UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF INDIANA
INDIANAPOLIS DIVISION

ROBERT W. BEATTY,	)	
	)	
Plaintiff,	)	
	)	
vs.	)	No. 1:14-cv-01139-JMS-MJD
	)	
CAROLYN W. COLVIN Acting Commissioner of Social Security,	)	
	)	
Defendant.	)	

REPORT AND RECOMMENDATION

Robert Beatty ("Plaintiff" or "Beatty") requests judicial review of the final decision of the Commissioner of the Social Security Administration ("Commissioner") denying his application for Social Security Disability Insurance Benefits ("DIB") under Title II of the Social Security Act ("the Act"). *See* 42 U.S.C. §§ 416(i), 423(d). For the reasons set forth below, the Magistrate Judge recommends that the decision of the Commissioner be **AFFIRMED**.

Procedural History and Background

Beatty filed an application for DIB on November 2, 2011, alleging an onset of disability on May 11, 2011. [R. at 17.] At the time of his application, he had past work experience as a heavy equipment operator, press operator, forklift operator, and team leader. [R. at 26, 37, 40.] He alleged disability due to chronic obstructive pulmonary disease ("COPD"); shoulder, neck, and back pain; degenerative disc disease; left eye enucleation; and obesity. [R. at 19, 152; *see also* Dkt. 17 at 2 (Pl.'s Br.).][1]

[1] Plaintiff recited the relevant factual and medical background in more detail in his opening brief. [*See* Dkt. 17.] The Commissioner, unless otherwise noted herein, does not dispute these facts. [*See* Dkt. 20.] Because these facts involve Plaintiff's confidential and otherwise sensitive medical information, the Court will incorporate by reference the factual background in the parties' briefs and will articulate only specific facts as needed herein.

Beatty's application was denied initially on December 29, 2011 and on reconsideration on April 9, 2012. [R. at 17.] Beatty requested a hearing, which occurred before Administrative Law Judge ("ALJ") Belinda Brown on February 25, 2013. [R. at 31.] Also present at the hearing were Plaintiff's attorney, Stacy Crider, and a vocational expert, Robert Barber. [*Id.*] The ALJ determined that Plaintiff had not been under a disability at any time from the alleged date of onset through the date of the ALJ's March 4, 2013 decision. [R. at 26-27.] The Appeals Council denied Plaintiff's request for review on May 6, 2014, [R. at 1-3], rendering the ALJ's decision final. Plaintiff filed his complaint with this Court on July 8, 2014.[2] [Dkt. 1.]

Applicable Standard

To be eligible for SSI or DIB, a claimant must have a disability under 42 U.S.C. § 423.[3] 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). In order to be found disabled, a claimant must demonstrate that his physical or mental limitations prevent him from doing not only his previous work, but any other kind of gainful employment which exists in the national economy, considering his age, education, and work experience. 42 U.S.C. § 423(d)(2)(A).

In determining whether a claimant is disabled, the Commissioner employs a five-step sequential analysis. At step one, if the claimant is engaged in substantial gainful activity, he is

[2] Although a claimant has only 60 days to request judicial review of the Appeals Council's denial, the 60 days do not begin to run until the claimant receives notice of the Council's decision. [*See* R. at 2.] Unless the claimant shows otherwise, this notice is assumed to occur five days after the date of the Council's decision, [*see id.*], such that Plaintiff's complaint in this case was timely.

[3] In general, the legal standards applied in the determination of disability are the same regardless of whether a claimant seeks DIB or SSI. However, separate, parallel statutes and regulations exist for DIB and SSI claims. Therefore, citations in this opinion should be considered to refer to the appropriate parallel provision as context dictates. The same applies to citations of statutes or regulations found in quoted court decisions.

not disabled despite his medical condition and other factors. 20 C.F.R. § 404.1520(b). At step two, if the claimant does not have a "severe" impairment (i.e., one that significantly limits his ability to perform basic work activities), he is not disabled. 20 C.F.R. § 404.1520(c). At step three, the Commissioner determines whether the claimant's impairment or combination of impairments meets or medically equals any impairment that appears in the Listing of Impairments, 20 C.F.R. pt. 404, subpt. P, App. 1, and whether the impairment meets the twelve-month duration requirement; if so, the claimant is disabled. 20 C.F.R. § 404.1520(d). At step four, if the claimant is able to perform his past relevant work, he is not disabled. 20 C.F.R. § 404.1520(f). At step five, if the claimant can perform any other work in the national economy, he is not disabled. 20 C.F.R. § 404.1520(g).

In reviewing the ALJ's decision, the ALJ's findings of fact are conclusive and must be upheld by this Court "so long as substantial evidence supports them and no error of law occurred." *Dixon v. Massanari*, 270 F.3d 1171, 1176 (7th Cir. 2001). "Substantial evidence means such relevant evidence as a reasonable mind might accept as adequate to support a conclusion." *Id.* This court may not reweigh the evidence or substitute its judgment for that of the ALJ. *Overman v. Astrue*, 546 F.3d 456, 462 (7th Cir. 2008). The ALJ "need not evaluate in writing every piece of testimony and evidence submitted." *Carlson v. Shalala*, 999 F.2d 180, 181 (7th Cir. 1993). However, the "ALJ's decision must be based upon consideration of all the relevant evidence." *Herron v. Shalala*, 19 F.3d 329, 333 (7th Cir. 1994). To be affirmed, the ALJ must articulate her analysis of the evidence in her decision; while she "is not required to address every piece of evidence or testimony," she must "provide some glimpse into her reasoning . . . [and] build an accurate and logical bridge from the evidence to her conclusion." *Dixon*, 270 F.3d at 1176.

The ALJ's Decision

The ALJ first determined that Plaintiff met the insured status requirements of the Act through December 31, 2015. [R. at 19.] Applying the five-step analysis, the ALJ found at step one that Plaintiff had not engaged in substantial gainful activity ("SGA") since May 11, 2011, the alleged onset date. [*Id.*] At step two, the ALJ found that Plaintiff suffered from the severe impairments of left eye enucleation and obesity. [*Id.*] She also noted that Plaintiff had degenerative disc disease, acromioclavicular joint diastasis, and lymphatoid papulosis, but she concluded that these impairments were not severe because they had no more than a mild limitation on Plaintiff's ability to perform basic work activities. [*Id.*] Finally, she observed that Plaintiff alleged that he suffered from chronic obstructive pulmonary disease ("COPD"), but she determined that this allegation was not supported by the medical evidence and was therefore not a medically determinable impairment.[4] [R. at 20.]

At step three, the ALJ found that Plaintiff did not have an impairment or combination of impairments that met or medically equaled a Listed impairment. [R. at 20.] She specifically considered and rejected Listing 2.02 (loss of central visual acuity), Listing 2.03 (contraction of the visual fields in the better eye), and Listing 2.04 (loss of visual efficiency). [*Id.*] She also considered Plaintiff's obesity with reference to Social Security Ruling ("SSR") 02-1p. [R. at 21.] Ultimately, however, she determined that Plaintiff's obesity had not resulted in loss of function and had not intensified the severity of his other impairments to the point that his impairments met or medically equaled any listing. [*Id.*]

[4] The ALJ noted that Plaintiff had received albuterol inhalers to treat a respiratory ailment, but she determined that the inhalers were meant to address bronchitis, rather than COPD. [R. at 20 (citing R. at 206).] Plaintiff does not challenge the COPD finding, [*see* Dkt. 17], but, as described below, Plaintiff's use of inhalers is relevant to the ALJ's credibility determination.

The ALJ next analyzed Plaintiff's residual functional capacity ("RFC") and concluded that Plaintiff could perform the full range of medium work as defined in 20 CFR § 404.1567(c), except that his field of vision was limited to fifty percent. [R. at 21.] The ALJ then proceeded to step four of the sequential evaluation process. Relying on testimony from the vocational expert, she noted that Plaintiff had past relevant work at the "medium" exertional level as a heavy equipment operator, forklift operator, and press operator. [R. at 26.] She determined that Plaintiff's RFC allowed him to perform his past relevant work, and she accordingly concluded that Plaintiff was not disabled. [*Id.*]

Discussion

Plaintiff presents three arguments for remand for the ALJ's decision. He first argues that the ALJ erred by concluding that his back impairment was not severe. [Dkt. 17 at 9.] He then argues that the ALJ erred in her negative assessment of Plaintiff's credibility. [*Id.*] Finally, he contends that the ALJ improperly discounted the medical opinions in the record. [*Id.*] The Court addresses these arguments in turn.

A. Severity of Plaintiff's Back Impairment

Plaintiff contends that the ALJ erred at step two by concluding that Plaintiff's back impairment was not severe. An impairment or combination of impairments is "severe" if it "significantly limit[s] [the claimant's] physical or mental ability to do basic work activities." 20 C.F.R. § 404.1521(a). This is not a demanding threshold: A finding that an impairment is not severe is appropriate "when medical evidence establishes only a *slight* abnormality or a combination of slight abnormalities which would have no more than a *minimal* effect on an individual's ability to work." SSR 85-28 (emphasis added). "Great care should be exercised in

applying the not severe impairment concept." *Id.* If the ALJ cannot "determine clearly the effect of an impairment," the five-step evaluation process should continue beyond step two. *Id.*

The claimant bears the burden of establishing a severe impairment. *Young v. Sec'y of Health & Human Servs.*, 957 F.2d 386, 389 (7th Cir. 1992). As Plaintiff notes, this is not a demanding burden, [*see* Dkt. 17 at 11; *see also Johnson v. Sullivan*, 922 F.2d 346, 347 (7th Cir. 1990)], but it "cannot be satisfied when medical evidence shows that the person has the ability to perform basic work activities." SSR 85-28.

Plaintiff argues that the record in this case contains enough evidence to support a finding that Plaintiff's back impairment was severe. [Dkt. 17 at 10-12.] Dr. Ryan Whitesell, for instance, performed a consultative examination for the state disability determination bureau. He observed that Plaintiff had limitations on the range of motion in his cervical spine, [*see, e.g.*, R. at 208 ("Extension of the cervical spine is limited to 20 degrees. . . . Rotation is limited to 45 [degrees] on the right and 20 [degrees] on the left.")], and noted similar limitations in his dorsolumbar spine. [R. at 208-09 ("Forward flexion of the lumbosacral spine is limited to 60 degrees. . . . Later bend is . . . limited to 10 [degrees] in the left.)."] Dr. Whitesell also offered a medical source statement in which he stated that Plaintiff complained of "severe neck and back pain, which significantly limits his range of motion at both sites." [R. at 209.] He added that the pain persisted despite surgery on Plaintiff's cervical and lumbar spine, [*id.*], and he noted that Plaintiff stated that he could walk only one block and climb only one flight of stairs before "he is limited by back pain." [R. at 210.] Together, these observations could certainly support a finding that Plaintiff's back pain had "more than a minimal effect" on his ability to work, SSR 85-28, such that the ALJ should have deemed Plaintiff's back pain severe.

At the same time, however, other considerations do not support a finding that Plaintiff's back impairment was severe. Notably, the most limiting aspects of Whitesell's medical source statement—the complaints of "severe" pain and the claimed inability to walk long distances or climb multiple flights of stairs—were derived from Plaintiff's subjective complaints, rather than any sort of diagnostic test. [*See, e.g.*, R. at 207 (emphasis added) ("*He complains* more today of his cervical pain."); R. at 210 (emphasis added) ("*He states* he can walk around one block[.]").] As explained below, the ALJ had ample reason to discount Plaintiff's credibility, making it reasonable for the ALJ to accord little weight to the statements relayed by Dr. Whitesell.

In addition, the objective evidence did little to indicate a severe impairment: imaging of Plaintiff's spine showed only "mild" degenerative disc changes and only "minimal" spondylolisthesis. [R. at 211.] Plaintiff correctly notes that functional limitations may in some cases exceed diagnostic findings, [Dkt. 21 at 2-3], but here, Dr. Whitesell also noted that Plaintiff had a "steady gait" [R. at 208]; that Plaintiff could "bend over . . . without difficulty" [*id.*]; and that Plaintiff could "tandem walk" and "perform a full squat maneuver without difficulty." [R. at 209.] In light of such findings, the ALJ reasonably concluded that Plaintiff's back impairments did not "significantly limit" Plaintiff's ability to do basic work activities, 20 C.F.R. § 404.1521(a), such that the impairment was not severe.

Ultimately, however, the resolution of the severity issue is unnecessary, for even if the ALJ did err in determining that Plaintiff's back pain was not a "severe" impairment, that error was harmless: At step two of the sequential evaluation process, an error is harmful only if the ALJ stops his analysis at that step and does not consider Plaintiff's impairments at future steps. *See, e.g.*, *Castile v. Astrue*, 617 F.3d 923, 927 (7th Cir. 2010) (noting that step two determination was "of no consequence with respect to the outcome of the case" because the ALJ "recognized

numerous other severe impairments" and proceeded to later steps). Thus, as long as the ALJ finds at least one severe impairment, continues his analysis, and considers a Plaintiff's non-severe impairments at the later steps of his determination, a court need not remand a case to correct a step two error. *See id.*; *see also Curvin v. Colvin*, No. 13-3622, 2015 WL 542847, at *3 (7th Cir. Feb. 11, 2015) ("What is more, even if there were such an error at step 2, it would have been harmless because the ALJ properly considered all of [plaintiff's] severe and non-severe impairments, the objective medical evidence, her symptoms, and her credibility when determining her RFC immediately after step 3.").

The ALJ in this case complied with these requirements. Although she determined that Plaintiff's back pain was not severe, she found that other impairments—namely, his eye enucleation and his obesity—*were* severe. [R. at 19.] She thus continued with her analysis, and, in constructing Plaintiff's RFC, she extensively considered the effects of Plaintiff's back pain. [*See, e.g.*, R. at 22 (noting complaints of "'severe' pain in spine"); R. at 23 (noting Dr. Whitesell's findings of limited range of motion); R. at 24 (noting complaints that "sitting or standing hurt [Plaintiff's] back").] She also considered the objective medical evidence related to Plaintiff's spinal impairment, [*see, e.g.*, R. at 23 (noting "mild degenerative disc disease" in imaging results)], and she specifically commented on Plaintiff's credibility. [*See, e.g.*, R. at 21 (describing factors that influenced her credibility finding).] The ALJ's step-two finding thus did not impact her later consideration of Plaintiff's back pain, and so "even if there were a mistake at Step 2, it does not matter." *Curvin*, No. 13-3622, 2015 WL 542847, at *3 (quoting *Arnett v. Astrue*, 676 F.3d 586, 591 (7th Cir. 2012)). Any error, in short, was harmless, and Plaintiff's argument on this point does not require remand.

B. Credibility Determination

Plaintiff contends that the ALJ erred in determining that Plaintiff's complaints about the severity of his impairments and any resulting limitations were not credible. [Dkt. 17 at 15.] A court will overturn the ALJ's credibility determination only if that determination was "patently wrong." *Terry v. Astrue*, 580 F.3d 471, 477 (7th Cir. 2009) (quoting *Prochaska v. Barnhart*, 454 F.3d 731, 738 (7th Cir.2006)). Nonetheless, the ALJ's credibility determination must still comply with applicable SSA rules and regulations. *See id.* As the ALJ in this case noted, [R. at 21], Social Security Ruling 96-7p sets out a specific framework for credibility determinations. Under this Ruling, the ALJ must "carefully consider" the claimant's own statements about symptoms such as pain. SSR 96-7p. The ALJ may not disregard the claimant's statements "solely because they are not substantiated by objective medical evidence;" rather, the ALJ "must consider the entire case record," including the objective evidence; the individual's subjective complaints; statements and observations from third parties; and "any other relevant evidence." *Id.* The Ruling then instructs ALJs to consider the following factors:

> 1. The individual's daily activities;
> 2. The location, duration, frequency, and intensity of the individual's pain or other symptoms;
> 3. Factors that precipitate and aggravate the symptoms;
> 4. The type, dosage, effectiveness, and side effects of any medication the individual takes or has taken to alleviate pain or other symptoms;
> 5. Treatment, other than medication, the individual receives or has received for relief of pain or other symptoms;
> 6. Any measures other than treatment the individual uses or has used to relieve pain or other symptoms (e.g., lying flat on his or her back, standing for 15 to 20 minutes every hour, or sleeping on a board); and
> 7. Any other factors concerning the individual's functional limitations and restrictions due to pain or other symptoms.

Id. The ALJ in this case specifically discussed each of these factors, [R. at 22-25], but Plaintiff contends that the ALJ erred in her consideration of factors four and five. [Dkt. 17 at 15-16.]

Factor four concerns the "type, dosage, effectiveness, and side effects of any medication the individual takes or has taken to alleviate pain or other symptoms." SSR 96-7p. The ALJ observed that Plaintiff "does not take any narcotic based pain relieving medication," thereby undercutting Plaintiff's claim of "allegedly disabling symptoms and limiting pain." [R. at 24.] Plaintiff contends this statement was erroneous because Plaintiff was actually "prescribed Vicodin,[5] Norco, and Prednisone for back pain." [Dkt. 17 at 15 (citing R. at 197, 202).]

The portion of the record Plaintiff cites describes an August 21, 2011 doctor's appointment. At that time, Plaintiff presented with active back pain and received a prescription for Norco and Prednisone. [R. at 197; *see also* R. at 202.] The Norco prescription lasted five days, [*see id.* (dispensing 15 pills to be taken three times per day)], and the Prednisone prescription lasted twelve days. [*See id.* (directing Plaintiff to reduce dosage over 12-day period).] Neither prescription included refills, [*see id.*], and the record contains no evidence of later prescriptions for narcotics. [*See, e.g.*, Dkt. 20 at 2 (noting that the "only treatment Plaintiff sought during the relevant period occurred on August 21, 2011").] At the hearing, Plaintiff also testified that he did not have any prescription for medication for his back pain; instead, he would take only ibuprofen or, on "really bad day[s]," one of the "pain pills" he had saved from when he had his teeth pulled. [R. at 48-49.]

Based on this evidence, the ALJ was justified in finding that Plaintiff's complaints of "disabling symptoms and pain" were inconsistent with his medication. The record contained a single incident indicating that Plaintiff's pain was severe enough for a few days in August 2011

[5] The records that Plaintiff cites do not mention "Vicodin." [*See* R. at 197, 202.] The confusion appears to stem from the fact that Norco and Vicodin are both combinations of hydrocodone and acetaminophen. *See Bayer v. Astrue*, No. CIV. 12-743-CJP, 2012 WL 6553981, at *4 & n.2 (S.D. Ill. Dec. 14, 2012). The record in this case indicates that Plaintiff was prescribed "hydrocodone 5/Acetaminophen 325," [R. at 197], and Plaintiff apparently concludes that this prescription was for Vicodin. This particular combination, however, refers to Norco. [*See* R. at 202 (prescribing "Norco" rather than Vicodin).]

that he sought prescription medication. That Plaintiff sought no further medication during the eighteen months between the August 2011 appointment and the February 2013 hearing before the ALJ is a telling indication that his complaints were exaggerated. *See, e.g.*, *Powers v. Apfel*, 207 F.3d 431, 435-36 (7th Cir. 2000) ("The ALJ found [plaintiff's] complaints of severe pain to be inconsistent with . . . the absence of drugs prescribed for severe pain. . . . The discrepancy between the degree of pain attested to by the witness and that suggested by the medical evidence is probative that the witness may be exaggerating [his] condition.").

Similar reasoning applies to SSR 96-7p factor five. This factor involves "[t]reatment, other than medication, the individual receives or has received for relief of pain or other symptoms." SSR 96-7p. The ALJ in this case noted that the record included only "infrequent trips to the doctor or hospital for treatment of [Plaintiff's] symptoms." [R. at 24.] In particular, the doctor at the August 2011 appointment instructed Plaintiff to "schedule an appointment to see any provider within 3 months for [pain] management suggestions" and recommended a "physical therapy consult [to] evaluate and treat" Plaintiff's pain. [R. at 197.] The record, however, contains no evidence that Plaintiff followed this advice, and, when asked at the hearing, Plaintiff's counsel indicated that Plaintiff had no additional medical records to submit. [R. at 68.] Again, then, the ALJ was justified in concluding that Plaintiff's symptoms were not as severe as Plaintiff alleged. *See, e.g.*, *Cain-Wesa v. Astrue*, No. 11-C-1063, 2012 WL 2160443, at *11 (E.D. Wis. June 13, 2012) (citing *Simila v. Astrue*, 573 F.3d 503, 519 (7th Cir.2009)) ("[T]he ALJ may reasonably consider such limited treatment . . . in finding claimed symptoms and limitations exaggerated.").

In his reply brief, Plaintiff nonetheless contends that the ALJ erred because he did not adequately consider *why* Plaintiff may have failed to seek prescription medications or more

extensive treatment. [Dkt. 21 at 3-4.] He notes that before discrediting a claimant's testimony on the basis of lack of treatment, the ALJ "must . . . consider[] any explanations that the individual may provide, or other information in the case record, that may explain infrequent or irregular medical visits or failure to seek medical treatment." [*Id.* at 4 (quoting SSR 96-7p).] Such explanations may include intolerable side effects; inability to afford treatment; or structuring of daily activities to avoid symptoms. SSR 96-7p. In such cases, lack of treatment is not a permissible basis for discounting the claimant's credibility. *See id.*; *see also* SSR 82-59 (noting that "[inability] to afford prescribed treatment" is a "justifiable" reason for not complying with treatment recommendations).

In this case, Plaintiff argues that he did not obtain additional prescription pain medications not because he was exaggerating his symptoms, but because "he could not continue to take them after losing his insurance." [Dkt. 21 at 3.] He thus contends that it would violate SSR 96-7p and SSR 82-59 to draw a negative credibility determination on the basis of lack of medication. [*See id.* at 3-4.]

This argument is unpersuasive. First, the ALJ noted that the record of Plaintiff's August 2011 appointment contains a note indicating that Plaintiff "was just accepted" for an insurance plan. [R. at 24 (citing R at 201).] Having "just" obtained such coverage, it seems unlikely that the insurance would have expired so quickly that he could not have sought or obtained another prescription at any time within the eighteen months before the hearing with the ALJ. In addition, Plaintiff testified at the hearing that he had insurance coverage through his wife's plan, which she had obtained "a few months ago." [R. at 47.] Hence, even if Plaintiff's own insurance *had* expired shortly after the August 2011 appointment, he still had coverage through his wife's plan

for "months" before the hearing. That he nonetheless did not seek or obtain a prescription to treat his back pain is thus evidence that his pain was in fact exaggerated.

As support for his argument, Plaintiff also cites Dr. Whitesell's December 2011 consultative exam. [Dkt. 17 at 15.] Plaintiff contends that he told Dr. Whitesell at that appointment that "he did not use his prescribed medications because his insurance ran out and he cannot afford them." [*Id.*] This assertion, however, suffers from two flaws: First, as described above, Plaintiff *did* have insurance for much of the time period at issue, such that even if his insurance had lapsed at the time of Dr. Whitesell's examination, the lack of insurance cannot justify failure to seek treatment or medication at *other* times. Second, Plaintiff's comment at Dr. Whitesell's appointment referred only to the albuterol inhalers that Plaintiff had received for his alleged COPD. [R. at 207 ("He was prescribed what sounds like albuterol inhalers which he tells me he does not use because his insurance ran out and he can't afford them.").] The statement included nothing about Plaintiff's pain medication, [*see id.*], and hence does little to justify Plaintiff's lack of treatment for his back pain. As a result, the Whitesell appointment does not establish that Plaintiff's sparse treatment for his back pain was the result of inadequate insurance, and Plaintiff's reliance on the appointment to support this argument is misplaced.[6]

[6] Plaintiff also briefly argues that the ALJ erred by failing to specifically mention the comment to Dr. Whitesell or the prescriptions for Norco and Prednisone. [*See* Dkt. 17 at 15 (arguing that ALJ "select[ed] certain pieces of evidence to support his findings, while ignoring others that contradict").] An ALJ, however, "is not required to provide a 'complete written evaluation of every piece of testimony and evidence.'" *Rice v. Barnhart*, 384 F.3d 363, 370 (7th Cir. 2004) (quoting *Diaz v. Chater*, 55 F.3d 300, 308 (7th Cir.1995)). Here, the ALJ specifically addressed Plaintiff's allegation that he lacked insurance. [R. at 24 ("[The claimant testified that he had not sought medical treatment due to a lack of insurance . . . . [T]he record directly contradicted this statement[.]"] She also extensively considered the August 2011 appointment at which Plaintiff received the Norco and Prednisone prescriptions, [R. at 23-25], and noted that although "[Plaintiff's] medications . . . may confirm the existence of impairments," they do "not establish an inability to work at the level assessed." [R. at 24.] Thus, even if the ALJ did not specifically emphasize the prescriptions or the comment to Dr. Whitesell, she still considered these pieces of evidence and therefore did not err by "ignoring" them.

In addition, the ALJ provided numerous other reasons for discounting Plaintiff's credibility. The first factor in SSR 96-7p, for instance, concerns the "individual's daily activities." SSR 96-7p. Here, the ALJ noted that Plaintiff complained "that he had difficulty donning his socks." [R. at 24; R. at 50 ("My wife will help me get a shower and get my shoes and socks on because I can't get them on in the morning myself.").] As the ALJ noted, however, Dr. Whitesell specifically wrote that Plaintiff could "bend over and attend to footwear without difficulty." [R. at 208.] The ALJ thus properly observed that the examining doctor's observations did not comport with Plaintiff's claimed limitations, such that Plaintiff's complaints were less credible. *See* SSR 96-7p ("In determining the credibility of the individual's statements, the adjudicator must consider . . . statements and other information provided by treating or examining physicians[.]").

Next, the ALJ noted that Plaintiff's work history was inconsistent with his claimed limitations. [*See* R. at 25.] In particular, the August 21, 2011 appointment indicated that Plaintiff's back pain was a chronic condition that had waxed and waned over the previous nine years. [R. at 201.] During much of this time, however, Plaintiff was working as a heavy equipment operator or a forklift operator. [*See* R. at 37-38 (describing work history).] The ALJ thus concluded that Plaintiff's impairments had not prevented him from working in the past, such that his claims that those same impairments were now totally disabling were not credible. [*See* R. at 25.] Moreover, the ALJ specifically considered whether Plaintiff's impairments had worsened over the years. He noted, however, that the record contained little medical evidence of such worsening, [*see id.* (noting that "the objective evidence regarding [Plaintiff's] shoulder and back reveal[ed] only mild findings")], and that Plaintiff's employment ended not because of any worsening in his condition, but because his employer downsized its operations. [R. at 25, 39, 44.]

The ALJ thus properly determined that Plaintiff's past ability to work harmed his credibility. *See* SSR 96-7p (noting that claimant's "prior work record" can affect "[a]ssessment of the credibility of an individual's statements about pain").

The ALJ then considered Plaintiff's receipt of unemployment benefits. [R. at 25.] From the second quarter of 2011 through the fourth quarter of 2012 (well after Plaintiff's alleged onset of disability), Plaintiff received unemployment benefits from the state of Indiana. [R. at 144-46.] As a condition of receiving these benefits, he had to "certify to the state unemployment agency that he was physically able to look for and accept employment[.]" [R. at 25.] The record also indicated that Plaintiff was in fact looking for work, as he reported during his August 21, 2011 appointment that he had a job interview later that week. [R. at 201.] Thus, despite Plaintiff's complaints of allegedly disabling pain, he was actively seeking work and was presenting himself as able to work. The ALJ was therefore warranted in concluding that Plaintiff's complaints were not as credible as they might have been. *See, e.g.*, *Johll v. Colvin*, No. 13-CV-630-JDP, 2014 WL 4678266, at *7 (W.D. Wis. Sept. 18, 2014) (quoting *Schmidt v. Barnhart*, 395 F.3d 737, 746 (7th Cir.2005)) ("[T]he ALJ correctly considered plaintiff's receipt of unemployment benefits as 'one of many factors adversely impacting his credibility.'").[7]

Based on this analysis, the ALJ had ample reason to discredit Plaintiff's complaints: Plaintiff sought and received little treatment; rarely took any prescription medication; was able to work in the past despite his impairments; and held himself out as able to work even after the alleged onset of disability. The Court therefore cannot say that the ALJ's credibility

[7] In his reply, Plaintiff contends that "he should not be condemned for trying to find employment" in August 2011 because "he did not even apply for disability benefits until November 2011." [Dkt. 21 at 5.] This point is irrelevant: Plaintiff alleged that he became disabled in May of 2011. [R. at 17.] The fact that he was seeking employment after this date thus indicates that his impairments were not as disabling as he alleged, regardless of when he ultimately decided to apply for disability insurance benefits. Moreover, even if Plaintiff's argument did have merit, it would be undercut by the fact that Plaintiff continued to collect unemployment even *after* he applied for disability insurance benefits. [*See* R. at 25 (noting Plaintiff collected unemployment throughout 2012).]

determination was "patently wrong," and the Court accordingly cannot overrule that determination. *See Terry*, 580 F.3d at 477.

C. Weight Given to Medical Opinions

Plaintiff next argues that the ALJ erred by giving too little weight to the opinions of the state agency consultative examiner, Dr. Whitesell, and the state agency reviewing physician, Dr. J. Sands. [Dkt. 17 at 15; *see also* Dkt. 21 at 5.] As noted above, Dr. Whitesell examined Plaintiff and provided a medical source statement. [R. at 209-210.] Among other findings, Dr. Whitesell noted that Plaintiff complained of "severe neck and back pain" and had a limited range of motion at both sites. [*Id.*] He suggested that physical therapy or referral to a pain management specialist could be helpful, but he did not comment on Plaintiff's ability to perform specific job-related tasks. [*See id.*] Dr. J. Sands then reviewed Plaintiff's records and completed a physical residual functional capacity assessment. [R. at 212.] He specifically cited Dr. Whitesell's findings, [R. at 213-214], and he concluded that Plaintiff could work at a "light" exertional level. [*See id.*; *see also* R. at 25.]

The ALJ gave Dr. Whitesell's opinion "little probative weight." [R. at 25.] She then stated that she gave Dr. Sands' report "significant weight," but she ultimately determined that Plaintiff was "capable of performing work at the [medium] level assessed herein, rather than the light exertional level determined by [Dr. Sands.]" [R. at 25.] Plaintiff now contends that the ALJ's evaluations of these opinions were erroneous because the ALJ "play[ed] doctor" by "rejecting all medical opinion of record and drawing her own lay conclusions of the evidence." [Dkt. 17 at 16.]

20 C.F.R. § 404.1527 governs the evaluation of medical opinions. This section provides that an ALJ must evaluate every medical opinion in the record and, in determining the value of

the opinion, must consider factors such as whether the medical source has examined the claimant; whether the medical source has adequately supported his or her opinion; whether the opinion is consistent with the record as a whole; and whether the source has a particular specialization in a given area. *Id.* § 404.1527(c). The section also provides that the final conclusions on certain issues, such as analysis of a claimant's functional capacity, are reserved to the Commissioner. *Id.* § 404.1527(d).

In this case, the ALJ explained that she gave Dr. Whitesell's opinion "little probative weight" because the statement was "vague and nonspecific regarding what, if any, physical capabilities, limitations, or restrictions the claimant would endure because of his impairments or related symptoms." [R. at 25.] This assessment properly addresses the "supportability" factor described in the regulations above. *See* 20 C.F.R. § 404.1527(c)(3) ("Supportability. . . . The better an explanation a source provides for an opinion, the more weight we will give that opinion."). In addition, the opinion's lack of any specific job-related limitations made it especially appropriate for the ALJ to give the opinion little weight in constructing Plaintiff's RFC. *See, e.g.*, *Luna v. Shalala*, 22 F.3d 687, 690 (7th Cir. 1994) (approving ALJ's decision to reject "cursory" report that did not "describe [plaintiff's] ability to do work-related activities"); *Liggins v. Colvin*, No. 12 C 4010, 2013 WL 6645440, at *6 (N.D. Ill. Dec. 17, 2013) (upholding ALJ who gave little weight to "physician's opinion [that] was vague and lacked a function by function analysis").

Next, the ALJ explained that although she accorded "significant weight" to Dr. Sands' opinion, she nonetheless found that "the totality of the evidence" supported a finding that Plaintiff could work at a "medium" exertional level. [R. at 25.] She specifically noted that a medium exertional level was consistent with the "objective medical evidence;" the "lack of

medical treatment" for Plaintiff's alleged impairments; and Plaintiff's "continued engagement in work activity at the medium exertional level with the impairment." [R. at 26.] The ALJ thus complied with 20 C.F.R. § 404.1527(c) by explaining that Dr. Sands' opinion was not supported by or consistent with the record as a whole. Moreover, because the ultimate analysis of a claimant's RFC is reserved to the Commissioner, *see* 20 C.F.R. § 404.1527(d), the ALJ did not err by departing from Dr. Sands' opinion to conclude that Plaintiff could perform "medium" rather than "light" work.

In addition, any error in the ALJ's evaluation of the medical opinions was harmless. At step four of the sequential evaluation process, the ALJ determined that Plaintiff could perform his past relevant work at a "medium" exertional level. [R. at 26.] The ALJ thus ended her decision at that step. [*Id.*] At the hearing, however, the ALJ proceed to step five of the analysis. At this step, an ALJ considers whether a claimant's RFC allows him to perform any work that exists "in significant numbers in the national economy." 20 C.F.R. § 404.1560(c). If so, the claimant is not disabled. *See id.*

The ALJ in this case addressed step five by asking a series of hypothetical questions: in particular, she asked the vocational expert to consider a "hypothetical individual of the claimant's past work experience and education" who could perform work "at the light level." [R. at 62.] She also imposed a series of additional restrictions to limit the person's sitting, walking and standing; reaching and handling; climbing and balancing; and kneeling, crouching, and crawling. [*Id.*] The vocational expert then testified that such a person would be able to perform work as an usher. [R. at 63.] He added that there were 1,230 such jobs in Indiana and 78,200 such jobs in the nation, [*id.*], such that the work did in fact exist in significant numbers in the national economy. *See, e.g.*, *Liskowitz v. Astrue*, 559 F.3d 736, 743 (7th Cir. 2009) (citation

omitted) ("As few as 174 jobs has been held to be significant and it appears to be well-established that 1,000 jobs is a significant number.").

This questioning indicates that, even if the ALJ *had* accepted the limitations described by the medical sources, the ALJ's ultimate decision would have been the same. If, that is, the ALJ had determined—as did Dr. Sands[8]—that Plaintiff was capable of performing only "light" work, the ALJ would have concluded that Plaintiff could not have performed his past relevant work at a "medium" level. She thus would have continued to step five, *see* 20 C.F.R. § 404.1560(c), and would have then considered the vocational expert's testimony that a hypothetical Plaintiff who could perform only "light" work could nonetheless hold a job as an usher. Because this job exists in significant numbers in the national economy, [*see* R. at 63], the ALJ would have concluded that Plaintiff was not disabled, *see* 20 C.F.R. § 404.1560(c), and the ultimate outcome of Plaintiff's claim would have been the same.

In short, the ALJ's decision to discount the doctors' opinions in this case was meaningless: she could have granted the doctors' opinions more weight, in which case the analysis would have ended at step five with a finding that Plaintiff was not disabled; instead, she granted the doctors' opinions less weight, and the analysis ended at step four with the same finding that Plaintiff was not disabled. Any error in the ALJ's evaluation of the opinions was therefore harmless, and the Court need not remand this case for further proceedings. *See, e.g.*, *McKinzey v. Astrue*, 641 F.3d 884, 892 (7th Cir. 2011) (citing *Spiva v. Astrue*, 628 F.3d 346, 353 (7th Cir.2010)) ("[W]e will not remand a case to the ALJ for further specification where we are convinced that the ALJ will reach the same result.").

[8] Because Dr. Sands relied on Dr. Whitesell's findings to determine Plaintiff's RFC, [*see* R. at 213-14], any incorporation of Dr. Sands' opinion necessarily incorporates any limitations that Dr. Whitesell may have suggested.

Conclusion

For the foregoing reasons, the Court finds that substantial evidence supports the ALJ's decision that Robert Beatty is not entitled to Disability Insurance Benefits. The Magistrate Judge therefore recommends that the Commissioner's decision be **AFFIRMED**. Any objections to the Magistrate Judge's Report and Recommendation shall be filed with the Clerk in accordance with 28 U.S.C. § 636(b)(1) and Fed. R. Civ. P. 72(b), and failure to timely file objections within fourteen days after service shall constitute a waiver of subsequent review absent a showing of good cause for such failure.

Dated: 03/12/2015

Mark J. Dinsmore
United States Magistrate Judge
Southern District of Indiana

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