judge or the Appeals Council before a decision of disability based on medical equivalence can be made.

CITATIONS (AUTHORITY): Sections 216(i), 223(d) and 1614(a) of the Social Security Act (the Act), as amended; Regulations No. 4, sections 404.1502, 404.1512(b)(6), 404.1526, 404.1527, and 404.1546; and Regulations No. 16, sections 416.902, 416.912(b)(6), 416.926, 416.927, and 416.946.

INTRODUCTION: Regulations 20 CFR 404.1527 and 416.927 set forth detailed rules for evaluating medical opinions about an individual's impairment(s) offered by medical sources[FN1] and the medical opinions of State agency medical and psychological consultants and other nonexamining sources. Paragraph (a) of these regulations provides that "medical opinions" are statements from physicians and psychologists or other acceptable medical sources that reflect judgments about the nature and severity of an individual's impairment(s), including symptoms,

diagnosis and prognosis, what the individual can still do despite his or her impairment(s), and the individual's physical or mental restrictions. Paragraph (b) provides that, in deciding whether an individual is disabled, the adjudicator will always consider the medical opinions in the case record together with the rest of the relevant evidence. Paragraphs (c), (d), and (e) then provide general rules for evaluating the record, with particular attention to medical and other opinions from acceptable medical sources.

*2 Paragraph (f) provides that findings of fact made by State agency medical and psychological consultants and other program physicians and psychologists become opinions at the administrative law judge and Appeals Council levels of administrative review and requires administrative law judges and the Appeals Council to consider and evaluate these opinions when making a decision in a particular case.

State agency medical and psychological consultants are highly qualified physicians and psychologists who are experts in the evaluation of the medical issues in disability claims under the Act. As members of the teams that make determinations of disability at the initial and reconsideration levels of the administrative review process (except in disability hearings), they consider the medical evidence in disability cases and make findings of fact on the medical issues, including, but not limited to, the existence and

severity of an individual's impairment(s), the existence and severity of an individual's symptoms, whether the individual's impairment(s) meets or is equivalent in severity to the requirements for any impairment listed in 20 CFR part 404, subpart P, appendix 1 (the Listing of Impairments), and the individual's residual functional capacity (RFC).

POLICY INTERPRETATION: Because State agency medical and psychological consultants and other program physicians and psychologists are experts in the Social Security disability programs, the rules in 20 CFR 404.1527(f) and 416.927(f) require administrative law judges and the Appeals Council to consider their findings of fact about the nature and severity of an individual's impairment(s) as opinions of nonexamining physicians and psychologists. Administrative law judges and the Appeals Council are not bound by findings made by State agency or other program physicians and psychologists, but they may not ignore these opinions and must explain the weight given to the opinions in their decisions.

Paragraphs 404.1527(f) and 416.927(f) provide that the rules for considering medical and other opinions of treating sources and other sources in paragraphs (a) through (e) also apply when we consider the medical opinions of nonexamining sources, including State agency medical and psychological consultants and other program physi-

cians and psychologists. The regulations provide progressively more rigorous tests for weighing opinions as the ties between the source of the opinion and the individual become weaker. For example, the opinions of physicians or psychologists who do not have a treatment relationship with the individual are weighed by stricter standards, based to a greater degree on medical evidence, qualifications, and explanations for the opinions, than are required of treating sources.

For this reason, the opinions of State agency medical and psychological consultants and other program physicians and psychologists can be given weight only insofar as they are supported by evidence in the case record, considering such factors as the supportability of the opinion in the evidence including any evidence received at the administrative law judge and Appeals Council levels that was not before the State agency, the consistency of the opinion with the record as a whole, including other medical opinions, and any explanation for the opinion provided by the State agency medical or psychological consultant or other program physician or psychologist. The adjudicator must also consider all other factors that could have a bearing on the weight to which an opinion is entitled, including any specialization of the State agency medical or psychological consultant.

*3 In appropriate circumstances, opinions from State agency medical and psychological consult-

ants and other program physicians and psychologists may be entitled to greater weight than the opinions of treating or examining sources. For example, the opinion of a State agency medical or psychological consultant or other program physician or psychologist may be entitled to greater weight than a treating source s medical opinion if the State agency medical or phychological consultant'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.

The following additional guidelines apply at the administrative law judge and Appeals Council levels to opinions about equivalence to a listing in the Listing of Impairments and RFC assessments, issues that are reserved to the Commissioner in 20 CFR 404.1527(e) and 416.927(e). (See also SSR 96-5p, "Titles II and XVI: Medical Source Opinions on Issues Reserved to the Commissioner.")

Medical Equivalence to an Impairment in the Listing of Impairments.

The administrative law judge or Appeals Council is responsible for deciding the ultimate legal question whether a listing is met or equaled. As trier of the facts, an administrative law judge or the Appeals Council is not bound by a finding by a State agency medical or psychological consult-

ant or other program physician or psychologist as to whether an individual's impairment(s) is equivalent in severity to any impairment in the Listing of Impairments. However, longstanding policy requires that the judgment of a physician (or psychologist) designated by the Commissioner on the issue of equivalence on the evidence before the administrative law judge or the Appeals Council must be received into the record as expert opinion evidence and given appropriate weight.

The signature of a State agency medical or psychological consultant on an SSA-831-U5 (Disability Determination and Transmittal Form) or SSA-832-U5 or SSA-833-U5 (Cessation or Continuance of Disability or Blindness) ensures that consideration by a physician (or psychologist) designated by the Commissioner has been given to the question of medical equivalence at the initial and reconsideration levels of administrative review. Other documents, including the Psychiatric Review Technique Form and various other documents on which medical and psychological consultants may record their findings, may also ensure that this opinion has been obtained at the first two levels of administrative review.

When an administrative law judge or the Appeals Council finds that an individual s impairment(s) is not equivalent in severity to any listing, the requirement to receive expert opinion evidence into the record may be satisfied by any

of the foregoing documents signed by a State agency medical or psychological consultant. However, an administrative law judge and the Appeals Council must obtain an updated medical opinion from a medical expert[FN2] in the following circumstances:

*4 * When no additional medical evidence is received, but in the opinion of the administrative law judge or the Appeals Council the symptoms, signs, and laboratory findings reported in the case record suggest that a judgment of equivalence may be reasonable; or

* When additional medical evidence is received that in the opinion of the administrative law judge or the Appeals Council may change the State agency medical or psychological consultant's finding that the impairment(s) is not equivalent in severity to any impairment in the Listing of Impairments.

When an updated medical judgment as to medical equivalence is required at the administrative law judge level in either of the circumstances above, the administrative law judge must call on a medical expert. When an updated medical judgment as to medical equivalence is required at the Appeals Council level in either of the circumstances above, the Appeals Council must call on the services of its medical support staff.

Assessment of RFC.

Although the administrative law judge and the Appeals Council are responsible for assessing an individual's RFC at their respective levels of administrative review, the administrative law judge or Appeals Council must consider and evaluate any assessment of the individual's RFC by a State agency medical or psychological consultant and by other program physicians or psychologists. At the administrative law judge and Appeals Council levels, RFC assessments by State agency medical or psychological consultants or other program physicians or psychologists are to be considered and addressed in the decision as medical opinions from nonexamining sources about what the individual can still do despite his or her impairment(s). Again, they are to be evaluated considering all of the factors set out in the regulations for considering opinion evidence.

FN1. "Medical sources" are defined in 20 CFR 404.1502 and 416.902 as "treating sources," "sources of record" (i.e., medical sources that have provided an individual with medical treatment or evaluation, but do not have or did not have an ongoing treatment relationship with the individual), and "consultative examiners" for the Social Security Administration.

FN2. The term "medical expert" is being used to refer to the source of expert medical opinion designated as a "medical advisor" in 20 CFR 404.1512(b)(6), 404.1527(f), 416.912(b)(6), and

416.927(f). This term is being used because it describes the role of the "medical expert" as an expert witness rather than an advisor in the course of an administrative law judge hearing.