Obtaining Benefits for Claimants with Autoimmune Disease

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Autoimmune Disorders and Social Security Disability

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This session will address some of the most common autoimmune disorders and what is required to qualify for disability benefits from the Social Security Administration (Disability Insurance Benefits and/or Supplemental Security Income). We will focus first on the requirements set forth in the Listing of Impairments in Section 14.00, and then discuss issues related to proving disabling limitations at Steps Four and Five of the sequential evaluation process.

Social Security uses a five-step sequential evaluation to determine disability. First, is the individual performing Substantial Gainful Activity (SGA)? If so, she is not disabled. Second, does the individual have at least one medically determinable impairment which is “severe” (i.e., imposes more than minimal limitations on functioning)? If not, she is not disabled. Third, does the individual’s impairment(s) meet or equal the requirements of the Listing of Impairments found in Social Security regulations at 20 CFR Part 404, Subpart P, Appendix 1? If so, she is disabled. If not, Fourth, does the individual’s impairment(s) prevent the performance of past relevant work? If not, she is not disabled. If so, Fifth, can the individual perform other work in the national economy? If not, she is disabled.

What follows is a discussion of the criteria for several of the most common autoimmune disorders found in Section 14.00 of the Listing of Impairments.
Section 14.10 Sjogren’s syndrome. As described in 14.00D7 which provides:

Sjogren’s syndrome is an immune-mediated disorder of the exocrine glands. Involvement of the lacrimal and salivary glands is the hallmark feature, resulting in symptoms of dry eyes and dry mouth, and possible complications, such as corneal damage, blepharitis (eyelid inflammation), dysphagia (difficulty in swallowing), dental caries, and the inability to speak for extended periods of time. Involvement of the exocrine glands of the upper airways may result in persistent dry cough.

Many other organ systems may be involved, including musculoskeletal (arthritis, myositis), respiratory (interstitial fibrosis), gastrointestinal (dysmotility, dysphagia, involuntary weight loss), genitourinary (interstitial cystitis, renal tubular acidosis), skin (purpura, vasculitis), neurologic (central nervous system disorders, cranial and peripheral neuropathies), mental (cognitive dysfunction, poor memory), and neoplastic (lymphoma). Severe fatigue and malaise are frequently reported. Sjogren’s syndrome may be associated with other autoimmune disorders (for example, rheumatoid arthritis or SLE); usually the clinical features of the associated disorder predominate.

14.00D7 (continued):

Documentation of Sjogren’s syndrome. If you have Sjogren’s syndrome, the medical evidence will generally, but not always, show that your disease satisfies the criteria in the current “Criteria for the Classification of Sjogren’s Syndrome” by the American College of Rheumatology found in the most recent edition of the Primer on the Rheumatic Diseases published by the Arthritis Foundation.

In order to meet the requirements of Listing 14.10, an individual with Sjogren’s Syndrome as documented above must have:

A. Involvement of two or more organs/body systems, with:
   1. One of the organs/body systems involved to at least a moderate level of severity; and
   2. At least two of the constitutional symptoms or signs (severe fatigue, fever, malaise, or involuntary weight loss).

OR

B. Repeated manifestations of Sjogren’s syndrome, with at least two of the constitutional symptoms or signs (severe fatigue, fever, malaise, or involuntary weight loss) and one of the following at the marked level:
   1. Limitation of activities of daily living.
   2. Limitation in maintaining social functioning.
   3. Limitation in completing tasks in a timely manner due to deficiencies in concentration, persistence, or memory.
Section 14.00C provides definitions of two of the constitutional symptoms or signs:

Severe fatigue means a frequent sense of exhaustion that result in significantly reduced physical activity or mental function.

Malaise means frequent feelings of illness, bodily discomfort, or lack of well-being that result in significantly reduced physical activity or mental function.

Section 14.00G of the Listing of Impairments provides that in considering your functional limitations, we will consider factors including the effects of medications (including adverse side effects), the intrusiveness and complexity of your treatment (for example, the dosing schedule, need for injections), the effect of treatment on your mental functioning, variability of your response to treatment, and the interactive and cumulative effects of your treatment and the duration of your treatment.

Section 14.00I provides that a “marked” limitation means that the signs and symptoms interfere seriously with your ability to function. On a five-point scale, “marked” would be the fourth point on a scale consisting of no limitation, mild limitation, moderate limitation, marked limitation, and extreme limitation.

A marked limitation of activities of daily living will be found if you have a serious limitation in ability to maintain a household or take public transportation because of symptoms (such as pain, fatigue, anxiety or difficulty concentrating) even if you are able to perform some self-care activities.

A marked limitation in social functioning means you have a serious limitation in your capacity to interact independent, appropriately and effectively with others on a sustained basis because of your symptoms, even if you are able to communicate with close friends or relatives.

A marked limitation in completing tasks means you have a serious limitation in your ability to sustain concentration or pace adequate to complete work-related tasks because of symptoms, even if you are able to do some routine activities of daily living.
Federal courts have been receptive to cases involving Sjogren’s syndrome. For example, in Broussard v. Comm’r of Soc. Sec., 2015 WL 5025402 (W.D. La. 2015), the court reversed and awarded benefits where the ALJ had failed even to find Plaintiff’s Sjogren’s to be a severe impairment at Step Two, where there were clinical findings including dry eyes, difficulty in swallowing, sicca, joint problems and arthritis, she had been prescribed Plaquenil, and her physicians made consistent findings. In Cummings v. Astrue, 2011 WL 2434756 (W.D. Va. 2011), the court remanded for a new hearing where the treating rheumatologist provided a new opinion that Plaintiff’s Sjogren’s met the ACR criteria and at least equaled the criteria of Section 14.10 of the Listing of Impairments, and that Plaintiff’s prognosis was poor. In Steen v. Astrue, 2008 WL 4499602 (N.D. Cal. 2008), the court awarded benefits where the treating rheumatologist diagnosed Sjogren’s complicated by a monoclonal gammopathy and fibromyalgia, xerostomia with dysphagia, keratoconjunctivitis sicca, and “overwhelming constitutional symptoms,” and ruled that “the totality of her disease associated symptoms render her disabled.” However, courts are not always sympathetic, and the outcome of a case will depend on the quality of the evidence and the facts presented. For example, in Mansfield v. Barnhart, 2005 WL 1476370 (S.D. Ind. 2005), the court affirmed SSA’s denial of benefits where Plaintiff’s testimony about severe fatigue and inability to function resulting from her Sjogren’s and rheumatoid arthritis were belied by her daily activities, improvement with methotrexate injections, physical therapy, and Plaquenil. Her case was also undermined by her treating rheumatologist’s opinion that she had the capacity to lift 50 pounds and sit throughout an 8-hour workday. Under regulations which took effect in 2015, all such medical opinions which are expressed in writing must be submitted to SSA; thus, it is imperative to ascertain your physician’s ideas about your limitations (and perhaps about disability in general) before asking him/her to express such an opinion in writing.

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Localized scleroderma (linear scleroderma and morphea). Localized scleroderma (linear scleroderma and morphea) is more common in children than in adults. However, this type of scleroderma can persist into adulthood. To assess the severity of the impairment, we need a description of the extent of involvement of linear scleroderma and the location of the lesions. For example, linear scleroderma involving the arm but not crossing any joints is not as functionally limiting as sclerodactyly (scleroderma localized to the fingers). Linear scleroderma of a lower extremity involving skin thickening and atrophy of underlying muscle or bone can result in contractures and leg length discrepancy. Such cases may be evaluated under the musculoskeletal listings (1.00).

When there is isolated morphea of the face causing facial disfigurement from unilateral hypoplasia of the mandible, maxilla, zygoma, or orbit, adjudication may be more appropriate under the criteria in the affected body system, such as special senses and speech (2.00) or mental disorders (12.00).

Chronic variants of these syndromes include disseminated morphea, Shulman’s disease (diffuse fascitis with eosinophilia), and eosinophilia-myalgia syndrome (often associated with toxins such as toxic oil or contaminated tryptophan), all of which can impose medically severe musculoskeletal dysfunction and may also lead to restrictive pulmonary disease. We evaluate these variants of the disease under the criteria in the musculoskeletal listings (1.00) or respiratory system listings (3.00).

14.04 Systemic sclerosis (scleroderma) As described in 14.00D. With:
A. Involvement of two or more organs/body systems, with:
   1. One of the organs/body systems involved to at least a moderate level of severity; and
   2. At least two of the constitutional symptoms or signs (severe fatigue, fever, malaise, or involuntary weight loss).

OR
B. With one of the following:
1. Toe contractures or fixed deformity of one or both feet, resulting in the inability to ambulate effectively as defined in 14.00C6; or
2. Finger contractures or fixed deformity in both hands, resulting in the inability to perform fine and gross movements effectively as defined in 14.00C7; or
3. Atrophy with irreversible damage in one or both lower extremities, resulting in the inability to ambulate effectively as defined in 14.00C6; or
4. Atrophy with irreversible damage in both upper extremities, resulting in the inability to perform fine and gross movements effectively as defined in 14.00C7.

OR

C. Raynaud’s phenomenon, characterized by:
1. Gangrene involving at least two extremities; or
2. Ischemia with ulcerations of toes or fingers, resulting in the inability to ambulate effectively or to perform fine and gross movements effectively as defined in 14.00C6 and 14.00C7; or

OR

D. Repeated manifestations of systemic sclerosis (scleroderma), with at least two of the constitutional symptoms or signs (severe fatigue, fever, malaise, or involuntary weight loss) and one of the following at the marked level:
1. Limitation of activities of daily living
2. Limitation in maintaining social functioning,
3. Limitation in completing tasks in a timely manner due to deficiencies in concentration, persistence, or pace.
Representative Scleroderma Cases

Martz v. Comm’r of Soc. Sec., 649 F. Appx. 948 (11th Cir. 2016) (remand to consider whether claimant’s scleroderma continued to be disabling beyond the closed period granted by ALJ)

A.R.M. ex rel. Morlock v. Astrue, 2013 WL 785627 (D. Minn.) (remand to consider scleroderma)

Brewer v. Comm’r of Soc. Sec., 2016 WL 7634431 (N.D. Ohio) (remand to consider whether claimant’s scleroderma and lupus were disabling during insured period pursuant to SSR 83-20)

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Section 14.00D5: Undifferentiated and mixed connective tissue disease (14.06).

a. General. This listing includes syndromes with clinical and immunologic features of several autoimmune disorders, but which do not satisfy the criteria for any of the specific disorders described. For example, you may have clinical features of SLE and systemic vasculitis, and the serologic (blood test) findings of rheumatoid arthritis.

b. Documentation of undifferentiated and mixed connective tissue disease. Undifferentiated connective tissue disease is diagnosed when clinical features and serologic (blood test) findings, such as rheumatoid factor or antinuclear antibody (consistent with an autoimmune disorder) are present but do not satisfy the criteria for a specific disease. Mixed connective tissue disease (MCTD) is diagnosed when clinical features and serologic findings of two or more autoimmune diseases overlap.

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Representative UCTD Cases

Flake v. Comm'r of Soc. Sec., 2016 WL 7017355 (N.D.N.Y. 2016) (remand to consider 14.06 and 14.02)

Jones v. Colvin, 2014 WL 2458155 (N.D. Ill. 2014) (remand to consider UCTD and application of Section 14.06)


Winters v. Barnhart, 2003 WL 22384784 (N.D. Cal. 2003) (remand to consider ME testimony re UCTD)

Section 14.00D6: Inflammatory arthritis (14.09).

a. General. The spectrum of inflammatory arthritis includes a vast array of disorders that differ in cause, course, and outcome. Clinically, inflammation of major peripheral joints may be the dominant manifestation causing difficulties with ambulation or fine and gross movements; there may be joint pain, swelling, and tenderness. The arthritis may affect other joints, or cause less limitation in ambulation or the performance of fine and gross movements. However, in combination with extra-articular features, including constitutional symptoms or signs (severe fatigue, fever, malaise, involuntary weight loss), inflammatory arthritis may result in an extreme limitation.

b. Inflammatory arthritis involving the axial spine (spondyloarthropathies). In adults, inflammatory arthritis involving the axial spine may be associated with disorders such as:

(i) Reiter’s syndrome;
(ii) Ankylosing spondylitis;
(iii) Psoriatic arthritis;
(iv) Whipple’s disease;
(v) Behçet’s disease; and
(vi) Inflammatory bowel disease.

c. Inflammatory arthritis involving the peripheral joints. In adults, inflammatory arthritis involving peripheral joints may be associated with disorders such as:

(i) Rheumatoid arthritis;
(ii) Sjögren’s syndrome;
(iii) Psoriatic arthritis;
(iv) Crystal deposition disorders (gout and pseudogout);
(v) Lyme disease; and
(vi) Inflammatory bowel disease.
e. How we evaluate inflammatory arthritis under the listings.

(i) Listing-level severity in 14.09A and 14.09C1 is shown by an impairment that results in an “extreme” (very serious) limitation. In 14.09A, the criterion is satisfied with persistent inflammation or deformity in one major peripheral weight-bearing joint resulting in the inability to ambulate effectively (as defined in 14.00C6) or one major peripheral joint in each upper extremity resulting in the inability to perform fine and gross movements effectively (as defined in 14.00C7). In 14.09C1, if you have the required ankylosis (fixation) of your cervical or dorsolumbar spine, we will find that you have an extreme limitation in your ability to see in front of you, above you, and to the side. Therefore, inability to ambulate effectively is implicit in 14.09C1, even though you might not require bilateral upper limb assistance.

(ii) Listing-level severity is shown in 14.09B, 14.09C2, and 14.09D by inflammatory arthritis that involves various combinations of complications of one or more major peripheral joints or other joints, such as inflammation or deformity, extra-articular features, repeated manifestations, and constitutional symptoms or signs. Extra-articular impairments may also meet listings in other body systems.

(iv) If both inflammation and chronic deformities are present, we evaluate your impairment under the criteria of any appropriate listing.

(iii) Extra-articular features of inflammatory arthritis may involve any body system; for example: Musculoskeletal (heel enthesopathy), ophthalmologic (tracioditis, keratoconjunctivitis sicca, uveitis), pulmonary (pneumonia, pulmonary fibrosis or nodules, restrictive lung disease), cardiovascular (scleroderma, systemic sclerosis, coronary artery disease), myocardiitis, pericarditis, Raynaud’s phenomenon, systemic vasculitis, renal (amyloidosis of the kidney), hematologic (chronic anemia, thrombocytopenia), neurologic (peripheral neuropathy, radiculopathy, spinal cord or cauda equina compression with sensory and motor loss), mental (cognitive dysfunction, poor memory), and immune system (Felty’s syndrome (hypersplenism with compromised immune competence)).
14.09 Inflammatory arthritis. As described in 14.00D6, with:

A. Persistent inflammation or persistent deformity of:
   1. One or more major peripheral weight-bearing joints resulting in the inability to ambulate effectively (as defined in 14.00C6); or
   2. One or more major peripheral joints in each upper extremity resulting in the inability to perform fine and gross movements effectively (as defined in 14.00C7).
OR

B. Inflammation or deformity in one or more major peripheral joints with:
   1. Involvement of two or more organ/body systems with one of the organ/body systems involved to at least a moderate level of severity; and
   2. At least two of the constitutional symptoms or signs (severe fatigue, fever, malaise, or involuntary weight loss).
OR

C. Ankylosing spondylitis or other spondyloarthropathies, with:
   1. Ankylosis (fixation) of the dorsolumbar or cervical spine as shown by appropriate medically acceptable imaging and measured on physical examination at 45° or more of flexion from the vertical position (zero degrees); or
   2. Ankylosis (fixation) of the dorsolumbar or cervical spine as shown by appropriate medically acceptable imaging and measured on physical examination at 30° or more of flexion (but less than 45°) measured from the vertical position (zero degrees), and involvement of two or more organ/body systems with one of the organ/body systems involved to at least a moderate level of severity.
OR
D. Repeated manifestations of inflammatory arthritis, with at least two of the constitutional symptoms or signs (severe fatigue, fever, malaise, or involuntary weight loss) and one of the following at the marked level:
1. Limitation of activities of daily living
2. Limitation in maintaining social functioning.
3. Limitation in completing tasks in a timely manner due to deficiencies in concentration, persistence, or pace.

Representative Inflammatory Arthritis Cases

Jones v. Berryhill, 2017 WL 658000 (S.D.W.V. 2017) (affirming finding that 14.09 was not met)
Epting v. Colvin, 2016 WL 1278888 (N.D. Ind. 2016) (remand to consider RA)
Standen v. Colvin, 2016 WL 915254 (N.D. Ohio 2016) (remand to consider Listing)

Section 14.00D1: Systemic lupus erythematosus
a. General. Systemic lupus erythematosus (SLE) is a chronic, inflammatory disease that can affect any organ or body system. It is frequently, but not always, accompanied by constitutional symptoms or signs (severe fatigue, fever, malaise, involuntary weight loss). Major organ or body system involvement can include Respiratory (pleuritis, pneumonitis), cardiovascular (endocarditis, myocarditis, pericarditis, vasculitis), renal (glomerulonephritis), hematologic (anemia, leukopenia, thrombocytopenia), skin (photosensitivity), neurologic (neuropathy, seizures), mental (anxiety, fluctuating cognition ("lupus fog"), mood disorders, organic brain syndrome, psychosis), or immune system disorders (inflammatory arthritis). Immunologically, there is an array of circulating serum auto-antibodies and pro- and anti-coagulant proteins that may occur in a highly variable pattern.
14.02 Systemic lupus erythematosus. As described in 14.00D1. With

A. Involvement of two or more organ/body systems, with:
   1. One of the organ/body systems involved to at least a moderate level of severity; and
   2. At least two of the constitutional symptoms or signs (severe fatigue, fever, malaise, or involuntary weight loss).

OR

B. Repeated manifestations of SLE, with at least two of the constitutional symptoms or signs (severe fatigue, fever, malaise, or involuntary weight loss) and one of the following at the marked level:
   1. Limitation of activities of daily living.
   2. Limitation in maintaining social functioning.
   3. Limitation in completing tasks in a timely manner due to deficiencies in concentration, persistence, or pace.

Representative Lupus Cases
Congious v. Colvin, 2016 WL 5219747 (N.D. Ind. 2016) (remand to consider Listing 14.02)
Hanovich v. Astrue, 579 F.Supp.2d 1172 (D. Minn. 2008)
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