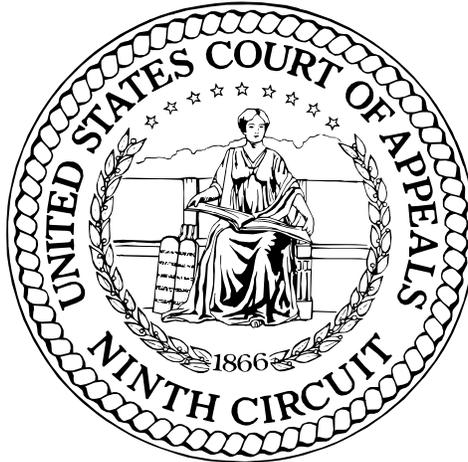


SOCIAL SECURITY OUTLINE



Updated 2023

Office of Staff Attorneys
United States Court of Appeals
for the Ninth Circuit

*This outline is intended as a starting point for research.
It is not an authoritative statement of the law in the Ninth Circuit and
may not be cited to or by the courts of this circuit.*

Please send corrections and comments to
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Acknowledgment

The outline was originally written by Dennis J. Hanna in July 2000. It is updated by the Office of Staff Attorneys and the Ninth Circuit Court Librarians.

Introduction

This outline summarizes procedural and substantive principles relating to Social Security law in the Ninth Circuit. General citations are provided, with the expectation that you will read the cited case law, code sections, and regulations, and will find more specific, relevant, and current citations through independent research.

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I. Two Programs: Social Security & Supplemental Security Income

A. Social Security Program

The Social Security Program is financed by a system of contributory social insurance, whereby employees, employers, and the self-employed contribute to special trust funds. The program provides monthly benefits to retired and disabled workers. For benefits to be paid, a worker must have sufficient earnings in covered employment to gain insured status. A worker's benefit amount is related to covered earnings averaged over a working lifetime. Monthly benefits are payable to a retired worker at age 62 or to a disabled worker at any age.

Benefits are also available for workers' eligible dependents (spouses and children) and survivors. These auxiliary and survivor beneficiaries must generally meet an age, a disability, or a childcare requirement. Amounts for auxiliaries and survivors are based on a percentage of the worker's benefit.

1. Social Security Disability Insurance Benefits

This benefit is also referred to as "DI," "DIB," "SSDI," "SSDIB," or "Title II benefits." Disability Insurance Benefits are available to individuals who have worked in recent years (five out of the last 10 years in most cases) who are now disabled. Because this is not a "needs-based" benefit, it is paid regardless of a claimant's income or assets. Benefits are paid based upon an individual's Social Security earnings record. *See* 42 U.S.C. §§ 401–33; 20 C.F.R. §§ 401–404.2127. "A claimant can qualify for SSDI only if her disability begins by her date last insured, and these benefits can be paid for up to 12 months before her application was filed." *Wellington v. Berryhill*, 878 F.3d 867, 872 (9th Cir. 2017).

There are also two other types of Social Security disability insurance benefits: Disabled Widow's and Widower's Benefits and Disabled Adult Child Benefits.

a. Disabled Widow's and Widower's Benefits

Disabled Widow's and Widower's Benefits are available to individuals who are at least 50 and become disabled within a certain amount of time after the death of their husband or wife. The late husband or wife must have worked enough under Social Security to be insured. *See generally* 42 U.S.C. § 402.

b. Disabled Adult Child Benefits

Disabled Adult Child Benefits are available to the children of persons who are deceased or who are drawing Social Security disability or retirement benefits. The child must have become disabled before age 22. *See generally* [42 U.S.C. § 402](#).

B. Supplemental Security Income Program

The Supplemental Security Income (“SSI”) Program is financed out of general revenues and provides a national program with uniform payment standards and eligibility requirements for the aged, blind, and disabled with limited income and resources. Because SSI is a “needs-based” program, it does not matter for SSI whether an individual has worked in the past or not. The Federal SSI payment is determined by the recipient’s income, living arrangement, and marital status. A state may supplement the payment levels of all or selected categories of recipients. States may choose to administer these supplemental payments or have Social Security administer payments on their behalf.

1. Supplemental Security Income Disability Insurance

This benefit is also referred to as “SSI,” “SSIDI,” or “Title XVI benefits.” Supplemental Security Income disability insurance benefits are available to individuals who are disabled and meet certain income and asset limits. *See* [42 U.S.C. §§ 1381–83f](#); [20 C.F.R. §§ 416.101–416.2227](#). “[A] claimant is eligible for SSI once she becomes disabled, but she cannot receive benefits for any period before her application date.” *Wellington*, [878 F.3d at 872](#).

II. Exhaustion of Administrative Remedies

All claimants must exhaust the administrative remedies set forth in [42 U.S.C. § 405\(g\)](#) to invoke the district court’s jurisdiction. *See Bass v. Soc. Sec. Admin.*, [872 F.2d 832, 833 \(9th Cir. 1989\)](#) (per curiam); *see also Shaibi v. Berryhill*, [883 F.3d 1102, 1109 \(9th Cir. 2017\)](#) (amended Feb. 28, 2018) (holding that “when a claimant fails entirely to challenge a vocational expert’s job numbers during administrative proceedings before the agency, the claimant forfeits such a challenge on appeal [in the district court], at least when that claimant is represented by counsel”). “Section 405(g) provides that a civil action may be brought only after (1) the claimant has been party to a hearing held by the Secretary, and (2) the Secretary has made a final decision on the claim.” *Bass*, [872 F.3d at 833](#). A decision is “not final until the Appeals Council denies review or, if it accepts a

case for review, issues its own findings on the merits.” *Brewes v. Comm’r of Soc. Sec. Admin.*, 682 F.3d 1157, 1162 (9th Cir. 2012). *See also Sims v. Apfel*, 530 U.S. 103, 106–07 (2000) (“SSA regulations provide that, if the Appeals Council grants review of a claim, then the decision that the Council issues is the Commissioner’s final decision. But if, . . . , the Council denies the request for review, the ALJ’s opinion becomes the final decision.”); *Luther v. Berryhill*, 891 F.3d 872, 876 (9th Cir. 2018) (ALJ’s decision became final decision of the Commissioner when Appeals Council denied request for review).

A. Application for Disability Benefits

A disability examiner at the state disability determination agency, working with a doctor, makes the initial decision on a claimant’s application. The disability examiner may request more information from the claimant, including additional medical reports and/or tests and evaluations. *See* 20 C.F.R. §§ 404.900(a)(1), 404.902–06, 404.1503, 416.903, 416.1400(a)(1), 416.1402–06.

B. Reconsideration

If the agency denies the claim initially, within 60 days after receiving notice of this determination the claimant may request “reconsideration” of the denial. The case is then sent to a different disability examiner, in the same state disability determination agency, for a new decision. Again, the examiner may request more information. The claimant also may submit additional materials. *See* 20 C.F.R. §§ 404.900(a)(2), 404.907–22, 416.1400(a)(2), 416.1407–22.

C. Hearing

If the agency denies the claim at reconsideration, within 60 days after receiving notice of this denial the claimant may request a hearing, and the case is sent to an Administrative Law Judge (“ALJ”) who works for the Social Security Administration. The ALJ makes an independent decision on the claim. This is the only level at which the claimant and the decision maker see each other. The hearings are fairly informal, and in general, the claimant will appear by video teleconferencing, in person, or in limited circumstances by telephone. The only people likely to be there are the ALJ, a hearing assistant (to record or type a record of the proceedings), the claimant, the claimant’s attorney or other representative (if the claimant is represented), and any witnesses the claimant wishes to have testify. Claimants may also submit additional evidence prior to or at the hearing. In some cases, the ALJ also has a medical doctor or vocational expert present to testify at the hearing. This is not supposed to be an adversarial hearing; there is no attorney

advocating on behalf of the Social Security Administration. Many claimants, however, retain an attorney or other representative. The ALJ issues a written decision after the hearing that is mailed to the claimant. *See* 20 C.F.R. §§ 404.900(a)(3), 404.929–61, 416.1400(a)(3), 416.1429–61.

D. Appeals Council

If the ALJ denies the claim, within 60 days after receiving notice of this denial the claimant may request review by the Appeals Council, which is located in Falls Church, Virginia. The Appeals Council usually reviews a case based on the written documents in the file. The claimant, or the claimant’s attorney, can submit a brief to the Council. Rarely does the Council grant requests for hearings. If the Appeals Council determines there might be merit to a claim, it normally remands the case to the ALJ to hold a new hearing in consideration of its written decision. *See* 20 C.F.R. §§ 404.900(a)(4), 404.966–82, 416.1400(a)(4), 416.1466–82.

E. Federal Court

If the Appeals Council denies review of the ALJ’s decision, within 60 days after receiving notice of this denial the claimant can file an action in United States District Court, requesting review of the Social Security Administration’s decision. If the claimant loses in District Court, they can appeal that decision to the Circuit Court of Appeals. If the claimant loses on appeal, he or she can petition for certiorari to the United States Supreme Court. *See* 42 U.S.C. § 405(g); 20 C.F.R. §§ 404.900(a)(5), 416.1400(a)(5).

III. The ALJ’s Disability Determination

A. Disability Defined

For purposes of social security disability insurance benefits, disability is defined as the “inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months.” 42 U.S.C. § 423(d)(1)(A); *see also* 42 U.S.C. § 1382c(a)(3)(A) (nearly identical standard for SSI); *Beltran v. Astrue*, 700 F.3d 386, 388–89 (9th Cir. 2012) (defining disability and reversing district court’s grant of summary judgment to the Commissioner); *Ludwig v. Astrue*, 681 F.3d 1047, 1048 n.1 (9th Cir. 2012) (defining disability and affirming denial of application for disability insurance benefits); *Ukolov v. Barnhart*, 420 F.3d 1002, 1004–05 (9th

Cir. 2005) (considering whether claimant established the existence of a medically determinable impairment).

B. Insured Status

To qualify for social security disability insurance benefits (*not* SSI disability Title XVI benefits), a claimant must be fully insured and have at least twenty quarters of coverage in the forty-quarter period which ends with the quarter in which the disability occurred. *See* 42 U.S.C. §§ 416(i)(3), 423(c)(1); 20 C.F.R. § 404.130(b). The requirement for disability insured status is sometimes referred to as the “currently insured” or “special insured” status requirement and has become known as the “20/40” requirement. The termination of a claimant’s insured status is frequently referred to as the “date last insured” or “DLI.”

See also Chapman v. Apfel, 236 F.3d 480, 482 (9th Cir. 2000) (addressing issue of whether claimant established that they had insured status); *Harvell v. Chater*, 87 F.3d 371, 372 (9th Cir. 1996) (per curiam).

C. ALJ’s Duty to Consider the Evidence and Develop the Record

The ALJ will consider all evidence in the claimant’s case record when making a disability determination. 20 C.F.R. §§ 404.1520(a)(3); 416.920(a)(3). “The ALJ is responsible for studying the record and resolving any conflicts or ambiguities in it.” *Diedrich v. Berryhill*, 874 F.3d 634, 638 (9th Cir. 2017). *See also Wellington*, 878 F.3d at 872. Under the “significant probative evidence” standard, an ALJ is not required to discuss all evidence presented, but “must explain why significant probative evidence has been rejected.” *Kilpatrick v. Kijakazi*, 35 F.4th 1187, 1193 (9th Cir. 2022) (quoting *Vincent ex rel. Vincent v. Heckler*, 739 F.2d 1393, 1394-95 (9th Cir. 1984)).

“The ALJ has a duty to develop the record ... even when the claimant is represented by counsel.” *DeLorme v. Sullivan*, 924 F.2d 841, 849 (9th Cir. 1991); *see also Garcia v. Comm’r of Soc. Sec.*, 768 F.3d 925, 930 (9th Cir. 2014) (holding the ALJ’s failure to develop the record to include a complete set of IQ scores was legal error). When a claimant is not represented by counsel, “it is incumbent upon the ALJ to scrupulously and conscientiously probe into, inquire of, and explore for all the relevant facts.” *Higbee v. Sullivan*, 975 F.2d 558, 561 (9th Cir. 1992) (per curiam) (quoting *Cox v. Califano*, 587 F.2d 988, 991 (9th Cir. 1978)); *see also Celaya v. Halter*, 332 F.3d 1177, 1183 (9th Cir. 2003). “If the ALJ thought he needed to know the basis of [a doctor’s] opinions in order to evaluate them, he had a duty to conduct an appropriate inquiry, for example, by subpoenaing the

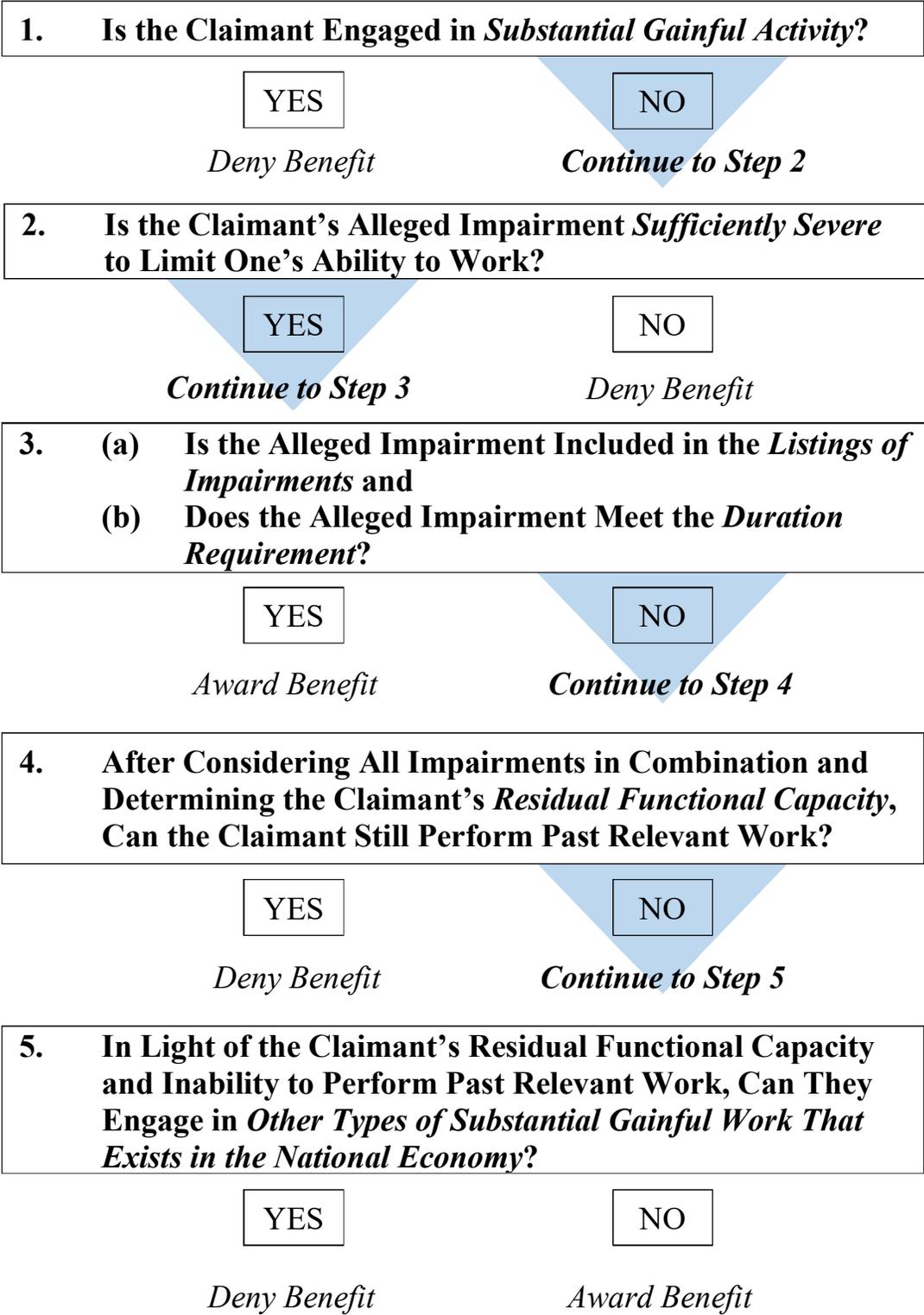
physicians or submitting further questions to them.” *Smolen v. Chater*, 80 F.3d 1273, 1288 (9th Cir. 1996); *see also* *Diedrich*, 874 F.3d at 639 (holding “that the Commissioner erred by not calling a medical advisor at the hearing to help determine the precise onset date of Diedrich’s disability under these circumstances—that is, where there are large gaps in the medical records documenting a slowly progressive impairment and an ALJ’s assessment of the disability onset date would be mere speculation without the aid of a medical expert”); *McLeod v. Astrue*, 640 F.3d 881, 885 (9th Cir. 2011) (as amended) (“A specific finding of ambiguity or inadequacy of the record is not necessary to trigger this duty to inquire, where the record establishes ambiguity or inadequacy.”); *Tonapetyan v. Halter*, 242 F.3d 1144, 1150 (9th Cir. 2001); *Tidwell v. Apfel*, 161 F.3d 599, 602 (9th Cir. 1999) (as amended); *Armstrong v. Comm’r of Soc. Sec. Admin.*, 160 F.3d 587, 589–90 (9th Cir. 1998) (holding that where the record is ambiguous as to the onset date of disability, the ALJ must call a medical expert to aid in determining the onset date). *Cf.* *Wellington*, 878 F.3d at 876 (“Because the record was adequate even before Wellington saw a mental health specialist and no reasonable medical expert could have inferred that her disability began before May 2010, we conclude that SSR 83-20 did not require the ALJ to consult a medical advisor before determining Wellington’s disability onset date.”).

D. Disability Determination (The Five-Step Sequential Evaluation)

The Commissioner is governed by a five-step sequential evaluation process for determining whether a plaintiff is disabled. *See* 20 C.F.R. §§ 404.1520, 416.920; *see also* *Maxwell v. Saul*, 971 F.3d 1128, 1130 & n.2 (9th Cir. 2020). In steps one through four, the burden is on the claimant to demonstrate a severe impairment and an inability to perform past work. At step five, if there has not yet been a determination, the burden shifts to the Commissioner to demonstrate the claimant is not disabled. *See* *Kilpatrick*, 35 F.4th at 1191; *Maxwell*, 971 F.3d at 1130 n.2; *Ford v. Saul*, 950 F.3d 1141, 1148–49 (9th Cir. 2020); *Valentine v. Comm’r of Soc. Sec. Admin.*, 574 F.3d 685, 689 (9th Cir. 2009) (“To establish eligibility for Social Security disability benefits, a claimant has the burden to prove he is disabled[,]” however the burden shifts to the Commissioner at step five to show that claimant can do other kinds of work); *Bray v. Comm’r of Soc. Sec. Admin.*, 554 F.3d 1219, 1222 (9th Cir. 2009).

Below is a graphic representation of this five-step process.

Social Security Disability Determinations: Five-Step Sequential Evaluation



1. Whether the Claimant is Engaged in *Substantial Gainful Activity*.

The first step involves a determination of whether the claimant has worked since filing for benefits and whether the work is substantial gainful activity. If the claimant has engaged in substantial gainful activity, then the claimant cannot be found to be disabled, regardless of their medical condition, age, education, or work experience. *See* 20 C.F.R. §§ 404.1520(b), 416.920(b). The activity must be both substantial and gainful. *See* 20 C.F.R. §§ 404.1572, 416.972. If the claimant has not engaged in substantial gainful activity, the ALJ then proceeds to step two.

a. Gainfulness; Amount of Compensation

“Gainful work activity is work activity that you do for pay or profit. Work activity is gainful if it is the kind of work usually done for pay or profit, whether or not a profit is realized.” 20 C.F.R. §§ 404.1572(b), 416.972(b). If the claimant has earned *less* than a certain minimum amount then the ALJ will generally conclude that the claimant has not engaged in substantial gainful activity. *See* 20 C.F.R. §§ 404.1574(b)(3), 416.974(b)(3). If, however, the claimant has earned *more* than that minimum amount, the ALJ will generally conclude the claimant has engaged in substantial gainful activity. *See* 20 C.F.R. §§ 404.1574(b)(2), 416.974(b)(2).

The ALJ generally considers other information in addition to the claimant’s earnings if evidence suggests that the claimant is engaging in substantial gainful activity or that the claimant controls the amount and time of wage payment. This other information includes whether the claimant’s work compares to that of unimpaired people in the same or similar occupations — taking into account the time, energy, skill, and responsibility involved in the work. The ALJ also determines if the claimant clearly does not receive compensation equal to the value of the work, according to the pay scales in the local community. *See* 20 C.F.R. §§ 404.1574(b)(3)(ii), 416.974(b)(3)(ii).

b. Substantiality of the Activity

“Substantial work activity is work activity that involves doing significant physical or mental activities. ... [W]ork may be substantial even if it is done on a part-time basis or if you do less, get paid less, or have less responsibility than when you worked before.” 20 C.F.R. §§ 404.1572(a), 416.972(a). The factors considered by the ALJ include the time spent working, quality of a person’s performance, special working conditions, and the possibility of self-employment. *See Keyes v. Sullivan*, 894 F.2d 1053, 1056 (9th Cir. 1990); *see also* 20 C.F.R.

§§ 404.1573, 416.973. The amount of time spent working is only one factor considered in determining substantial gainful activity; the ALJ may find part-time work substantial. *See Keyes*, 894 F.2d at 1056; *see also* 20 C.F.R. §§ 404.1572(a), 416.972(a); *Katz v. Sec’y of Health & Human Servs.*, 972 F.2d 290, 292–94 (9th Cir. 1992) (the plaintiff’s testimony that she was “extremely slow,” often made mistakes, and needed help from co-workers was insufficient to rebut the presumption of substantial gainful activity where plaintiff worked 20 hours per week, work was worth amount paid, and the modifications made by the employer were relatively minor).

This court has held that “substantial gainful activity means more than merely the ability to find a job and physically perform it; it also requires the ability to hold the job for a significant period of time.” *Gatliff v. Comm’r of Soc. Sec. Admin.*, 172 F.3d 690, 694 (9th Cir. 1999) (claimant’s 15 years of working in jobs generally lasting no more than two months did not amount to substantial gainful activity).

c. Trial Work Period

A claimant for disability insurance benefits (*not* SSI disability Title XVI benefits) is entitled to a trial work period of up to nine months during a five-year period “during which [they] may test [their] ability to work and still be considered disabled.” 20 C.F.R. § 404.1592; *see also* 42 U.S.C. § 422(c).

2. Whether the Claimant’s Alleged Impairment is Sufficiently Severe to Limit One’s Ability to Work.

“Step two is ... a threshold determination meant to screen out weak claims.” *Buck v. Berryhill*, 869 F.3d 1040, 1048 (9th Cir. 2017); *see also Webb v. Barnhart*, 433 F.3d 683, 687 (9th Cir. 2005) (“Step two, then, is a de minimis screening device [used] to dispose of groundless claims” (internal quotation marks and citation omitted)). Claimants must have a severe impairment, or combination of impairments, significantly limiting their physical or mental ability to do basic work activities, or they are found not disabled. *See* 20 C.F.R. §§ 404.1520(c), 416.920(c). In making this determination, the ALJ does not consider a claimant’s age, education, and work experience. *See* 20 C.F.R. §§ 404.1520(c), 416.920(c). *See also Bowen v. Yuckert*, 482 U.S. 137, 148 (1987). If the impairment is severe, the ALJ then proceeds to step three. Step two “is not meant to identify the impairments that should be taken into account when determining the [residual functional capacity].” *Buck*, 869 F.3d at 1048–49.

In general, the claimant must prove the physical or mental impairment by providing relevant evidence. *See* 20 C.F.R. §§ 404.1512(a); 416.912(a). Note the regulations regarding the evaluation of medical evidence were revised effective March 27, 2017. The revised regulations apply to claims filed on or after March 27, 2017.

Categories of evidence include objective medical evidence, medical opinions, other medical evidence, evidence from nonmedical sources, and prior administrative medical findings. *See* 20 C.F.R. §§ 404.1513; 416.913. Evidence is considered pursuant to 20 C.F.R. §§ 404.1520b, 404.1520c, 416.920b, 416.920c, or under §§ 404.1527, 416.927 for claims filed before March 27, 2017. 20 C.F.R. §§ 404.1513(a), 416.913(a). Evidence is evaluated according to the rules pertaining to the relevant category of evidence. *Id.*

An impairment or combination of impairments can be found “not severe” only if the medical evidence clearly establishes a slight abnormality that has “no more than a minimal effect on an individual’s ability to work.” SSR 85-28, 1985 WL 56856 at *3 (1985) (Program Policy Statement; Titles II and XVI: Medical Impairments That Are Not Severe).¹ *See also Webb*, 433 F.3d at 686; *Smolen*, 80 F.3d at 1290 ; *Yuckert v. Bowen*, 841 F.2d 303, 306 (9th Cir. 1988) (adopting SSR 85-28).

¹ Social Security Rulings are available on Westlaw. While lacking the force of law, these rulings constitute the Social Security Administration’s official interpretations of the statute it administers and of its own regulations. *See Wellington*, 878 F.3d at 872 ; *Molina v. Astrue*, 674 F.3d 1104, 1114 n.5 (9th Cir. 2012); *Bray*, 554 F.3d at 1224; *Quang Van Han v. Bowen*, 882 F.2d 1453, 1457 & n.6 (9th Cir. 1989); *see also* 20 C.F.R. § 402.35(b)(1). Social Security Rulings are entitled to some deference as long as consistent with the Social Security Act and regulations. *See Diedrich*, 874 F.3d at 638; *Bray*, 554 F.3d at 1224 (concluding that ALJ erred in disregarding SSR 82-41); *Massachi v. Astrue*, 486 F.3d 1149, 1152 n.6 (9th Cir. 2007). These rulings are binding on ALJs. *See Molina*, 674 F.3d at 1114 n.5; *Bray*, 554 F.3d at 1224; *Quang Van Han*, 882 F.2d at 1457 n.6; *Paulson v. Bowen*, 836 F.2d 1249, 1252 n.2 (9th Cir. 1988).

A determination that an impairment(s) is not severe requires a careful evaluation of the medical findings which describe the impairment(s) and an informed judgment about its (their) limiting effects on the individual's physical and mental ability(ies) to perform basic work activities; thus, an assessment of function is inherent in the medical evaluation process itself.

[SSR 85-28, 1985 WL 56856](#) at *4. Basic work activities are defined as the abilities and aptitudes necessary to do most jobs, such as (1) walking, standing, sitting, lifting, pushing, pulling, reaching, carrying, or handling; (2) seeing, hearing, and speaking; (3) understanding, carrying out, and remembering simple instructions; (4) use of judgment; (5) responding appropriately to supervision, co-workers and usual work situations; and (6) dealing with changes in a routine work setting. *See* [20 C.F.R. §§ 404.1522, 416.922](#).

a. Combined Effect of Multiple Impairments

It is important at this step for the ALJ to consider the combined effect of all of the claimant's impairments on their ability to function, without regard to whether each alone is sufficiently severe. *See* [Smolen, 80 F.3d at 1289–90](#) ; *see also* [42 U.S.C. § 423\(d\)\(2\)\(B\)](#); [20 C.F.R. §§ 404.1523, 416.923](#); [Vasquez v. Astrue, 572 F.3d 586, 594–97 \(9th Cir. 2009\)](#) (citing [20 C.F.R. § 404.1523](#) when concluding that ALJ did not account for mental impairments when determining RFC).

b. Evaluations of Allegations of Pain

The ALJ considers all of claimant's statements about their symptoms, "such as pain, and any description [claimant's] medical sources or nonmedical sources may provide about how the symptoms affect [claimant's] activities of daily living and [claimant's] ability to work." [20 C.F.R. §§ 404.1529\(a\), 416.929\(a\)](#).

However, statements about [claimant's] pain or other symptoms will not alone establish that [claimant is] disabled. There must be objective medical evidence from an acceptable medical source that shows [claimant has] a medical impairment(s) which could reasonably be expected to produce the pain or other symptoms alleged and that, when considered with all of the other evidence (including statements about the intensity and persistence of [claimant's] pain or other symptoms which may reasonably be accepted as consistent with the medical signs

and laboratory findings), would lead to a conclusion that [claimant is] disabled.

Id.

The ALJ evaluates the intensity and persistence of a claimant's symptoms, including pain, considering all available evidence, including medical history, the medical signs, and laboratory findings and statements. *See id.* The ALJ then determines the extent to which the alleged functional limitations and restrictions due to pain or other symptoms can reasonably be accepted as consistent with the medical signs, laboratory findings, and other evidence, and decides how these symptoms affect the claimant's ability to work. *See id.*

Once the claimant has produced medical evidence of an underlying impairment which is reasonably likely to be the cause of the alleged pain, medical findings are not required to support the alleged severity of pain. *See Bunnell v. Sullivan*, 947 F.2d 341, 343 (9th Cir. 1991) (en banc); *see also Berry v. Astrue*, 622 F.3d 1228, 1234 (9th Cir. 2010); *Bray*, 554 F.3d at 1227 (concurrency); *Lingenfelter v. Astrue*, 504 F.3d 1028, 1036 (9th Cir. 2007); SSR 16-3p, 2017 WL 5180304 (2017) (Titles II & XVI: Evaluation of Symptoms in Disability Claims); SSR 96-3p, 1996 WL 374181 (1996) (Policy Interpretation Ruling Titles II and XVI: Considering Allegations of Pain and Other Symptoms in Determining Whether a Medically Determinable Impairment is Severe).

3. Whether the Alleged Impairment (1) is Included in the Listings of Impairments and (2) Meets the Duration Requirement.

At the third step, the ALJ also considers the severity of the claimant's impairment and awards benefits to the most severely impaired claimants. A claimant with an impairment which (1) meets or equals an impairment listed in Appendix I and (2) meets the duration requirement will be found disabled. *See 20 C.F.R. §§ 404.1520(d), 416.920(d)*. In making this determination, the ALJ does not consider a claimant's age, education, and work experience. *See id.* If the claimant does not satisfy the test, the ALJ then proceeds to step four.

a. The Listing of Impairments

The ALJ must determine whether a claimant's impairment meets or equals an impairment listed in the "Listing of Impairments" ("the Listings"). *See 20 C.F.R. Part 404, Subpt. P, App. 1*. The Listings describe specific impairments of each of the major body systems which are considered "severe enough to prevent a

person from doing any gainful activity, regardless of his or her age, education, or work experience.” See 20 C.F.R. §§ 404.1525(a), 416.925(a). Most of these impairments are “permanent or expected to result in death.” 20 C.F.R. §§ 404.1525(c)(4), 416.925(c)(4). For some impairments, the evidence must show that the impairment has lasted for a specific time period. *Id.* “For all others, the evidence must show that [the impairment] has lasted or can be expected to last for a continuous period of at least 12 months.” *Id.* If a claimant’s impairment meets or equals a listed impairment, they will be found disabled at step three without further inquiry. See 20 C.F.R. §§ 404.1520(d), 416.920(d).

The Listings describe the “the objective medical and other findings needed to satisfy the criteria of that listing.” See 20 C.F.R. §§ 404.1525(c)(3), 416.925(c)(3). A mere diagnosis is insufficient to meet or equal a listed impairment. See 20 C.F.R. §§ 404.1525(d), 416.925(d). To meet a listed impairment, a claimant must establish that the claimant “satisfies all of the criteria of that listing, including any relevant criteria in the introduction, and meets the duration requirement.” 20 C.F.R. §§ 404.1525(c)(3), 416.925(c)(3). “An impairment that manifests only some of those criteria, no matter how severely, does not qualify.” *Ford*, 950 F.3d at 1148 (internal quotation marks and citation omitted). To equal a listed impairment, a claimant must establish symptoms, signs, and laboratory findings “at least equal in severity and duration” to the characteristics of a relevant listed impairment. If a claimant’s impairment is not listed, then the impairment will be compared to listings that are “closely analogous” to the claimant’s impairment. See generally 20 C.F.R. §§ 404.1526, 416.926 (explaining medical equivalence). See also *Ford*, 950 F.3d at 1148 (“If an impairment does not meet a listing, it may nevertheless be ‘medically equivalent to a listed impairment’ if the claimant’s ‘symptoms, signs, and laboratory findings are at least equal in severity to’ those of a listed impairment.” (citing 20 C.F.R. 404.1529(d)(3))).

b. Multiple Impairments

If a claimant suffers from multiple impairments and none of them individually meet or equal a listed impairment, the collective findings of the claimant’s impairments will be evaluated to determine whether they meet or equal the characteristics of any relevant listed impairment. See 20 C.F.R. §§ 404.1526(b)(3), 416.926(b)(3); see also *Marcia v. Sullivan*, 900 F.2d 172, 176 (9th Cir. 1990). “An ALJ is not required to discuss the combined effects of a claimant’s impairments or compare them to any listing in an equivalency

determination, unless the claimant presents evidence in an effort to establish equivalence.” See *Burch v. Barnhart*, 400 F.3d 676, 683 (9th Cir. 2005).

c. Duration Requirement

The ALJ determines whether a claimant’s alleged impairment meets the 12-month duration requirement. See 42 U.S.C. §§ 423(d)(1)(A), 416(i)(1), 1382c(a)(3)(A); 20 C.F.R. §§ 404.1505, 416.905, 404.1509, 416.909. Each individual impairment must meet the duration requirement; the ALJ will not combine the duration of unrelated impairments to satisfy the duration requirement. See 20 C.F.R. §§ 404.1523, 416.923. Multiple impairments being considered together to meet a single impairment on the Listings must together meet the duration requirement. *Id.*

Most of the listed impairments are permanent or expected to result in death. For some listings, we state a specific period of time for which [the] impairment[] will meet the listing. For all others, the evidence must show that [the] impairment[] has lasted or can be expected to last for a continuous period of at least 12 months.

20 C.F.R. §§ 404.1525(c)(4), 416.925(c)(4). Accordingly, a claimant can have a listed impairment without being presumptively disabled if the claimant’s impairment is not severe enough, or if the claimant has not had it for a long enough time. See *Young v. Sullivan*, 911 F.2d 180, 184 (9th Cir. 1990); see also *DeLorme*, 924 F.2d at 846–47 (“[A]n independent review of the record does not clearly demonstrate a twelve-month period during which DeLorme experienced a significant limitation of motion in the spine. Therefore, there is no twelve-month period in the record during which all the criteria in the Listing of Impairments are met.”).

4. Whether, After Considering All Impairments in Combination and Determining the Claimant’s *Residual Functional Capacity*, the Claimant Can Still Perform Past Relevant Work.

At the fourth step, the ALJ determines whether a claimant can perform their past relevant work. See 20 C.F.R. §§ 404.1520(f), 416.920(f); see also *Buck*, 869 F.3d at 1048 (describing the five-step analysis). The ALJ reviews a claimant’s residual functional capacity (“RFC”) and the physical and mental demands of the work they have previously performed. See 20 C.F.R. §§ 404.1520(f), 416.920(f); see also *Berry*, 622 F.3d at 1231.

The “RFC is an administrative assessment of the extent to which an individual’s medically determinable impairment(s), including any related symptoms, such as pain, may cause physical or mental limitations or restrictions that may affect his or her capacity to do work-related physical and mental activities.” SSR 96–8p, 61 Fed. Reg. 34474, 34475 (July 2, 1996).[] It “is the most [a claimant] can still do despite [their] limitations.” 20 C.F.R. § 416.945(a)(1).

Laborin v. Berryhill, 867 F.3d 1151, 1153 (9th Cir. 2017). “The ALJ assesses a claimant’s RFC based on all the relevant evidence in [the] case record.” *Id.* (quotation marks and citation omitted). If the ALJ determines the claimant has the RFC required to perform relevant past work, the claimant is found not disabled. See 20 C.F.R. §§ 404.1520(f), 416.920(f). If the claimant cannot perform relevant past work, the ALJ then proceeds to step five. See *Laborin*, 867 F.3d at 1153. “At step four, a claimant has the burden to prove that he cannot perform his past relevant work ‘either as actually performed or as generally performed in the national economy.’” *Stacy v. Colvin*, 825 F.3d 563, 569 (9th Cir. 2016) (quoting *Lewis v. Barnhart*, 281 F.3d 1081, 1083 (9th Cir. 2002)).

“An individual shall be determined to be under a disability only if his physical or mental impairment or impairments are of such severity that he is not only unable to do his previous work but cannot, considering his age, education, and work experience, engage in any other kind of substantial gainful work which exists in the national economy” 42 U.S.C. § 423(d)(2)(A); see also *Berry*, 622 F.3d at 1231 (“Generally, a claimant who is physically and mentally capable of performing past relevant work is not disabled, whether or not he could actually obtain employment.”).

At step four, the ALJ may consider any of the claimant’s daily activities that “may be seen as inconsistent with the presence of a condition which would preclude all work activity.” *Curry v. Sullivan*, 925 F.2d 1127, 1130 (9th Cir. 1990) (upholding denial of disability benefits where claimant could “take care of her personal needs, prepare easy meals, do light housework, and shop for some groceries”); see also *Burch*, 400 F.3d at 681 (upholding ALJ’s decision to deny benefits that was based, in part, on determining claimant performed daily activities that were transferable to a work setting). The ALJ also notes any of the claimant’s daily activities that “involv[e] the performance of physical functions that are transferable to a work setting.” *Orn v. Astrue*, 495 F.3d 625, 639 (9th Cir. 2007) (quoting *Fair v. Bowen*, 885 F.2d 597, 603 (9th Cir. 1989) and concluding that claimant’s activities were not transferable to a work setting); see also *Reddick v.*

Chater, 157 F.3d 715, 722 (9th Cir. 1998) (noting that a claimant should not be “penalized for attempting to lead [a] normal [life] in the face of [their] limitations”); *Fair*, 885 F.2d at 603 (noting that a claimant is not required to be totally disabled to be eligible for benefits and that “many home activities are not easily transferable to what may be the more grueling environment of the workplace, where it might be impossible to periodically rest or take medication”).

a. Past Relevant Work

Work that a claimant performed within the last 15 years, which lasted long enough for them to learn to do it, and was substantial gainful activity, is considered past relevant work. See 20 C.F.R. §§ 404.1565(a), 416.965(a). An ALJ will frequently consult the *Dictionary of Occupational Titles* to determine the physical and mental demands of a claimant’s former work. See SSR 82-62, 1982 WL 31386 (1982) (Program Policy Statement; Titles II and XVI: A Disability Claimant’s Capacity to do Past Relevant Work, In General). The ALJ must make findings as to the physical and mental demands and the stress of the past work; these findings must be based on adequate documentation. See *id.*

b. Residual Functional Capacity

Simply stated, a claimant’s residual functional capacity (“RFC”) assessment is a determination of what the claimant can still do despite their physical, mental and other limitations. See 20 C.F.R. §§ 404.1545(a), 416.945(a). See also *Laborin*, 867 F.3d at 1153 (explaining that the RFC is the most a claimant can still do despite their limitations). Social Security regulations describe RFC as the “maximum degree to which the individual retains the capacity for sustained performance of the physical-mental requirements of jobs.” 20 C.F.R. Part 404, Subpt. P, App. 2, § 200.00(c).

In determining a claimant’s RFC, an ALJ must assess all the evidence (including the claimant’s and others’ descriptions of limitation, and medical reports) to determine what capacity the claimant has for work despite their impairment(s). See 20 C.F.R. §§ 404.1545(a), 416.945(a); *Laborin*, 867 F.3d at 1153. The ALJ considers a claimant’s ability to meet physical and mental demands, sensory requirements, and other functions. See 20 C.F.R. §§ 404.1545(b)–(d), 416.945(b)–(d).

“[I]n assessing RFC, the adjudicator must consider limitations and restrictions imposed by all of an individual’s impairments, even those that are not ‘severe.’” *Titles II & XVI: Assessing Residual Functional*

Capacity in Initial Claims, Social Security Ruling (“SSR”) 96-8p, 1996 WL 374184, at *5 (S.S.A. July 2, 1996). The RFC therefore *should* be exactly the same regardless of whether certain impairments are considered “severe” or not.

Buck, 869 F.3d at 1049.

The RFC assessment must “[c]ontain a thorough discussion and analysis of the objective medical and other evidence, *including the individual’s complaints of pain and other symptoms* and the adjudicator’s personal observations, if appropriate.” SSR 96–8p, 61 Fed. Reg. at 34478 (emphasis added). In other words, the ALJ must take “the claimant’s subjective experiences of pain” into account when determining the RFC. *Garrison v. Colvin*, 759 F.3d 995, 1011 (9th Cir. 2014).

Laborin, 867 F.3d at 1153.

It is claimant’s responsibility to inform the agency about and submit all evidence that relates to whether claimant is disabled. “This duty is ongoing and requires [claimant] to disclose any additional related evidence about which [claimant] becomes aware. This duty applies at each level of the administrative review process” 20 C.F.R. §§ 404.1512(a)(1), 416.912(a)(1); *see also* 20 C.F.R. §§ 404.1545(a)(3), 416.945(a)(3) (stating in general, claimant is “responsible for providing the evidence [used] to make a finding about ... residual functional capacity”). However, before the ALJ determines claimant is not disabled, the ALJ is responsible for developing claimant’s complete medical history, “including arranging for a consultative examination(s) if necessary, and making every reasonable effort to help [claimant] get medical reports from [claimant’s] own medical sources.” 20 C.F.R. §§ 404.1545(a)(3), 416.945(a)(3).

i. Mental Impairments

In evaluating the severity of mental impairments, a special procedure must be followed at each level of administrative review. *See* 20 C.F.R. §§ 404.1520a(a), 416.920a(a). First, the ALJ evaluates a claimant’s “pertinent symptoms, signs, and laboratory findings to determine whether [claimant has] a medically determinable mental impairment[.]” 20 C.F.R. §§ 404.1520a(b)(1), 416.920a(b)(1). The ALJ must also “specify the symptoms, signs, and laboratory findings that substantiate the presence of [each determined] impairment and document [the] findings” 20 C.F.R. §§ 404.1520a(b)(1), 416.920a(b)(1).

Next, the ALJ rates “the degree of functional limitation resulting from [claimant’s] impairment.” 20 C.F.R. §§ 404.1520a(b)(2), 416.920a(b)(2). Rating the degree of functional limitation is a highly individualized process that requires the ALJ to consider all relevant evidence to determine the extent to which a claimant’s impairment interferes with their “ability to function independently, appropriately, effectively, and on a sustained basis.” 20 C.F.R. §§ 404.1520a(c), 416.920a(c). There are four broad functional areas in which the ALJ will rate the degree of functional limitation: “Understand, remember, or apply information; interact with others; concentrate, persist, or maintain pace; and adapt or manage oneself.” *Id.* The ALJ rates the degree of limitation in each of the four areas using a five-point scale: “None, mild, moderate, marked, and extreme.” *Id.*; *see also Hoopai v. Astrue*, 499 F.3d 1071, 1077–78 (9th Cir. 2007) (“[T]he ALJ is required to rate the degree of functional limitations in four areas The ALJ clearly met this requirement by rating and assessing [claimant’s] limitations in each of these four functional areas. The ALJ was not required to make any more specific findings of the claimant’s functional limitations.”).

After determining the degree of functional limitation, the ALJ then determines the severity of the mental impairment. *See* 20 C.F.R. §§ 404.1520a(d), 416.920a(d). Lastly, the ALJ must provide the proper documentation. At the initial or reconsideration levels of the administrative review process, this involves the completion of a standard document to record how the administration applied the technique. *See* 20 C.F.R. §§ 404.1520a(e), 416.920a(e). The written decision of any later review must also “document application of the technique.” *See id.*

c. Ability to Return to Previous Work

A claimant has the ability to return to previous work if they can perform the “actual functional demands and job duties of a particular past relevant job” or “[t]he functional demands and job duties of the [past] occupation as generally required by employers throughout the national economy.” *Pinto v. Massanari*, 249 F.3d 840, 845 (9th Cir. 2001) (quoting SSR 82-61, 1982 WL 31387 (1981) (Titles II and XVI: Past Relevant Work – The Particular Job or the Occupation as Generally Performed)).

This inquiry as to whether a claimant may perform their past relevant work does not require the use of vocational testimony. *See Crane v. Shalala*, 76 F.3d 251, 255 (9th Cir. 1996). If a claimant has the residual functional capacity to do their previous work (the usual work or other applicable past work), the ALJ will

determine that the claimant is not disabled. See 20 C.F.R. §§ 404.1560(b)(3), 416.960(b)(3).

5. Whether the Claimant, in Light of Their Residual Functional Capacity and Inability to Perform Past Relevant Work, Can Engage in Other Types of Substantial Gainful Work That Exists in the National Economy.

At step five ... the ALJ considers the applicant's background and residual functional capacity, that is, what physical tasks the applicant can still perform despite their limitations, to decide if the applicant can make an adjustment to some other available job.

Gutierrez v. Colvin, 844 F.3d 804, 806 (9th Cir. 2016) (citing *Tackett v. Apfel*, 180 F.3d 1094, 1100 (9th Cir. 1999)). In addition to claimant's residual functional capacity, the ALJ will consider claimant's age, education, and work experience to determine if claimant can make an adjustment to other work. If claimant is able to make an adjustment to other work, the ALJ will find that claimant is not disabled. If claimant cannot make an adjustment to other work, the ALJ will find that claimant is disabled. 20 C.F.R. §§ 404.1520(g), 416.920(g).

At the fifth step, the burden shifts to the Social Security Administration to demonstrate that the claimant is not disabled and that they can engage in some type of substantial gainful activity that exists in "significant numbers" in the national economy. See *Kilpatrick*, 35 F.4th at 1192; *Ford*, 950 F.3d at 1149. "[T]he agency may meet its burden either '(1) by the testimony of a vocational expert, or (2) by reference to the Medical-Vocational Guidelines at 20 C.F.R. pt. 404, subpt. P, app. 2.'" *Maxwell*, 971 F.3d at 1130 & n.2 (quoting *Tackett*, 180 F.3d at 1099). See also *Zavalin v. Colvin*, 778 F.3d 842, 845 (9th Cir. 2015) ("At [step five], the Commissioner has the burden to identify specific jobs existing in substantial numbers in the national economy that [a] claimant can perform despite [their] identified limitations." (internal quotation marks and citation omitted)); *Lockwood v. Comm'r of Soc. Sec. Admin.*, 616 F.3d 1068, 1071 (9th Cir. 2010) (where claimant establishes that they suffer from a severe impairment that prevents them from doing past work, burden shifts to the Commissioner to show that they can perform some other work); *Valentine*, 574 F.3d at 689 (the burden shifts to Commissioner at step five to show the claimant can do other kinds of work).

The step five analysis includes a detailed assessment of the medical evidence, the claimant's daily activities, prior work record, any functional restrictions and limitations, medication, other treatment for relief of symptoms, and

information and observations by treating and examining physicians and third parties regarding the nature and extent of the claimant's symptoms. *See* 20 C.F.R. §§ 404.1529, 416.929. Credibility determinations are the province of the ALJ; however, the ALJ must make specific findings which support a conclusion that claimant's allegations of severity are not credible. *See Lingenfelter*, 504 F.3d at 1036; *Robbins v. Soc. Sec. Admin.*, 466 F.3d 880, 883 (9th Cir. 2006). *See also Ford*, 950 F.3d at 1149 (stating the ALJ is responsible for determining credibility, resolving conflicts in medical testimony, and for resolving ambiguities); *Dale v. Colvin*, 823 F.3d 941, 945 (9th Cir. 2016) (holding that at Step 5, the ALJ erred when he discounted another source's *entire* testimony because of inconsistency with evidence in the record, when the ALJ divided the testimony into distinct parts and determined that only one part of the testimony was inconsistent).

a. Medical-Vocational Guidelines (Grids)

The Medical-Vocational Guidelines are a matrix system for handling claims that involve substantially uniform levels of impairment. *See* 20 C.F.R. Part 404, Subpt. P, App. 2. These guidelines are commonly known as the grids or tables that give a finding of disabled or not disabled for various combinations of age, education, and work experience. The grids provide a uniform conclusion about the availability of jobs for all persons whose medical condition is categorized in the same way. *See id.* "The Grids were designed to relieve the Commissioner of the need to rely on a vocational expert in every case to establish the number of jobs available to a person with the claimant's physical ability, age, education, and work experience." *Barnes v. Berryhill*, 895 F.3d 702, 705 (9th Cir. 2018). *See generally Maxwell*, 971 F.3d at 1130-31 (discussing the grids).

The grids categorize jobs by their physical-exertional requirements and consist of three separate tables, one table for each category (sedentary work, light work, and medium work). *See* 20 C.F.R. Part 404, Subpt. P, App. 2, § 200.00. If a claimant is found able to work the full range of heavy work, this "generally is sufficient for a finding of not disabled . . ." 20 C.F.R. Part 404, Subpt. P, App. 2, § 204.00. Each grid presents various combinations of factors relevant to a claimant's ability to find work. The factors in the grids are the claimant's age, education, and work experience. For each combination of these factors, *e.g.*, fifty years old, limited education, and unskilled work experience, the grids direct a finding of either disabled or not disabled based on the number of jobs in the national economy in that category of physical-exertional requirements. *See* 20 C.F.R. Part 404, Subpt. P, App. 2, § 200.00. This approach allows the Commissioner to streamline the administrative process and encourages uniform

treatment of claims. See *Heckler v. Campbell*, 461 U.S. 458, 460–62 (1983) (discussing the creation and purpose of the grids). **NOTE:** As used in the grids, the word “do” means “ditto” or “same as above.”

“For purposes of applying the grids, there are three age categories: younger person (under age 50), person closely approaching advanced age (age 50–54), and person of advanced age (age 55 or older).” *Lockwood*, 616 F.3d at 1071. The ALJ is not required to use an older age category, even if the claimant is within a few days or a few months of reaching an older age category. *Id.* Rather, the regulations only require that the ALJ consider whether to use the older age category. *Id.*

i. Grids Not Appropriate for Non-Exertional Limitations

The grids may be used only where they “completely and accurately represent a claimant’s limitations.” *Tackett*, 180 F.3d at 1101 ; see *Lounsbury v. Barnhart*, 468 F.3d 1111, 1115 (9th Cir. 2006) (quoting *Tackett*, 180 F.3d at 1103); *Jones v. Heckler*, 760 F.2d 993, 998 (9th Cir. 1985). “Since the rules are predicated on an individual’s having an impairment which manifests itself by limitations in meeting the strength requirements of jobs, they may not be fully applicable where the nature of an individual’s impairment does not result in such limitations” 20 C.F.R. § Pt. 404, Subpt. P, App. 2; see also 20 C.F.R. §§ 404.1569a; 416.969a (“Limitations or restrictions which affect your ability to meet the demands of jobs other than the strength demands, that is, demands other than sitting, standing, walking, lifting, carrying, pushing or pulling, are considered nonexertional.”).

[N]ot all claimants fit neatly into the categories established by the Grids. In particular, each of the three Grid tables encompasses specific strength requirements, or “exertional limitations.” *Lounsbury v. Barnhart*, 468 F.3d 1111, 1115 (9th Cir. 2006). However, significant “non-exertional limitations” such as “pain, postural limitations, or environmental limitations” that do not result in strength limitations may “limit the claimant’s functional capacity in ways not contemplated by the guidelines.” *Tackett*, 180 F.3d at 1102. Reliance on the Grids alone will then be inappropriate.

Barnes, 895 F.3d at 706.

“Application of the grids is not discretionary” where the claimant suffers only exertional limitations. *Lounsbury*, 468 F.3d at 1115. If claimant’s

limitations are only exertional, the ALJ must apply the grids. *See id.* If claimant’s limitations are only non-exertional, “the grids are inappropriate, and the ALJ must rely on other evidence.” *Id.* If claimant’s limitations are both exertional and non-exertional, the “ALJ must consult the grids first.” *See id.* If the person “is ‘disabled’ under the grids, there is no need to examine the effect of the non-exertional limitations. But if the same person is not disabled under the grids, the non-exertional limitations must be examined separately.” *Id.* at 1116. *See also Desrosiers v. Sec’y of Health & Human Servs.*, 846 F.2d 573, 576–77 (9th Cir. 1988) (noting that a sufficiently severe, non-exertional impairment may limit a claimant’s functional capacity in ways not contemplated by the guidelines, rendering the guidelines inapplicable and noting that pain, postural limitations, or environmental limitations are examples of non-exertional limitations).

ii. Physical Exertion Requirements

The physical exertion requirements are commonly referred to and relied on. *See* 20 C.F.R. §§ 404.1567(a)–(e), 416.967(a)–(e).

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. *See* 20 C.F.R. §§ 404.1567(a), 416.967(a).

Light work involves lifting no more than 20 pounds at a time with frequent lifting or carrying of objects weighing up to 10 pounds. *See* 20 C.F.R. §§ 404.1567(b), 416.967(b).

Medium work involves lifting no more than 50 pounds at a time with frequent lifting or carrying of objects weighing up to 25 pounds. *See* 20 C.F.R. §§ 404.1567(c), 416.967(c).

Heavy work involves lifting no more than 100 pounds at a time with frequent lifting or carrying of objects weighing up to 50 pounds. *See* 20 C.F.R. §§ 404.1567(d), 416.967(d).

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. *See* 20 C.F.R. §§ 404.1567(e), 416.967(e).

b. Vocational Expert (“VE”)

In cases where the Guidelines are “not fully applicable,” the ALJ may meet their burden under step five by propounding to a vocational expert a hypothetical that is based on medical assumptions supported by substantial evidence in the record and that reflects all the claimant’s limitations. *See Roberts v. Shalala*, 66 F.3d 179, 184 (9th Cir. 1995); *Magallanes v. Bowen*, 881 F.2d 747, 756 (9th Cir. 1989); *see also Gutierrez*, 844 F.3d at 806–07 (“To aid in making this determination, the ALJ may rely on an impartial vocational expert to provide testimony about jobs the applicant can perform despite his or her limitations.”); *Valentine*, 574 F.3d at 690 (a hypothetical that fails to take into account a claimant’s limitations is defective); *Bray*, 554 F.3d at 1228–29; *Widmark v. Barnhart*, 454 F.3d 1063, 1069–70 (9th Cir. 2006). The ALJ’s depiction of the claimant’s impairments must be “accurate, detailed, and supported by the medical record.” *Tackett*, 180 F.3d at 1101. An ALJ posing a hypothetical question to a vocational expert “must include ‘all of the claimant’s functional limitations, both physical and mental’ supported by the record.” *Thomas v. Barnhart*, 278 F.3d 947, 956 (9th Cir. 2002) (quoting *Flores v. Shalala*, 49 F.3d 562, 570–71 (9th Cir. 1995)); *see also Valentine*, 574 F.3d at 690; *Magallanes*, 881 F.2d at 756; *but see Terry v. Saul*, 998 F.3d 1010, 1011–12 (9th Cir. 2021) (holding that the ALJ’s failure to include claimant’s standing and walking limitations in questioning the VE was not reversible error because “knowledge of the Social Security Administration’s longstanding interpretation of the term ‘medium work’ as requiring standing or walking for approximately six hours out of an eight-hour workday can be imputed to a qualified vocation expert.”) It is, however, proper for an ALJ to limit a hypothetical to only those restrictions that are supported by substantial evidence in the record. *See Magallanes*, 881 F.2d at 756–57. An ALJ “need not include all claimed impairments in his hypotheticals, [but] he must make specific findings explaining his rationale for disbelieving any of the claimant’s subjective complaints not included in the hypothetical.” *Light v. Soc. Sec. Admin.*, 119 F.3d 789, 793 (9th Cir. 1997). These restrictions on hypothetical questions apply to the hypothetical on which the ALJ bases their findings. *See Lewis v. Apfel*, 236 F.3d 503, 517–18 (9th Cir. 2001) (finding improper the ALJ’s reliance on the VE’s response to a hypothetical question that did not include all of claimant’s impairments, even though another hypothetical question the ALJ asked *had* accounted for all of claimant’s impairments).

By responding to hypothetical questions, the vocational expert testifies as to: (1) what jobs the claimant would be able to perform; and (2) the availability of such jobs in the national economy. *See Kilpatrick*, 35 F.4th at 1192; *Tackett*, 180

F.3d at 1101. If there are significant numbers of jobs either in the region where the claimant lives or in several other regions of the country, then the claimant is not disabled. See 20 C.F.R. §§ 404.1566, 416.966; see also *Burkhart v. Bowen*, 856 F.2d 1335, 1340 (9th Cir. 1988) (holding that the vocational expert must identify specific jobs within the claimant’s capabilities). If there are no jobs claimant could perform, or if such jobs do not exist in sufficient numbers, then claimant is “disabled.” See *Tackett*, 180 F.3d at 1101. See also *Maxwell*, 971 F.3d at 1131 (holding that two occupations do not constitute a “significant range of work”); *Beltran*, 700 F.3d at 388–89 (reversing district court’s grant of summary judgment to Commissioner concluding that the availability of jobs in the region that claimant could do did not constitute a significant number of jobs).

It is inappropriate for a vocational expert to conclude that a claimant can transfer to a different job in a wholly different industry that requires more than the minimal adjustment contemplated under the regulation. See *Renner v. Heckler*, 786 F.2d 1421, 1424 (9th Cir. 1986) (vocational expert failed to demonstrate that the claimant would be able to perform the jobs identified with very little, if any, vocational adjustment because “[e]ach of these jobs appears to require some adjustment to new industries and work settings”).

“If the assumptions in the hypothetical are not supported by the record, the opinion of the vocational expert that claimant has a residual working capacity has no evidentiary value.” *Gallant v. Heckler*, 753 F.2d 1450, 1456 (9th Cir. 1984). “To qualify as substantial evidence, the testimony of a vocational expert must be reliable in light of the medical evidence.” *Jones*, 760 F.2d at 998; *Kilpatrick*, 35 F.4th at 1192-93 (“[A] VE’s expert opinion may count as substantial evidence even when unaccompanied by supporting data) (citing *Biestek v. Berryhill*, 139 S. Ct. 1148, 1155 (2019) (rejecting argument that VE testimony could never qualify as substantial evidence when the VE refused to produce her underlying data), and *Bayliss v. Barnhart*, 427 F.3d 1211, 1218 (9th Cir. 2005) (“A VE’s recognized expertise provides the necessary foundation for his or her testimony. Thus, no additional foundation is required.”)). “If a vocational expert’s hypothetical does not reflect all the claimant’s limitations, then the expert’s testimony has no evidentiary value to support a finding that the claimant can perform jobs in the national economy.” *Matthews v. Shalala*, 10 F.3d 678, 681 (9th Cir. 1993) (internal quotes and citation omitted).

Before an ALJ can rely on the testimony of a vocational expert, the ALJ must first inquire as to whether there exists a conflict between the expert’s testimony and the *Dictionary of Occupational Titles*. See *Kilpatrick*, 35 F.4th at

1194-95; *Massachi v. Astrue*, 486 F.3d at 1153. “Although evidence provided by a vocational expert generally should be consistent with the *Dictionary of Occupational Titles*, neither the *Dictionary of Occupational Titles* nor the vocational expert evidence automatically trumps when there is a conflict.” *Id.* If the ALJ determines a conflict exists, “the ALJ must then determine whether the vocational expert’s explanation for the conflict is reasonable and whether a basis exists for relying on the expert rather than the *Dictionary of Occupational Titles.*” *Id.*; see also *Shaibi*, 883 F.3d at 1109 (“[A]n ALJ is required to investigate and resolve any apparent conflict between the VE’s testimony and the DOT, regardless of whether a claimant raises the conflict before the agency.”); *Lamear v. Berryhill*, 865 F.3d 1201, 1205 (9th Cir. 2017) (where there is an apparent conflict between the vocational expert’s testimony and the DOT, the ALJ is required to reconcile the inconsistency); *Gutierrez*, 844 F.3d at 807 (same); *Rounds v. Comm’r Soc. Sec. Admin.*, 807 F.3d 996, 1003 (9th Cir. 2015) (same); *Zavalin*, 778 F.3d at 846 (same). “[T]he ALJ has an affirmative duty to ask the expert to explain the conflict and then determine whether the vocational expert’s explanation for the conflict is reasonable before relying on the expert’s testimony to reach a disability determination.” *Rounds*, 807 F.3d at 1003 (internal quotation marks and citations omitted). Note “the conflict must be ‘obvious or apparent’ to trigger the ALJ’s obligation to inquire further.” *Lamear*, 865 F.3d at 1205; *Gutierrez*, 844 F.3d at 807; see also *Ford*, 950 F.3d at 1160 (ALJ’s duty to develop the record not triggered where there was no obvious or apparent conflict). “To avoid unnecessary appeals, an ALJ should ordinarily ask the [vocational expert] to explain in some detail why there is no conflict between the DOT and the applicant’s RFC.” *Lamear*, 865 F.3d at 1205. However, “an ALJ may rely on a vocational expert’s testimony concerning the number of relevant jobs in the national economy, and need not inquire *sua sponte* into the foundation for the expert’s opinion.” *Shaibi*, 883 F.3d at 1110.

When claimant provides job numbers that conflict with those of a vocational expert, the ALJ is required to consider the conflicting job numbers only if the job numbers supplied by claimant constitute “significant probative evidence.” See *Kilpatrick*, 35 F.4th at 1193-94 (holding that the “significant probative evidence” standard applies when claimant introduces job numbers that conflict with those of the VE, and that claimant failed to satisfy this standard because her counsel’s estimated job numbers lacked a sufficient foundation); see also *White v Kijakazi*, 44 F.4th 828, 837 (9th Cir. 2022) (applying *Kilpatrick*’s “significant probative evidence” standard and holding that the job-number estimates that claimant provided created an inconsistency in the record that the agency was required to resolve).

E. Medical Opinions as Evidence

1. 2017 Revisions to Rules Regarding the Evaluation of Medical Evidence, for Claims Filed *on or after* March 27, 2017

In 2017, the rules regarding the evaluation of medical evidence were revised. The revisions altered the ALJ articulation and reasoning requirements for evaluating medical evidence, for claims filed *on or after* March 27, 2017. *See Revisions to Rules Regarding the Evaluation of Medical Evidence*, 82 FR 5844-01, 2017 WL 168819 (January 18, 2017); Carolyn A. Kubitschek & Jon C. Dubin, *Social Security Disability Law and Procedure in Federal Court* § 6:20, Explanation of ALJ’s assessment of evidence (Updated February 2023); Harvey L. McCormick, updated by David D. Camp, *Social Security Claims and Procedures* § 8:103, Treating physician rule (Sixth Edition, Updated August 2022).

The revised rules clarify that while all evidence received is considered, there are specific articulation requirements regarding how medical opinions and prior administrative medical findings are considered. 20 C.F.R. §§ 404.1520c(a)–(b), 416.920c(a)–(b). *See also Revisions to Rules Regarding the Evaluation of Medical Evidence*, 82 FR 5844-01, 2017 WL 168819 (January 18, 2017). Under the revised rules, the ALJ is no longer required to defer to or assign each medical opinion a specific evidentiary weight. 20 C.F.R. §§ 404.1520c(a), 416.920c(a). Instead, the ALJ will articulate the persuasiveness of the medical opinions or prior administrative findings, based on factors set forth in the regulations, the most important factors being consistency and supportability. 20 C.F.R. §§ 404.1520c(a)–(b), 416.920c(a)–(b); *see Woods v. Kijakazi*, 32 F.4th 785, 791-92 (9th Cir. 2022). Supportability means the extent to which a medical source supports the medical opinion by explaining the ‘relevant . . . objective medical evidence.’ *Woods*, 32 F.4th at 791-92 (quoting 20 C.F.R. § 404.1520c(c)(1)). “Consistency means the extent to which a medical opinion is ‘consistent . . . with the evidence from other medical sources and nonmedical sources in the claim.’” *Woods*, 32 F.4th at 792 (quoting 20 C.F.R. § 404.1520c(c)(2)). Other factors that may be considered include the treatment relationship, specialization, and whether the source has familiarity with other evidence in the claim or an understanding of the disability program’s policies and evidentiary requirements. 20 C.F.R. §§ 404.1520c(a), (c), 416.920c(a), (c). “The revised regulations recognize that a medical source’s relationship with the claimant is still relevant when assessing the persuasiveness of the source’s opinion. *Woods*, 32 F.4th at 792. “However, the ALJ no longer needs to make specific findings regarding these relationship factors[.]” *Woods*, 32 F.4th at 792.

The revised rules also state that adjudicators will articulate how they consider medical opinions from all medical sources, regardless of whether or not the medical source is an “acceptable medical source.” 20 C.F.R. §§ 404.1520c, 416.920c (“We will articulate in our determination or decision how persuasive we find all of the medical opinions and all of the prior administrative medical findings in your case record.”). See also *Revisions to Rules Regarding the Evaluation of Medical Evidence*, 82 FR 5844-01 at 5844 (“[W]e are revising our rules to state that our adjudicators will articulate how they consider medical opinions from all medical sources, regardless of whether or not the medical source is an [acceptable medical source].”). The revised regulations expand the list of acceptable medical sources to include licensed audiologists, licensed advance practice registered nurses, and licensed physician assistants. See 20 C.F.R. §§ 404.1502, 416.902. See also *Social Security Claims and Procedures* § 8:103, Treating physician rule. See *Woods*, 32 F.4th at 792 (“Even under the new regulations, an ALJ cannot reject an examining or treating doctor's opinion as unsupported or inconsistent without providing an explanation supported by substantial evidence. The agency must “articulate ... how persuasive” it finds “all of the medical opinions” from each doctor or other source, and “explain how [it] considered the supportability and consistency factors” in reaching these findings (citing 20 C.F.R. § 404.1520c(b) and § 404.1520c(b)(2))).

The articulation requirements in the revised rules do not apply to the ALJ’s consideration of evidence from nonmedical sources. 20 C.F.R. §§ 404.1520c(d), 416.920c(d). See also *Social Security Disability Law & Procedure in Federal Court* § 6:20, Explanation of ALJ’s assessment of evidence.

2. Evaluation of Medical Evidence for Claims Filed *before* March 27, 2017

When considering medical opinions and prior administrative findings for claims filed *before* March 27, 2017, the rules in 20 C.F.R. §§ 404.1527, 416.927 apply. 20 C.F.R. §§ 404.1520c, 404.1527, 416.920c, 416.927. Cases cited below involve claims filed *before* March 27, 2017.

There are three types of medical opinions (treating, examining, and nonexamining). See *Valentine*, 574 F.3d at 692 ; *Lester v. Chater*, 81 F.3d 821, 830–31 (9th Cir. 1995) (amended April 9, 1996). For claims filed before March 27, 2017, each type is accorded different weight. 20 C.F.R. §§ 404.1527, 416.927. Generally, more weight is given to the opinion of a treating source than the opinion of a doctor who did not treat the claimant. See *Coleman v. Saul*, 979 F.3d 751, 756 (9th Cir. 2020); *Garrison*, 759 F.3d at 1012; *Turner v. Comm’r of Soc. Sec.*

Admin., 613 F.3d 1217, 1222 (9th Cir. 2010); *Winans v. Bowen*, 853 F.2d 643, 647 (9th Cir. 1987). Medical opinions and conclusions of treating physicians are accorded special weight because these physicians are in a unique position to know claimants as individuals, and because the continuity of their dealings with claimants enhances their ability to assess the claimants' problems. See *Embrey v. Bowen*, 849 F.2d 418, 421–22 (9th Cir. 1988); *Winans*, 853 F.2d at 647; see also *Bray*, 554 F.3d at 1228 (“A treating physician’s opinion is entitled to ‘substantial weight.’”). This court “afford[s] greater weight to a treating physician’s opinion because ‘he is employed to cure and has a greater opportunity to know and observe the patient as an individual.’” *Magallanes*, 881 F.2d at 751 (quoting *Sprague v. Bowen*, 812 F.2d 1226, 1230 (9th Cir. 1987)). Accordingly, more weight is given to the opinion of an examining source than to a nonexamining source. See *Lester*, 81 F.3d at 830–31; *Pitzer v. Sullivan*, 908 F.2d 502, 506 & n.4 (9th Cir. 1990).

“The ALJ must consider all medical opinion evidence.” *Tommasetti v. Astrue*, 533 F.3d 1035, 1041 (9th Cir. 2008) (citing 20 C.F.R. § 404.1527(b)). “Where an ALJ does not explicitly reject a medical opinion or set forth specific, legitimate reasons for crediting one medical opinion over another, he errs.” *Garrison*, 759 F.3d at 1012.

“An ALJ is not required to take medical opinions at face value, but may take into account the quality of the explanation when determining how much weight to give a medical opinion.” *Ford*, 950 F.3d at 1155. “[A]n [ALJ] may disregard medical opinion that is brief, conclusory, and inadequately supported by clinical findings.” *Britton v. Colvin*, 787 F.3d 1011, 1012 (9th Cir. 2015) (per curiam); see also *Burrell v. Colvin*, 775 F.3d 1133, 1140 (9th Cir. 2014).

Under certain circumstances, the opinion of a treating provider who is not an acceptable medical source may be given greater weight than the opinion of a treating provider who is an acceptable medical source — for example, when the provider ‘has seen the individual more often than the treating source, has provided better supporting evidence and a better explanation for the opinion, and the opinion is more consistent with the evidence as a whole.’

Revels v. Berryhill, 874 F.3d 648, 655 (9th Cir. 2017) (quoting 20 C.F.R. § 404.1527(f)(1)).

“[O]nly licensed physicians and certain other qualified specialists are considered ‘[a]cceptable medical sources.’” *Molina v. Astrue*, 674 F.3d 1104,

1111 (9th Cir. 2012) (quoting 20 C.F.R. § 404.1513(a)). A social worker is not considered an acceptable medical source under the regulations. See *Turner*, 613 F.3d at 1223–24. Nurse practitioners and physician assistants also are not considered acceptable medical sources, and are instead defined as “other sources” that are not entitled to the same deference as acceptable medical sources. See *Dale*, 823 F.3d at 943; *Britton*, 787 F.3d at 1013; *Molina*, 674 F.3d at 1104. “An ALJ may discount the opinion of an ‘other source,’ such as a nurse practitioner, if she provides ‘reasons germane to each witness for doing so.’” *Popa v. Berryhill*, 872 F.3d 901, 906 (9th Cir. 2017) (citation omitted). Note that for claims filed *on or after* March 27, 2017, the rules were revised to expand the list of acceptable medical sources, 20 C.F.R. §§ 404.1502, 416.902, and to state that adjudicators will articulate how they consider medical opinions from all medical sources, regardless of whether or not the medical source is an acceptable medical source, 20 C.F.R. §§ 404.1520c and 416.920c (stating, the ALJ “will articulate in [his] determination or decision how persuasive [he] find[s] all of the medical opinions and all of the prior administrative medical findings in [the claimant’s] case record”). See also *Revisions to Rules Regarding the Evaluation of Medical Evidence*, 82 FR 5844-01, 2017 WL 168819 (January 18, 2017) (stating, “[W]e are revising our rules to state that our adjudicators will articulate how they consider medical opinions from all medical sources, regardless of whether or not the medical source is an AMS.”); Harvey L. McCormick, updated by David D. Camp, *Social Security Claims and Procedures* § 8:103, Treating physician rule, (Sixth Edition, Updated August 2022).

a. Rejecting Uncontroverted Sources (requires *clear and convincing reasons*)

i. Opinions

For claims filed *before* March 27, 2017, the ALJ accords “controlling weight” to a treating doctor’s opinion where medically-approved, diagnostic techniques support the opinion and the opinion is not inconsistent with other substantial evidence. See 20 C.F.R. § 404.1527(c)(2); *Revels*, 874 F.3d at 654 ; *Error! Bookmark not defined.* If a treating doctor’s opinion is not contradicted by another doctor (*i.e.*, there are no other opinions from examining or nonexamining sources), it may be rejected only for “clear and convincing” reasons supported by substantial evidence in the record. See *Coleman*, 979 F.3d at 756; *Popa*, 872 F.3d at 906 (“In considering whether an applicant qualifies as disabled, an ALJ may reject the uncontradicted medical opinion of an examining psychologist only if the ALJ provides ‘clear and convincing’ reasons supported by substantial evidence in

the record.”); *Ryan v. Comm’r of Soc. Sec. Admin.*, 528 F.3d 1194, 1198 (9th Cir. 2008); *Lester*, 81 F.3d at 830. Treating physicians’ subjective judgments are important, and “properly play a part in their medical evaluations.” *Embrey*, 849 F.2d at 422.

“Because [the] law requires ‘specific and legitimate reasons that are supported by substantial evidence’ for rejecting a treating source’s medical opinion, that precedent surely implies that an ALJ must discuss the relevant views of a treating source.” *Marsh v. Colvin*, 792 F.3d 1170, 1173 (9th Cir. 2015).

“If a treating provider’s opinions are based to a large extent on an applicant’s self-reports and not on clinical evidence, and the ALJ finds the applicant not credible, the ALJ may discount the treating provider’s opinion.” *Ghanim v. Colvin*, 763 F.3d 1154, 1162 (9th Cir. 2014) (internal quotation marks omitted).

ii. Conclusions of Disability

For claims filed *before* March 27, 2017, treating physicians’ uncontroverted “ultimate conclusions . . . must be given substantial weight; they cannot be disregarded unless clear and convincing reasons for doing so exist and are set forth in proper detail.” *Embrey*, 849 F.2d at 422. Although the ALJ “‘is not bound by the uncontroverted opinions of the claimant’s physicians on the ultimate issue of disability, . . . he cannot reject them without presenting clear and convincing reasons for doing so.’” *Matthews*, 10 F.3d at 680 (quoting *Montijo v. Sec’y of Health & Human Servs.*, 729 F.2d 599, 601 (9th Cir. 1984) (per curiam)); *see also Reddick*, 157 F.3d at 725 (stating that “reasons for rejecting a treating doctor’s credible opinion on disability are comparable to those required for rejecting a treating doctor’s medical opinion”); *Lester*, 81 F.3d at 830. “Particularly in a case where the medical opinions of the physicians differ so markedly from the ALJ’s, it is incumbent on the ALJ to provide detailed, reasoned, and legitimate rationales for disregarding the physicians’ findings.” *Embrey*, 849 F.2d at 422. “[A]n ALJ cannot avoid these requirements simply by not mentioning the treating physician’s opinion and making findings contrary to it.” *Lingenfelter*, 504 F.3d at 1038 n.10.

b. Rejecting Controverted Sources (requires *specific and legitimate reasons*)

For claims filed *before* March 27, 2017, the ALJ must defer to the treating or examining physician’s opinion, even if contradicted by another doctor, unless the ALJ makes findings setting forth specific, legitimate reasons for rejecting it that

are based on substantial evidence in the record. See *Smith v. Kijakazi*, 14 F.4th 1108, 1114 (9th Cir. 2021); *Coleman*, 979 F.3d at 756; *Revels*, 874 F.3d at 654 ; *Turner*, 613 F.3d at 1222 ; *Valentine*, 574 F.3d at 692 ; *Orn*, 495 F.3d at 632 ; *Magallanes*, 881 F.2d at 751–55; see also 20 C.F.R. §§ 404.1527(c)(2), 416.927(c)(2); cf. *Bray*, 554 F.3d at 1228 (also explaining that the “ALJ need not accept the opinion of any physician, including a treating physician, if that opinion is brief, conclusory, and inadequately supported by clinical findings.” (internal quotation marks and citation omitted)). “The ALJ can meet this burden by setting out a detailed and thorough summary of the facts and conflicting clinical evidence, stating his interpretation thereof, and making findings.” *Magallanes*, 881 F.2d at 751 (internal quotation marks and citation omitted); see also *Revels*, 874 F.3d at 654. The ALJ’s personal observations of the claimant at the hearing do not constitute a substantial reason for rejecting the opinions of a treating physician when the claimant professes psychological impairment. See *Montijo*, 729 F.2d at 602 (per curiam). “The ALJ must do more than offer his conclusions. He must set forth his own interpretations and explain why they, rather than the doctors’, are correct.” *Embrey*, 849 F.2d at 421–22. “When an examining physician relies on the same clinical findings as a treating physician, but differs only in his or her conclusions, the conclusions of the examining physician are not ‘substantial evidence.’” *Orn*, 495 F.3d at 632.

c. Relying on Nonexamining Medical Advisor

For claims filed *before* March 27, 2017, the ALJ must give specific, legitimate reasons based on substantial evidence for rejecting the opinion of a treating or examining physician based in part on the testimony of a nonexamining medical advisor. See *Andrews v. Shalala*, 53 F.3d 1035, 1043 (9th Cir. 1995); *Magallanes*, 881 F.2d at 752–53; see also 20 C.F.R. §§ 404.1527(f), 416.927(f). “The opinion of a nonexamining physician cannot by itself constitute substantial evidence that justifies the rejection of the opinion of either an examining physician or a treating physician.” *Lester*, 81 F.3d at 831; see also *Ryan*, 528 F.3d at 1202 .

d. VA Determination of Disability

“The ALJ must consider the VA’s finding in reaching his decision and the ALJ must ordinarily give great weight to a VA determination of disability.” *Luther*, 891 F.3d at 876 (citation and quotation marks omitted). See also *Berry*, 622 F.3d at 1236; *Valentine*, 574 F.3d at 694–95; *McCartey v. Massanari*, 298 F.3d 1072, 1076 (9th Cir. 2002). “However, a VA rating is not conclusive and does not necessarily compel the SSA to reach an identical result.” *Luther*, 891 F.3d

at 876 (internal quotation marks and citation omitted). “An ALJ may give less weight to the VA’s rating ‘if [the ALJ] gives persuasive, specific, valid reasons for doing so that are supported by the record.’” *Id.* (quoting *Valentine*, 574 F.3d at 695); *Berry*, 622 F.3d at 1236; *McCartey*, 298 F.3d at 1076; *see also Turner*, 613 F.3d at 1225 .

F. Credibility Determinations

“[T]he ALJ ‘is responsible for determining credibility, resolving conflicts in medical testimony, and for resolving ambiguities.’” *Ford*, 950 F.3d at 1149 (quoting *Andrews*, 53 F.3d at 1039). *See also Lingenfelter*, 504 F.3d at 1035–36; *Magallanes*, 881 F.2d at 750 (“The ALJ is responsible for determining credibility and resolving conflicts in medical testimony.”). The ALJ’s credibility findings must be supported by specific, cogent reasons. *See Greger v. Barnhart*, 464 F.3d 968, 972 (9th Cir. 2006); *Rashad v. Sullivan*, 903 F.2d 1229, 1231 (9th Cir. 1990).

1. Assessing Claimant’s Pain Testimony

“In evaluating the credibility of a claimant’s testimony regarding subjective pain, an ALJ must engage in a two-step analysis.” *Vasquez*, 572 F.3d at 591 ; *see also Leon v. Berryhill*, 880 F.3d 1041, 1046 (9th Cir. 2018) (as amended); *Diedrich*, 874 F.3d at 641; *Trevizo v. Berryhill*, 871 F.3d 664, 678 (9th Cir. 2017) (as amended); *Garrison*, 759 F.3d at 1014; *Molina*, 674 F.3d at 1112. “First, the ALJ must determine whether the claimant has presented objective medical evidence of an underlying impairment which could reasonably be expected to produce the pain or other symptoms alleged.” *Lingenfelter*, 504 F.3d at 1036 (internal quotation marks and citation omitted); *Smith*, 14 F.4th at 1111 (quoting *Garrison*, 759 F.3d at 1014); *see also Coleman*, 979 F.3d at 756 (“An ALJ, however, may not discredit the claimant’s subjective complaints solely because the objective evidence fails to fully corroborate the degree of pain alleged.”) (citing *Reddick*, 157 F.3d at 722.; *Leon*, 880 F.3d at 1046; *Trevizo*, 871 F.3d at 678; *Molina*, 674 F.3d at 1112. “Second, if the claimant meets this first test, and there is no evidence of malingering, the ALJ can reject the claimant’s testimony about the severity of her symptoms only by offering specific, clear and convincing reasons for doing so.” *Lingenfelter*, 504 F.3d at 1036 (internal quotation marks and citation omitted); *see also Leon*, 880 F.3d at 1046; *Diedrich*, 874 F.3d at 643 (concluding “that none of the ALJ’s given reasons for finding Diedrich only partially credible is clear and convincing”); *Trevizo*, 871 F.3d at 678; *Molina*, 674 F.3d at 1112; *Valentine*, 574 F.3d at 693 ; *Vasquez*, 572 F.3d at 591–93 (concluding that ALJ failed to provide “specific, clear, and convincing” reasons to

support adverse credibility determination); *Lester*, 81 F.3d at 834; *see also Dodrill v. Shalala*, 12 F.3d 915, 918 (9th Cir. 1993); *Swenson v. Sullivan*, 876 F.2d 683, 687 (9th Cir. 1989). “General findings are insufficient; rather, the ALJ must identify what testimony is not credible and what evidence undermines the claimant’s complaints.” *Berry*, 622 F.3d at 1234 (internal quotation marks and citation omitted); *see also Smith*, 14 F.4th at 1113 (“In other words, to reject the specific portions of the claimant's testimony that the ALJ has found not to be credible, we require that the ALJ provide clear and convincing reasons relevant to that portion.” (internal citations omitted)); *Lambert v. Saul*, 980 F.3d 1266, 1268 (9th Cir. 2020) (“the ALJ must identify the specific testimony that he discredited and explain the evidence undermining it.”); *Lester*, 81 F.3d at 834; *Dodrill*, 12 F.3d at 918.

In weighing a claimant’s credibility, the ALJ may consider their reputation for truthfulness; inconsistencies either in their testimony or between their testimony and their conduct; their daily activities; work record; and testimony from physicians and third parties concerning the nature, severity, and effect of the symptoms of which they complain. *See Smolen*, 80 F.3d at 1284 (citations omitted). *See also Rounds*, 807 F.3d at 1006 (as amended) (to assess credibility the ALJ “may consider, among other factors, ‘ordinary techniques of credibility evaluation,’ ‘inadequately explained failure to seek treatment or to follow a prescribed course of treatment,’ and ‘the claimant’s daily activities.’” (citation omitted)); *Turner*, 613 F.3d at 1224 n.3 ; *Valentine*, 574 F.3d at 693 (“[T]he ALJ provided clear and convincing reasons to reject [the claimant’s] subjective complaint testimony.”).

Effective March 28, 2016, the Social Security Administration rescinded Social Security Ruling 96-7p, which previously governed evaluations of claimant symptom testimony, and eliminated the term “credibility” to make clear that subjective symptom evaluation is not an examination of a claimant’s character. *See SSR 16-3p*, 2016 WL 1119029, at *1 (Mar. 16, 2016). SSR 16-3p does not alter the Ninth Circuit standard for evaluating claimant symptom testimony. It “makes clear what our precedent already required: that assessments of an individual's testimony by an ALJ are designed to ‘evaluate the intensity and persistence of symptoms after [the ALJ] find[s] that the individual has a medically determinable impairment(s) that could reasonably be expected to produce those symptoms,’ and not to delve into wide-ranging scrutiny of the claimant's character and apparent truthfulness.” *Trevizo*, 871 F.3d at 678 n.5 .

G. Other Considerations

1. Social Security “Disability” and ADA “Disability”

The Supreme Court has emphasized the fact that an Americans with Disabilities Act (“ADA”) claim of ability to work with accommodation does not necessarily clash with a disability claim assertion of inability to do substantial gainful work in the national economy. *See Cleveland v. Policy Management Sys. Corp.*, 526 U.S. 795, 800–04 (1999); *see also Fredenburg v. Contra Costa Cnty. Dep’t of Health Servs.*, 172 F.3d 1176, 1179 (9th Cir. 1999); *Johnson v. Oregon*, 141 F.3d 1361, 1367 (9th Cir. 1998).

“It is possible, due to the different definitions of disability employed by various agencies, to qualify for disability benefits and to satisfy the ADA’s definition of a qualified person with a disability. The distinct purposes of the ADA, Social Security, and disability insurance inform the different definitions of disability employed.” *Johnson*, 141 F.3d at 1366. “Thus, neither application for nor receipt of disability benefits automatically bars a claimant from establishing that she is a qualified person with a disability under the ADA.” *Id.* at 1367. Claimants’ factual statements on prior disability benefits applications are not irrelevant to ADA cases as such representations constitute useful evidence. *See id.* at 1368–69. “‘Straightforward summary judgment analysis, rather than theories of [judicial] estoppel’ will be appropriate in most cases.” *Id.* at 1369 (quoting *Griffith v. Wal-Mart Stores, Inc.*, 135 F.3d 376, 382–83 (6th Cir. 1998)).

2. Alcoholism and Drug Abuse

In determining whether a claimant’s alcoholism or drug addiction is material under 42 U.S.C. § 423(d)(2)(C), the test is whether an individual would still be found disabled if they stopped using alcohol or drugs. *See* 20 C.F.R. §§ 404.1535(b), 416.935(b); *Parra v. Astrue*, 481 F.3d 742, 746–47 (9th Cir. 2007); *Sousa v. Callahan*, 143 F.3d 1240, 1245 (9th Cir. 1998). A claimant will not be deemed “disabled” if alcoholism is a “contributing factor material to the Commissioner’s determination of disability.” 42 U.S.C. § 423(d)(2)(C). “In making this determination, [the Commissioner] will evaluate which of [the claimant’s] current physical and mental limitations ... would remain if [the claimant] stopped using drugs or alcohol and then determine whether any or all of [the claimant’s] remaining limitations would be disabling.” 20 C.F.R. §§ 404.1535(b)(2), 416.935(b)(2). If the Commissioner determines that the claimant’s remaining limitations would not be disabling, then the Commissioner

finds that the claimant's drug addiction or alcoholism is a contributing factor material to the determination of disability. *See* 20 C.F.R. §§ 404.1535(b)(2)(i), 416.935(b)(2)(i). If the Commissioner determines that the claimant's remaining limitations are disabling, then the Commissioner finds that the claimant is disabled, independent of their drug addiction or alcoholism, and that the claimant's addiction or alcoholism is not a contributing factor material to the determination of disability. *See* 20 C.F.R. §§ 404.1535(b)(2)(ii), 416.935(b)(2)(ii).

3. Chronic Fatigue Syndrome (“CFS”) or Epstein-Barr Virus Syndrome

“Chronic fatigue syndrome [“CFS”] is a disease that did not become widely known in the medical community until 1988 when the first diagnostic article was published. It was also in 1988 that the CDC accepted chronic fatigue syndrome as a disease.” *Reddick*, 157 F.3d at 723 n.3 . “Chronic fatigue is defined as ‘self-reported persistent or relapsing fatigue lasting six or more consecutive months.’” *Id.* at 726 (emphasis in original) (quoting Centers for Disease Control, *The Chronic Fatigue Syndrome: A Comprehensive Approach to its Definition and Study*, 121 ANNALS OF INTERNAL MEDICINE 954 (1994)). Although CFS has many symptoms, “the presence of persistent fatigue is necessarily self-reported ... [and a] final diagnosis is made ‘by exclusion,’ or ruling out other possible illnesses.” *Reddick*, 157 F.3d at 726; *see also Sisco v. United States Dep’t of Health & Human Servs.*, 10 F.3d 739, 743–44 (10th Cir. 1993) (holding ALJ erred in rejecting diagnosis of CFS because of lack of “dipstick” laboratory test for CFS where no such test existed and it is instead diagnosed, in part, by excluding other possible disorders).

H. Witness Testimony

“In determining whether a claimant is disabled, an ALJ must consider lay witness testimony concerning a claimant's ability to work.” *Stout v. Comm’r of Soc. Sec. Admin.*, 454 F.3d 1050, 1053 (9th Cir. 2006) (citing *Dodrill*, 12 F.3d at 919); 20 C.F.R. §§ 404.1513(d)(4) & (e), 416.913(d)(4) & (e)); *see also Molina*, 674 F.3d at 1114 (“Lay testimony as to a claimant's symptoms or how an impairment affects the claimant's ability to work is competent evidence that the ALJ must take into account.”); *Bruce v. Astrue*, 557 F.3d 1113, 1115 (9th Cir. 2009); *Carmickle v. Comm’r of Soc. Sec. Admin.*, 533 F.3d 1155, 1164 (9th Cir. 2007). Lay testimony is competent evidence and cannot be disregarded without comment. *See Diedrich*, 874 F.3d at 640; *Molina*, 674 F.3d at 1114; *Stout*, 454 F.3d at 1053 (citing *Nguyen v. Chater*, 100 F.3d 1462, 1467 (9th Cir.1996)). To discount lay witness testimony, the ALJ must give reasons germane to each witness. *See Leon*, 880 F.3d at 1046 (as amended); *Diedrich*, 874 F.3d at 640;

Dale, 823 F.3d at 943 (nurse practitioner testimony); *Britton*, 787 F.3d at 1013 (per curiam); *Molina*, 674 F.3d at 1114; *Bruce*, 557 F.3d at 1115; *Carmickle*, 533 F.3d at 1164 (concluding ALJ had proper basis to reject lay witness testimony); *Stout*, 454 F.3d at 1053; *Lewis*, 236 F.3d at 511 (“Lay testimony as to a claimant’s symptoms is competent evidence that an ALJ must take into account, unless he or she expressly determines to disregard such testimony and gives reasons germane to each witness for doing so.” (citations omitted)). The court has not, “however, required the ALJ to discuss every witness’s testimony on an individualized, witness-by-witness basis. Rather, if the ALJ gives germane reasons for rejecting testimony by one witness, the ALJ need only point to those reasons when rejecting similar testimony by a different witness.” *Molina*, 674 F.3d at 1114 (determining the ALJ erred where she gave reasons for rejecting claimant’s testimony but failed to provide a reason for disregarding the lay witness testimony either individually or in the aggregate, and holding that the error was harmless).

IV. Judicial Review

A. Jurisdiction

After a “final decision” by the Commissioner, judicial review of disability claims is authorized for the district courts. See 42 U.S.C. § 405(g). The court of appeals also has jurisdiction pursuant to 42 U.S.C. § 405(g) (“judgment of the court shall be final except that it shall be subject to review in the same manner as a judgment in other civil actions”) and 28 U.S.C. § 1291. Note that the denial of a motion to reopen a prior Social Security benefits determination is a discretionary decision that is not final, and thus generally not reviewable by a district court. See *Klemm v. Astrue*, 543 F.3d 1139, 1144 (9th Cir. 2008).

Section 405(g) has three requirements for judicial review: “(1) a final decision of the Secretary made after a hearing; (2) commencement of a civil action within 60 days after the mailing of notice of such decision (or within such further time as the Secretary may allow); and (3) filing of the action in an appropriate district court.” See *Weinberger v. Salfi*, 422 U.S. 749, 763–64 (1975). Section 405(h) “prevent[s] review of decisions of the Secretary save as provided in the [Social Security] Act, which provision is made in § 405(g).” *Salfi*, 422 U.S. at 757.

B. Federal District Court

1. Standard of Review

The district court reviews the Commissioner’s final decision under the substantial evidence standard; the decision will be disturbed only if it is not supported by substantial evidence or is based on legal error. *See* 42 U.S.C. § 405(g) (“findings of the Commissioner of Social Security as to any fact, if supported by substantial evidence, shall be conclusive”); *Smolen*, 80 F.3d at 1279 ; *Andrews*, 53 F.3d at 1039. “Substantial evidence is such relevant evidence as a reasonable mind might accept as adequate to support a conclusion.” *Webb*, 433 F.3d at 686 . “‘Substantial evidence’ means ‘more than a scintilla,’ but ‘less than a preponderance.’” *Smolen*, 80 F.3d at 1279 (quoting *Richardson v. Perales*, 402 U.S. 389, 401 (1971) and *Sorenson v. Weinberger*, 514 F.2d 1112, 1119 n.10 (9th Cir. 1975)) (internal citations omitted); *see also Ford*, 950 F.3d at 1154; *Biestek*, 139 S. Ct. at 1154; *Bray*, 554 F.3d at 1222.

2. Pro Se Litigants

The court has “an obligation where the petitioner is pro se ... to construe the pleadings liberally and to afford the petitioner the benefit of any doubt.” *Bretz v. Kelman*, 773 F.2d 1026, 1027 n.1 (9th Cir. 1985) (en banc); *see also Haines v. Kerner*, 404 U.S. 519, 520–21 (1972) (per curiam).

3. Administrative Res Judicata

An unappealed denial of an application for disability benefits operates as res judicata as to the finding of non-disability through the date of the prior decision. Although applied less rigidly to administrative than to judicial proceedings, the principles of res judicata apply to administrative decisions. *See Vasquez*, 572 F.3d at 597 ; *Chavez v. Bowen*, 844 F.2d 691, 693 (9th Cir. 1988); *Gregory v. Bowen*, 844 F.2d 664, 666 (9th Cir. 1988).

A binding determination of non-disability also creates a presumption of continuing non-disability with respect to the period after the date of the prior decision. *See Lester*, 81 F.3d at 827; *Miller v. Heckler*, 770 F.2d 845, 848 (9th Cir. 1985); *Lyle v. Sec’y of Health & Human Servs.*, 700 F.2d 566, 568–69 (9th Cir. 1983); *see also Vasquez*, 572 F.3d at 597–98. The presumption does not apply, however, if there are “changed circumstances.” *See Taylor v. Heckler*, 765 F.2d 872, 875 (9th Cir. 1985); *see also Vasquez*, 572 F.3d at 597 (explaining that presumption does not apply where the claimant raises a new issue, such as the

existence of an impairment not considered previously). The presumption may be overcome by a showing of “changed circumstances,” by new facts establishing a previously unlitigated impairment or other apparent error in the prior determination, or where the claimant’s unrepresented status has resulted in an inadequate record. See *Lester*, 81 F.3d at 827–28; see also *Vasquez*, 572 F.3d at 597–98. While this court has recognized a presumption of continuing non-disability where there is a prior finding of non-disability, a claimant’s prior disability determination does not entitle a claimant to a presumption of continuing disability. *Lambert*, 980 F.3d at 1276.

In *Gregory*, this court held that res judicata could not be applied to bar Gregory’s disability claim because she was not represented by counsel in her first application and, in her second application, she raised a psychological impairment not previously considered. See *Gregory*, 844 F.2d at 666. In *Chavez*, the claimant’s 55th birthday and “attainment of ‘advanced age’ constitute[d] a changed circumstance” that precluded the application of res judicata to the first ALJ’s finding of non-disability. See *Chavez*, 844 F.2d at 693. In *Lester*, res judicata was not appropriately applied because in the second application Lester alleged a mental impairment not raised in the first application (or addressed in the first denial) and Lester turned 50 shortly after the first denial. See *Lester*, 81 F.3d at 827–28. In *Vasquez*, the court determined that it was improper to apply a presumption of continuing non-disability when deciding Vasquez’s second application, where Vasquez raised a new issue (mental impairment), and also entered into a new age category. *Vasquez*, 572 F.3d at 597–98. This court has also declined to apply res judicata where an ALJ considers, on the merits, whether a claimant had a disability during an already-adjudicated period. *Lewis*, 236 F.3d at 510 (“When an ALJ de facto reopens the prior adjudication in that manner, the Commissioner’s decision as to the prior period is subject to judicial review.”).

4. Summary Judgment Standard

Many appeals to this court involving a denial of Social Security disability benefits are from a district court’s grant of summary judgment. *Fed. R. Civ. P. 56(a)* states:

A party may move for summary judgment, identifying each claim or defense—or the part of each claim or defense—on which summary judgment is sought. The court shall grant summary judgment if the movant shows that there is no genuine dispute as to any material fact and the movant is entitled to judgment as a matter of law.

“The moving party has the burden of establishing the absence of a genuine dispute of material fact.” *Swoger v. Rare Coin Wholesalers*, 803 F.3d 1045, 1047 (9th Cir. 2015). “The court must view the evidence in the light most favorable to the non-movant and draw all reasonable inferences in the non-movant’s favor.” *Id.* See also *Celotex Corp v. Catrett*, 477 U.S. 317, 322–23 (1986); *Sierra Med. Servs. All. v. Kent*, 883 F.3d 1216, 1222 (9th Cir. 2018) (“Summary judgment is appropriate only if, taking the evidence and all reasonable inferences drawn therefrom in the light most favorable to the non-moving party, there are no genuine issues of material fact and the moving party is entitled to judgment as a matter of law.” (internal quotation marks and citations omitted)).

A party opposing summary judgment may not rest upon the mere allegations or denials of its pleadings. Rather, responses, either by affidavits or as otherwise provided in the rule, must set forth specific facts showing that there is a genuine issue for trial. A mere “scintilla” of evidence supporting the nonmoving party’s position will not suffice. There must be enough of a showing that the jury could reasonably find for the nonmoving party. See *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 250 (1986).

The question in summary judgment motions is whether “reasonable minds could differ as to the import of the evidence.” See *Eisenberg v. Insurance Co. of North Am.*, 815 F.2d 1285, 1288 (9th Cir. 1987) (internal quotations and citation omitted). “If the evidence is merely colorable . . . or is not significantly probative, summary judgment may be granted.” *Id.* at 1288 (internal quotations and citation omitted).

5. New Evidence

a. Materiality of New Evidence

Although a district court may remand a case to the Commissioner for consideration of new evidence, it may do so only when the new evidence is material. See *Clem v. Sullivan*, 894 F.2d 328, 332 (9th Cir. 1990); see also 42 U.S.C. § 405(g). “New evidence is material when it bear[s] directly and substantially on the matter in dispute, and if there is a reasonabl[e] possibility that the new evidence would have changed the outcome of the . . . determination.” *Luna v. Astrue*, 623 F.3d 1032, 1034 (9th Cir. 2010) (internal quotation marks and citations omitted); *Booz v. Sec’y of Health & Human Servs.*, 734 F.2d 1378, 1380 (9th Cir. 1984) (Evidence is material “only where there is a reasonable possibility that the new evidence would have changed the outcome of the [Commissioner’s]

determination had it been before him.” (quotation marks and citation omitted)); *see also* 42 U.S.C. § 405(g).

b. Good Cause Requirement

“The Act states that a reviewing court presented with new evidence may remand to the agency for consideration of that evidence, but only upon a showing of ‘good cause for the failure to incorporate such evidence into the record in a prior proceeding.’” *Shaibi*, 883 F.3d at 1109 (amended Feb. 28, 2018) (quoting 42 U.S.C. § 405(g)). *See also Van v. Barnhart*, 483 F.3d 600, 605 & n.4 (9th Cir. 2007); *Booz v. Sec’y of Health & Human Servs.*, 734 F.2d 1378, 1380 (9th Cir. 1984) (For a district court to order a remand, the plaintiff must also show “that there is good cause for the failure to incorporate such evidence into the record in a prior proceeding.” (quoting 42 U.S.C. § 405(g))). For example, in *Booz*, the court found good cause for Booz’s failure to present the evidence to the ALJ because of Booz’s limited financial means and his inability to afford a qualified medical specialist to review his records within the time allotted by the ALJ. *Booz*, 734 F.2d at 1380.

6. Attorneys’ Fees

a. 42 U.S.C. § 406

The district court and the court of appeals may award fees under 42 U.S.C. § 406(b)(1) (“Whenever a court renders a judgment favorable to a claimant under this subchapter who was represented before the court by an attorney, the court may determine and allow as part of its judgment a reasonable fee for such representation, not in excess of 25 percent of the total of the past-due benefits to which the claimant is entitled by reason of such judgment”). “[A]n award under § 406(b) compensates an attorney for all the attorney’s work before a federal court on behalf of the Social Security claimant in connection with the action that resulted in past-due benefits.” *Parrish v. Comm’r of Soc. Sec. Admin.*, 698 F.3d 1215, 1220 (9th Cir. 2012). While 42 U.S.C. § 406(b) governs the award and collection of fees for representation of claimants in court, 42 U.S.C. § 406(a) governs the award and collection of attorney’s fees for the representation of Social Security claimants in proceedings before the Administration. *Clark v. Astrue*, 529 F.3d 1211, 1214 (9th Cir. 2008). This court has held that § 406(b) only limits the amount of attorney’s fees awarded under § 406(b), not the combined fees awarded under § 406(a) and § 406(b). *See Clark*, 529 F.3d at 1218.

The district court's award of attorneys' fees under 42 U.S.C. § 406(b)(1) is reviewed under an abuse of discretion standard. See *Crawford v. Astrue*, 586 F.3d 1142, 1146–47 (9th Cir. 2009); *Clark*, 529 F.3d at 1214; *Widrig v. Apfel*, 140 F.3d 1207, 1209 (9th Cir. 1998).

For attorneys' fees pursuant to 42 U.S.C. § 406(b)(1), the claimant carries the burden of producing “satisfactory evidence,” in addition to their attorney's own affidavits, that the requested rates comport with “those prevailing in the community for similar services by lawyers of reasonably comparable skill, experience, and reputation.” See *Widrig*, 140 F.3d at 1209–10 (quoting *Blum v. Stenson*, 465 U.S. 886, 895–96 n.11 (1984)). Unlike a “fee-shifting” statute, which requires the losing party to pay the prevailing party's attorneys' fees, § 406(b)(1) deals with the amount a prevailing plaintiff must pay their attorney. See *Widrig*, 140 F.3d at 1210–11; see also *Crawford*, 586 F.3d at 1147; *Straw v. Bowen*, 866 F.2d 1167, 1169 (9th Cir. 1989). Congress passed the statute to limit contingency fees and avoid inordinate deprivations of disability benefits. See *Straw*, 866 F.2d at 1169. This court has recognized that it is inappropriate for “victorious claimants to ‘subsidize’ the claims of losing claimants [by taking] large portions out of disabled people's recoveries to fund the representation of other claimants.” *Id.* at 1171. Section 406(b)(1) “strikes a balance between encouraging lawyers to represent disability claimants, and protecting the already inadequate stipend most claimants receive.” *Allen v. Shalala*, 48 F.3d 456, 460 (9th Cir. 1995), *abrogated by Gisbrecht v. Barnhart*, 535 U.S. 789 (2002); see also *MacDonald v. Weinberger*, 512 F.2d at 146–47 .

In *Gisbrecht*, the Supreme Court held that in conducting the fee analysis the court should begin with the contingent fee agreement, and then test it for reasonableness. 535 U.S. at 808–09; see also 3 Social Security Practice Guide § 27.03 (Updated October 2022).

Note that while the § 406(b) fee is limited to 25% of the past-due benefits, this court has held that no similar limit applies to § 406(a) fees. See *Clark*, 529 F.3d at 1215.

Federal courts have no jurisdiction to review attorney fees awarded by the Social Security Administration; pursuant to 42 U.S.C. § 406(a), the Commissioner alone has the authority to award fees for representation of a claimant in an administrative proceeding. See *MacDonald*, 512 F.2d at 146; see also *Clark*, 529 F.3d at 1215 (“Section 406(a) grants the Social Security Administration exclusive

jurisdiction to award attorney’s fees for representation of a Social Security claimant in proceedings before the Administration.”).

b. Equal Access to Justice Act

Under the Equal Access to Justice Act (“EAJA”):

a court shall award to a prevailing party other than the United States fees and other expenses ... , incurred by that party in any civil action (other than cases sounding in tort), including proceedings for judicial review of agency action, brought by or against the United States ... , unless the court finds that the position of the United States was substantially justified or that special circumstances make an award unjust.

28 U.S.C. § 2412(d)(1)(A); *see also Decker v. Berryhill*, 856 F.3d 659, 663–64 (9th Cir. 2017); *Gardner v. Berryhill*, 856 F.3d 652, 656 (9th Cir. 2017); *Hardisty v. Astrue*, 592 F.3d 1072, 1076 (9th Cir. 2010). “As the Supreme Court [] reiterated, ‘[b]efore deciding whether an award of attorney’s fees is appropriate ... a court must determine whether the party seeking fees has prevailed in the litigation.’” *Wood v. Burwell*, 837 F.3d 969, 973 (9th Cir. 2016) (quoting *CRST Van Expedited, Inc. v. EEOC*, 578 U.S. 419, 422 (2016)).

“[F]ees and other expenses” include “reasonable attorney fees.” 28 U.S.C. § 2412(d)(2)(A). Under the EAJA, attorney’s fees are set at the market rate, but capped at \$125 per hour. *See id.* The statute explicitly permits the court, in its discretion, to reduce the amount awarded to the prevailing party to the extent that the party “unduly and unreasonably protracted” the final resolution of the case. 28 U.S.C. §§ 2412(d)(1)(C), 2412(d)(2)(D). “[I]f a court awards attorney fees under § 2412(d) for the representation of a Social Security claimant on an action for past-due benefits, and also awards attorney fees under § 406(b)(1) for representation of the same claimant in connection with the same claim, the claimant’s attorney ‘receives fees for the same work’ under both § 2412(d) and § 406(b)(1) for purposes of the EAJA savings provision,” and the court must offset the EAJA award against the SSA award. *Parrish*, 698 F.3d at 1221 . Note that the court of appeals, in addition to the district court, is authorized by EAJA to award attorney fees and costs to the claimant. *See Orn v. Astrue*, 511 F.3d 1217, 1218–20 (9th Cir. 2008) (order).

The district court’s denial of attorneys’ fees under EAJA is reviewed under an abuse of discretion standard. *See Decker*, 856 F.3d at 663; *Gardner*, 856 F.3d

at 656; *Le v. Astrue*, 529 F.3d 1200, 1201 (9th Cir. 2008); *Sampson v. Chater*, 103 F.3d 918, 921 (9th Cir. 1996).

“The government has the burden of showing that its position was substantially justified.” *Gardner*, 856 F.3d at 656; *see also Tobeler v. Colvin*, 749 F.3d 830, 832 (9th Cir. 2014). “‘Substantially justified’ means ‘justified to a degree that could satisfy a reasonable person.’ ... The government’s position is not substantially justified simply because our precedents have not squarely foreclosed the position. ... Rather, ‘the government’s position must have a reasonable basis both in law and fact.’” *Decker*, 856 F.3d at 664 (citations omitted); *see also Gardner*, 856 F.3d at 656. If no reasonable basis in law and fact exists for the government’s position with respect to the issue on which the court based its remand, EAJA fees are warranted. *See Flores*, 49 F.3d at 569–71 (government’s position not substantially justified when ALJ failed to consider a relevant vocational report); *see also Hardisty*, 592 F.3d at 1079; *Lewis*, 281 F.3d at 1085. “Whether the claimant is ultimately found to be disabled or not, the government’s position at each stage must be ‘substantially justified.’” *Corbin v. Apfel*, 149 F.3d 1051, 1053 (9th Cir. 1998); *see also Shafer v. Astrue*, 518 F.3d 1067, 1071 (9th Cir. 2008) (concluding that government’s defense of the ALJ’s procedural errors was not substantially justified); *Lewis*, 281 F.3d at 1085. If the claimant wins at any intermediate stage of the proceedings, they are considered a “prevailing party” for EAJA purposes even though there may not have been an ultimate disposition of the disability claim. *See Corbin*, 149 F.3d at 1053.

The fourth sentence of 42 U.S.C. § 405(g) provides that “[t]he court shall have power to enter, upon the pleadings and transcript of the record, a judgment affirming, modifying, or reversing the decision of the Commissioner of Social Security, with or without remanding the cause for a rehearing.” A “sentence four” remand should result in entry of a final judgment by the district court, at which point the claimant is a prevailing party. *See Shalala v. Schaefer*, 509 U.S. 292, 302 (1993); *see also Wood*, 837 F.3d at 977.

EAJA limits the amount of time that a claimant may file a fee application. *See Van v. Barnhart*, 483 F.3d at 605–07 (in case involving a sentence-six remand, the court discusses timeliness of EAJA application). Under 28 U.S.C. § 2412(d)(1)(B), “[a] party seeking an award of fees and other expenses shall, within thirty days of final judgment in the action, submit to the court an application for fees and other expenses which shows that the party is a prevailing party” *Id.*; *see also Van*, 483 F.3d at 604. Thus, for a fee application to be timely, the

application must be filed “within 30 days after a judgment that is final and not appealable.” *Van*, 483 F.3d at 604 (internal quotation marks and citation omitted).

C. Court of Appeals

1. Standard of Review²

This court reviews de novo the district court’s order. *See Kilpatrick*, 35 F.4th at 1192; *Ford*, 950 F.3d at 1153–54 (reviewing district court’s order affirming the ALJ’s denial of social security benefits); *Barnes*, 895 F.3d at 704; *Dale*, 823 F.3d at 943; *Berry*, 622 F.3d at 1231; *Robbins*, 466 F.3d at 882 . The court’s “review of the Commissioner’s decision is ‘essentially the same as that undertaken by the district court.’” *Tidwell*, 161 F.3d at 601 (quoting *Stone v. Heckler*, 761 F.2d 530, 532 (9th Cir. 1985)). The statute itself reads: “The judgment of the [district] court shall be final except that it shall be subject to review in the same manner as a judgment in other civil actions.” 42 U.S.C. § 405(g).

However, “when a district court remands a disability benefits case to the Social Security Administration pursuant to sentence four of 42 U.S.C. § 405(g), its decision whether such a remand is for further proceedings or for an immediate payment of benefits is reviewable for abuse of discretion rather than de novo.” *Harman v. Apfel*, 211 F.3d 1172, 1178 (9th Cir. 2000).

Like the district court, this court reviews the Commissioner’s final decision under the substantial evidence rule. *See Barnes*, 895 F.3d at 704; *Dale*, 823 F.3d at 943; *Flaten v. Sec’y of Health & Human Servs.*, 44 F.3d 1453, 1457 (9th Cir. 1995). This court may set aside the denial of benefits only if it is not supported by substantial evidence or if it is based on legal error. *See Kilpatrick*, 35 F.4th at 1192; *Woods*, 32 F.4th at 788; *Ford*, 950 F.3d at 1154; *Berry*, 622 F.3d at 1231; *Flaten*, 44 F.3d at 1457. The decision must be affirmed if substantial evidence supports the ALJ’s findings and the ALJ applied the correct legal standards. *See Smith*, 14 F.4th at 1111 (The court of appeals will “reverse only if the ALJ’s decision was not supported by substantial evidence in the record as a whole or if the ALJ applied the wrong legal standard.”); *Shaibi*, 883 F.3d at 1108 ; *Gutierrez*,

² The appropriate standard of review is discussed in more depth in the *Ninth Circuit Court of Appeals Standards of Review* outline.

844 F.3d at 807; *Moncada v. Chater*, 60 F.3d 521, 523 (9th Cir. 1995) (per curiam).

Substantial evidence means more than a mere scintilla, but less than a preponderance. See *Biestek*, 139 S. Ct. at 1154; *Ford*, 950 F.3d at 1154; *Revels*, 874 F.3d at 654 ; *Orn*, 495 F.3d at 630; see also *Young*, 911 F.2d at 183 . It is such relevant evidence as a reasonable mind might accept as adequate to support a conclusion. See *Orn*, 495 F.3d at 630. “If the evidence can reasonably support either affirming or reversing the [Commissioner’s] conclusion, the court may not substitute its judgment for that of the [Commissioner].” *Flaten*, 44 F.3d at 1457; see also *Shaibi*, 883 F.3d at 1108 (stating that if evidence is susceptible to more than one rational interpretation, the ALJ’s conclusion must be upheld); *Orn*, 495 F.3d at 630; *Woods*, 32 F.4th at 788; *Coleman*, 979 F.3d at 756 (the court “will not disturb the ALJ’s differing rational interpretation where the ALJ’s interpretation is adequately supported.” (citing *Burch*, 400 F.3d at 679 (“Where evidence is susceptible to more than one rational interpretation, it is the ALJ’s conclusion that must be upheld.”))). However, the Commissioner’s decision cannot be affirmed “simply by isolating a specific quantum of supporting evidence.” *Hammock v. Bowen*, 879 F.2d 498, 501 (9th Cir. 1989) (internal quotation marks and citation omitted); see also *Hill v. Astrue*, 698 F.3d 1153, 1159 (9th Cir. 2012); *Orn*, 495 F.3d at 630. The record as a whole must be considered. See *Ghanim*, 763 F.3d at 1160; *Howard v. Heckler*, 782 F.2d 1484, 1487 (9th Cir. 1986). This court reviews “only the reasons provided by the ALJ in the disability determination and may not affirm the ALJ on a ground upon which he did not rely.” *Orn*, 495 F.3d at 630; see also *Luther*, 891 F.3d at 875.

Note that “[a] decision of the ALJ will not be reversed for errors that are harmless.” *Burch*, 400 F.3d at 679 (citing *Curry*, 925 F.2d at 1131); see also *Buck*, 869 F.3d at 1048 (“The Court may not reverse an ALJ’s decision on account of a harmless error.”); *Molina*, 674 F.3d at 1111; *Lockwood*, 616 F.3d at 1071; *Tommasetti*, 533 F.3d at 1038 (“[T]he court will not reverse the decision of the ALJ’s decision for harmless error, which exists when it is clear from the record that the ALJ’s error was inconsequential to the ultimate nondisability determination.” (internal quotation marks and citation omitted)); *Stout*, 454 F.3d at 1054 . To determine whether an error is harmless, the court will “look at the record as a whole to determine whether the error alters the outcome of the case.” *Molina*, 674 F.3d at 1115–16 (discussing harmless error principles and providing examples where errors were found to be harmless). “Overall, the standard of review is ‘highly deferential.’” *Rounds*, 807 F.3d at 1002 (as amended).

A reviewing court may not make independent findings based on the evidence before the ALJ to conclude that the ALJ's error was harmless. . . . Rather, "[the court is] constrained to review the reasons the ALJ asserts." . . . If the ALJ fails to specify their reasons for finding claimant testimony not credible, a reviewing court will be unable to review those reasons meaningfully without improperly "substitut[ing] [its] conclusions for the ALJ's, or speculat[ing] as to the grounds for the ALJ's conclusions." . . . Because [the court] cannot engage in such substitution or speculation, such error will usually not be harmless.

Brown-Hunter v. Colvin, 806 F.3d 487, 492 (9th Cir. 2015) (as amended) (citations omitted).

2. Waiver

A failure to raise an argument before the Social Security Appeals Council does not waive that argument in district court. See *Sims*, 530 U.S. at 112 ("Claimants who exhaust administrative remedies need not also exhaust issues in a request for review by the Appeals Council in order to preserve judicial review of those issues."). Note that *Sims* concerned only whether a claimant must present all relevant issues to the Appeals Council to preserve them for review, it did not decide "[w]hether a claimant must exhaust issues before the ALJ." *Sims*, 530 U.S. at 107; see also *Shaibi*, 883 F.3d at 1109 (distinguishing *Sims* from case in which the issue was not presented before either the ALJ or the Appeals Council).

This court has held that "at least when claimants are represented by counsel, they must raise all issues and evidence at their administrative hearings in order to preserve them on appeal." *Meanel v. Apfel*, 172 F.3d 1111, 1115 (9th Cir. 1999) (as amended); see also *Shaibi*, 883 F.3d at 1109 (explaining that *Sims* was not clearly irreconcilable with *Meanel*, and that *Meanel* remained binding on the court with respect to proceedings before an ALJ).

When an issue is not raised before the district court, it has been waived on appeal to this court. See *Ghanim*, 763 F.3d at 1160; *Greger*, 464 F.3d at 973; *Sandgathe v. Chater*, 108 F.3d 978, 980 (9th Cir. 1997) (per curiam). Claimants may, however, raise new issues on remand before the ALJ. See *Gonzalez v. Sullivan*, 914 F.2d 1197, 1202 (9th Cir. 1990); see also 20 C.F.R. §§ 404.946(b)(1), 416.1446(b)(1).

3. Substitution of the Current Commissioner

The current Commissioner of Social Security is the proper defendant-appellee. The named defendant-appellee in federal court historically has been the Secretary of Health and Human Services (*e.g.*, Shalala, Sullivan, Bowen, Heckler, Schweiker, and Harris). However, effective March 31, 1995, pursuant to [Pub. L. No. 103-296](#), 108 Stat. 1464, [42 U.S.C. §§ 901–904](#), the Social Security Independence and Program Improvements Act of 1994, the function of the Secretary of Health and Human Services in Social Security cases was transferred to the Commissioner of the Social Security Administration (*e.g.*, Saul, Berryhill, Colvin, and Astrue). In accordance with § 106(d) of the Act, the Commissioner of the Social Security Administration, was substituted for the Secretary.

Because the *current* Commissioner of Social Security Administration is the proper defendant-appellee, it is appropriate to substitute them pursuant to [Fed. R. App. P. 43\(c\)\(2\)](#) and [Fed. R. Civ. P. 25\(d\)](#). A sample footnote to follow the caption is:

Andrew Saul, Commissioner of Social Security, is substituted for his predecessor, Nancy A. Berryhill, Acting Commissioner of Social Security, pursuant to [Fed. R. App. P. 43\(c\)\(2\)](#).

4. Disposition

“When the ALJ denies benefits and the court finds error, the court ordinarily must remand to the agency for further proceedings before directing an award of benefits.” [Leon](#), 880 F.3d at 1045 (amended January 25, 2018). However, “[t]he decision whether to remand a case for additional evidence, or simply to award benefits is within the discretion of the court.” [Sprague](#), 812 F.2d at 1232 ; *see also* [Trevizo](#), 871 F.3d 664, 682 (9th Cir. 2017) (as amended); [Dominguez v. Colvin](#), 808 F.3d 403, 407 (9th Cir. 2015) (amended Feb. 5, 2016) (“The only issue on appeal is whether the district court abused its discretion in remanding for further proceedings instead of remanding for benefits.”); [Terry v. Sullivan](#), 903 F.2d 1273, 1280 (9th Cir. 1990) (noting that the court has the “discretion to remand so that the Secretary may further develop the record” but invoking its discretion to order payment of benefits because the claimant was then 64 years old, had applied for benefits almost four years prior to the decision, and “further delays at this point would be unduly burdensome”). “[I]f additional proceedings can remedy defects in the original administrative proceeding, a social security case should be remanded for further proceedings.” [Trevizo](#), 871 F.3d at 682 (quotation marks and

citation omitted). *See also Leon*, 880 F.3d at 1045 (remanding for further proceedings where presentation of further evidence might prove enlightening, and where even if record was fully developed and improperly discredited evidence was credited as true, a finding of disability was not certain); *Luna*, 623 F.3d at 1035 (concluding that “further consideration of the factual issues was appropriate to determine whether the outcome of the first application should have been be different.”); *Connett v. Barnhart*, 340 F.3d 871, 876 (9th Cir. 2003) (explaining that the court was not required to enter award of benefits where the findings were insufficient as to whether testimony should be credited as true, and remanding for reconsideration of credibility). Moreover, “[w]here, . . . , an ALJ makes a legal error, but the record is uncertain and ambiguous, the proper approach is to remand the case to the agency.” *Treichler v. Comm’r of Soc. Sec. Admin.*, 775 F.3d 1090, 1105 (9th Cir. 2014); *Lambert*, 980 F.3d at 1277-78 (remanded because the ALJ erred in failing to provide sufficient reasons for rejecting claimant’s testimony and the error was not harmless).

The court may direct the award of benefits where “no useful purpose would be served by further administrative proceedings, . . . or where the record has been thoroughly developed.” *Varney v. Sec’y of Health & Human Servs.*, 859 F.2d 1396, 1399 (9th Cir. 1988) (citation omitted); *see also Maxwell*, 971 F.3d at 1132 (remanding with instruction for payment of benefits, where the ALJ committed legal error, the record was fully developed and further administrative proceedings would serve no useful purpose); *Garrison*, 759 F.3d at 1019 (9th Cir. 2014) (explaining that *Varney* clarified the scope of judicial power to remand for an award of benefits). This is a recognition of the “need to expedite disability claims.” *Varney*, 859 F.2d at 1401; *see also Smolen*, 80 F.3d at 1292 (noting that remand for payment of benefits is proper when no outstanding issues need to be resolved before a determination of disability can be made); *Winans*, 853 F.2d at 647 (because the court found that substantial evidence did not support the ALJ’s findings disbelieving the treating physician, and the court accepted the treating physician’s opinion, the court ordered the payment of benefits). However, an “automatic award of benefits in a disability benefits case is a rare and prophylactic exception to the well-established ordinary remand rule.” *Leon*, 880 F.3d at 1044 & 1045.

To remand for an award of benefits,

[t]he district court must first determine that the ALJ made a legal error, such as failing to provide legally sufficient reasons for rejecting evidence. . . . If the court finds such an error, it must next review the

record as a whole and determine whether it is fully developed, is free from conflicts and ambiguities, and “all essential factual issues have been resolved.” *Treichler [v. Comm’r of Soc., Sec. Admin.]*, 775 F.3d at 1001.]

Dominguez, 808 F.3d at 407 (concluding that the district court did not err in remanding the case for further factual proceedings, rather than payment of benefits, where there were inconsistencies, conflicts, and gaps in the record that required further administrative proceedings); *see also Maxwell*, 971 F.3d at 1132. If the record has been fully developed, and there are no outstanding issues to be resolved, the court next considers if taking the record as a whole, there is no doubt to disability. *Leon*, 880 F.3d at 1045. “Unless the district court concludes that further administrative proceedings would serve no useful purpose, it may not remand with a direction to provide benefits.” *Dominguez*, 808 F.3d at 407.

Even if all conditions are met, it is within the court’s discretion either to make a direct award of benefits or to remand for further proceedings. *Leon*, 880 F.3d at 1045 (explaining that the credit-as-true rule does not require remand for an immediate award of benefits even if all conditions are satisfied). *See also Trevizo*, 871 F.3d at 682–83 & n.11 (explaining that where all conditions are met, the court will generally remand for an award of benefits, but noting that in rare instances where all conditions are met, yet the record as a whole leaves serious doubt as to whether claimant is actually disabled, the court will remand for further development of the record); *Garrison*, 759 F.3d at 1023 (9th Cir. 2014) (concluding that the claimant satisfied all three conditions of the credit-as-true rule and that a careful review of the record disclosed no reason to seriously doubt that she was, in fact, disabled, and remanding for an award of benefits).

Publications

Carolyn A. Kubitschek & Jon C. Dubin, *Social Security Disability Law and Procedure in Federal Court*, Thomson/West (Updated February 2023).

Harvey L. McCormick, updated by David D. Camp, *Social Security Claims and Procedures*, West Group (Sixth Edition, Updated August 2022).

Matthew Bender, *Social Security Practice Guide* (Updated October 2022).

Websites

National Organization of Social Security Claimants and Representatives:
<https://www.nosscr.org>

The Social Security Administration's homepage: <http://www.ssa.gov/>

The Social Security Administration's Region 9 homepage:
<http://www.ssa.gov/sf/>