

STATE BAR OF MICHIGAN
SOCIAL SECURITY

A Publication of the Social Security Section of the State Bar of Michigan



Winter 2005
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Current Update from NOSSCR - Philadelphia

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The City of Brotherly Love was the site for NOSSCR's 25th Anniversary Conference. Nancy Shor spoke about NOSSCR's fledgling start and how the organization has grown today. NOSSCR is now a formidable organization that works together with the Commissioner's policies affecting claimants and representatives.

From the representative standpoint, Nancy indicated that without NOSSCR we would still have the \$4,000 cap on attorney fees, the egregious 6.7% user fee, and there would not be attorney fees withholding for SSI cases. From the claimant's perspective, NOSSCR leadership and membership has been instrumental in identifying potential problems and offering solutions for proposed regulations affecting claimants.

Nancy indicated there are going to be problems that will occur with the roll-out of the SSI attorney fee withholding program. She is addressing NOSSCR's concerns to the Administration that the local offices may not be adequately instructed on implementation of this new attorney fee withholding procedure. We were told to expect many problems until the bugs are worked out. She told the membership that all representatives should let Social Security know in advance whether the representative wants the attorney fee withheld or

whether they are going to file a fee petition. *Editor's note:* The best way to insure that an SSI attorney fee is withheld is to contact the local office and find out who the claim's rep (CR) is who is handling that particular case. Then leave a voice mail message and follow up with a letter enclosing your 1696 requesting that the attorney fee be withheld and sent to your office.

Nancy also indicated that the GAO will be starting a five-year study on attorney fee withholding beginning in March 2006. They will be interviewing claimants, representatives and the administration. The GAO will be studying the impact of attorney fee withholding for SSI cases and whether claimants will receive more effective representation following this new program.

Bill Gray for SSA Speaks

Bill Gray, the Deputy Commissioner for Systems, spoke on the electronic file and data collection system known as eDib. Mr. Gray indicated that a large majority of the field offices are already online with the eDib collection system. The 3368 application is now being electronically created. The field office will then upload it to DDS creating the electronic folder.

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2004-2005

Medicare and Michigan Workers' Compensation

By Barry Adler and Steve Stillman

Medicare is available to Social Security Retirement Benefit recipients who are over 65 and to those who have received Social Security Disability insurance benefits (SSDIB) for more than 24 months (29 months after the *disability onset date* when you factor in the five-month waiting period). According to federal law, workers' compensation is primary for payment of medical expenses when they could be covered under either workers' compensation or Medicare. Medicare is administered by the Centers for Medicare and Medicaid Services (CMS).

Michigan claims for workers' compensation benefits are routinely settled for a lump sum, which includes payment of past and future medical expenses. This poses unique problems for the Michigan workers' compensation practitioner when settling the case. Attorneys must be acutely aware of the procedures for notifying CMS of the settlement and obtaining CMS approval for the settlement.

There are two issues related to the payment of medical expenses and settlement of Michigan workers' compensation claims. First, there is the issue of whether or not Medicare has paid for any medical treatment for the **claimed condition(s)**. Secondly, to cover the issue of Medicare payments for future medical treatment, Medicare is required to make a determination regarding the appropriate amount to be "set aside" for future medical treatment out of the settlement proceeds.

CMS is currently advising that it will pre-approve allocations for future medical expenses in workers' compensation redemptions when a claimant is entitled to Medicare benefits, or if there is a "reasonable expectation" of Medicare entitlement within 30 months of

the settlement date and the settlement is over \$250,000. If the settlement is less than \$250,000 and the claimant is not a Medicare recipient, you do not need to notify CMS of the settlement.

Set forth below is an outline of the steps that need to be taken in order to obtain CMS approval for the settlement of a workers' compensation claim in Michigan. You do not need to contact CMS.

Start the Process

The first step is to open up an account on behalf of the claimant with CMS and to advise CMS that you are representing a particular Medicare beneficiary in a workers' compensation settlement. The first step is to call CMS to set up a claim at **800-999-1118** or **646-548-6761**. Please be prepared to have the claimant's name; social security number; date of injury; the workers' compensation insurance name, address and phone number; the injury/disease date; a description of the injury (the ICD-9 diagnosis code is very helpful); as well as the name of the attorney representing the employer or workers' compensation insurance carrier.

Within two to three weeks of opening the file, you will receive a standard letter from CMS acknowledging that CMS has been advised of your retention to represent the claimant, notifying you of CMS' lien pursuant to the Secondary Payor laws and a Consent to Release form. Please have your client sign the Consent to Release form immediately and proceed to the next step leading to the redemption of the claimant's workers' compensation claim.

You must contact two areas of CMS in order to settle and redeem. Prior to the settlement, you must obtain from CMS

a summary of conditional payments already made by Medicare pertaining to the claimant's injuries and you must contact a different division of CMS in order to determine the "adequacy in protecting Medicare's interests in workers' compensation settlements, i.e., set-aside arrangements."

Determine Conditional Payments

In order to determine the amount of conditional payments already made by Medicare for the claimant's injuries, you must send a copy of the Consent to Release form signed by claimant with a short introductory letter listing your claimant's name; social security number (or health insurance claim number - HIC#); date of injury; and the injuries/conditions claimed. In your letter, advise CMS that you are representing this claimant, give a brief description of the claim, and request a summary of conditional payments made to date by Medicare contractors.

Additionally, provide CMS with a copy of the completed Redemption/Settlement Order (which is to be entered with the court at hearing) as well as the Worker's Settlement Statement listing the attorney fees and costs or any other deductions.

The information above should be sent to:

CMS/United Government
Services, L.L.C.
401 West Michigan Street
Milwaukee, WI 53203-2804
Attn: Medicare Secondary Payor
Unit

If you have any questions regarding the conditional payments, you can call CMS in Milwaukee at 414-226-6300.

Within six to eight weeks you will receive a letter from CMS/United Government Services acknowledging your representation of the claimant and advising of the total amount paid by Medicare Part A and Medicare Part B. If an itemization is not provided with the correspondence, you can contact

CMS in Milwaukee and request an itemized statement for each and every conditional payment. It is always wise to do this to determine if, in fact, the charges pertain to your claimant's work-related injury. Our experience has been that often there are other medical expenses that have nothing to do with the alleged work-related injuries that are included in the conditional payments list.

Medicare regulations require that the claimant pay Medicare back within sixty (60) days of your client's receipt of settlement or insurance proceeds, and these amounts should be sent by check or money order in the amount specified to the following address:

United Government Services
Michigan MSP
Box 88981
Milwaukee, WI 53288-0981

However, the final determination of the amount due won't be determined by CMS until after the case is settled and you send a copy of the Redemption Order to United Government Services in Milwaukee. They may actually reduce the amount of conditional payments due after a Medicare Liability Settlement Claim Reimbursement Summary. This is a rather complicated formula where the conditional payment demanded is actually discounted proportionately by the attorney fees and other procurement costs incurred by the claimant's attorney.

In one recent example, the total amount of the workers' compensation settlement was \$25,000. The amount of conditional payments made through Medicare Part B was \$18.45. The total amount of attorney fees on the \$25,000 settlement was \$3,738.51 with attorney costs listed at \$176.58 for a total procurement cost of \$3,915.09. Medicare

"Attorneys must be acutely aware of the procedures for notifying CMS of the settlement and obtaining CMS approval for the settlement."

will divide the total procurement cost by the amount of the settlement to determine the procurement cost ratio. In this particular case, it was 0.1566036. Thus, the conditional payment of \$18.45 (that Medicare already paid for Part B benefits prior to the settlement) was divided by the procurement ratio, and Medicare's share of procurement costs was \$2.89. Thus, the amount Medicare requested to be recovered was \$15.56 (\$18.45 - \$2.89 = \$15.56).

Set-Aside Agreement

As stated above, you must also contact another division of CMS to determine the amount of benefits that your client will have to put away in a set-aside agreement for future medical care for the work-related injury. The part of CMS that determines this is as follows:

Budgets & Collections Branch
Division of Medicare Financial
Management
233 North Michigan Avenue
Suite 600
Chicago, Illinois 60601-5519
Attn: Gloria J. Walker, Manager

Again, you must write a summary of your case, but you need to include much more detail. We have attached what appears to be a daunting list of information requested by CMS but it is readily at your disposal, as follows:

The next paragraph should indicate the employer's information including its name, address, and telephone number. (Additionally, the workers' compensation insurance information should be listed including name, address, and phone number.) You should also identify the names of the attorneys representing the employer or workers' compensation carrier.

Continued on next page

Additionally, you must identify the injury/disease date as well as the type of injury claimed, including the ICD-9 diagnosis code if you know it. You should also indicate the total workers' compensation settlement amount, enclosing a copy of the Worker's Settlement Statement and a copy of a completed (but not yet entered) Redemption Order.

Your letter should also contain an evaluation of the case, including the statements and opinions of the treating and examining physicians as well as a description of the current and future treatment that will be anticipated by reason of the work-related medical conditions. It is very helpful to submit with this letter medical reports summarizing the particular claimant's case from both the claimant's and defendant's perspectives. Oftentimes, it is extremely helpful to submit directly to CMS copies of the transcripts of deposition testimony of both the defense and plaintiff doctors.

CMS also requests that you put forth your own evaluation of the appropriate set-aside amount. In most cases, if you fairly evaluate the situation, CMS will adopt your proposed set-aside amount. When CMS began this process, they were requesting 5% of the net proceeds to be put forth in a set-aside account. If the claimant's case is dubious at best, you might want to put heavy focus on the defense doctors' opinions and request only a nominal set-aside amount such as \$250 or \$500 (or less depending on the amount of the settlement) or even a waiver. If the claimant's case is a good case and is being paid a fair settlement, then a proposal of 3% or 5%

of the net payable to claimant should be indicated. CMS will put great emphasis on the anticipated future medical required.

If CMS needs additional information, they will contact you and request that specific information. The quicker you get back to them, the quicker you can get a proposed set-aside arrangement completed. We typically advise our clients to go to their local bank once they receive the net proceeds of the redemption and have the bank set up the trust as specified by the set-aside arrangement. The proposed set-aside arrangement is not made in stone. You can ask that CMS re-review their own proposal if you think that they are requesting the client set aside too much money. You must specify your reasons for same, and CMS typically responds within 30 to 45 days. We have many examples where CMS reduced the amount requested in a set-aside arrangement upon receiving additional "persuasive" argument and evidence.

Conclusion - Redeem Your Case

Once you have been advised of the conditional payments requested by CMS (and you have verified that those payments are for work-related injuries), and you received a proposed set-aside arrangement, you can now proceed to redeem and settle your case. In the beginning, CMS used to request that a client sign off on the set-aside arrangement. That is no longer required. However, CMS is now requesting a copy of the Redemption/Settlement Order

once it is signed by the magistrate and entered with the court. Additionally, CMS is now requesting that there be a designation on the Redemption Order, as follows:

MEDICARE: The sum of \$ _____ is designated as the sum to be regarded as a workers' compensation Medicare Set-Aside Arrangement.

The above statement (with the amount of set-aside written in the blank) should be typed on the Redemption Order that is signed by the magistrate. Of course, you should clarify with your client on the record at the redemption that they understand their responsibilities to arrange for a set-aside trust to be opened at their local bank (or take the chance they could lose their Medicare coverage if they do not). Further, you should advise the claimant that there might also be additional conditional payments between the time you receive the first notice of conditional payments from CMS and the time the Redemption Order is entered with the court. Typically, the claimant may know whether there are going to be any additional payments requested by CMS if they are aware of the treatment being billed to their Medicare card by their providers.

**"It's so hard to know what to do when one wishes earnestly to do right."
(George Bernard Shaw, Man and Superman)**

When DDS requests records, they will send a cover letter with a bar code. Medical care providers are requested to send records with this cover letter that will facilitate earmarking the case to the electronic folder.

Medical care providers and representatives have several ways to submit medical records or other information:

1. By snail mail - once received at DDS or OHA, the records will be scanned in to the system.
2. By fax - a paper copy will *not* be generated at the receiving end either at DDS or OHA. It will be electronically sent to that appropriate folder.
3. By e-mail - this is a little bit trickier because when submitting records the cover letter with the bar code should be sent electronically and therefore the cover letter will have to be scanned in to your computer and then combined with the records that you want to send electronically.

It was obvious that when SSA set up the system they were not at all familiar with the electronic filing under the Federal Court system using Pacer. That certainly would have been nice if the administration had the foresight to use the same type of system. Rather, instead of using a PDF format that is used by the Court and that is more widely accepted throughout the world, the administration reverts the page into a "tif" image.

At the Hearing Office, the database is entitled Case Processing Management System (CPMS) which allows OHA to access the electronic folder. The Hearing Office will be able to burn a CD rather than having to copy the file. The CD has information on how the electronic folder works and trouble shooting tips. The CD will also have an exhibit list. You can open any medical record by merely clicking on the listed exhibit.

Additionally, it will prove very handy in brief writing both from the administration and representative standpoint by cutting and pasting directly out of the exhibit. Mr. Gray indicated you open up the record, highlight and right click it and select it.

Each representative will have a password to allow them to send records electronically. They will *not* send a folder to the representative's office electronically because of security concerns. Representatives will not have access to the electronic folder other than through a CD.

Unrepresented claimants who do not have a computer can receive a copy of their file by paper. Since the file is on CD, it can be printed up rather than copied.

At the hearing, the ALJ, representative and VE will each have their own monitor and keyboard to view the file. All three can look at a certain exhibit but the three are totally independent from each other. In other words, all three can be looking at different parts of the folder at the same time. This is also very helpful when a representative wants to point out something in an exhibit to the ALJ or vice versa. It will also be helpful when cross-examining the vocational expert by asking him to refer to a certain exhibit.

Additionally, a digital recording is on the horizon and Mr. Gray indicates that he is not sure whether that will be combined with a CD of the folder or whether it will be two separate CDs.

Following Mr. Gray's talk, there were a multitude of questions, most of which could not be answered by Mr. Gray. It was pointed out several times by representatives that the 3368, which

is the initial application, only provided for two impairments. There is also not enough space on this form for adding additional information in other areas of the form. It was obvious from the questions being asked that many are already using the system and finding a lot of glitches.

From the large amount of unanswered questions, the eDib system was not thought out as thoroughly as the administration would like the public to think. The concept is good, it is just that there is a long

way to go to bring the system so that it is designed for the use that it has been intended. However, these problems are to be expected as the electronic folder is a radical departure from the burdensome paper folder. A new and "improved" 3368 initial application will be available this Spring. Technically, the current version can only be submitted by the claimant (although a Rep can fill it out). This new version will allow the Rep to *send* the 3368 electronically.

There were many good suggestions brought up by the membership to Mr. Gray and hopefully the glitches will slowly be corrected. If you discover glitches that warrant attention or have a solution to a problem, contact NOSSCR first as other members may have discovered the same problem and/or solution. The electronic folder is a welcome change and with help of the representatives, it can be made more user-friendly making all of our lives a little easier.

"It was obvious that when SSA set up the system they were not at all familiar with the electronic filing under the Federal Court system using Pacer."

Writing Persuasive Briefs

The following are excerpts from Charles Martin, a long-time NOSSCR member and prolific Federal Court practitioner who gave a presentation on effective brief writing tips at the NOSSCR Seminar in Philadelphia.

When writing a brief either at the Federal Court or Appeals Council level, obviously the first place to begin is to re-review the ALJ's decision-making notes as you go. Once you've finished reviewing the decision, several issues will come to mind. The next step is to organize those notes/thoughts into an outline for issues that you would like the Appeals Council or Federal Court to review.

When presenting the facts of the case, try to make it personal and simple enough that it can be understood by a 7th grader. If you cannot describe the facts and issues in basic simplistic terms, then how are you ever going to persuade the Appeals Council let alone Federal Court? The further up the food chain you go, the more simplistic you need to make your arguments. That is because of the simple fact that the higher you go in the appeal process, the less disability issues your reviewing court encounters, and the less Social Security law your reviewing court understands.

It is also important to keep in mind that the audience you are writing for when you are in Federal Court is not so much the Magistrate or District Court Judge. Rather, your audience is the federal law clerks who are fresh out of law school or, heaven forbid, still attending law school. As one law clerk for a well-known Federal District Judge explained it, she was informed by her boss that "In most Social Security cases, the government is right. However, you have to keep a watchful eye because once in awhile there are some cases out there that should be remanded or reversed." The editor is paraphrasing, but the gist of the message is in Federal Court and at the Appeals Council, the reviewing body is already predisposed to deny your claim. Your

mission is to explain in layman's terms why the ALJ performed an injustice to your client.

In presenting the facts, make sure you avoid undefined medical terms. Simplify the medical evidence as much as possible. In other words, demystify the medical lingo. Do not take for granted that the reviewing body knows the significance of a 50 or lower GAF score. Do not assume that the reviewing body knows the difference between a Stent and a CABG.

When drafting your issue statement, Mr. Martin likes to use a Syllogism (syl-o-gisim) approach. This Syllogism has three parts: (1) You cite the black letter law; (2) you describe the harm that SSA did to your client; and (3) ask a (loaded) question, which provides only one answer, i.e., that your client has been harmed by the adverse decision. A Syllogism in these three short sentences in the beginning of your brief should show the reviewing body within 30 seconds why you should win.

Syllogisms use ordinary language. In other words, language that is normally comfortable speaking to someone else. Do not use legalese. For example: Is it proper for an ALJ to rely on an incomplete hypothetical question? The ALJ did not incorporate the claimant's reduced intellect in the hypothetical. Is it an error for the ALJ to formulate a hypothetical to the vocational expert that fails to include cognitive difficulties associated with Borderline Intellectual Functioning with a full scale IQ of 67, which is less than two percent (2%) of the general population.

When drafting your argument, it is best to stick to the tried and true law school analysis, i.e., (1) cite the law; (2) cite the specific facts of your case; and, (3) demonstrate when applying the facts to your particular case an injustice occurred to the extent that your client's case should either be remanded for a new hearing or reversed for payment of benefits. Please remember when you

are drafting your brief to make sure it passes the 7th-grader test so that the issue of fairness is obvious.

However, in many cases, the injustice may not be so obvious initially. When the ALJ has failed to follow a technical procedural requirement such as failing to ask the vocational expert whether the jobs comport with those listed in the DOT under SSR 00-04p. It is not merely enough to argue that the ALJ failed to comply with this law and therefore the case should be remanded for a new hearing. Rather, you need to show the injustice of the ALJ failing to follow the mandatory procedure requirements under SSR 00-04p. In other words, take a look at the specific jobs that were listed by the vocational expert and explain why at least one of those jobs, if not more, is not consistent with the DOT. This may take some work on your part as in this particular issue you will need to look up the jobs listed by the vocational expert in the DOT if you forgot to ask them at the hearing.¹

Mr. Martin also stressed the importance of brevity in your brief writing. He gave a few pearls of wisdom or quotes from sources most of which are humorous but also to the point, i.e.,

If you can't write your idea on the back on my business card, you don't have a clear idea;

Things, when short, are twice as good;

Brevity is the soul of lingerie;

It is with words as with sunbeams, the more they are condensed the deeper they burn;

Throw the corn where the short-legged hogs can get it.

Choose your words carefully. Make sure when proofing your brief that you avoid adjectives and adverbs that unnecessarily tend to exaggerate the injustice done to your client or exaggerate the nature of your client's medical problems. In other words, do not overstate your client's impairments or the harm done.

When concluding each issue, try to sum it up in two sentences or less. If you cannot do this, then you may have not distilled the issues to the point that it can be understood by a 7th grader. By the time you get to the Sixth Circuit, dial down a couple of notches to a 5th grade level or you are going to be in trouble. During a recent EAJA attorney fee case in the Sixth Circuit the first question from the Chief Judge was “Why can’t you get your attorney fees from your *client* like any other Social Security case?”

Effective and concise brief writing takes years of practice. It is much more difficult to write a concise and cogent brief than one that requires pages of explaining the harm done to your client. If you keep it simple, a message to the reviewing body will be loud and clear.

Endnote

¹ It is important to elicit a representative sample of DOT numbers for the job listed by the vocational expert unless you are thoroughly convinced that the ALJ is going to pay the case. As with all good ALJs, most do not tip their hand at the hearing and therefore when you leave the room, you do not know which way the judge is going to go. It is a rare case for the vocational expert to provide accurate DOT numbers given the parameters of the hypothetical by the ALJ. Therefore it is incumbent upon the practitioner to elicit a representative sample of DOT numbers for each job listed to preserve your client’s rights if the claim is denied.

STATE BAR OF MICHIGAN
SOCIAL SECURITY SECTION

2005 SSI Break-Even Chart

As this is such a widely used reference, listed below is the Table of Deeming Break-Even Points:

Effective January 2005	Parent to Child				Spouse to Spouse	
	EARNED		UNEARNED		EARNED	UNEARNED
	One Parent	Two Parents	One Parent	Two Parents		
0						
Reduction Begins	\$1,283	\$1,863	\$ 619	\$ 909	\$ 665	\$ 310
Payment Stops	\$2,441	\$2,302	\$1,198	\$1,488	\$1,823	\$ 889
1						
Reduction Begins	\$1,573	\$2,153	\$ 909	\$1,199	\$ 955	\$ 600
Payment Stops	\$2,731	\$3,311	\$1,488	\$1,778	\$2,113	\$1,179
2						
Reduction Begins	\$1,863	\$2,443	\$1,199	\$1,489	\$1,245	\$ 890
Payment Stops	\$3,021	\$3,601	\$1,778	\$2,068	\$2,403	\$1,469
3						
Reduction Begins	\$2,153	\$2,733	\$1,489	\$1,779	\$1,535	\$1,180
Payment Stops	\$3,311	\$3,891	\$2,068	\$2,358	\$2,693	\$1,759
4						
Reduction Begins	\$2,443	\$3,023	\$1,779	\$2,069	\$1,825	\$1,470
Payment Stops	\$3,601	\$4,181	\$2,358	\$2,648	\$2,983	\$2,049
5						
Reduction Begins	\$2,733	\$3,313	\$2,069	\$2,359	\$2,115	\$1,760
Payment Stops	\$3,891	\$4,471	\$2,648	\$2,938	\$3,273	\$2,339
6						
Reduction Begins	\$3,023	\$3,603	\$2,359	\$2,649	\$2,405	\$1,050
Payment Stops	\$4,181	\$4,761	\$2,938	\$3,228	\$3,563	\$2,629

Individual FBR \$579

Couple FBR \$869

Ineligible Child Allocation B \$290

All rates assume an Fla of A or C, that all children have no income, and only one eligible child is in the household. The chart does not apply when there is a combination of earned and unearned income. REDUCTION BEGINS when income exceeds amounts shown. PAYMENT STOPS with amounts shown. Reference: SI 01320ff

Sixth Circuit Publishes Favorable Case From Michigan

Wilson v Commissioner, 378 F.3d. 541 (6th. Cir. 2004) - This case has some good language on several issues common to all Social Security claims. There is language regarding the treating source rule under 404.1527(d)(2) and the common defense of "harmless error."

The Court did not buy the Defendant's argument as well as the District Court's ruling that failing to give good rationale for rejecting the treating doctor's opinion amounted to no more than "harmless error." The District Court arrived at the "harmless error" rationale by arguing that there was sufficient evidence in the record for the ALJ to discount the treating source's opinion.

It is very common practice for the Defendant to step into the shoes of the ALJ and argue *Post Hoc* that regardless of the procedural error, the claimant would lose anyway due to the substantial evidence standard. In strong language, the Sixth Circuit stated that arguing substantial evidence as a defense for failure to comply with the Commissioner's regulations "would afford the Commissioner the ability to violate the regulations with impunity and render the protections promised therein illusory." The Sixth Circuit also quoted the Administrative Procedures Act under 5 USC §706(2)(D) that the reviewing Court can set aside the agency action where it was found that procedures required by law were not followed.

The Court clarified however that in order to remand a case for an agency's violations, the Plaintiff must show that the claimant has been prejudiced on the merits of the case or deprived substantial rights because of the agency's procedural lapses. The Court found the treating source rule under 404.1527 is a substantial right bestowed on Claimants rather than an agency rule that gives the adjudicator *discretion* in following that rule.

In this case there is also some disturbing language on a transferrable skills issue that was used as an alternate

argument. Basically the Sixth Circuit, although acknowledging the ruling under SSR 82-41, which requires transferable skills to be identified, ruled that this regulation "does not explicitly mandate the enumeration of transferable skills at Step 5." This is an incorrect interpretation of the clear language in the ruling but it amounts to dicta as the Court had already ruled and remanded on the merits of the principle issue in the case.

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SOCIAL SECURITY SECTION MEETINGS

Friday, February 18, 2005 Understanding SSI
Qualifying and
Disqualifying Rules

Friday, June 3, 2005 Topic to be announced

*Separate registration cards will be sent with time
and particulars for each meeting.*

SBM

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