

SOCIAL SECURITY LAW

NOSSCR CONFERENCE UPDATE

Editor's Note: As has been his custom, Lewis Seward was kind enough to provide the following summary of the seminars and events from the NOSSCR conference that took place in San Antonio, TX. For this issue, we focus on Appeals to Federal Court.

The attorney at this presentation discussed getting a case ready for Federal District Court. One of the first things to be done is to become acquainted with the 15 or 20 important Sixth Circuit cases. It is also helpful to have the ability to conduct legal searches online, through Westlaw or other online legal services. Also, it is a good idea to have a book, such as Sarah Bohr's *Book on Issue Spotting*. Both the speaker and I found this book to be very helpful.

The following are other preliminary considerations in analyzing a case for Federal District Court:

1. Check the date last insured and check with your claimant to see whether there are any unreported earnings. Check to see when the date last insured was computed and what years of income were reported. Ask your client if they have worked since the date on the report.
2. Is your client over 55 years old and unable to perform medium work? If so, an impaired claimant over 55 would presumably be found disabled unless they have skills which are

Analyzing

a case for a

District

Court

Appeal



transferable to less demanding work. In order to find transferability of skills at age 55, there must be very little, if any, vocational adjustment. (201.00(f)). In order to establish that there are transferable skills for people 55 and over, SSA has the burden to show that the claimant's past relevant work was so closely related to other jobs that they could be expected to perform these jobs at a high degree of proficiency with a minimal amount of job orientation. (SSR 82-41.)

If a claimant age 55 or older is denied at Step 5, the reviewing Court must review the record for specific findings identifying the claimant's job skills and the positions to which they are easily transferable. (See *Nielson v Sullivan*, 992 F2d 1118, (10th Cir. 1993)). Failure by the ALJ to make specific findings targeted at a level of adjustment by a claimant over 55 constitutes reversible error.

3. Check to see if your client has less than a high school education and has performed 35+ years of unskilled labor. Although this is fairly a rare situation, such a person would be found disabled under §404.1562, if he or she is unable to perform his/her past relevant work. This is the famous "worn out worker" rule.
4. Check for a documented mental

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Social Security Lawyers Section

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From the Chair



Deanna Lee-Kaniowski
Weisberg & Walkon, P.C.
Southfield, MI

1999 is proving to be a very busy year for our section. Our current membership has grown to 272 members!! On January 22, 1999, we held our winter meeting at the University Club, with Kirk B. Roose as our guest speaker. Mr. Roose (also known as "Dr. EAJA") is a managing partner of Roose & Birmingham in Ohio and frequently lectures to NOSSCR and other bar groups about federal court practice and the Equal Access to Justice Act (EAJA). His lecture was very informative and interesting, giving our members (approximately 30 in attendance) helpful practice tips on filing for EAJA fees and deciding when to take a case to Federal Court. Interestingly, Mr. Roose indicated that the United States District Court, Eastern Division, has one of the highest case loads. Some highlights of his speech pertaining to EAJA fees included the following:

EAJA (Equal Access to Justice Act, 28 U.S.C. Section 2412 (d)) is now the primary source for attorney fees in court. You must think of EAJA first, because applications are usually due long before fee motions under the Social Security Act. Also, you may be ethically obligated to take as much of your fee as possible from the government rather than your client!

1.) EAJA fees are only for cases which went to federal court at some point. Statutory requirements are as follows: net worth of claimant less than 2 million, claimant is prevailing party, attorney submits itemizations of services rendered and alleges denial was not "substantially justified" (discussed below).

2.) legal service programs, as well as private practitioners, can receive EAJA fees (may change with future legislation).

3.) EAJA fees are awarded only where the government's position was not substantially justified and no special circumstances would make the award unjust ("substantially justified" is equivalent to "reasonable" and is a higher standard than merely "not frivolous" *Pierce v. Underwood*, 108 S. Ct. 2541, 2550-1 (1988)).

4.) EAJA procedure: file application, agency replies, may be able to file response. Some applications may be settled and some are aggressively opposed.

5.) EAJA fees only reimburse services in the civil action (exception under "sixth sentence" remands, where administrative time can be included).

6.) EAJA will also reimburse for reasonable time spent preparing the EAJA application.

7.) EAJA fees must be reasonable and based upon the "prevailing rates for the kind of quality of services furnished", with the current standard hourly rate cap at approximately \$120.00 per hour.

8.) You must have to use separate hourly rate caps for each year of services.

9.) You may also ask for expenses in your EAJA application (filing fee, brief copying, postage, etc.)

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SECTION ACTIVITIES CALENDAR

1999

Summer Meeting

June 4, 1999

University Club
Lansing, MI

Summer Weekend Seminar

August 27 – 29, 1999

Treetops Sylvan Resort
Gaylord, MI

Annual Meeting and Seminar

September 16, 1999

Grand Rapids, MI

Section Cocktail Party

September 16, 1999

*(in conjunction with the Grand Rapids, MI
Worker's Compensation Section)*

*The Section Meeting on 6/4/99 will be held at the
University Club, 3435 Forest Road, Lansing, MI (517) 353-
5111 (See attached map).

UPCOMING EVENTS

6th Circuit Seminar

August 13 – 14, 1999

Kings Island Resort & Conference Center
5691 Kings Island Drive
Kings Island, OH

For More Information, Contact:
Evan A. Zagoria, Esq.,
6875 Telegraph Rd, #400
Bloomfield Hills, MI 48301
(248) 642-0444

Social Security Disability

Law Conference

November 3–6, 1999

Riverside Hilton Hotel
New Orleans, LA

Social Security Disability

Law Conference

May 3–6, 2000

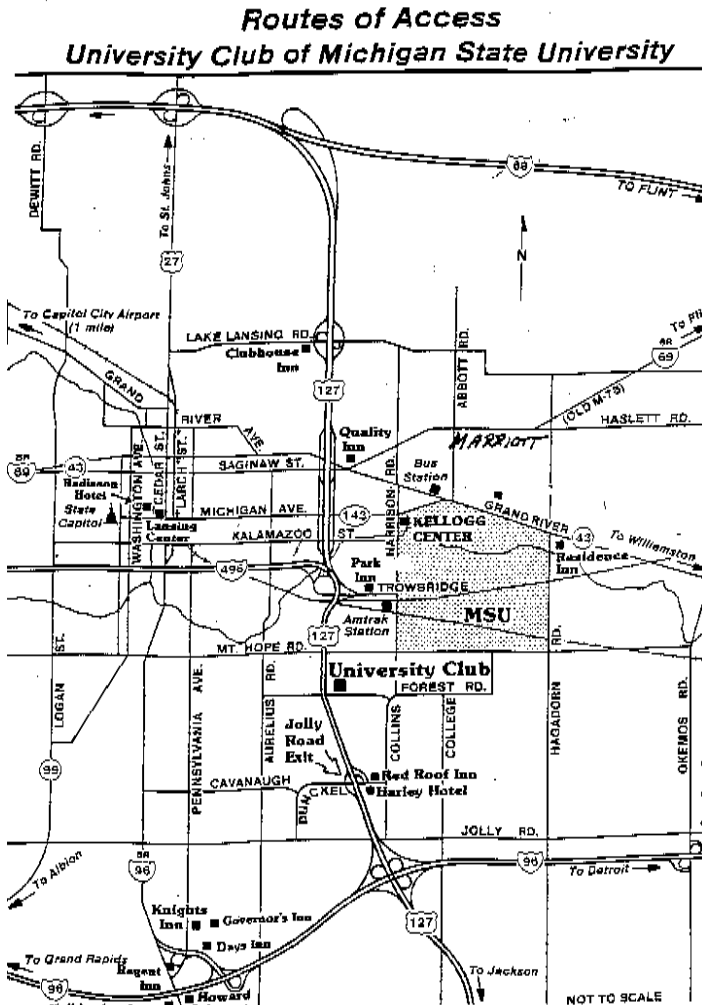
Disney World Hilton Hotel
Orlando, FL

For More Information, Contact:

NOSSCR

6 Prospect Street
Midland Park, NJ 07432
(800) 431-2804

<http://www.nosscr.org>



Practice Pointers

I took a case where the claimant was denied at the Appeals Council and who was in pro per. Several attorneys outright rejected the case over the phone. When I saw him in my office, he also had some more recent medical (although it was probably over a year old at that point). Looking at the medical, (and not having the benefit of looking at the entire Social Security file other than the ALJ denial and an AC denial), I told the client it was a long shot but I'll send it into the Appeals Council arguing that he may be close to meeting a listing.

I also told the client that the chances of getting a favorable reply from the Appeals Council are marginal at best, but I felt the evidence was strong enough to send it anyway for them to take another look at the case. I spoke with the person who drafted the decision at the Appeals Council and told him the situation and sent them the medical with my analysis as how the claimant may have a listing level impairment. We only had three weeks to file a Federal District Court case if we didn't receive any word from the Appeals Council.

Having not received a reply from the Appeals Council (and not really expecting one) we filed a Federal District Court case. Unknown to me at the time, the medical that I sent to the Appeals Council must have had some merit since it was forwarded on to an

Appeals Council physician who found that the claimant met a listing. The Appeals Council never notified me of this fact. However, three months after filing the Federal Court complaint, I received a call from the U. S. Attorney's office indicating that they are agreeable to a stipulation for remand back to the Appeals Council to issue a favorable decision going back a couple of weeks prior to the claimant's initial application. It was only then that I found out that the medical that I sent to the Appeals Council, along with my cover letter, was the reasoning for the remand.

The lesson learned from all of this is that if you have some good medical even after the Appeals Council upholds the denial, you may reopen their decision at the Appeals Council, or in this case find the claimant disabled after filing a Federal District Court complaint (without even having to draft a motion and brief for summary judgment).

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Editor's Note: The Practice Pointer Column exits for Section Members to offer advice or techniques for the effective handling of Social Security Disability Claims or to raise questions of concern that may be of interest to the general Section membership. Please submit any suggestions, comments or questions to:

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P.O. Box 07399
Detroit, MI 48207-0399
Telephone: (313) 571-6400
Fax: (313) 579-1923
E-Mail: carlatty@ix.netcom.com

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impairment. The attorney pointed out that the rules of professional conduct recognize that an attorney has a “*heightened duty*” to a mentally ill client whose decision-making or coping abilities may be affected by the mental impairment. Of course, it is too late if you are at the District Court level to have your client undergo a psychological CE or refer them to a community mental health provider. As mental illness (especially depression) goes hand in hand with disability, the speaker indicated you are doing your client a major injustice by not referring them to the appropriate mental health professionals for follow-up treatment. Let the mental health professionals determine whether a person needs counseling and further treatment if you suspect an undocumented mental illness.

5. When preparing your case, read the findings of fact in the ALJ’s denial first. By reading the findings of fact first you will be able to determine which step you are at in the sequential evaluation process, and you will obtain a general idea of the issues that need to be addressed. Next, read through the decision to pick up the other issues.
6. If you are stuck on an issue or do not exactly know how to properly frame it, refer to a treatise, such as Sarah Bohr’s book.
7. *Carefully* review the transcript. Make sure that the record contains the evidence you submitted. This is especially true for evidence that is submitted just before or after the hearing (hopefully you would have picked up this error once you receive your denial letter by reviewing the exhibit list).

I like to take the exhibit list that is compiled with the Court record (which also refers to the exhibit pages in the ALJ denial) and take notes as to the importance or relevance of an exhibit. I write the notes right on the copy of the exhibit list.

8. Check the ALJ’s evaluation of the evidence with the list of exhibits. If the ALJ ignored an important piece of the evidence, you may have grounds for a remand. The ALJ’s decision must reflect that he evaluated all of the evidence.
9. If your claimant was pro se at the hearing level, check to see whether the ALJ adequately and fully developed the record. Otherwise, it is reversible error.
10. Compare the PTRF filled out by the ALJ with the hypothetical to the vocational expert. Does the hypothetical reflect the emotional problems that the claimant is having?
11. Compare the RFC listed in the findings with the RFC discussed in the body of the opinion. Not only does the speaker find that this is an important thing to check, a recent case which I personally handled showed that it was inconsistent, and we were awarded attorney fees under EAJA.
12. Compare the ALJ’s RFC with the medical evidence, especially those of the treating physician. Often a denial is based upon a mischaracterization or ignoring crucial medical data or important restrictions. Check whether the file reflects that your client is unable to perform work on a regular and continuous basis, *i.e.*, 40 hours per week as required by SSR 96-8p.

One thing the speaker pointed out was that the ALJ may not “*link*” the RFC with the specific evidence in the record. If

this is the case, the conclusions in the RFC would not be supported by substantial evidence as a matter of law. The ALJ must explain the rationale in his conclusions to the specific medical evidence in the record and the weight that he accords to the evidence. Usually there are only a few medical records that are key to proving your client’s disability. Frequently, you will find the ALJ interposing his own opinion of the medical evidence.

Obviously if you have lost, the judge has rejected the treating source’s medical opinion or statements concerning your client’s restrictions. The ALJ cannot reject the treating physician’s opinion just because it is inconsistent with other medical evidence. SSR 96-2p thoroughly addresses this issue. See also 20 CFR §404.1527(D)(2-6). Review the evidence yourself in light of the factors set forth in the ruling and the above statute to aid in developing a convincing argument as to why a particular medical opinion should or should not be given weight.

13. In any denial, the ALJ must make a finding that the claimant’s testimony was not credible if SSR 96-7p thoroughly treats this issue. Of course, if this is the only thing you have to go on for an appeal, your best bet would be to have the case remanded and then to fully develop the record to document your client’s disability. Oftentimes an unrepresented client will have an inadequately developed record, the best cure for which is a remand. There is plenty of case law on this subject which boils down to whether there is a direct link (in contrast to a casual or indirect cause) between failure to follow the doctor’s medical advice and the resultant harmful effects of such. One popular way an ALJ may reject the claimant’s testimony is looking at whether he finds that the claimant failed to follow prescribed treatment. (See additional discussion of this topic in “Hot Disability Issues in Federal Court”).
14. If yours is a Step 4 denial, check to see whether the past relevant work cited by the vocational expert meets the 15 year durational requirement. Also look to see whether the work was performed for a long enough duration to be considered past relevant work. In close situations, check SSR 86-62, which states that an individual who has worked sporadically for only brief periods of time during the past 15 years may not have past relevant work experience. Also look to see whether the work was performed at the SGA level. If this was a Step 4 denial based on an incorrect assumption of past relevant work, then it should have been a Step 5 denial where the burden of proof shifts to the commissioner. This is clear reversible error. Compare the parameters given by the ALJ’s RFC as the hypothetical questions asked to the VE. The speaker correctly points out that often the ALJ will give specific parameters to the VE which did not appear in the decision, *i.e.*, either the restrictions were misstated or deleted when the decision was drafted. Compare the transcript with the hypothetical given to the vocational expert and compare it with the findings in the RFC.
15. Check the answers given by the VE relative to whether the jobs listed fall within the question to the VE. In other words, check the specific jobs listed with the DOT number to see whether they fall into the right exertional category in the RFC. The

vocational expert may also be wrong in stating the skill that is required for a specific job. In other words, some of the jobs listed in the DOT are of a higher skill than testified to by the vocational expert. SSR 83-12 severely limits finding that a person who must alternate sitting and standing can do unskilled light or sedentary work.

When writing your brief, focus your attention on certain facts you identify as critical to support your theory of the case. Discuss the points that weaken your case, since you know that the Defendant is going to point them out. It is usually best to tell the story in a chronological fashion. If a client has a laundry list of impairments, *i.e.*, more than three, it might be better to discuss each impairment separately to give a clear picture to the magistrate as to what exactly your claimant's impairments are.

Once you determine the issues in your case, draft an outline, putting the key exhibit numbers in the outline.

If your goal is to remand the case, make sure you make the brief very specific as to what you want. Also make sure that when the case is remanded that the Stipulated Order contains all the provisions to document your client's disability.

HOT DISABILITY ISSUES IN FEDERAL COURT

VE Discrepancy with the DOT

The majority view among Courts of Appeal is that the VE must explain the discrepancy between the DOT and their testimony otherwise the VE testimony will not be accepted. One important point when questioning the VE that was brought up in the seminar was preserving the case for an appeal. Ask the VE if the jobs listed are in the DOT. If yes, ask if the jobs described are substantially similar to the ones listed in the DOT. If the answer is yes, then ask for the DOT number and you have preserved the record on appeal. You can even ask the Court for some time to review those DOT's and if they do not comport with the requirements of the hypothetical send the judge a letter regarding this. However, you want to avoid the judge asking for a supplemental hearing since you are probably just giving the VE and the judge another crack at denying your case. In some cases, however, this may be better than going to the Appeals Council and having it remanded back 18 months later for a hearing on this narrow issue.

Determination of the Onset Date Without Medical Expert Testimony

SSR 83-20 is used for the fairly rare situation where you need to have a medical opinion to determine when the onset of a disability began. This is called a retrospective medical opinion since the physician looks at the record and determines when the person came to a point that they were no longer able to work. Therefore,

when the onset of the disability is ambiguous and the commissioner must infer the onset date, SSR 83-20 requires "*that inference be based on an informed judgment.*" The commissioner cannot make such an inference without the assistance of a medical advisor.

The Sixth Circuit is the only one in the country that takes a slightly different approach in using SSR 83-20. The Sixth Circuit (which the presenter indicates is a wrong reading of this ruling) states that the only time SSR 83-20 comes into play is when the judge has already made a finding that the claimant is disabled (but usually rules that the onset date was later than you would like). This is especially crucial on a concurrent claim where the claimant's date last insured ran out and they are only left with Title XVI. In any event, in our circuit, this bad case law means that you can only use SSR 83-20 if the judge has already made a finding at some point in the claimant's case that they are disabled (usually after the DLI expires and the ALJ finds the client disabled under T-XVI). See *Key v Callahan*, 109 F3d 270 (6th Cir. 1997).

Raise It or Waive It

This is bad law that has found its way into most of these circuits throughout the country. In other words, if you fail to raise an issue before the Appeals Council you have effectively waived it when you file your District Court appeal. If for some reason the government raises this issue you have several ways to attack it:

There is a provision under 20 CFR §404.976(a), §416.1476(a), which provides that the Appeals Council must notify an individual if it intends to limit the issues it will review. It can be argued that if there is no such notification by the Appeals Council its review preserves *all* issues for Federal Court review.

You can also argue that the denial letter indicating that you can file an appeal with the Appeals Council does not say that you must raise all the issues. The speaker indicated that in this letter it also explicitly says that the Appeals Council will address all issues if the cases appeal to their office. (*Check the standard denial letter.*)

Newly Submitted Evidence to the Appeals Council

A majority of Circuit Court cases allow admission of evidence at the Appeals Council level to be included in the District Court appeal. However, the Sixth Circuit adopts the minority view (*Cotton v Sullivan*, 2 F3d 692 (6th Cir. 1993), which does not permit evidence into a District Court appeal that was submitted to the Appeals Council *unless good cause for not submitting it earlier can be found.*

Medical Equivalency under 12.05(C)

This subissue looked at IQ's that were slightly over 70. I was aware that DSM III discussed that IQ scores are accurate only within five points. However, I was unaware that there was a POMS on this same issue. POMS 24515.056(D)(1)(c) expressly recognized that IQ's "*slightly higher*" than 70 "*e.g., 70-75 in the presence of other physical or mental disorders that impose additional and significant work-related limitations of function may support an equivalence determination.*"

**“The only battle worth
fighting is a lost cause.”**

Duty to Comply with Prescribed Treatment

This was quite an interesting topic and there is a lot of case law on this point. Just because a physician tells a claimant to stop smoking (and the claimant continues to smoke) does not automatically mean that the claimant should not be found disabled. In the case of *Kelly v Callahan*, (8th Cir. 1998), the Court ruled that because the doctor did not indicate that smoking was the cause of the claimant's problems or that the complaints would be relieved by quitting, the judge cannot make a finding that failure to quit smoking is failure to comply with prescribed treatment. In *Farley v Secretary of HHS*, 733 F2d 437 (6th Cir. 1984), the commissioner must show that alleged treatment would restore the claimant's ability to work.

The Courts have recognized that being unable to afford treatment is a reasonable justification for not pursuing it. In *Lovelace v Bowen*, treatment an indigent person cannot afford is no more of a cure for his condition than if it had never been discovered. In *Gordon v Schwiker*, the Court stated that it flies in the face of the patent purpose of the Social Security Act to deny benefits to someone because he or she is too poor to obtain medical treatment that may help him or her.

Social Security Ruling 82-59 indicates that a person who otherwise meets the disability criteria may not be denied benefits for failure to obtain treatment he or she cannot afford.

In mental impairments, the lack of medication or treatment does not prove that a disabling mental condition does not exist. A person suffering from a mental condition may not recognize the need for treatment. (*Kelly v Railroad Retirement Board*. See also HALLEX II-5-301, which indicates that a mental impairment can provide good cause for failure to comply with prescribed treatment).

Another hot topic is the failure to lose weight. You cannot automatically equate that it is voluntary non-compliance. Several cases were stated including one which indicated the Court is certainly not entitled to presumptions that obesity is remedial or that an individual's failure to lose weight is "willful." "The notion that all fat people are self-indulgent souls who can eat more than others appears to be no more than the baseless prejudice of the intolerant svelte."

Another twist on failure to comply is a person who is reluctant to have surgery. In *Kahn v Chater*, it states that the commissioner

must address whether the claimant's fear of surgery is credible and constitutes good cause for refusal.

VOLUME FEDERAL COURT PRACTICE

This was a very enlightening presentation. The two speakers were from a Tulsa firm that are currently handling 485 open Federal District Court files out of the 1,000 open files that they currently have. Amazingly, they do this with two attorneys, a law student and about ten support staff. The following is the philosophy of the firm:

1. The only battle worth fighting is a lost cause.
2. There is no way to learn the Social Security Disability law better than to do appellate work. It causes you also to be better prepared when getting cases ready at the hearing level.
3. Intellectually, it is mentally challenging.

There is a daily sense of satisfaction since you are able to turn the "dog cases" into dollars for your client.

With the above philosophy, it is probably apparent that you do not turn down many cases. In fact, about 3/4 of their Federal District Court work is referred by other attorneys.

Their philosophy is also that they take the good cases with the bad

cases, and therefore just try to formulate an argument with whatever is in the file unless it is something they feel is crucial. In those cases, they will at least contact the U.S. Attorney's office.

Because of their large Federal Court practice, only one person is assigned to take care of docketing time deadlines. That is best handled by one of the attorneys since it is the attorney's malpractice that is on the line and not that of one of the assistants. One of the presenter stated that doing the docketing allows him to get a good night's sleep.

One of the important aspects that was brought out by one of the presenters is that only ten percent of the Appeals Council denial cases get appealed to District Court. This is a travesty since nearly half of all cases that go to District Court get a fairly favorable result, i.e., either remanded or reversed (I believe the 1997 statistics were 44% were remanded and eight percent were reversed nationally).

In conjunction with the docketing, they also have a "to do" list that is updated and reviewed every day. This list includes the due dates for briefs and it is reviewed to make sure that the workload weekly and throughout the month does not get to be too intense.

■



Procedure for New Claim Filed When Prior Claim is Pending at Appeals Council

Editor's Note: The following excerpt is taken from a circular issued by the Payment Policy Division of the Office of Program Benefits. It specifies SSA procedure for the processing of a new filing during the period that the claimant has an appeal pending either at the Appeals Council or District Court.

NOTE: SSA will always accept a claim from a person who insists on filing. SSA employees will explain the requirements for entitlement and/or the necessity for filing and leave the decision of whether or not to file up to the individual (see GN 00201.005). "If the claimant insists on filing, review the Office of Hearing and Appeals Query (OHAQ) to see if an appeal is pending."

NEW CLAIM FILED IS THE SAME TITLE AS AC APPEAL

If the new claim is the same title AND THE SAME ISSUE (*e.g.*, disability) as the claim pending at the AC, forward the new claim to the AC with the annotation to associate it with the prior claim. Per the HALLEX, Section I-3-086, the AC will associate the new claim with the claim under appeal and expedite the appeal (see DI 12045.027).

If the AC makes a fully favorable decision, the AC consolidates the new claim with the AC decision. For example, if the AC finds that the person is disabled and the disability is continuing (*i.e.* it is not a closed period of disability), a disability determination is not needed for the new claim.

If the AC affirms the unfavorable decision of the ALJ, the AC returns the new claim to the FO for processing. The AC notifies the claimant of the AC decision and that the FO will process the new

claim. The FO must develop and process the new claim. If it is a disability claim, the FO should send the medical information on to the disability determination service (DDS) for a medical determination back to the onset date, which should be no earlier than the day after the ALJ decision.

If all non-medical requirements are met after the date of the ALJ decision, the FO forwards the new claim to the DDS with the following restriction:

"THE ONSET DATE MAY NOT BE ESTABLISHED BEFORE THE DAY

AFTER THE DATE OF THE ALJ'S DECISION OF _____"

(DATE)

If the AC affirms the unfavorable ALJ decision in the first claim, and all non-medical requirements are not met in the new claim, deny the new claim.

New Claim Under Another Title Filed Before AC

Process the claim whether or not there is a common issue per DI 12045.010 E. If there is a medical issue, route the claim to the DDS with a report of contact stating that a prior claim is pending AC review. If the FO denies the claim for a non-medical reason, send a copy of the SSA-831 to the AC.

New Claim Filed When The Prior Claim Is Pending In Court Or The Court Remands The Prior Claim To Ssa

The FO must accept the new claim. See GN 03106.090 for instructions on determining if a common issue exists. If a common issue exists, treat the new claim as a duplicate. If a common issue does not exist, follow the development and routing instructions in GN 03106.095.



SOCIAL SECURITY RELATED WEB LINKS

Social Security Online: http://www.ssa.gov/SSA_Home.html

NOSSCR Online: <http://www.nosscr.org>

Social Security Advisory Service: <http://www.ssas.com>

From the Chair—continued from page 2

10.) **TIMELINESS TRAP!!** EAJA applications must be filed within 30 days from “final judgment in action.” (“final” means “not appealable” and generally, the 60 day appeal period applies).

11.) Most remands are considered “fourth sentence” remands, where the claimant is considered the prevailing party. You can apply for and receive fees even if you never win the claim!!

12.) In “sixth sentence” remands (generally for consideration of new evidence or on motion of the agency before the answer), the claimant is not the prevailing party and no EAJA application is due until you go back to court with your new favorable administrative decision and ask for final judgment.

13.) EAJA fees are offset against any fee the claimant pays you out of the past due benefits for the same services (you get to keep the larger).

Our Spring meeting was held on March 26, 1999 (also at the University Club in Lansing). Our guest speaker was Dr. Norm Abells, a vocational expert (VE) who regularly testifies in Lansing and director of the psychology clinic at Michigan State University. He addressed recurrent “problem” areas that come up during vocational testimony (i.e., sit/stand option, leg elevation, absenteeism, pain, IQ scores, GAF scores and the famous “security monitor” job) and took questions from our membership. We had approximately 40 members attend and the feedback was very positive!

By this time, members have probably already heard that the adjudication officer (AO) program has been eliminated and the

senior staff attorney program has been extended until next year (originally scheduled to end September of 1999). Michigan will also be using the single-decision maker and we are also scheduled to be a pilot state for the elimination of reconsideration. As this year progresses, we are in for many changes and our Section will address the details as they become available.

Other updates include a new policy from the VA, which now allows their physicians to render opinions regarding their patient’s disability. Hopefully, this will prove useful to us practitioners who have attempted in the past (with no success) to obtain physical or mental residual functional capacity evaluations, narrative reports or interrogatories. Further, the future of the Obesity Listing is still on hold, with no elimination as of yet. I would also like to remind our members that thanks to Evan Zagoria, we have an agreement with SMART Copy Service for a \$26.50 (\$25.00 for records, plus \$1.50 for tax) flat fee for records requested for Social Security claims. It is my understanding that as of February 1, 1999, their staff should now be fully aware of this policy.

I would like to remind our members once again to note all upcoming meetings on their calendar. Our summer meeting is scheduled for June 4, 1999, at the University Club and the “64th Annual State Bar of Michigan Meeting” will be held for our section on September 16, 1999, at 2:00 PM in Grand Rapids, Michigan. Please mark your calendars now!! Unfortunately, member turnout for our 1998 annual meeting in Lansing was very low. I hope by continually reminding our members, we will get a much higher turnout this year. If anyone has any suggestions for our next guest speaker, (6/4/99), please call me. Also, if you are interested in serving on the council, let me know! ■

Welcome To Our Home!



**Be Sure to Visit
Our Home Page on the Internet!
<http://www.michbar.org>**

SECTION NEWS

Medical Records Bill

At the urging of our section, a medical records cost containment bill has been introduced in the Michigan House of representatives. It is extremely important that our section members show their support for this legislation. Send Letters of Support to:

State Representative Gerald H. Law
Michigan State Capitol
P.O. Box 30014
Lansing, MI 48909-7514

in support of House Bill #4294
(Consumer Protection Bill Supporting Reasonable Costs for Copies
of Medical Records)

Webmaster Wanted

Our section is looking for someone to serve as a webmaster for our web page, which is part of the State Bar of Michigan website at <http://www.michbar.org>. We hope to provide a member directory, past issues of the section newsletter, links to other social security related sites and other useful information via the internet. Interested persons should contact:

Carl A. Anderson
P.O. Box 07399
Detroit, MI 48207-0399
(313) 571-6400
Fax: (313) 579-1923
e-mail: carlatty@ix.netcom.com

Grand Rapids Copying Service

Professional Courier Services, ("PCS"), has advised our section that they will provide photocopies of social security files from the Grand Rapids Office of Hearings and Appeals for a fee of \$20.00 per file. In order to copy a file, they will need a copy of the Appointment of Representative Form and a letter authorizing PCS to copy the file. Photocopies will be provided within one week from the date of the request. Rush service will be provided for an additional fee. Interested section members should contact:

Ms. Cathy Smith, President
Professional Courier Services
205-G Waters Building
Grand Rapids, MI 49503
(616) 451-4445

REVISED OCO MODULE TELEPHONE NUMBERS

Editor's Note: The Office of Central Operations (OCO) - formerly called ODIO - is composed of 4 Divisions. Each Division consists of 9 Modules, plus 3 Modules reserved for future use. Each Module handles a specific range of Social Security Numbers (SSNs) which correspond with SSNs issued in various States. OCO has jurisdiction in cases where an individual is under age 55 and is entitled to Title II disability benefits. OCO handles non-disability issues such as the worker's compensation offset, correctness of benefit, selection of payee, overpayment and waiver, relationship issues, insured status, other family member entitlement, and representation fees.

SSA Commissioner: Kenneth S. Apfel 410-965-3120

OCO Director: W. Burnell Hurt 410-966-7000

The area code for all telephone numbers below is 410

Division I

Division Director: Robert M. Johnson—410-966-8201
SSNs 001-00 through 234-70

Mod	SSN Range	Manager	Inquiries	Fax
1	001-00 thru 024-56	966-2916	966-2930	966-2933
2	024-57 thru 051-44	966-2944	966-2958	966-4591
3	051-45 thru 080-54	966-2972	966-2986	966-4592
4	future use			
5	080-55 thru 108-80	966-2706	966-2721	966-0884
6	108-81 thru 137-50	966-2739	966-2753	966-4594
7	137-51 thru 164-52	966-2768	966-2784	966-4328
8	future use			
9	164-53 thru 199-58	966-6465	965-2861	966-1527
10	199-59 thru 224-08	966-6469	966-6471	597-0490
11	224-09 thru 234-70	966-6472	966-6513	966-3023
12	future use			

Division III

Division Director: Frank Zamostny—410-966-4006
SSNs 370-83 through 479-40

Mod	SSN Range	Manager	Inquiries	Fax
25	370-83 thru 388-52	966-2362	966-2375	966-1398
26	388-53 thru 404-56	966-2391	966-2404	966-2386
27	404-57 thru 413-02	966-2419	966-2433	966-2382
28	future use			
29	413-03 thru 422-64	966-3919	966-3933	965-5644
30	422-65 thru 430-35	966-3948	966-3963	966-1537
31	430-36 thru 438-52	966-3978	966-3993	966-1542
32	future use			
33	438-53 thru 452-77	966-2208	966-2222	965-0244
34	452-78 thru 463-02	966-2238	966-2253	966-5570
35	463-03 thru 479-40	966-2267	966-2280	966-1775
36	future use			

Division II

Division Director: Marge Dickerson—410-966-1600
SSNs 234-71 through 370-82

Mod	SSN Range	Manager	Inquiries	Fax
13	234-71 thru 243-60	966-1648	966-1661	966-5260
14	243-61 thru 251-58	966-1676	966-1691	966-5261
15	251-59 thru 259-92	966-2614	966-2628	966-5262
16	future use			
17	259-93 thru 266-58	966-3400	966-3416	966-0621
18	266-59 thru 283-86	966-5264	966-3436	966-3450 966-3430
19	283-87 thru 304-76	966-3460	966-3477	966-5265
20	future use			
21	304-77 thru 323-70	966-2507	966-2521	966-5267
22	323-71 thru 350-32	966-2536	966-2551	966-5273
23	350-33 thru 370-82	966-5274	966-2581	966-5278 966-2565
24	future use			

Division IV

Division Director: Murrel Taylor—410-966-3095
SSNs 479-41 through 763-99

Mod	SSN Range	Manager	Inquiries	Fax
37	479-41 thru 497-66	966-0229	966-2839	966-2841 966-2824
38	497-67 thru 517-48	966-3123	966-2870	966-4656
39	517-49 thru 528-19	966-2885	966-2903	966-4341
40	future use			
41	528-20 thru 544-92	966-3037	966-3054	966-4658
42	544-93 thru 554-72	966-3002	966-3018	966-1867
43	554-73 thru 564-82	966-3066	966-3080	966-1873
44	future use			
45	564-83 thru 574-84	966-2467	966-2483	966-4650
46	574-85 thru 583-49	966-2497	966-4111	597-4652
47	583-50 thru 763-99	966-4126	966-4140	966-4651
48	future use			

Social Security Law Section
State Bar of Michigan
Michael Franck Building
306 Townsend Street
Lansing, MI 48933-2083

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