IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF ILLINOIS

CAROLYN D. HOLLOWAY, Plaintiff, vs. NANCY A. BERRYHILL, Acting Commissioner of Social Security, Defendant.[1]	))))))))))	Case No. 15-cv-1172-JPG-CJP

MEMORANDUM and ORDER

In accordance with 42 U.S.C. § 405(g), plaintiff Carolyn D. Holloway, represented by counsel, seeks judicial review of the final agency decision denying her application for Disability Insurance Benefits (DIB) pursuant to 42 U.S.C. § 423.

Procedural History

Plaintiff filed for DIB in 2009 alleging disability beginning April 13, 2008. After holding an evidentiary hearing, Administrative Law Judge (ALJ) William Hafer denied benefits in a decision dated December 3, 2010. (Tr. 11-18.) The Appeals Council denied review. (Tr. 1-3.)

Plaintiff exhausted her administrative remedies and filed a timely complaint with this Court, which reversed and remanded the ALJ's decision on October 10, 2012. (Tr. 464-79.)

While plaintiff's complaint was pending before this Court, plaintiff filed an additional application for DIB in 2010. (Tr. 731-38.) After an evidentiary hearing, ALJ James E. Craig issued a partially favorable decision on August 21, 2012, finding that plaintiff became disabled on August 1, 2011. (Tr. 497-509.) The Appeals Council granted review of ALJ Craig's decision and found that substantial evidence did not support his determination that plaintiff was not

[1] Nancy A. Berryhill is now the Acting Commissioner of Social Security. *See* https://www.ssa.gov/agency/commissioner.html (visited Feb. 7, 2017). She is automatically substituted as defendant in this case. *See* Fed. R. Civ. P. 25(d); 42 U.S.C. § 405(g).

disabled prior to August 1, 2011. The Appeals Council consolidated both of plaintiff's cases and remanded them to the ALJ. (Tr. 488-89.)

Following remand, ALJ Craig found that plaintiff was not disabled through August 1, 2011, in a decision dated March 18, 2014. (Tr. 397.) The Appeals Council granted review and found that plaintiff was not disabled through July 31, 2011. (Tr. 369-72.)

Plaintiff filed a timely complaint with this Court. (Tr. 1.)

Issues Raised by Plaintiff

Plaintiff raises the following points:

1. The Appeals Council erred by not considering Dr. James Graham's opinion.
2. The Appeals Council improperly adopted the ALJ's flawed analysis of the medical evidence.
3. The onset determination was not supported by substantial evidence.
4. The Appeals Council erred by adopting the ALJ's credibility determination.

Applicable Legal Standards

To qualify for DIB, a claimant must be disabled within the meaning of the applicable statutes. For these purposes, "disabled" means unable "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).

A "physical or mental impairment" is an impairment resulting from anatomical, physiological, or psychological abnormalities which are demonstrable by medically acceptable clinical and laboratory diagnostic techniques. 42 U.S.C. § 423(d)(3). "Substantial gainful activity" is work activity that involves doing significant physical or mental activities and that is done for pay or profit. 20 C.F.R. § 404.1572.

Social Security regulations set forth a sequential five-step inquiry to determine whether a claimant is disabled. The Seventh Circuit Court of Appeals has explained this process as follows:

> The first step considers whether the applicant is engaging in substantial gainful activity. The second step evaluates whether an alleged physical or mental impairment is severe, medically determinable, and meets a durational requirement. The third step compares the impairment to a list of impairments that are considered conclusively disabling. If the impairment meets or equals one of the listed impairments, then the applicant is considered disabled; if the impairment does not meet or equal a listed impairment, then the evaluation continues. The fourth step assesses an applicant's residual functional capacity ("RFC") and ability to engage in past relevant work. If an applicant can engage in past relevant work, he is not disabled. The fifth step assesses the applicant's RFC, as well as his age, education, and work experience to determine whether the applicant can engage in other work. If the applicant can engage in other work, he is not disabled.

Craft v. Astrue, 539 F.3d 668, 674 (7th Cir. 2008); *accord Weatherbee v. Astrue*, 649 F.3d 565, 568-69 (7th Cir. 2011).

Stated another way, it must be determined: (1) whether the claimant is presently unemployed; (2) whether the claimant has an impairment or combination of impairments that is serious; (3) whether the impairments meet or equal one of the listed impairments acknowledged to be conclusively disabling; (4) whether the claimant can perform past relevant work; and (5) whether the claimant is capable of performing any work within the economy, given his or her age, education and work experience. 20 C.F.R. § 404.1520; *Simila v. Astrue*, 573 F.3d 503, 512-13 (7th Cir. 2009); *Schroeter v. Sullivan*, 977 F.2d 391, 393 (7th Cir. 1992).

If the answer at steps one and two is "yes," the claimant will automatically be found disabled if he or she suffers from a listed impairment, determined at step three. If the claimant does not have a listed impairment at step three, and cannot perform his or her past work (step four), the burden shifts to the Commissioner at step five to show that the claimant can perform

some other job. *Rhoderick v. Heckler*, 737 F.2d 714, 715 (7th Cir. 1984); *see also Zurawski v. Halter*, 245 F.3d 881, 886 (7th Cir. 2001) (Under the five-step evaluation, an "affirmative answer leads either to the next step, or, on Steps 3 and 5, to a finding that the claimant is disabled. . . . If a claimant reaches step 5, the burden shifts to the ALJ to establish that the claimant is capable of performing work in the national economy.").

This Court reviews the Commissioner's decision to ensure that the decision is supported by substantial evidence and that no mistakes of law were made. It is important to recognize that the scope of review is limited. "The findings of the Commissioner of Social Security as to any fact, if supported by substantial evidence, shall be conclusive . . . ." 42 U.S.C. § 405(g). Thus, this Court must determine not whether plaintiff was, in fact, disabled at the relevant time but whether the ALJ's findings were supported by substantial evidence and whether any errors of law were made. *See Books v. Chater*, 91 F.3d 972, 977-78 (7th Cir. 1996) (citing *Diaz v. Chater*, 55 F.3d 300, 306 (7th Cir. 1995)). This Court uses the Supreme Court's definition of substantial evidence, *i.e.*, "such relevant evidence as a reasonable mind might accept as adequate to support a conclusion." *Richardson v. Perales*, 402 U.S. 389, 401 (1971).

In reviewing for "substantial evidence," the entire administrative record is taken into consideration, but this Court does not reweigh evidence, resolve conflicts, decide questions of credibility, or substitute its own judgment for that of the ALJ. *Brewer v. Chater*, 103 F.3d 1384, 1390 (7th Cir. 1997); *Moore v. Colvin*, 743 F.3d 1118, 1121 (7th Cir. 2014). However, while judicial review is deferential, it is not abject; this Court does not act as a rubber stamp for the Commissioner. *See Parker v. Astrue*, 597 F.3d 920, 921 (7th Cir. 2010), and cases cited therein.

The Decisions of the ALJ and the Appeals Council

On remand, following the consolidation of plaintiff's cases, ALJ Craig found that

plaintiff was last insured through March 31, 2013, and had not engaged in substantial gainful activity from her alleged onset date of April 13, 2008. From the onset date through August 1, 2011, the ALJ found that plaintiff had severe impairments of fibromyalgia, plantar fasciitis in combination with heel spur and tarsal tunnel syndrome, adjustment disorder, and anxiety.

ALJ Craig found that plaintiff had the RFC to perform light work with the following exceptions: she could not push and/or pull with her upper and lower extremities; she could not crawl but could occasionally kneel, crouch, and stoop; she could frequently reach, handle, finger, and feel; she could not work at jobs that required exposure to weather, extreme cold, wetness, humidity, moving mechanical parts, electric shock, or high places; and she could not perform detailed or complex work. She was also limited to work requiring an SVP[2] of three or less.

In conclusion, ALJ Craig found that plaintiff was capable of performing past relevant work as a bartender and as a cashier from April 13, 2008, through August 1, 2011, and therefore was not under a disability during this period.

The Appeals Council reviewed ALJ Craig's decision. It disagreed with his finding that plaintiff was limited to work requiring an SVP of three or less "because this is a vocational rather than a functional assessment." It further disagreed with the ALJ's determination that plaintiff could perform past relevant work as a bartender and cashier.

The Appeals Council did, however, agree with the ALJ regarding plaintiff's severe impairments and found that plaintiff could perform light, unskilled work. It also adopted the ALJ's adverse credibility determination and the vocational expert's opinion that plaintiff was able to perform a number of jobs in the national economy. It concluded that plaintiff was not

[2] SVP stands for "specific vocational preparation" and indicates on a scale of one to nine the amount of time required for a typical claimant to "[l]earn the techniques, [a]cquire the information, and [d]evelop the facility needed for average performance in a job." *See* Social Security Administration Program Operations Manual System DI 25001.001A.77, available at https://secure.ssa.gov/apps10/poms.nsf/lnx/0425001001#a77 (visited June 29, 2017).

disabled at any time from April 13, 2008, to July 31, 2011. (Tr. 369-71).

The Evidentiary Record

The Court has reviewed and considered the entire evidentiary record in formulating this Memorandum and Order. The following summary of the record is directed to the points raised by plaintiff.

1. Agency Forms

Plaintiff was born in 1957 and was fifty-one years old on the alleged onset date. (Tr. 117.) Plaintiff alleged severe impairments of fibromyalgia, colitis, and arthritis. She said she was fatigued and had severe pain. (Tr. 121.) She stated she could not stand for very long, lift, or carry. (Tr. 121.) Plaintiff previously worked as a bartender and as a cashier. She also worked as a cook in a restaurant. (Tr. 141.) Plaintiff completed the ninth grade. (Tr. 128.)

2. Evidentiary Hearing

An evidentiary hearing was held on February 4, 2014, before ALJ Craig. (Tr. 403.) Dr. Morton Tavel, a medical expert, testified that he reviewed plaintiff's medical records but never actually examined her. He noted plaintiff's complaints of fibromyalgia, carpel tunnel syndrome, lumbar neuritis, osteoarthritis, and pain in her ankle, back, and lumbar. (Tr. 410-11.)

Dr. Tavel opined that plaintiff did not have a severe impairment from April 13, 2008, to August 1, 2011. He defined "severe impairment" as "any impairment that would prevent someone from doing any type of work at all." (Tr. 410-11.)

Dr. Tavel retired a month before the hearing and actively worked as a cardiologist until then. Dr. Tavel testified numerous times in Social Security disability cases, so the concept of a "severe impairment" was not new to him. (Tr. 420.)

A vocational expert (VE) then testified regarding an individual with plaintiff's vocational

and educational background who was limited to light work. This hypothetical individual could not push or pull in the upper or lower extremities continuously; could not crawl; could occasionally stoop, kneel, and crouch; could frequently reach, handle, finger, and feel; could not be exposed to cold weather, wetness, humidity, or dangerous moving mechanical parts; and could not perform detailed or complex work. (Tr. 422-23.)

The VE testified that this person could perform a number of jobs that existed in the national economy. However, the individual would be unemployable if she had to take additional breaks for at least a fourth of an hour up to two or three times per day. Also, if this person had to miss two days of work per month, she would be unemployable. (Tr. 423-25.)

3. Medical Records

The Court previously summarized plaintiff's medical records from March 6, 2008, through August 30, 2010, which document plaintiff's diagnoses of fibromyalgia, plantar fasciitis, and tarsal tunnel syndrome (TTS).[3] The following summary relates the relevant records between 2008 and 2010, as well as additional records submitted on review.

a. Dr. Mark Stern's Treatment

Dr. Mark Stern first treated plaintiff for her fibromyalgia on January 30, 2009. Plaintiff said she experienced pain all over. On exam, Dr. Stern noted pain in many areas, including plaintiff's left shoulder, neck, thoracic spine, lumbar spine, hips, right metatarsal joint, and foot. She had weakness in the right leg. He noted that she walked with a limp on the right. She had a large spur on the right heel. X-rays of the lumbar spine were negative. He recommended a lumbar MRI and prescribed Decadron. He referred her to physical therapy for a heel brace or cushion. (Tr. 252-54.) Dr. Stern saw plaintiff again in February 2009 and prescribed physical

[3] Plaintiff has not challenged the ALJ's findings regarding her mental and emotional status, so the Court will not delve into that evidence in any detail.

therapy for her right heel pain. (Tr. 251.)

Plaintiff attended twelve physical therapy sessions from February 26 to March 25, 2009. According to the discharge note, "no significant improvement [was] noted." (Tr. 208.) Plaintiff attempted physical therapy again from January 17 to February 16, 2011, and attended twelve sessions. Her last treatment record notes improved strength but no significant change in pain. (Tr. 985-95.)

Dr. Stern treated plaintiff in April, June, August, and December 2009. He continued to assess her with fibromyalgia and administered injections in her right heel. (Tr. 249-50, 269, 302-03.)

Dr. Stern completed a report entitled Residual Functional Capacity Report on March 15, 2010. This form asked the doctor to assume that plaintiff was capable of no more than light exertional work. He wrote that her diagnoses were fibromyalgia, facet degeneration at L5-S1 level, and plantar spur on the right. For objective findings, he wrote "soft tissue pain and multiple trigger points." He opined that she should avoid even moderate exposure to extremes of temperature, environmental irritants and hazards such as machinery and heights. He also opined that she would miss work about twice a month due to her impairments or treatment. (Tr. 310-12.)

Dr. Stern saw plaintiff on May 19, 2010. He noted that her fibromyalgia was unchanged. He also noted that she still had pain in her right heel despite trying heel injections, pain patches and physical therapy. Plaintiff did experience mild improvement after receiving heel injections. (Tr. 338-39.)

On December 20, 2010, Dr. Stern noted that plaintiff had tinnitus for the previous three months and that her fibromyalgia symptoms seemed to be worse than before. (Tr. 898-99.) On

February 17, 2011, he reported that plaintiff still had chronic complaints of pain in multiple areas, and did not benefit from physical therapy, heat ultrasound, or phonophoresis. (Tr. 1045-46.)

Plaintiff presented to Dr. Stern in February, May, and September 2011 with complaints of pain. He noted that her fibromyalgia remained unchanged. (Tr. 1051-52, 1047-48, 1049-50.)

On May 22, 2012, Dr. Stern completed a Residual Function Capacity Report under the assumption that plaintiff was limited to light work. He stated he last examined plaintiff some time in 2012[4] and diagnosed her with fibromyalgia, osteoarthritis, lumbar neuritis, and L5-S1 facet disease. Dr. Stern opined that plaintiff's impairments would cause her pain and fatigue but would not require her to take breaks totaling an hour or more over the course of an eight-hour workday. He stated that she should avoid all exposure to extreme cold and heat, wetness, humidity, noise, fumes, odors, dusts, gases, poor ventilation, and hazards such as machinery and heights. Dr. Stern supported these limitations by noting that fibromyalgia patients are typically sensitive to a variety of external stimuli that causes them discomfort. Furthermore, he stated that her impairments would cause her to miss about two days of work per month. He also remarked that plaintiff "had a very difficult and refractory case of fibromyalgia that has responded only to the best treatment." (Tr. 1073-75.)

b. Dr. James Graham's Treatment

Plaintiff began seeing a podiatrist, Dr. James Graham, for her right heel pain on February 26, 2010. He noted a history of right heel pain for the past eighteen months. She was not as tender since her heel had been injected by Dr. Stern, but she still had throbbing pain. He noted that she was "active in housework duties." Dr. Graham noted positive Tinel's and Valleix's signs of the tibial nerve and its branches on neurological exam. The assessment was plantar fasciitis,

[4] The report was handwritten and the exact date is not legible.

bursitis, hypermobile foot, TTS and pain in limb. Orthotics were prescribed. (Tr. 343-44.) Plaintiff presented to Dr. Graham again in March and May 2010. (Tr. 345-46.) Treatment included steroid injections in plaintiff's foot. He also noted positive findings on neurological testing of the tibial nerve. Dr. Graham discussed doing an endoscopic plantar fasciotomy alone or in conjunction with a tarsal tunnel decompression (TTD). A TTD procedure would involve general anesthetic and three weeks in a non-weight-bearing cast. (Tr. 346.)

Plaintiff underwent surgery on July 13, 2010. (Tr. 349.) There were eight postoperative visits. (Tr. 931-34.) The last visit was on September 15, 2010. Dr. Graham noted that she had sixty to sixty-five percent improvement but continued to have pain. She again had positive findings on neurological testing of the tibial nerve, and the diagnoses were TTS and chronic plantar fasciitis. (Tr. 931.)

On February 28, 2011, plaintiff followed up with Dr. Graham after six weeks of physical therapy. She stated that a steroid injection into her right hip from Dr. Stern was beneficial. She did not relate any improvement with physical therapy. Neurological testing of the tibial nerve was negative. (Tr. 998.)

On March 11 and 18, 2011, Dr. Graham noted two lesions and positive findings on neurological testing of the tibial nerve. He assessed plaintiff with TTS. On March 18, 2011, Dr. Graham also discussed plaintiff undergoing a TTD with an endoscopic plantar fasciotomy and curettage. She wanted to proceed with the surgery before June. (Tr. 999.)

Plaintiff underwent a TTD of her right foot on June 28, 2011. Both her preoperative and postoperative diagnosis was TTS in her right lower extremity. (Tr. 1033.)

Plaintiff attended five follow up evaluations with Dr. Graham following the TTD. (Tr. 1030-32.) On July 26, 2011, plaintiff reported some pain on ambulation. Dr. Graham noted she

experienced only twenty percent improvement since surgery. On August 10, 2011, the last evaluation in the record, plaintiff related that her pain somewhat improved and she was slowly responding to the surgery. Negative findings were noted on neurological testing of the tibial nerve.

On August 18, 2015, Dr. Graham wrote a letter stating that during the six weeks following plaintiff's TTD of the right foot, "she was in no way physically capable or available to be on work status duty of a minimum of six hours out of eight hours for a full time basis of 40 hours per week." He continued to opine, "During the period of 2/26/10-9/19/11 it would be improbable if not impossible for her to do a standing job of the six out of eight hour days working there on a full time basis." (Tr. 1079.)

c. Dr. Secundino Rubio's Treatment

Dr. Secundino Rubio began providing primary care to plaintiff in November 2008. (Tr. 242.) He noted her pain, fatigue, and fibromyalgia throughout treatment. (Tr. 243, 273, 329.) Dr. Rubio referred plaintiff to several specialists and tracked her progress with them. (Tr. 241, 331, 1071.)

On August 10, 2011, Dr. Rubio wrote a letter stating that plaintiff was very credible about her condition based upon his two and a half years of treating her. He also wrote that she was "certainly disabled." (Tr. 1072.)

Dr. Rubio completed a Residual Functional Capacity Report on August 25, 2011. He was asked to assume that plaintiff was limited to light work. He stated that plaintiff last presented to him on August 25, 2011. She had progressive complaints of pain all over. Dr. Rubio suspected fibromyalgia and referred plaintiff to a rheumatologist. (Tr. 1036.)

He opined that plaintiff should avoid all exposure to extreme cold and heat, wetness,

humidity, noise, fumes, odors, dusts, gases, poor ventilation, and hazards such as machinery and heights. He noted that these limitations were due to her "tremendous pain all over." (Tr. 1037.)

Dr. Rubio also opined that plaintiff would miss more than fifteen workdays per month. He explained that "her conditions [were] getting worse in regard to her pain and [] fatigue in the last 5 years." (Tr. 1038.)

4. Dr. Charles Wabner's RFC Assessments

State agency consultant Charles Wabner, M.D., reviewed medical records and assessed plaintiff's residual functional capacity (RFC) on July 6, 2009. He indicated that the primary diagnosis was fibromyalgia, with a secondary diagnosis of rectal polyp and "other alleged impairment" of osteoarthritis. He opined that Ms. Holloway was able to meet the exertional requirements of light work, that is, occasionally lifting twenty pounds, frequently lifting ten pounds, standing/walking for six out of eight hours, sitting for six out of eight hours, and unlimited ability to push/pull with upper and lower extremities. He opined that she was further limited to only occasional climbing of ladders, ropes and scaffolds due to fibromyalgia, but she had no other postural limitations. She had no manipulative limitations, and the only environmental limitation was that she should avoid concentrated exposure to hazards such as machinery and heights. (Tr. 258-65.)

5. Dr. Lenore Gonzalez' RFC Assessment

On November 4, 2009, state agency consultant Dr. Lenore Gonzalez affirmed Dr. Wabner's RFC assessment. (Tr. 298-300.)

Dr. Gonzalez conducted a second RFC assessment of plaintiff on February 22, 2011. (Tr. 941-48.) She opined that plaintiff could occasionally lift and/or carry twenty pounds, frequently lift and/or carry ten pounds, stand and/or walk for about six hours in an eight-hour workday, sit

for a total of about six hours in an eight-hour workday, and push and/or pull an unlimited amount. Additionally, plaintiff could occasionally climb ramps and stairs but never climb ladders, ropes, or scaffolds. (Tr. 942-43.)

Dr. Gonzalez found plaintiff partially credible, giving credence to her history of plantar fasciitis, fibromyalgia, and facet degeneration. However, Dr. Gonzalez noted that an EMG from April 2009 was normal and knee x-rays from January 2009 were negative. (Tr. 946.) Dr. Gonzalez also pointed to Dr. Stern's exam report from December 20, 2010, which noted the absence of JVD, cyanosis, ulcerations, dependent edema, evidence of active synovitis in any joint, or neurological deficits. The exam noted clear lungs and regular cardiac rate and rhythm. (Tr. 948.)

On June 1, 2011, another state agency consultant affirmed Dr. Gonzalez' RFC assessment. (Tr. 1006-08.)

Analysis

Plaintiff asserts that the ALJ's analysis of the medical evidence in the record is fundamentally flawed. This Court agrees.

The opinions of treating physicians are afforded controlling weight if they are "well-supported by medically acceptable clinical and laboratory diagnostic techniques and [are] not inconsistent with other substantial evidence." *Campbell v. Astrue*, 627 F.3d 299, 306 (7th Cir. 2010). An ALJ can only reject treating source opinions for "good reasons." *Id.*

Two of plaintiff's treating physicians, Dr. Stern and Dr. Rubio, testified that plaintiff would be required to miss multiple days of work each month. The ALJ rejected these opinions and, in doing so, manifestly failed to build a logical bridge between the evidence and his conclusions. These opinions were particularly important because the VE testified that an

individual with plaintiff's RFC would be unemployable if she missed two workdays per month.

The ALJ rejected Dr. Stern's opinion because it was inconsistent with the opinions of "the state agency medical expert" and Dr. Tavel. (Tr. 394.) It is uncertain which state-agency consultant the ALJ was referring to or if he intended to refer to both of them. Regardless, he did not explain why those opinions warranted greater weight, and "a contradictory opinion of a non-examining physician does not, by itself," constitute substantial evidence to reject an examining physician's opinion. *Gudgel v. Barnhart*, 345 F.3d 467, 470 (7th Cir. 2003).

The ALJ also asserted that Dr. Tavel's opinion was entitled to "great weight" because he "is a medical expert and he [] had the benefit of reviewing the most comprehensive record." (Tr. 391.) It is unclear how Dr. Tavel is any more of a "medical expert" than plaintiff's treating physicians. Dr. Tavel testified that he was a cardiologist, which is not especially pertinent to the treatment of plantar fasciitis or fibromyalgia. Furthermore, at the hearing, Dr. Tavel demonstrated a lack of understanding as to what a "severe impairment" means. He testified that a severe impairment was "any impairment that would prevent someone from doing any type of work at all." (Tr. 410-11.) Actually, a "severe impairment" is "any impairment or combination of impairments which significantly limits [the claimant's] physical or mental ability to do basic work activities." *Barnhart v. Thomas*, 540 U.S. 20, 24 (2003) (citing 20 C.F.R. §§ 404.1520(c), 416.920(c)).

The ALJ's assertion that Dr. Tavel had "the most comprehensive record" is similarly unavailing. Dr. Tavel may have had a complete snapshot of plaintiff's medical history as a reviewing expert, but the regulations require the ALJ to assess a doctor's opinion against a variety of other factors such as supportability, specialization, and the treatment relationship with the claimant. 20 C.F.R. § 404.1527. The ALJ did not address any of these, and his lack of

analysis makes it virtually impossible to tell whether his decision was logical and supported by substantial evidence.

Moreover, the records from the treating sources suggest they were engaged in plaintiff's overall treatment and were no less informed than Dr. Tavel. Dr. Rubio, for instance, referred plaintiff to Dr. Stern and other specialists, and both of these doctors made notations in their records of plaintiff's treatment with other doctors. In sum, the ALJ failed to build the logical bridge between the evidence and his decision to give greater weight to Dr. Tavel than the treating sources.

The ALJ also rejected Dr. Rubio's opinion that plaintiff would need extra breaks and would be absent from work more than fifteen times each month. The ALJ gave this opinion "limited weight" because "it indicates that the claimant could perform the exertional requirements of light work, but not on a continuous basis." (Tr. 396.) The ALJ's reasoning is not discernible here and, without more, this Court cannot conduct a meaningful review. *Taylor v. Barnhart*, 425 F.3d 345, 351 (7th Cir. 2005) ("In addition to relying on substantial evidence, the ALJ must also explain his analysis of the evidence with enough detail and clarity to permit meaningful appellate review.").

Defendant argues that the ALJ properly gave limited weight to Dr. Rubio's opinion because "the ultimate issue of disability is a decision reserved to the Commissioner." However, the ALJ did not reject Dr. Rubio's opinion on this basis, so setting forth this argument violates the *Chenery* doctrine. The doctrine "forbids an agency's lawyers to defend the agency's decision on grounds that the agency itself had not embraced." *Parker v. Astrue*, 597 F.3d 920, 922 (7th Cir. 2010).

The ALJ failed to offer "good reasons" or substantial evidence for rejecting the opinions

of the treating physicians in favor of Dr. Tavel and other non-examining sources. Thus, the Appeals Council erred in adopting the ALJ's analysis of the medical evidence.

Because this error, alone, warrants reversal, this Court will not address plaintiff's remaining arguments. However, on remand, the Commissioner must still consider all of the evidence in the record and reach a credibility determination in accordance with the regulations.

Conclusion

The Commissioner's final decision denying application for social security disability benefits is **REVERSED** and **REMANDED** to the Commissioner for rehearing and reconsideration of the evidence, pursuant to sentence four of 42 U.S.C. § 405(g).

The Clerk of Court is directed to enter judgment in favor of plaintiff.

IT IS SO ORDERED.

DATE: July 14, 2017

s/ J. Phil Gilbert
J. PHIL GILBERT
DISTRICT JUDGE