UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF INDIANA
INDIANAPOLIS DIVISION

KAREN W.,[1]	)	
	)	
Plaintiff,	)	
	)	
v.	)	No. 1:19-cv-3960-JMS-DLP
	)	
ANDREW M. SAUL, Commissioner of the Social Security Administration,	)	
	)	
Defendant.	)	

ENTRY REVIEWING THE COMMISSIONER'S DECISION

Plaintiff Karen W. filed for disability benefits with the Social Security Administration ("SSA"), alleging a disability onset date of October 9, 2014. [Filing No. 7-5 at 2.] Her application was denied initially and upon reconsideration, [Filing No. 7-4 at 3-11; Filing No. 7-4 at 13-19], and a hearing was held before Administrative Law Judge Blanca B. de la Torre ("the ALJ"), [Filing No. 7-2 at 61-110]. The ALJ issued a decision denying Karen W. benefits on August 27, 2018, [Filing No. 7-2 at 7-26], and the SSA Appeals Council subsequently denied Karen W.'s request for review, [Filing No. 7-2 at 2]. Karen W. then filed suit, asking this Court to review her denial of benefits pursuant to 42 U.S.C. § 405(g) and 42 U.S.C. § 1383(c). [Filing No. 1.] She also filed a Motion to Reopen Prior Case Dated October 8th, 2014 ("Motion to Reopen"), asking this Court to reopen a prior case in which the SSA had also denied her benefits. [Filing No. 28.] The Court will first address the Motion to Reopen, before reviewing the August 2018 denial of benefits.

[1] To protect the privacy interests of claimants for Social Security benefits, consistent with the recommendation of the Court Administration and Case Management Committee of the Administrative Office of the United States Courts, the Southern District of Indiana has opted to use only the first name and last initial of non-governmental parties in its Social Security judicial review opinions.

I.
MOTION TO REOPEN

In her Motion to Reopen, Karen W. argues that her prior social security case, which culminated in a decision dated October 8, 2014, should be reopened because there are medical records that were overlooked or misinterpreted, and had she had proper legal representation at the time, "the issue would have been resolved." [Filing No. 28 at 1.] She attaches to the motion "medical records that were not presented to courts prior, and some that probably were." [Filing No. 28 at 1; Filing No. 28-1.] She argues that "you should not be able to reduce the time period to less than 18 months. This is not enough time to review medical records." [Filing No. 28 at 1.]

In response, the Commissioner argues that this Court lacks jurisdiction to reopen Karen W.'s prior case relating to the 2014 ALJ decision because Karen W. did not timely file a civil action in federal court seeking review of that decision. [Filing No. 29 at 1.] The Commissioner asserts that the Appeals Council informed Karen W. that it had denied her request for review of the 2014 ALJ decision and advised her that she had sixty days to either file an action in federal court or seek an extension of time from the Appeals Council. [Filing No. 29 at 1.] Because Karen W. did not take either of these actions, the Commissioner argues, the Court cannot reopen her prior case. [Filing No. 29 at 1.]

Karen W. did not file a reply.

Under 42 U.S.C. § 405(g), a claimant, "after any final decision of the Commissioner of Social Security made after a hearing to which [she] was a party, . . . may obtain review of such decision by a civil action commenced within sixty days after the mailing to [her] of notice of such decision or within such further time as the Commissioner of Social Security may allow." Otherwise, "[t]he findings and decision of the Commissioner of Social Security after a hearing shall be binding upon all individuals who were parties to such hearing." 42 U.S.C. § 405(h).

Although the time limit is not jurisdictional, claimants only have sixty days to seek judicial review of a decision by the SSA. *Alfreds v. Colvin*, 618 F. App'x 289, 290 (7th Cir. 2015) (citing *Day v. McDonough*, 547 U.S. 198, 205-06 (2006); *Bowen v. City of New York*, 476 U.S. 467, 478 (1986)). Because Karen W. did not file a civil action in federal court or seek an extension within sixty days of the Appeals Council's denial of review of the ALJ's October 8, 2014 decision, that decision became final and this Court cannot reopen the case or otherwise review it. *See Alfreds*, 618 F. App'x at 290; *see also Sipp v. Berryhill*, 699 F. App'x 576, 577-78 (7th Cir. 2017) ("If Sipp wanted to appeal the 2005 ruling, he needed to file a written request with the Appeals Council within 60 days, or otherwise seek an extension of time from the Appeals Council to file an appeal. Sipp filed, however, not a request for an extension but a new application for benefits."). Accordingly, Karen W.'s Motion to Reopen is **DENIED**.

II.
REVIEW OF THE AUGUST 2018 DENIAL OF BENEFITS

A. Standard of Review

"The Social Security Act authorizes payment of disability insurance benefits and Supplemental Security Income to individuals with disabilities." *Barnhart v. Walton*, 535 U.S. 212, 214 (2002). As explained by the Supreme Court,

> The statutory definition of 'disability' has two parts. First, it requires a certain kind of inability, namely, an inability to engage in any substantial gainful activity. Second it requires an impairment, namely, a physical or mental impairment, which provides reason for the inability. The statute adds that the impairment must be one that has lasted or can be expected to last . . . not less than 12 months.

Id. at 217 (quotations omitted).

When an applicant appeals an adverse benefits decision, this Court's role is limited to ensuring that the ALJ applied the correct legal standards and that substantial evidence exists to

support the ALJ's decision. *Barnett v. Barnhart*, 381 F.3d 664, 668 (7th Cir. 2004) (citation omitted). For the purpose of judicial review, "[s]ubstantial evidence is such relevant evidence as a reasonable mind might accept as adequate to support a conclusion." *Id.* (quotation omitted). Because the ALJ "is in the best position to determine the credibility of witnesses," *Craft v. Astrue*, 539 F.3d 668, 678 (7th Cir. 2008), this Court must afford the ALJ's credibility determination "considerable deference," overturning it only if it is "patently wrong," *Prochaska v. Barnhart*, 454 F.3d 731, 738 (7th Cir. 2006) (quotations omitted).

The ALJ must apply the five-step inquiry set forth in 20 C.F.R. § 404.1520(a)(4)(i)-(v), evaluating the following, in sequence:

> (1) whether the claimant is currently [un]employed; (2) whether the claimant has a severe impairment; (3) whether the claimant's impairment meets or equals one of the impairments listed by the [Commissioner]; (4) whether the claimant can perform her past work; and (5) whether the claimant is capable of performing work in the national economy.

Clifford v. Apfel, 227 F.3d 863, 868 (7th Cir. 2000) (citations omitted) (alterations in original). "If a claimant satisfies steps one, two, and three, she will automatically be found disabled." *Knight v. Chater*, 55 F.3d 309, 313 (7th Cir. 1995). However, "[i]f a claimant satisfies steps one and two, but not three, then she must satisfy step four. Once step four is satisfied, the burden shifts to the SSA to establish that the claimant is capable of performing work in the national economy." *Id.*

After Step Three, but before Step Four, the ALJ must determine a claimant's residual functional capacity ("RFC") by evaluating "all limitations that arise from medically determinable impairments, even those that are not severe." *Villano v. Astrue*, 556 F.3d 558, 563 (7th Cir. 2009). In doing so, the ALJ "may not dismiss a line of evidence contrary to the ruling." *Id.* The ALJ uses the RFC at Step Four to determine whether the claimant can perform her own past relevant work and, if not, at Step Five to determine whether the claimant can perform other work. *See* 20 C.F.R.

§ 416.920(e), (g). The burden of proof is on the claimant for Steps One through Four; only at Step Five does the burden shift to the Commissioner. *Clifford*, 227 F.3d at 868.

If the ALJ committed no legal error and substantial evidence exists to support the ALJ's decision, the Court must affirm the denial of benefits. *Barnett*, 381 F.3d at 668. When an ALJ's decision is not supported by substantial evidence, a remand for further proceedings is typically the appropriate remedy. *Briscoe ex rel. Taylor v. Barnhart*, 425 F.3d 345, 355 (7th Cir. 2005). An award of benefits "is appropriate only where all factual issues have been resolved and the record can yield but one supportable conclusion." *Id.* (citation omitted).

B. Background[2]

Karen W. filed for disability benefits with the Social Security Administration on March 28, 2016, alleging a disability onset date of October 9, 2014. [Filing No. 7-5 at 2.] She alleged that she was disabled due to spurs in the spine, osteoporosis in the lower back, arthritis, fibromyalgia, histoplasmosis syndrome in the right eye, essential tremors, hyper-extensive joints, spurs in the right toe and heel, hallux rigidus in the right toe, and generalized anxiety. [Filing No. 7-4 at 6.] At the time of the alleged onset date, Karen W. was 53 years old. [*See* Filing No. 7-5 at 2.]

The ALJ followed the five-step sequential evaluation set forth by the Social Security Administration in 20 C.F.R. § 404.1520(a)(4) and ultimately concluded that Karen W. was not under a disability at any time between the alleged onset date, October 9, 2014, through the date last insured, March 3, 2016. [Filing No. 7-2 at 20.] Specifically, the ALJ found the following:

[2] The relevant evidence of record is amply set forth in the parties' briefs and need not be repeated here. Specific facts relevant to the Court's disposition of this case are discussed below.

- At Step One, Karen W. has not engaged in substantial gainful activity[3] during the period from her alleged onset date through her date of last insured March 31, 2016. [Filing No. 7-2 at 12.]

- At Step Two, Karen W. has the following severe impairments: mild multilevel degenerative disc disease of the lumbar spine, ocular histoplasmosis with macular scar in the right eye, and gastroesophageal reflux disease. [Filing No. 7-2 at 12-14.]

- At Step Three, Karen W.'s impairments or combination of impairments did not meet or medically equal the severity of one of the listed impairments in 20 CFR Part 404, Subpart P, Appendix 1, (20 CFR 404.1520(d), 404.1525, and 404.1526). [Filing No. 7-2at 15.]

- After Step Three but before Step Four, Karen W. has the following RFC:

> [S]he could lift, carry, push and pull twenty pounds occasionally and ten pounds frequently. With customary breaks in the morning, at lunch and in the afternoon, she could sit six hours in the eight-hour workday. She occasionally could climb stairs and ramps, balance, stoop, crouch, and kneel. She cannot crawl or work on ladders, ropes, or scaffolds. She cannot work with printed material smaller than the standard 12 point font. She cannot perform work requiring precise depth perception, as would be required in threading needles. She can use computer monitors frequently. She cannot work around dangerous, moving machinery or at unprotected heights. She cannot engage in commercial driving. [Filing No. 7-2 at 15.]

- At Step Four, Karen W. was unable to perform any past relevant work through the date last insured. [Filing No. 7-2 at 19.]

- At Step Five, considering Karen W.'s age, education, work experience, and RFC, there were jobs that existed in sufficient numbers in the national economy that she could have performed, such as assembler, inspector, and sorter. [Filing. No. 7-2 at 19-20.]

The Appeals Council denied Karen W.'s request for review of the ALJ's decision. [Filing No. 7-2 at 2-4.] Karen W. then filed this action asking this Court to review the denial of benefits. [Filing No. 1.]

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[3] Substantial gainful activity is defined as work activity that is both substantial (*i.e.*, involves significant physical or mental activities) and gainful (*i.e.*, work that is usually done for pay or profit, whether or not a profit is realized). 20 C.F.R. § 404.1572(a).

C. Discussion

Karen W. filed two separate opening briefs, [Filing No. 19; Filing No. 20], which contain much of the same information and arguments. However, because the briefs do contain some unique arguments, the Court will consider both documents and will treat them as one complete brief. In the briefs, Karen W. makes numerous arguments but largely fails to develop them.[4] She also uses her briefs to critique minor, individual statements in the ALJ's decision or to qualify statements in the medical record. But the Court's review of an SSA decision is limited, *Diaz v. Chater*, 55 F.3d 300, 305 (7th Cir. 1995) (citations omitted), and it is Karen W.'s burden to articulate and develop her arguments; failure to do so can result in waiver, *McMurty v. Berryhill*, 2018 WL 2320929, at *3 (N.D. Ill. May 22, 2018); *United States v Berkowitz*, 927 F.2d 1376, 1384 (7th Cir. 1991). The Court could deny Karen W.'s appeal outright based on her failure to adequately articulate and develop her arguments, but the Court will do its best to undertake an analysis of the merits.

The Court interprets Karen W.'s opening briefs as challenging the ALJ's decision on the following grounds: (1) the ALJ's decision as to her medical impairments is not supported by substantial evidence; (2) the ALJ cherry-picked only favorable evidence from the record, ignoring certain diagnoses and medical records; and (3) the ALJ's RFC determination is not supported by substantial evidence. The Court will consider each issue in turn.

[4] Karen W.'s opening briefs are repetitive and often rambling, and many of her "arguments" are no more than a sentence. The Court has done its best to parse out Karen W.'s arguments. To the extent that Karen W. intended to raise other arguments not identified by the Court, the Court finds those arguments waived for failure to clearly articulate them.

1. Whether the ALJ's Decision as to Karen W.'s Medical Impairments is Supported by Sufficient Evidence

Karen W. argues that the opinions of Dr. William A. Shipley and Dr. Donna Unversaw that she did not have a severe mental impairment cannot be relied upon because their reviews of the medical evidence "only use three Dr. Appointments, and the exact same appointments for examples." [Filing No. 19 at 2.] She also argues that the ALJ incorrectly stated that she was in the emergency room for a psychiatric exam, but she was actually there for a ganglion cyst of the flexor tendon sheath, [Filing No. 19 at 2], and she notes that the report from the emergency room visit was cited multiple times in the ALJ's decision, [Filing No. 19 at 3]. Karen W. takes issue with the ALJ's statement that she denied being fatigued, reasoning that the ALJ "would be presumptuous in stating [she] *denied* being fatigued at appointments." [Filing No. 19 at 3 (emphasis in original).] She argues that the ALJ did not rely on sufficient information when determining that she does not have a concentration or fatigue problem, and that "[f]atigue is mentioned several times in the many pages of Medical Records." [Filing No. 20 at 4.] She also maintains that "the ALJ erred in the review of Chronic Anxiety, under 'paragraph B' criteria, (20 CFR 4.04 1 5210a (d)(1)). Anxiety wax[es] and wan[e]s, but is consistent in all Dr. Appointments in listed 'Chronic Problems.' [The ALJ] [a]lso erred using the same medical report for the four 'Functional areas,' [and she] should have noted more Doctor reports that were in [the] file." [Filing No. 19 at 4.] Karen W. contends that the ALJ also failed to rely on sufficient information in determining that she interacts with other people. [Filing No. 20 at 3.] Karen W. states, "I do not have a social life; I don't go anywhere, talk to anyone, except my husband (most days). Talking to your Father once a month (or at all) and your Mother who suffers from Alzheimer's – she does not know who I am. I don't speak to my Brother or Sister at all; we do not get along. Also, . . . losing my job pertains to . . . getting along with others." [Filing No. 20 at 3.] She maintains that

the questionnaire she filled out over the phone with Public Consulting Group is incorrect because in response to the question "Do you have any problems getting along with family, friends, neighbors, or others?" it says "No." [Filing No. 19 at 3; *see* Filing No. 7-3 at 34.] She asserts that she "would never have put 'No,'" and that the answer to this question is "YES." [Filing No. 19 at 3.] She states that she does not have a social life, which "speaks volumes to [her] [a]nxiety issues." [Filing No. 19 at 3.] She provides a clarification to the ALJ's statement that "claimant reported that she struggles with stress but can go out alone and manage money," explaining that she only goes out alone to the doctor's office and the pharmacy for medication, and her bills are all on autopay. [Filing No. 20 at 4.] She argues that the "ALJ erred in stating incorrect diagnosis" of spinal arachnoiditis because she has lumbar spinal stenosis, which will last for the rest of her life. [Filing No. 20 at 5.] She also asserts that the "ALJ mentions some Dr. appointments that had nothing to do with [her] back." [Filing No. 19 at 4 (citing Filing No. 7-7 at 19, Filing No. 7-10 at 80, and Filing No. 7-8 at 30-32).] Finally, Karen W. argues that he ALJ's statement that "Physical exams have been generally negative" is problematic because the term "generally negative" "seems a little vague for explaining [her] chronic illness. To this point, [she does] not feel the information has been reviewed to the standards of the Social Security Department." [Filing No. 20 at 7 (citing Filing No. 7-2 at 16).]

In response, The Commissioner argues that the ALJ's determination is supported by substantial evidence, the ALJ applied the correct legal standard, and Karen W. failed to meet her burden of showing that she was disabled. [Filing No. 24 at 11-12.] The Commissioner argues that "[t]he ALJ's decision reflects close attention to the details of Plaintiff's medical records"—such as those "showing that Karen W. had no objective examination findings aside from her tremor and that medications controlled [her] pain"—and these records supported the ALJ's determination that

Karen W. was not disabled. [Filing No. 24 at 12-13.] The Commissioner points to the ALJ's consideration of Karen W.'s report to her treating physician, Dr. Leland Heller, that the pain patch he prescribed was "wonderful" and that with Norco she was getting 80% pain relief. [Filing No. 7-2 at 17.] The Commissioner also cites the treatment notes and subjective evidence from Karen W. regarding her reflux and nausea, foot issues, and vision. [Filing No. 24 at 12-15.] The Commissioner contends that the ALJ did not err by finding no mental limitations, arguing that "[a]side from a couple instances of appearing anxious, treatment notes found no psychological symptoms," Karen W.'s "own treating physician found no mental limitations," and "[s]he received no treatment from a mental health specialist and was taking no psychiatric medications at the time of the hearing." [Filing No. 24 at 1.] The Commissioner also contends that the ALJ gave good reasons for giving little weight to the opinion of Karen W.'s treating physician, Dr. Heller, and for giving some weight to the opinions of the state agency physicians, Dr. David Everetts and Dr. J. Sands. [Filing No. 24 at 15-18.] The Commissioner asserts that the ALJ considered and explained Karen W.'s subjective symptoms, but explained that they were not supported by the objective medical evidence, which all showed fully normal physical examinations aside from an occasional benign tremor and a bunion. [Filing No. 24 at 21.]

In reply, Karen W. argues that the doctors' reports noting no difficulty in walking do not accurately reflect her condition because the context of those reports are short appointments where she is mostly sitting in a chair and taking only fifteen steps to get from the waiting room to the chair in the doctors' offices. [Filing No. 27 at 3.] She claims that "Dr. Heller *never* gave her an examination for full range of motion and tenderness EVER. She always just sat in the chair and he would listen to her lungs. No movement to check anything." [Filing No. 27 at 12 (emphasis in original).] She also takes issue with the Commissioner's numerous citations to Karen W.'s

comment that the pain patch was "wonderful," arguing that she said this one time at a doctor's appointment and she later stopped using the patch and the withdrawal was "horrific." [Filing No. 27 at 6.] She also asserts that she never made the comment that she was "getting 80% pain relief." [Filing No. 27 at 6.] Regarding mental limitations, Karen W. argues that the fact that her treating physician was "medicating [her] with so many pills," shows that she had severe psychological disorders, and she was on Clonazepam at the time of the hearing. [Filing No. 27 at 7-8.] Karen W. asserts that she currently does not take any psychiatric medication "because it gives her thoughts of suicide," and she does not currently go to counseling because when she went in the past, "she hated it and found [that] it made her want to drink." [Filing No. 27 at 27.] She notes that "'Depression' is listed in every one of [her] Medical Records.'" [Filing No. 27 at 27.]

At Step Two, the ALJ "must determine whether or not the claimant has a medically determinable impairment that is 'severe' or a combination of impairments that is 'severe.'" 20 CFR 404.1520(c). An ALJ's decision must be based on consideration of all relevant evidence and her conclusions must be stated in a manner sufficient to permit an informed review. *Garfield v. Schweiker*, 732 F.2d 605, 610 (7th Cir. 1984). Here, the ALJ sufficiently articulated that she considered the combination of Karen W.s symptoms and conditions.

Regarding Karen W.'s anxiety and depression, the ALJ cited reports from Dr. Shipley and Dr. Unversaw concluding that Karen W. did not have a severe mental impairment and explaining that there was insufficient evidence prior to the date last insured to evaluate severity. [Filing No. 7-2 at 13 (citing Filing No. 7-3 at 30 (noting "insufficient evidence to substantiate the presence of a[n anxiety] disorder"); Filing No. 7-3 at 43 (same)).] The ALJ reasoned that these conclusions were generally consistent with the substantial evidence of record showing that Karen W. did not have any severe impairments stemming from her anxiety or depression. [Filing No. 7-2 at 13.]

The ALJ pointed to: (1) treatment notes from August 2015 showing a normal psychiatric exam and finding that Karen W. had normal judgment and thought content, [Filing No. 7-10 at 80]; (2) notes from several appointments with Dr. Heller where Karen W. showed no unusual anxiety and was doing well on medication to control her depression, [Filing No. 7-7 at 18; Filing No. 7-8 at 11; Filing No. 7-11 at 53-54]; and (3) reports from Karen W. and her husband showing that she is able to perform personal care tasks and remember to go places without being reminded, [Filing No. 7-6 at 34; Filing No. 7-6 at 6-9], get along with others and she visits her mother, [Filing No. 7-6 at 33-35; Filing No. 7-6 at 52; Filing No. 7-10 at 80], go out alone, manage money, drive, prepare meals, and do some housework, although with some difficulty, [Filing No. Filing No. 7-6 at 31-35]. Although Karen W. provides clarifications and/or additional information pertaining to her medical conditions in her briefs, it does not change the fact that, in light of the available evidence, the ALJ reasonably determined that her anxiety and depression were not severe impairments. The Court finds that the ALJ's determination of Karen W.s medical impairments was supported by substantial evidence.

Moreover, "Step [T]wo is merely a threshold inquiry," and "so long as one of a claimant's limitations is found to be severe, error at that step is harmless." *Ray v. Berryhill*, 915 F.3d 486, 492 (7th Cir. 2019); *see also Loftis v. Berryhill*, 2017 WL 2311214, at *2 n.1 (N.D. Ill. May 26, 2017) (citing *Curvin v. Colvin*, 778 F.3d 645, 649 (7th Cir. 2015) ("[A]ny error that an ALJ commits at step two is harmless as long as she goes on to consider the combined impact of a claimant's severe and non-severe impairments.")). Although the ALJ committed no error at Step Two, even if she had, such error would not require reversal because the ALJ proceeded through all five steps of the disability analysis.

2. Whether the ALJ Cherry-Picked from the Record

Karen W. argues that the ALJ erred by only listing the following conditions: mild multilevel degenerative disc disease of the lumbar spine, ocular histoplasmosis with macular scar in the right eye, and gastroesophageal reflux disease. [Filing No. 20 at 2-3.] She contends that she has several issues that affect her daily life that the ALJ should have addressed, including: spondylosis, cluster headaches, secondary issue with her left eye, chronic anxiety, irritable bowel syndrome, essential tremors, bunion deformity, hallux rigidus, plantar calcaneal spur, and nonunion wrist fracture (limited mobility). [Filing No. 20 at 2-3.] She also argues that the "ALJ has erred in not reviewing other medical records," [Filing No. 19 at 5], although she does not identify what other records the ALJ should have reviewed.

The Commissioner argues that the ALJ did not err by finding no limitations related to Karen W.'s wrist or failing to discuss fibromyalgia because the record does not reflect any active treatment for wrist problems and the treatment notes do not reflect positive trigger points. [Filing No. 19-20.] As for her back pain, the Commissioner points to the following evidence cited by the ALJ: (1) the August 2013 MRI of Karen W.'s lower back showed "relatively mild" degenerative changes and no disc herniation or mass effect, [Filing No. 7-2 at 16 (citing Filing No. 7-8 at 61)]; (2) examinations by two doctors were normal aside from a benign essential tremor, with full range of motion throughout Karen W.'s body and no musculoskeletal tenderness, [Filing No. 7-2 at 16 (citing Filing No. 7-7 at 18-31; Filing No. 7-10 at 80; Filing No. 7-11 at 57-62)]; (3) Karen W. told Dr. Heller that her pain patch was "wonderful" and controlled her pain, [Filing No. 7-2 at 17]; (4) Karen W. had normal examinations from Dr. Heller that continued into 2016, [Filing No. 7-11 at 53]; and (5) in January 2017, Dr. Heller noted that Karen W. stopped using the pain patch, her pain was doing well on Norco, she was getting 80% pain relief, and she was getting out to walk

more, [Filing No. 7-2 at 17 (citing Filing No. 7-12 at 9; Filing No. 7-18 at 8)]. [Filing No. 24 at 12-13.] Regarding Karen W.'s complaints of reflux and nausea, the Commissioner argues that the ALJ reasonably considered that: (1) Karen W. took medication for reflux as needed, [Filing No. 7-2 at 17 (citing Filing No. 7-11 at 69-70; Filing No. 7-12 at 24-25)]; (2) there was no discussion of the need for reflux surgery once she had her gall bladder removed, [Filing No. 7-2 at 17 (citing Filing No. 7-8 at 87)]; (3) her reflux was not noted to be severe, [Filing No. 7-2 at 17 (citing Filing No. 7-12 at 16-17)]; and (4) imaging of her abdomen in 2013 and 2104 was normal aside from stable cysts in her liver, [Filing No. 7-2 at 16 (citing Filing No. 7-8 at 65; Filing No. 7-8 at 72)]. [Filing No. 24 at 13.] The Commissioner asserts that the ALJ reasonably considered the objective evidence regarding Karen W.'s foot issues, citing: (1) the ALJ's consideration of Karen W.'s visit to her podiatrist, where the podiatrist did not impose any restriction on her activities and Karen W. declined surgical options because she wanted to play golf, [Filing No. 7-2 at 17]; and (2) Karen W.'s testimony that she had not obtained any treatment for her foot, [Filing No. 7-2 at 84]. [Filing No. 24 at 14.] Similarly, the Commissioner argues that the ALJ reasonably considered the objective evidence regarding Karen W.'s vision, including: (1) the April 2016 treatment notes reflecting visual acuity in her right eye of 20/20 PHNI and 20/20 in her left eye, no retinal hole, tear, or detachment, and stable condition of her eyes, [Filing No. 7-2 at 16 (citing Filing No. 7-12 at 55-56)]; and (2) Karen W.'s testimony that she could read, but had some trouble with it, she could drive a car, she passed the driver's license vision test, and she used the computer without accommodation other than sitting close to the screen, [Filing No. 7-2 at 16-17]. [Filing No. 24 at 14.] The Commissioner contends that the ALJ did not err by finding no mental limitations, arguing that "[a]side from a couple instances of appearing anxious, treatment notes found no psychological symptoms," Karen W.'s "own treating physician found no mental limitations," and "[s]he received

no treatment from a mental health specialist and was taking no psychiatric medications at the time of the hearing." [Filing No. 24 at 1.]

In reply, Karen W. corrects the Commissioner's statement that she "was taking no psychiatric medication at the time of the hearing," asserting that she was on Clonazepam at the time of the hearing. [Filing No. 27 at 8.] She also takes issues with the Commissioner's reliance on the report of her primary care physician, Dr. Patricia Hallett, which stated, "No noted abnormalities"; she argues that the blindness of the right eye, enlarged lymph node, esophagitis, fibromyalgia, and low back pain listed in the report are abnormalities. [Filing No. 27 at 9-10.]

The Seventh Circuit has emphasized that "an [ALJ] may not select only the evidence that favors [her] ultimate conclusion. [Her] written decision should contain, and [her] ultimate determination must be based upon, all of the relevant evidence in the record." *Garfield*, 732 F.2d at 609 (citations omitted). Courts "examine the [ALJ's] opinion as a whole to ascertain whether [s]he considered all of the relevant evidence, made the required determinations, and gave supporting reasons for [her] decisions." *Orlando v. Heckler*, 776 F.2d 209, 213 (7th Cir. 1985); *see also Davis v. Califano*, 603 F.2d 618, 625 (7th Cir. 1979). An ALJ's decision must be based on consideration of all relevant evidence and her conclusions must be stated in a manner sufficient to permit an informed review. *Garfield*, 732 F.2d at 610.

Here, the ALJ sufficiently articulated that she considered the combination of Karen W.'s symptoms and conditions. The ALJ considered Karen W.'s anxiety, as explained previously, including consideration of the treating physician's treatment notes, the reports of the state agency doctors, and reports from Karen W. and her husband. As for the acid reflux, the ALJ "considered Listings at 5.00 relating to the digestive system," and considered the effects of gastroesophageal reflux "when evaluating the claimant's impairments under the listings." [Filing No. 7-2 at 15.]

The ALJ also considered Karen W.'s macular scar in her right eye resulting from ocular histoplasmosis and some reported distortion of vision in the left eye, but stated that in May 2016, her "right eye was noted to be stable, and her eye exam findings were largely negative." [Filing No. 7-2 at 16.] Regarding Karen W.'s back issues, the ALJ considered an MRI from August 2013, reports from doctors observing she had a full range of motion, and an x-ray of Karen W.'s thoracic spine in April 2014. [Filing No. 7-2 at 17-18.] As for her foot issues, the ALJ considered notes from Karen W.'s podiatrist related to a bunion and some abnormalities on her right foot, which noted that Karen W. felt she did not need treatment for those conditions, as well as Karen W.'s testimony that she had not obtained treatment for her foot. [Filing No. 7-2 at 17.] Although the ALJ does not discuss Karen W.'s wrist, the record did not indicate that she was actively getting treatment for wrist problems, and her treating physician opined that she did not have any limitations in reaching, handling, or fingering. [Filing No. 7-13 at 7.] The ALJ did not discuss Karen W.'s history of fibromyalgia, but, as noted by Dr. Everetts upon his review, the record does not show that a physician provided evidence that falls within one or two sets of criteria for diagnosing fibromyalgia. [Filing No. 7-3 at 46; *see* SSR 12-2p, 2012 WL 3104869, at *2-*3 (reciting the criteria for a diagnosis of fibromyalgia).]

The ALJ's discussion of the evidence was more than adequate to permit the Court to meaningfully review her conclusions, and Karen W. has not shown that the ALJ cherry-picked only favorable evidence from the records or ignored lines of evidence that were contrary to her ultimate conclusions. *See Denton v. Astrue*, 596 F.3d 419, 425 (7th Cir. 2010) ("An ALJ has the obligation to consider all relevant medical evidence and cannot simply cherry-pick facts that support a finding of non-disability while ignoring evidence that points to a disability finding. But an ALJ need not mention every piece of evidence, so long [as s]he builds a logical bridge from the

evidence to h[er] conclusion. " (citations omitted)). To the extent that Karen W. challenges the accuracy of the medical records that the ALJ relied upon, [*see* Filing No. 19 at 3 ("Dr. [n]otes are not always correct because they are rushed and spend very little time with the patient.")], that is not a proper basis for remand. Karen W. had the burden to produce medical records showing that she is disabled, *Scheck v. Barnhart*, 357 F.3d 697, 702 (7th Cir. 2004) (citing 20 C.F.R. § 404.1512(c)), she did not do so, and the ALJ must render a decision based on the records she is given.

3. Whether the RFC Determination is Supported by Sufficient Evidence

Karen W. argues that the ALJ erred in determining her RFC because, during the hearing, the ALJ did not let Karen W. ask the vocational expert ("VE") a question about her nonunion wrist fracture, which was not discussed when determining the RFC. [Filing No. 19 at 4; *see also* Filing No. 7-2 at 108.] Karen W. asserts that she has "limited mobility, and receptive movement causes pain. [She] would not be able to do assembly work." [Filing No. 19 at 4.] She also contends that she could not work as an assembler, inspector, or sorter because she has arthritis in both hands, a nonunion wrist fracture, severe tremors, blindness in one eye, and an inability to stand for long periods of time. [Filing No. 20 at 6.] Karen W. also challenges the ALJ's discussion of her playing golf, clarifying that she plays only occasionally, does not follow the ordinary rules, and does not pick up her ball off the green or mark her ball before putting. [Filing No. 19 at 6.] She asserts that she "ride[s] in a cart just to get outside and feel normal for a[ ]while." [Filing No. 19 at 6.] Several of her arguments relating to the ALJ's determination of her severe impairments, detailed above, also apply to her argument that the ALJ's RFC determination was not supported by sufficient evidence.

The Commissioner argues that "[a]lthough Karen W. contends that she had greater restrictions, the record shows that the ALJ applied the correct legal standards and reached a reasoned decision supported by substantial evidence." [Filing No. 24 at 11.] The Commissioner asserts that the ALJ reasonably considered the objective evidence of Karen W.'s physical impairments, her reported subjective symptoms, and the medical opinion evidence regarding physical limitations. [Filing No. 24 at 11.] The Commissioner also argues that the ALJ reasonably weighed the medical opinion evidence and provided good reasons for giving some weight to Dr. Everetts' and Dr. Sands' opinions and not giving controlling weight to Dr. Heller's opinion. [Filing No. 24 at 15-17.] The Commissioner points out that although the ALJ determined that Dr. Everetts' and Dr. Sands' opinions "were 'somewhat consistent with the substantial evidence of record,' including the relatively normal physical examinations, . . . [t]he ALJ nonetheless determined, based upon [Karen W.'s] testimony, that she had limitations greater than those opined by Drs. Everetts and Sands." [Filing No. 24 at 16.] The Commissioner also notes that the ALJ did not entirely disregard Dr. Heller's opinion; she relied on the opinion to assess limitations beyond the range of medium exertional work that were opined by Dr. Everetts and Dr. Sands.

In reply, Karen W. challenges Dr. Sands' opinion that she could: (1) lift 50 pounds occasionally; (2) lift 25 pounds frequently; (3) stand, walk, or sit for six hours in an eight-hour work day; (4) occasionally climb ramps, stairs, ladders, ropes, or scaffolds; and (5) frequently balance, stoop, kneel, crouch, or crawl. [Filing No. 27 at 22 (citing Filing No. 7-3 at 24-33).] She states that she does not "see how [Dr. Sands] opined that [she] could lift 50 lb[s]. [E]ven occasionally is preposterous. [She] would love to achieve the above; but this is impossible." [Filing No. 27 at 23.] She does not directly respond to the Commissioner's argument that the ALJ reasonably weighed the medical opinions.

The Court finds that the ALJ's determination of Karen W.'s RFC was supported by substantial evidence. The ALJ considered Dr. Heller's physical RFC questionnaire, but gave it limited weight because "it is generally inconsistent with the substantial evidence of record discussed in this decision, including Dr. Heller's own physical exam findings" and his treatment of Karen W. was infrequent. [Filing No. 7-2 at 18.] Dr. Heller opined that Karen W.'s pain was "severe" and "excruciating" despite pain medications and that she should be limited to only two hours of activity, but the ALJ found this to be inconsistent with Dr. Heller's report from Karen W.'s December 2015 exam and appointment. [Filing No. 7-2 at 18.] The ALJ noted that Karen W. reported at that appointment that the pain patch was "wonderful" and that she continued to golf, which called into question whether her pain was "severe" and "excruciating." [Filing No. 7-2 at 18] The ALJ also relied on Karen W.'s husband's report, but gave it less weight than the opinions of the examining, treating, and reviewing medical sources, given that "[t]heir expertise and lack of personal interest in the outcome of the case make those opinions more reliable." [Filing No. 7-2 at 18.] Dr. Everetts reviewed Karen W.'s updated records in September 2016, and he agreed with Dr. Sands' opinion that Karen W. could: (1) lift 50 pounds occasionally; (2) lift 25 pounds frequently; (3) stand, walk, or sit for six hours in an eight-hour work day; (4) occasionally climb ramps, stairs, ladders, ropes, or scaffolds; and (5) frequently balance, stoop, kneel, crouch, or crawl. [Filing No. 27 at 22 (citing Filing No. 7-3 at 24-33).]

"When treating and consulting physicians present conflicting evidence, the ALJ may decide whom to believe, so long as substantial evidence supports that decision." *Dixon v. Massanari*, 270 F.3d 1171, 1178 (7th Cir. 2001). Furthermore, the opinion of a treating physician is not entitled to controlling weight if it is inconsistent with other evidence of record, and where such inconsistencies exist, an ALJ should consider several factors, including the treating

physician's area of specialty and the duration and frequency of the physician's interactions with the claimant. *Bauer v. Astrue*, 532 F.3d 606, 608 (7th Cir. 2008). The ALJ may also disregard a treating physician's opinion if it is "seriously flawed." *Id.*

Here, the ALJ reasonably gave limited weight to Dr. Heller's RFC assessment and explained that Dr. Heller's assessment was inconsistent with other evidence, including the opinions of Dr. Everetts and Dr. Sands, the fact that Karen W. continued to play golf, and Dr. Heller's own treatment notes indicating that Karen W.'s pain had been controlled with a pain patch. The ALJ also noted that Dr. Heller had treated Karen W. only infrequently. [Filing No. 7-2 at 18.] In addition, the ALJ adequately explained her reasoning for giving some weight to Dr. Everetts' and Dr. Sands' opinions and assessed additional limitations, beyond those identified in the opinions, based on the other medical evidence. [Filing No. 7-2 at 17-18.]

As for Karen W.'s nonunion wrist fracture, she points to no medical evidence of record that would suggest that additional limitations were required. Karen W. asserts in her briefs that her mobility is limited and that she often wears a brace on her wrist but does not cite to medical evidence supporting that assertion. Notably, Dr. Heller's RFC assessment form indicates that Karen W. has no limitations in reaching, handling, or fingering. [Filing No. 7-13 at 7.] Finally, Karen W.'s contention that she was not permitted to question the VE about her wrist is of no import, as she was represented by counsel at the hearing and counsel questioned the VE. [Filing No. 7-2 at 63; Filing No. 7-2 at 105-09.]

III.
CONCLUSION

"The standard for disability claims under the Social Security Act is stringent." *Williams-Overstreet v. Astrue*, 364 F. App'x 271, 271 (7th Cir. 2010). "The Act does not contemplate degrees of disability or allow for an award based on partial disability." *Id.* (citing *Stephens v. Heckler*, 766

F.2d 284, 285 (7th Cir. 1985)). "Even claimants with substantial impairments are not necessarily entitled to benefits, which are paid for by taxes, including taxes paid by those who work despite serious physical or mental impairments and for whom working is difficult and painful." *Williams-Overstreet*, 364 F. App'x at 274. Taken together, the Court can find no legal basis presented by Karen W. to reverse the ALJ's decision that she was not disabled during the relevant time period. Therefore, the decision below is **AFFIRMED**. Final judgment shall issue accordingly.

Date: 9/11/2020

Hon. Jane Magnus-Stinson, Chief Judge
United States District Court
Southern District of Indiana

Distribution via ECF only to all counsel of record

Distribution via U.S. mail to:

Karen W.
6190 N. Hurricane Road
Whiteland, IN 46184