UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF OHIO
WESTERN DIVISION

JUDY KOENIG-THOMAS,	:	Case No. 1:13-cv-357
	:	
Plaintiff,	:	Judge Timothy S. Black
	:	
vs.	:	
	:	
CAROLYN W. COLVIN, ACTING COMMISSIONER OF SOCIAL SECURITY,	:	
	:	
Defendant.	:	

ORDER THAT: (1) THE ALJ'S NON-DISABILITY FINDING IS FOUND SUPPORTED BY SUBSTANTIAL EVIDENCE, AND AFFIRMED; AND (2) THIS CASE SHALL BE CLOSED

This is a Social Security disability benefits appeal. At issue is whether the administrative law judge ("ALJ") erred in finding the Plaintiff "not disabled" and therefore not entitled to disability insurance benefits ("DIB") and supplemental security income ("SSI"). (*See* Administrative Transcript ("Tr.") (Tr. 19-28) ("ALJ's decision")).

I.

Plaintiff filed concurrent applications for SSI and DIB on February 22, 2010, and alleged that she became unable to work beginning September 1, 2006.[1] (Tr. 19). Plaintiff listed the following impairments on her application: (1) rotator cuff; (2) bad back with arthritis; (3) right knee problems; and (4) right forearm problems. (Tr. 186).

[1] Plaintiff previously filed an application for SSI in November 2008, which was denied initially and on reconsideration. (Tr. 78-79). Plaintiff did not request a hearing before an ALJ, but instead filed the applications now at issue before this Court.

Her claim was denied initially and on reconsideration. (Tr. 19). Plaintiff subsequently requested a hearing before an ALJ. (Tr. 98-99).

The ALJ held a hearing on Plaintiff's claims on November 8, 2011. (Tr. 108). Plaintiff and a vocational expert testified, with Plaintiff's attorney in attendance. (Tr. 34-35). On December 9, 2011, the ALJ rendered an unfavorable decision, finding that Plaintiff, despite severe physical impairments, had the residual functional capacity ("RFC") to perform a restricted range of light unskilled work.[2] (Tr. 19-28). Based on Plaintiff's age, education, work experience, and RFC, the ALJ found that there were a significant number of jobs in the national and regional economy that Plaintiff could perform. (Tr. 27). The ALJ further noted that even if Plaintiff's level of exertion were reduced to a sedentary range, there were still a significant number of jobs that Plaintiff could perform. (*Id.*) Therefore, the ALJ found that Plaintiff was not disabled. (Tr. 23, 29-30). This decision became final and appealable in March 2013 when the Appeals Council denied Plaintiff's request for review. (Tr. 1-3). Plaintiff seeks judicial review pursuant to section 205(g) of the Act. 42 U.S.C. §§ 405(g), 1383(c)(3).

At the time of the hearing, Plaintiff was a 44-year-old female with a 12th grade education and a commercial driver's license. (Tr. 64, 187). Prior to the hearing, Plaintiff worked in various positions including child monitor, bartender, bus driver, bakery sales clerk, and shuttle bus driver. (Tr. 64-65). However, the ALJ found that these positions

[2] A claimant's residual functional capacity ("RFC") is an assessment of "the most [she] can still do despite [her] limitations." 20 C.F.R. § 416.945(a)(1).

did not qualify as past relevant work, because the income Plaintiff earned did not meet the substantial gainful activity income threshold.[3] (Tr. 26).

The ALJ's "Findings," which represent the rationale of her decision, were as follows:

1. The claimant has not engaged in substantial gainful activity since February 22, 2010, the application date (20 CFR 416.971 *et seq*.).

2. The claimant has the following severe impairments: osteoarthritis of the shoulders, degenerative disc disease of the lumbar spine, ankle pain of unknown etiology, and right knee non-displaced meniscus tear (20 CFR 416.920(c)).

3. The claimant does not have an impairment or combination of impairments that meets or medically equals the severity of one of the listed impairments in 20 CFR Part 404, Subpart P, Appendix 1 (20 CFR 416.920(d), 416.925 and 416.926).

4. After careful consideration of the entire record, the undersigned finds that the claimant has the residual functional capacity to perform light work as defined in 20 CFR 416.967(b) except: the claimant is capable of no more than occasional pushing and pulling with the right upper extremity, she should never climb ladders, ropes or scaffolds, she should never crawl, the claimant can occasionally climb ramps or stairs, balance, stoop, kneel, and crouch, she can perform bilateral reaching on a frequent basis and bilateral overhead reaching on an occasional basis, handling and fingering are unlimited, and she should avoid concentrated exposure to extreme cold.

5. The claimant has no past relevant work (20 CFR 416.965).

6. The claimant was born on May 12, 1967 and was 42 years old, which is defined as a younger individual age 18-49, on the date the application was filed (20 CFR 416.963).

7. The claimant has at least a high school education and is able to communicate in English (20 CFR 416.964).

[3] The calculations set forth under 20 CFR 416.974(b)(2) determine whether earnings derived from a claimant's previous work meet the requirements for substantial gainful activity.

8. Transferability of job skills is not an issue because the claimant does not have past relevant work (20 CFR 416.968).

9. Considering the claimant's age, education, work experience, and residual functional capacity, there are jobs that exist in significant numbers in the national economy that the claimant can perform (20 CFR 416.969 and 416.969(a)).

10. The claimant has not been under a disability, as defined in the Social Security Act, since February 22, 2010, the date the application was filed (20 CFR 416.920(g)).

(Tr. 21-27).

In sum, the ALJ concluded that Plaintiff was not under a disability as defined by the Social Security Regulations and was therefore not entitled to DIB or SSI. (Tr. 28).

On appeal, Plaintiff argues that: (1) the ALJ improperly analyzed the medical opinion of treating physician, Dr. Michael Bertram ("Dr. Bertram"); (2) the ALJ failed to properly account for all the impairments in the RFC; and (3) the ALJ's credibility analysis is neither reasonable nor supported by the evidence. (Doc. 11 at 10-17). The Court will address each alleged error in turn.

II.

The Court's inquiry on appeal is to determine whether the ALJ's non-disability finding is supported by substantial evidence. 42 U.S.C. § 405(g). Substantial evidence is "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 performing this review, the Court considers the record as a whole. *Hephner v. Mathews*, 574 F.2d 359, 362 (6th Cir. 1978). If substantial evidence supports the ALJ's denial of benefits, that

finding must be affirmed, even if substantial evidence also exists in the record upon which the ALJ could have found plaintiff disabled. As the Sixth Circuit has explained:

> "The Commissioner's findings are not subject to reversal merely because substantial evidence exists in the record to support a different conclusion. The substantial evidence standard presupposes that there is a "zone of choice" within which the Commissioner may proceed without interference from the courts. If the Commissioner's decision is supported by substantial evidence, a reviewing court must affirm."

Felisky v. Bowen, 35 F.3d 1027, 1035 (6th Cir. 1994).

The claimant bears the ultimate burden to prove by sufficient evidence that she is entitled to disability benefits. 20 C.F.R. § 404.1512(a). That is, she must present sufficient evidence to show that, during the relevant time period, she suffered an impairment, or combination of impairments, expected to last at least twelve months, that left her unable to perform any job in the national economy. 42 U.S.C. § 423(d)(1)(A).

A.

The record reflects that:

1. Physical Impairments

Plaintiff alleges that she is disabled due to rotator cuff injuries, back pain with arthritis, right knee injury, and right forearm pain. (Tr. 186). However, the vast majority of Plaintiff's medical records refer only to her rotator cuff and back pain.[4]

[4] With regard to Plaintiff's knee injury, the ALJ's decision notes that "there is little information in evidence concerning [the] condition[]," and that, in fact, "[Plaintiff] is able to ambulate with a normal gait and does not require an assistive devise to walk." (Tr. 25).

In 2006, due to bilateral shoulder pain, and later chronic back pain, Plaintiff began treatment at Beacon Orthopedics & Sports Medicine. (Tr. 270-306, 383-390). Plaintiff had surgery on her right rotator cuff in 2006. In January 2007, a physical altercation caused Plaintiff to reinjure her rotator cuff, which required follow-up surgery to correct. (Tr. 301-02). Plaintiff's medical records reflect that by February 23, 2007, she was "[d]oing a lot better" and had "full range of motion." (Tr. 297). However, Plaintiff continued to experience pain, which she attempted to alleviate with steroid injections from May 2007 to November 2008. (Tr. 277, 286, 291).

In February 2008, an MRI of Plaintiff's left shoulder revealed rotator cuff tendinopathy, bursitis, and AC joint arthropathy. (Tr. 303). On December 1, 2008, after attempting conservative treatment, Dr. Peter Cha of Beacon Orthopedics performed left shoulder decompression to treat impingement syndrome. (Tr. 273). Shortly after the procedure, Plaintiff was in a motor vehicle accident, which further caused injury to her left shoulder. (Tr. 388). Plaintiff was sent for an MRI on January 5, 2009, which revealed a possible contusion, postoperative change, or tendinopathy. (Tr. 389). Dr. Cha's records document that Plaintiff continued to complain of stiffness, pain, and difficulty with overhead activities. (Tr. 384-86).

Plaintiff also sought pain management for her back and hip pain with Dr. Rajbir Minhas at the Freiberg Spine Institute in December 2007. (Tr. 308, 317-381). Dr. Minhas diagnosed Plaintiff with a lumbosacral sprain and a herniated lumbar disc. (Tr. 308). Plaintiff's medical records note regular complaints of aching, stabbing pain in her back, hip, and buttock areas that radiated to her legs, ankles, and feet. (Tr. 318, 323, 328,

331, 336, 341, 346, 351, 352, 357, 362, 372, 377). Plaintiff also complained that she felt as if she would fall due to the pain in her hip. (Tr. 308). Dr. Minhas noted that the lumbar MRI from 2008 revealed degenerative disc disease and a herniated disc that impinged on her L4 nerve root. (Tr. 323, 336).

On October 10, 2008, Plaintiff consulted with Dr. Gregory Goldberg regarding her chronic back pain. (Tr. 283). Dr. Goldberg examined Plaintiff, ordered and reviewed lumbar x-rays, and reviewed a lumbar MRI from September 2008, which indicated severe disc degeneration at L2-L3 and mild disc degeneration at L3-L4 and L4-L5. (Tr. 283). Dr. Goldberg noted that fusion surgery might be an option, but wanted Plaintiff to have a discogram to see if she was a good candidate and to determine which levels needed to be fused. (*Id*.)

From May through October 2009, Plaintiff treated with Dr. Bruce Kay at American Health and Pain Management. (Tr. 391-419). Dr. Kay's records reveal that Plaintiff had regular complaints of pain in her left shoulder, right forearm, and in both feet along with numbness and tingling in her right hand. (Tr. 393-94, 399). Radiographs from August 2009 of Plaintiff's pelvis revealed remote trauma to the symphysis pubis, and an x-ray of her lumbar spine from the same day confirmed degenerative disc disease. (Tr. 416-17).

In August 2009, Plaintiff began seeking treatment with various physicians at White Oak Family Practice. (Tr. 510-97). Plaintiff's first appointment at White Oak was with Dr. Eugene Reilly who treated her for persistent cough and chest congestion. (Tr. 565). Dr. Reilly's diagnoses of Plaintiff included backache, tobacco use disorder, cough,

fatigue, and other malaise. (Tr. 567). Dr. Reilly sent Plaintiff for chest x-rays and strongly suggested she discontinue her smoking habit of one and a half packs per day. (Tr. 566-67). In May 2011, Dr. David Mouch of White Oak treated Plaintiff for tension headaches. (Tr. 516). Dr. Mouch noted that Plaintiff acknowledged prominent situational stress, and he suggested supportive counseling to assist her. (Tr. 516-18). Apart from these two appointments, Plaintiff frequently sought treatment and medication at White Oak from August 2009 to August 2011. (Tr. 510-97).

In November 2009, Plaintiff began pain management treatment with Dr. Michael Bertram, Dr. Jose Martinez, and Dr. Muhammed Kaleem of Physicians Healthsource. (Tr. 422-456, 481-507, 598-661). The record indicates that Dr. Kaleem only saw Plaintiff on three occasions from April to June 2011, and that Plaintiff's appointments were primarily with Dr. Martinez. (Tr. 422-42, 481-507, 614-25, 626-52). According to Plaintiff's medical records, Dr. Martinez was her exclusive physician during her visits to Physicians Healthsource from November 2009 to March 2011.[5] (Tr. 422-42, 481-507, 626-52).

In May 2010, Dr. Martinez referred Plaintiff for an MRI of her right knee, which revealed a tear of the posterior horn of the medial meniscus. (Tr. 506). In March 2011, Dr. Martinez referred Plaintiff for an MRI of her lumbar spine, which revealed multilevel lumbar degenerative disc disease, most significantly at the L4-L5 level, including disc extrusion causing focal impingement of the left L4 nerve root. (Tr. 653).

[5] The string of record citations in Plaintiff's Statement of Errors indicating Plaintiff's regular appointments and ongoing pain management is incorrectly attributed to Dr. Bertram. (Doc. 11 at 4). Nearly all of the citations are to medical records that were signed by Dr. Martinez.

On one occasion in November 2009, Plaintiff also consulted with Dr. Bertram at Physicians Healthsource. (Tr. 445). During this initial appointment, Dr. Bertram noted that Plaintiff appeared to have chronic ongoing low back pain focal to the left side, bilateral numbness and tingling to the lower extremity, left shoulder rotator cuff repairs status post re-injury, and anxiety. (Tr. 446). In January 2010, Dr. Bertram performed an EMG for Plaintiff, which showed that all conduction studies and all muscles examined were within normal limits, and that there was no evidence of lumbosacral radiculopathy, plexopathy, peripheral neuropathy, or focal mononeuropathy. (Tr. 453). Plaintiff did not return to Dr. Bertram again until July 2011. (Tr. 613). In his notes for the July 2011 appointment, Dr. Bertram stated that he "had seen [Plaintiff] once before and discuss[ed] possible interventions [for her lower back pain] but she never followed back up." (*Id*.) From August to September 2011, Plaintiff returned to Dr. Bertram for two office visits and two procedures, including a lumbar medial branch block and steroid injections to Plaintiff's left sacroiliac joint. (Tr. 599-604, 610-11).

Dr. Bertram's notes from Plaintiff's appointments in July, August, and September 2011 express concern over Plaintiff's ongoing prescribed use of anxiety medication and opiates. (Tr. 602, 611, 613). In an attempt to find alternative pain management, Dr. Bertram referred Plaintiff to chiropractor, Dr. Jeffery Elwert. (Tr. 611). Plaintiff saw Dr. Elwert for an initial evaluation on August 24, 2011. (Tr. 607-09). However, as Dr. Bertram notes, despite his recommendation, Plaintiff did not return to Dr. Elwert, nor did she pursue chiropractic appointments. (Tr. 601-02).

In September 2011, Dr. Bertram completed a Basic Medical Form for the Ohio Department of Job and Family Services on behalf of Plaintiff, reporting that she suffers from chronic low back pain, right ankle pain, degenerative disc, and joint issues, with a history of multiple shoulder surgeries. (Tr. 663-64). Dr. Bertram also indicated that Plaintiff had no mental impairments and stated that there were no psychological or psychiatric findings to report. (Tr. 663). He opined that Plaintiff could stand/walk for only fifteen minutes without interruption and for two hours per eight-hour workday, that she could sit for thirty minutes without interruption and only for a total of four hours during an eight-hour workday, that she is limited to lifting or carrying six to ten pounds on an occasional basis, that she is extremely limited in her ability to push/pull, that she is markedly limited in her ability to bend and reach, and that she is moderately limited in her ability to perform repetitive foot movements.[6] (Tr. 664). Dr. Bertram concluded that Plaintiff was unemployable. (*Id.*)

In March 2010, Plaintiff had a surgical consultation with Dr. John Jacquemin of Mercy Orthopedic & Spine Specialists. (Tr. 421). After examination, Dr. Jacquemin noted that Plaintiff's gait was heel to toe with no limp or instability, that there was no pain with range of motion of major joints in her lower extremities, that Plaintiff experienced back pain on flexion and pain bilaterally on extension, and that she had

[6] Question 5 of the Basic Medical Form asks that the physician state the basis for his opinion regarding the patient's physical limitations. (Tr. 664). However, Dr. Bertram's response to this particular question is illegible. (*Id.*) Therefore, the Court cannot determine whether Dr. Bertram based his opinion upon the few occasions he had to observe the Plaintiff or upon the entirety of her medical history with Physicians Healthsource. The Court considers this point when determining the issue of whether the ALJ gave appropriate weight to Dr. Bertram's opinion as a treating physician.

reduced range of motion overall. (*Id*.) However, Dr. Jacquemin did not recommend surgery given his observations during the examination and stated that conservative pain treatment was the better option. (*Id*.)

While seeking treatment at Mercy Orthopedic & Spine Specialists, Plaintiff also consulted with Dr. Pamela Petrocy. (Tr. 466). In May 2010, Dr. Petrocy examined Plaintiff's shoulders, diagnosed her with bilateral shoulder impingement and right arm medial epicondylitis with intermittent muscle swelling, and administered a steroid injection to Plaintiff's right shoulder. (*Id*.) During a follow-up appointment that month, Dr. Petrocy noted that examination of Plaintiff's cervical spine demonstrated no palpable tenderness or step deformity and that Plaintiff exhibited full range of motion. (Tr. 591). Upon a bilateral shoulder evaluation, Dr. Petrocy stated that, although Plaintiff complained of tenderness from activity above ninety degrees, her examination demonstrated full range of motion in flexion and full range of motion in abduction. (*Id*.) Dr. Petrocy confirmed her earlier diagnosis and administered a steroid injection to Plaintiff's right shoulder. (*Id*.) Dr. Petrocy also referred Plaintiff for an MRI of her right shoulder and an x-ray of her left shoulder. (Tr. 468, 470). The x-ray was performed on May 18, 2010, revealing AC joint arthrosis with down-sloping of the acromion without evidence of acute bony abnormality. (Tr. 470). The right shoulder MRI was performed on May 28, 2010, and revealed no labral tearing, a small amount of abnormal linear signal in the supraspinatus tendon, and degenerative changes at the AC joint with moderate inferior spurring. (Tr. 468).

2. Psychological Impairments

The record indicates that Plaintiff was prescribed medication to treat "situational" anxiety, which was triggered by "life stressors," including Plaintiff's acrimonious divorce. (Tr. 290, 295-96, 446, 448, 516-18, 611, 613). There is no evidence to indicate that Plaintiff ever sought specialized psychological or psychiatric assistance. In fact, Plaintiff's treating physician, Dr. Bertram, expressed concern over Plaintiff's ongoing use of anti-anxiety medication. (Tr. 602, 611, 613). In July 2011, Dr. Bertram noted that Plaintiff would need to see a psychiatrist or her general practitioner for similar prescriptions going forward. (Tr. 613). Furthermore, in September 2011, Dr. Bertram completed the Ohio Department of Job and Family Services Basic Medical Form on behalf of Plaintiff and wrote that she did not have any mental impairments. (Tr. 663).

3. Opinions of Reviewing Physicians

In May 2010, Dr. Diane Manos conducted a state-agency review of Plaintiff's medical records in order to complete a Physical RFC Assessment. (Tr. 457-64). After reviewing all of the evidence, Dr. Manos opined that Plaintiff could frequently lift and/or carry up to ten pounds and occasionally up to twenty pounds, that she could stand and/or walk with normal breaks for a total of about six hours during an eight-hour workday, that she had certain postural limitations due to her shoulder and back pain, and that she was restricted to occasional pushing, pulling, and reaching due to left upper extremity limitations. (Tr. 457-60). Dr. Manos further noted that although she found Plaintiff's reports to be partially credible and supported by medical evidence, there were some inconsistencies between Plaintiff's self-reported physical restrictions and her admitted

daily activities. (Tr. 462). For instance, Plaintiff reported that she could not lift more than ten pounds and could walk only a short distance, but her admitted daily activities included light household chores and yard work with a riding lawn mower. (*Id*.) Dr. Manos also stated that Plaintiff's recent medical examinations show a normal gait and normal neurological function. (*Id*.)

In October 2010, a second state-agency review was conducted in response to Plaintiff's allegations that her physical condition had worsened. (Tr. 508). Dr. W. Jerry McCloud determined that Plaintiff's condition had in fact changed, and her RFC was updated to reflect that Plaintiff's manipulative limitations were now applicable to both upper extremities, rather than just the left. (*Id*.)

4. Hearing Testimony

a. Plaintiff's Testimony

At the hearing on November 8, 2011, Plaintiff testified that she experiences constant pain in both shoulders and her back. (Tr. 52). Plaintiff explained that her left shoulder markedly improved subsequent to arthroscopic surgery, but that there was still a small tear in her rotator cuff causing her pain. (Tr. 51). Plaintiff stated that her right shoulder is now the more problematic of the two, despite having undergone three surgeries to correct her rotator cuff injury. (Tr. 52). She also testified that she has ongoing pain in the lower left side of her back that occasionally shoots down her leg, causing weakness that previously resulted in her falling. (Tr. 55).

With regard to her physical limitations, Plaintiff explained that she is limited in her ability to lift, carry, and reach. (Tr. 51). Plaintiff also stated that she experiences

pain from sitting with her arms outstretched, such as at a desk or table. (*Id.*) Plaintiff testified that she is generally unable to sit for more than twenty-minutes before the pain requires her to stand up and walk around. (Tr. 56). However, she could sit for approximately an hour if she places a heating pad on her back. (Tr. 58).

Plaintiff testified that she is in constant pain from the moment she wakes in the morning. (Tr. 44). She stated that she takes pain medication as soon as she is awake and then must wait approximately twenty to thirty minutes for the medication to take effect before she is able to get out of bed. (*Id.*) Plaintiff explained that she has trouble with bathing, grooming, and dressing, unless she has substantial assistance from her husband and children. (Tr. 48). She claims that she is generally unable to do even light housework or anything that requires her to bend or reach, such as cooking and shopping. (Tr. 45-46). Furthermore, Plaintiff stated that her physical pain interrupts her ability to socialize and spend quality time with her husband and children. (Tr. 48-49, 53-56). She testified that she is able to watch television and read, but only for short periods at a time. (Tr. 45, 57).

Plaintiff claims that she is unable to sleep soundly throughout the night. (Tr. 63). She stated that she receives less than five hours of sleep a night at least five days a week. (*Id.*) However, Plaintiff stated further that she is generally able to go back to bed in the morning after her children have gone to school and she allows herself to sleep in as long as she is able. (Tr. 45).

Plaintiff testified that on a scale of zero (lowest) to ten (highest), her pain is generally a four in the morning and can occasionally rise as high as eight or nine during

the day. (Tr. 59). Even after taking her medication, Plaintiff explained that her pain is never alleviated, but only reduced to a three or four. (*Id*.) Furthermore, the pain medication only reduces her pain for approximately two hours at a time. (Tr. 60).

In addition to pain medication, Plaintiff also takes anti-anxiety medication, including Xanax and Klonopin. (Tr. 60). Plaintiff stated that her general practitioner prescribed these medications to treat her anxiety and also to control dizzy spells. (Tr. 60-61). Plaintiff explained that the cause of her anxiety is largely the extreme physical pain she endures. (Tr. 61). She stated that at least four or five times a week, she experiences pain so severe that it causes her to cry, become irritable and angry, and shut herself off from everyone around her. (Tr. 58-62).

Plaintiff testified that she was recently told she might need more surgery, but that her general practitioner was concerned about her health and would not give her a referral to a surgeon until further tests were performed. (Tr. 50).

b. Testimony of Vocational Expert

The ALJ called Vocational Expert, Vanessa Harris, to testify as to Plaintiff's past work and how Plaintiff's limitations would affect her ability to secure gainful employment. (Tr. 37, 64).

Ms. Harris first testified regarding the general skill and exertion level required to perform Plaintiff's past work as a child monitor, bar attendant, bus driver, bakery store clerk, and shuttle bus driver. (Tr. 64-65). Ms. Harris testified that given Plaintiff's limitations, the only position Plaintiff could still perform was child monitor. (Tr. 64). Although child monitor is a semi-skilled position, generally performed at a medium

exertion level, Plaintiff was only performing the work at a sedentary level. (*Id*.) Therefore, Ms. Harris testified that Plaintiff could continue performing the work at a sedentary level, despite her physical limitations. (*Id*.)

The ALJ also asked Ms. Harris whether there were other jobs in the regional and national economy that an individual with Plaintiff's RFC could perform. (Tr. 65-66). Ms. Harris testified that there were numerous jobs that Plaintiff or a similar individual could perform, both at a light and sedentary exertion level.[7] (Tr. 66-69).

In response to the ALJ's hypothetical inquiries, Ms. Harris also testified that it would adversely affect an employee's ability to perform unskilled work if she required additional unscheduled breaks of approximately ten minutes each. (Tr. 71). Furthermore, Ms. Harris stated that employers would generally not permit an employee to lie down on the job when they were not on a break. (*Id*.) Also, Ms. Harris testified that although, in isolation, absenteeism of one or two days a month would likely be tolerated by an employer, it would cause a problem if coupled with the need for excessive breaks and lying down throughout the workday. (Tr. 71-72).

5. ALJ Decision

In the ALJ's decision, she found that Plaintiff's osteoarthritis of the shoulders, degenerative disc disease of the lumbar spine, ankle pain, and right knee non-displaced

[7] Ms. Harris testified that Plaintiff could perform a significant number of unskilled jobs within the light and sedentary exertion range, including bottle packer (light exertion – 250 jobs locally/19,000 jobs nationally), silver wrapper (light exertion – 3,100 jobs locally/430,000 jobs nationally), order caller (light exertion – 500 jobs locally/54,000 jobs nationally), table worker (sedentary – 300 jobs locally/22,000 jobs nationally), document preparer (sedentary – 280 jobs locally/28,000 jobs nationally), and tube operator (sedentary – 150 jobs locally/11,700 jobs nationally). (Tr. 27).

meniscus tear are "severe" impairments. (Tr. 21). However, the ALJ found that Plaintiff did not have an impairment or combination of impairments that met or medically equaled a Listing of Impairments. (*Id*.) The ALJ found that Plaintiff has the RFC for a reduced range of light work. (Tr. 22). Thus, the ALJ denied Plaintiff's claims for benefits.

B.

First, Plaintiff alleges that the ALJ did not properly analyze Dr. Michael Bertram's medical opinion under the treating physician rule. (Doc. 11 at 10). Specifically, Plaintiff argues that the ALJ inadequately articulated the reason behind her decision to discount Dr. Bertram's opinion and did not specify which medical opinion was inevitably given controlling weight. (*Id*. at 10-11).

The Regulations clearly state that a treating doctor's opinion must be given "controlling weight" if "well-supported" by objective evidence. 20 C.F.R. § 1527(d)(2). More weight is generally given to treating sources because they can provide a detailed, longitudinal picture of one's medical impairments and may bring a unique perspective to the medical evidence that cannot be obtained from objective findings alone or from reports of individual examinations such as consultative examinations. *Id.* "If the opinion of a treating source is not accorded controlling weight, an ALJ must apply certain factors – namely, the length of the treatment relationship and the frequency of examination, the nature and extent of the treatment relationship, the supportability of the opinion, consistency of the opinion with the record as a whole, and the specialization of the treating source – in determining what weight to give the opinion." *Wilson v. Comm'r of Soc. Sec.*, 378 F.3d 541, 544 (6th Cir. 2004) (discussing 20 C.F.R. § 1527(d)(2)).

If an ALJ rejects the opinion of a treating physician, she must articulate clearly "good reasons" for doing so. *Wilson*, 378 F.3d at 544. In order to be "good," those reasons must be "supported by the evidence in the case record, and must be sufficiently specific to make clear to any subsequent reviewers the weight the adjudicator gave to the treating source's medical opinion and the reasons for that weight." SSR 96-2p. In fact, the Sixth Circuit has held that the ALJ's "failure to follow the procedural requirement of identifying the reasons for discounting the opinions and for explaining precisely how those reasons affected the weight" given "denotes a lack of substantial evidence, even where the conclusion of the ALJ may be justified based upon the record." *Rogers v. Comm'r of Soc. Sec.*, 486 F.3d 234, 243 (6th Cir. 2007).

In September 2011, Dr. Michael Bertram, who had seen Plaintiff for office visits once in 2009 and then three times (July, August, and September 2011) prior to the hearing (Tr. 599-613), completed the Ohio Department of Job and Family Services Basic Medical Form on behalf of Plaintiff. (Tr. 663-64). Dr. Bertram opined, among other things, that Plaintiff could stand and/or walk about two hours in an eight-hour workday but for no longer than fifteen minutes without interruption; could sit about four hours in an eight-hour workday but for no longer than thirty minutes without interruption; and could only occasionally lift and carry up to ten pounds. (Tr. 664). Dr. Bertram also noted that Plaintiff's health was "poor but stable." (Tr. 663). However, Dr. Bertram's

notes from Plaintiff's last office visit are inconsistent with these statements.[8] (Tr. 599-602). On September 15, 2011, Dr. Bertram noted that Plaintiff "feels medications are helpful and she is able to move." (Tr. 602). Furthermore, there is only one comment pertaining to Plaintiff's range of motion in the entirety of Dr. Bertram's notes from Plaintiff's 2011 office visits. (Tr. 599-613). It states: "[r]ange of movement is limited in extension and bilateral bending direction." (Tr. 613). Finally, Dr. Bertram's November 2009 notes indicate that Plaintiff could "easily stand and ambulate across the [room]," and that she was doing well apart from tenderness in her lower back. (Tr. 448).

The ALJ's opinion states that "Dr. Bertram's assessment is given less weight because it is not consistent with the claimant's normal neurological, muscular, and range of motion examination results. It is also not consistent with the claimant's relatively active daily routine." (Tr. 25). Despite Plaintiff's assertion to the contrary, the ALJ did point to specific inconsistencies between Dr. Bertram's assessment and the record evidence. For instance, she notes that just one month before Dr. Bertram completed the Basic Medical Form, Plaintiff's neurological examinations were normal and her "primary care physician reported that [she] demonstrated normal range of motion." (Tr. 24). The ALJ further states that Dr. Bertram's own notes from September 15, 2011 indicate that Plaintiff was doing well on her medication and was able to move about. (*Id.*) The ALJ also noted the extended period of time between Plaintiff's first appointment with Dr.

[8] The record indicates the Basic Medical Form that Dr. Bertram completed is dated September 11, 2011. (Tr. 662). However, this date cannot be correct. Although the form does not appear to be dated at all, Dr. Bertram indicates that the date of Plaintiff's last examination was September 15, 2011. (Tr. 664). Therefore, the form must have been completed subsequent to the September 15, 2011 appointment.

Bertram in November 2009 and her return to his care in July 2011. (Tr. 23). Therefore, the ALJ's reasons for discounting Dr. Bertram's opinion are appropriately articulated in the opinion and valid.

Additionally, the ALJ states that "[t]he State agency consultant's assessment from May 12, 2010 is given some weight, as it is generally consistent with the record evidence." (Tr. 25). The ALJ does disagree with the assessment "that [Plaintiff] is limited to occasional reaching," which she bases on "the *improvement* in [Plaintiff's] shoulder impairments" and "the variety of [Plaintiff's] admitted activities." (*Id*.) (emphasis added). However, this disagreement based on the *changes* to Plaintiff's condition since the date of the assessment does not indicate, as Plaintiff asserts, that the ALJ did not fully rely on the reviewing opinion.

Furthermore, Plaintiff's argument that the ALJ's reasoning is deficient because she did not specifically articulate which opinion was given "controlling" or "significant" weight is without merit. Due to Plaintiff's extensive medical records and the overlapping opinions of numerous physicians, the record is replete with inconsistencies. The ALJ addressed those inconsistencies appropriately, gave due weight to the opinions before her, and made a determination based on her assessment of the record as a whole. There are scenarios "where the Commissioner has met the goal of Section 404.1527(d)(2) – the provision of the procedural safeguard of reasons – even though she has not complied with the terms of the regulation." *Wilson v. Comm'r of Soc. Sec.*, 378 F.3d 541, 547 (6th Cir. 2004); *see, e.g.*, *Nelson v. Comm'r of Soc. Sec.*, 195 Fed. Appx. 462, 472 (6th Cir. 2006) (finding that even though the ALJ failed to meet the letter of the good-reason

requirement, the ALJ met the goal by indirectly attacking the consistency of the medical opinions). The same is true in the instant case. The Court's duty on appeal is not to re-weigh the evidence, but to determine whether the decision below is supported by substantial evidence. *Raisor v. Schweiker*, 540 F. Supp. 686 (S.D. Ohio 1982). The issue is not whether the record could support a finding of disability, but rather whether the ALJ's decision is supported by substantial evidence. *Casey v. Sec'y of Health & Human Servs.*, 987 F.2d 1230, 1233 (6th Cir. 1993). Here, substantial evidence supports the ALJ's finding that Plaintiff could perform a limited range of light work and therefore was not disabled.

C.

Next, Plaintiff alleges that the ALJ failed to account properly for all the impairments in the RFC. (Doc. 11 at 12). Specifically, Plaintiff argues that the ALJ did not adequately address Plaintiff's anxiety or the physical limitations associated with Plaintiff's severe impairments. (*Id*. at 13-14).

The ALJ must consider all of the Plaintiff's impairments, including impairments that are not severe, in making an RFC assessment. 20 C.F.R. § 416.945(a)(2). Particularly when the record evidence provides "conflicting opinions from various medical sources, it is the ALJ's function to evaluate the medical evidence and determine Plaintiff's RFC." *Swett v. Comm'r of Soc. Sec.*, 886 F.Supp.2d 656, 660 (S.D. Ohio 2012) (citations omitted). Subjective complaints may "support a claim for disability, *if there is also objective medical evidence* of an underlying medical condition in the

record." *Jones v. Comm'r of Soc. Sec.*, 336 F.3d 469, 475-76 (6th Cir. 2003) (emphasis added).

Plaintiff's application for benefits did not list anxiety as a work preclusive impairment. (Tr. 186). Furthermore, apart from Plaintiff's long-term use of anti-anxiety medication,[9] there are no medical opinions in the record to evidence that Plaintiff was diagnosed with an anxiety disorder, which would limit her ability to work. In fact, Plaintiff's medical records belie this assertion. Plaintiff's medical records generally characterize her anxiety as situational.[10] (Tr. 290, 295-96, 446, 448, 516-18, 611, 613). Plaintiff herself testified at the hearing that her anxiety was largely triggered by anger and irritability, due to her extreme pain. (Tr. 61). Furthermore, Plaintiff's own treating physician specifically stated in his Basic Medical Form that Plaintiff did not suffer from any mental impairment. (Tr. 663). Therefore, the ALJ did not err in failing to address Plaintiff's anxiety.

Additionally, Plaintiff's claim that the ALJ did not properly account for all of Plaintiff's limitations is misguided. Even if the ALJ's opinion fails to *articulate* certain limitations, they were nonetheless accounted for in her decision. All of Plaintiff's limitations were addressed at the hearing, and the vocational expert testified that there were jobs in the national and regional economy that an individual with Plaintiff's RFC

[9] Plaintiff testified that she was prescribed anti-anxiety medication by her general practitioner to treat anxiety and dizzy spells. (Tr. 60).

[10] The record reflects that in March 2011, Plaintiff also obtained a prescription for anti-anxiety medication from her general practitioner prior to a dental appointment. (Tr. 522). Although this was only one instance, there is no evidence in the record to indicate the precise medical reason or diagnosis for which Plaintiff obtained her other anti-anxiety prescriptions, apart from her own testimony.

and characteristics could perform. (Tr. 64-66). The list of jobs that were identified by the vocational expert included both light and sedentary level work. (Tr. 66-72). The ALJ's opinion states that "[a] finding of 'not disabled' is therefore appropriate" as Plaintiff "is capable of making a successful adjustment to other work that exists in significant numbers in the national economy." (Tr. 27).

The ALJ's RFC assessment was therefore appropriate and supported by substantial evidence.

D.

Last, Plaintiff alleges that the ALJ's credibility analysis was neither reasonable nor supported by the evidence. The Court must "accord the ALJ's determination of credibility great weight and deference particularly since the ALJ has the opportunity … of observing a witness's demeanor while testifying." *Jones*, 336 F.3d at 476. To appropriately evaluate the credibility of an individual's statements regarding subjective symptoms "the adjudicator must consider the entire case record and give specific reasons for the weight given to the individual's statements." SSR 96-7p. In making this determination, "[o]ne strong indication of the credibility of an individual's statements is their *consistency*, both internally and with other information in the case record." *Id*. (Emphasis added). In making a determination of disability, "an ALJ is not required to accept a claimant's subjective complaints and may properly consider [her] credibility." *Jones*, 336 F.3d at 476.

Plaintiff argues that "ALJ King misstated the evidence and testimony in order to paint a picture of a person far less impaired than Plaintiff actually is." (Doc. 11 at 15).

This statement is wholly without merit. The ALJ found that Plaintiff's testimony "concerning the presence of incapacitating discomfort and associated functional limitations was not credible." (Tr. 24). The ALJ states that "[t]he record evidence did not support a finding that the claimant's impairments are work preclusive," and goes on to specify inconsistencies between Plaintiff's allegations and her medical records. (Tr. 24-25). For instance, the ALJ notes that despite Plaintiff's allegations of debilitating pain, the treatment for her back and shoulder (post-surgery) have been conservative, that her pain medication dosage is relatively low, and that she has reported to her physicians that the medication is working to significantly reduce her pain. (*Id*.)

The ALJ also focuses on Plaintiff's admitted daily activities and notes that her activity level indicates that her impairments are not as limiting as she alleges. (Tr. 25). The ALJ explains that the Plaintiff is able to "care for her school age children and she is able to get them ready for school and prepare meals … maintain attention and concentration to read books, watch television, and drive … run[] errands and is able to straighten-up around her home and reported that *she does weeding and can use a riding mower*." (*Id*.) (emphasis added).

Most compelling, however, is the ALJ's statement that Plaintiff's "credibility is also diminished by her failure to follow-up on Dr. Bertram's recommendation that she pursue additional pain interventions" and her "fail[ure] to go to physical therapy as directed." (Tr. 25). The ALJ notes that "[t]his behavior is not consistent with that of an individual doing all that she can to alleviate her symptoms." (*Id*.) This Court agrees.

The Court affords great deference to the ALJ's decision regarding credibility and finds that it is supported by substantial evidence.

III.

For the foregoing reasons, Plaintiff's assignments of error are unavailing. The ALJ's decision is supported by substantial evidence and is affirmed.

IT IS THEREFORE ORDERED THAT the decision of the Commissioner that Judy Koenig-Thomas was not entitled to supplemental security income and disability insurance benefits is found **SUPPORTED BY SUBSTANTIAL EVIDENCE**, and **AFFIRMED**; the Clerk shall enter judgment accordingly; and, as no further matters remain pending for the Court's review, this case is to be **CLOSED**.

Date: 4/29/14

s / Timothy S. Black
Timothy S. Black
United States District Judge