UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF OHIO
WESTERN DIVISION

KEITH OGLESBY,
Plaintiff,

vs.

COMMISSIONER OF
SOCIAL SECURITY,
Defendant.

Case No. 1:13-cv-668

Litkovitz, M.J.

OPINION AND ORDER

Plaintiff brings this action pursuant to 42 U.S.C. §§ 405(g) and 1383(c)(3) for judicial review of the final decision of the Commissioner of Social Security (Commissioner) denying plaintiff's applications for disability insurance benefits (DIB) and supplemental security income (SSI). This matter is before the Court on plaintiff's Statement of Errors (Doc. 10), the Commissioner's response in opposition (Doc. 17), and plaintiff's reply memorandum (Doc. 20).

I. Procedural Background

Plaintiff filed applications for DIB and SSI in April 2010, alleging disability since October 31, 2006,[1] due to diabetes, high blood pressure and heart disease with stent placement. Plaintiff's applications were denied initially and upon reconsideration. Plaintiff, through counsel, requested and was granted a *de novo* hearing before administrative law judge (ALJ) Robert W. Flynn. Plaintiff and a vocational expert (VE) appeared and testified at the ALJ hearing. On July 30, 2012, the ALJ issued a decision denying plaintiff's DIB and SSI applications. Plaintiff's request for review by the Appeals Council was denied, making the decision of the ALJ the final administrative decision of the Commissioner.

[1]Plaintiff amended his alleged disability onset date to August 30, 2008, at the ALJ hearing. (Tr. 32, 316).

II. Analysis

A. Legal Framework for Disability Determinations

To qualify for disability benefits, a claimant must suffer from a medically determinable physical or mental impairment that can be expected to result in death or that 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) (DIB), 1382c(a)(3)(A) (SSI). The impairment must render the claimant unable to engage in the work previously performed or in any other substantial gainful employment that exists in the national economy. 42 U.S.C. §§ 423(d)(2), 1382c(a)(3)(B).

Regulations promulgated by the Commissioner establish a five-step sequential evaluation process for disability determinations:

> 1) If the claimant is doing substantial gainful activity, the claimant is not disabled.
>
> 2) If the claimant does not have a severe medically determinable physical or mental impairment – *i.e.*, an impairment that significantly limits his or her physical or mental ability to do basic work activities – the claimant is not disabled.
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> 3) If the claimant has a severe impairment(s) that meets or equals one of the listings in Appendix 1 to Subpart P of the regulations and meets the duration requirement, the claimant is disabled.
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> 4) If the claimant's impairment does not prevent him or her from doing his or her past relevant work, the claimant is not disabled.
>
> 5) If the claimant can make an adjustment to other work, the claimant is not disabled. If the claimant cannot make an adjustment to other work, the claimant is disabled.

Rabbers v. Comm'r of Soc. Sec., 582 F.3d 647, 652 (6th Cir. 2009) (citing §§ 404.1520(a)(4)(i)-(v), 404.1520(b)-(g)). The claimant has the burden of proof at the first four steps of the sequential evaluation process. *Id.*; *Wilson v. Comm'r of Soc. Sec.*, 378 F.3d 541, 548 (6th Cir.

2004). Once the claimant establishes a prima facie case by showing an inability to perform the relevant previous employment, the burden shifts to the Commissioner to show that the claimant can perform other substantial gainful employment and that such employment exists in the national economy. *Rabbers*, 582 F.3d at 652; *Harmon v. Apfel*, 168 F.3d 289, 291 (6th Cir. 1999).

B. The Administrative Law Judge's Findings

The ALJ applied the sequential evaluation process and made the following findings of fact and conclusions of law:

> 1. The [plaintiff] meets the insured status requirements of the Social Security Act through December 31, 2011.
>
> 2. The [plaintiff] has not engaged in substantial gainful activity since August 30, 2008, the alleged onset date (20 CFR 404.1571 *et seq.*, and 416.971 *et seq.*).
>
> 3. The [plaintiff] has the following severe impairments: ischemic heart disease (single vessel coronary artery disease); chronic heart failure secondary to dilated cardiomyopathy with reduced ejection fraction; hypertension, diabetes mellitus, and sleep apnea (20 CFR 404.1520(c) and 416.920(c)).
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> 4. The [plaintiff] does not have an impairment or combination of impairments that meets or medically equals one of the listed impairments in 20 C.F.R. Part 404, Subpart P, Appendix 1 (20 CFR 404.1520(d), 404.1525, 404.1526, 416.920(d), 416.925 and 416.926).
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> 5. After careful consideration of the entire record, the [ALJ] finds that the [plaintiff] has the residual functional capacity to lift up to ten pounds occasionally and push/pull within that lifting restriction; in an eight-hour workday, he can stand/walk a total of two hours and sit a total of six hours; overhead reaching with the (non-dominant) left upper extremity is reduced to frequent; he can occasionally stoop, crouch, kneel, crawl, and climb ramps or stairs; he should never climb ladders, ropes, or scaffolds; he must avoid concentrated exposure to extreme cold, extreme heat, humidity, and pulmonary irritants such as fumes, odors, dust, chemicals, gases, and poorly ventilated areas; he is restricted to indoor work only; he should not work at unprotected heights or use moving machinery. The [plaintiff] is also limited to simple, routine, and repetitive tasks; in a low stress environment defined as free of fast-paced production requirements;

involving only simple, work-related decisions; and with few, if any, workplace changes.

6. The [plaintiff] is unable to perform any past relevant work[2] (20 CFR 404.1565 and 416.965).

7. Born [in] . . . 1963, the [plaintiff] was 45 years old on the alleged onset date and is now age 49, at all times a "younger individual age 45-49" (20 CFR 404.1563 and 416.963).

8. The [plaintiff] has a "limited" education and is able to communicate in English (20 CFR 404.1564 and 416.964).

9. Transferability of job skills is not material to the determination of disability because using the Medical-Vocational Rules as a framework supports a finding that the [plaintiff] is "not disabled," whether or not he has transferable job skills (See SSR 82-41 and 20 CFR Part 404, Subpart P, Appendix 2).

10. Considering the [plaintiff]'s age, education, work experience, and residual functional capacity, there are jobs that exist in significant numbers in the national economy that he can perform (20 CFR 404.1569, 404.1569(a), 416.969, and 416.969(a)).[3]

11. The [plaintiff] has not been under a disability, as defined in the Social Security Act, from August 30, 2008 (his amended alleged onset date), through the date of this decision (20 CFR 404.1520(g) and 416.920(g)).

(Tr. 13-20).

C. Judicial Standard of Review

Judicial review of the Commissioner's determination is limited in scope by 42 U.S.C. § 405(g) and involves a twofold inquiry: (1) whether the findings of the ALJ are supported by substantial evidence, and (2) whether the ALJ applied the correct legal standards. *See Blakley v.*

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[2]Plaintiff has past relevant work as a laborer in a foundry, a bagel baker, and a delivery driver, and in food preparation. (Tr. 33-35, 56-57).

[3]The ALJ relied on the VE's testimony to find that plaintiff would be able to perform 138,000 unskilled, sedentary jobs in the national economy, citing as examples of such jobs a call-out operator, order clerk, security monitor, and information clerk. (Tr. 19, 59-60).

Comm'r of Soc. Sec., 581 F.3d 399, 406 (6th Cir. 2009); *see also Bowen v. Comm'r of Soc. Sec.*, 478 F.3d 742, 745-46 (6th Cir. 2007).

The Commissioner's findings must stand if they are supported by "such relevant evidence as a reasonable mind might accept as adequate to support a conclusion." *Richardson v. Perales*, 402 U.S. 389, 401 (1971) (citing *Consolidated Edison Co. v. N.L.R.B.*, 305 U.S. 197, 229 (1938)). Substantial evidence consists of "more than a scintilla of evidence but less than a preponderance. . . ." *Rogers v. Comm'r of Soc. Sec.*, 486 F.3d 234, 241 (6th Cir. 2007). In deciding whether the Commissioner's findings are supported by substantial evidence, the Court considers the record as a whole. *Hephner v. Mathews*, 574 F.2d 359 (6th Cir. 1978).

The Court must also determine whether the ALJ applied the correct legal standards in the disability determination. Even if substantial evidence supports the ALJ's conclusion that the plaintiff is not disabled, "a decision of the Commissioner will not be upheld where the SSA fails to follow its own regulations and where that error prejudices a claimant on the merits or deprives the claimant of a substantial right." *Rabbers*, 582 F.3d at 651 (quoting *Bowen*, 478 F.3d at 746). *See also Wilson*, 378 F.3d at 545-46 (reversal required even though ALJ' s decision was otherwise supported by substantial evidence where ALJ failed to give good reasons for not giving weight to treating physician's opinion, thereby violating the agency's own regulations).

D. Medical Evidence

The following is a summary of the pertinent medical evidence of record.

After experiencing intermittent chest pain for approximately two weeks, plaintiff was admitted to University Hospital on August 30, 2008. Positive cardiac enzymes and EKG changes indicated a non-ST elevation myocardial infarction. Plaintiff underwent a left heart

catheterization, selective coronary angiography, left ventriculography, and percutaneous intervention of the left anterior descending artery; he was released after four days and was scheduled for follow-up treatment through the cardiac clinic. (Tr. 436-595).

Plaintiff treated at the general adult medicine clinic and cardiology clinic at University Hospital. Treatment records show that in October 2008, plaintiff exhibited no chest deformities, no apparent respiratory distress, normal chest inspection, normal S1/S2, no gallop, rub or click, regular rate and rhythm, and no murmur. (Tr. 647-49).

In December 2008, examination revealed normal regular rate and rhythm, normal S1/S2, no gallop or rub or click, no lower extremity edema and normal carotids. It was noted plaintiff's blood pressure was high and he was off his medication. His palpitation symptoms were resolved. Plaintiff reported that he can "walk several miles and does stairs regularly." (Tr. 642-44). In January 2009, plaintiff exhibited a normal gait and his cardiovascular examination findings were normal. (Tr. 640).

Consultative examining physician Jennifer Wischer Bailey, M.D., examined plaintiff on behalf of the state agency on March 17, 2009. Plaintiff's chief complaint was "[s]hortness of breath"; he reported that after walking more than three blocks and climbing stairs he experiences shortness of breath. Plaintiff complained of chest pain with exertion since the stenting in September 2008. He noted his chest pain occurred once or twice a week and lasted less than five minutes. Dr. Bailey described plaintiff as "massively" obese at 327 pounds. His blood pressure was 170/99. Plaintiff exhibited full strength throughout with normal range of motion. Plaintiff ambulated with a normal gait and he could stand on either leg without difficulty. Plaintiff exhibited no muscle weakness or atrophy with intact sensation. Dr. Bailey assessed

morbid obesity, dyspnea, myocardial infarction with chest pain likely anginal, hypertension, and insulin dependent diabetes. Dr. Bailey noted that plaintiff's obesity contributes to his symptoms and weight reduction would diminish his complaints. She found no contraindications to graded exercise testing. Dr. Bailey concluded that plaintiff appeared capable of performing at least a "mild amount" of sitting, standing, walking, bending, kneeling, pushing, pulling, lifting, and carrying heavy objects. She noted that plaintiff had no difficulty reaching, grasping, and handling objects. (Tr. 354-61).

When seen in December 2009, his diabetes was noted to be poorly controlled. He was unable to perform 4x daily injection. Plaintiff reported that he forgets to take his medication "once in a while." (Tr. 621). On examination, plaintiff's blood pressure was 152/96 with diminished sensation. It was noted plaintiff used cocaine one month prior. (Tr. 620-24). Plaintiff exhibited diminished sensation again in February 2010 with continued cocaine use. (Tr. 613-15). Plaintiff's June 2010 examination findings revealed that he was diabetes medication non-compliant. Examination showed plaintiff's blood pressure was 140/100, his cardiac examination showed S1/S2 normal, regular rate and rhythm with no murmurs, rubs or gallops, and no JVD (jugular-venous distension). EKG results showed normal sinus rhythm. (Tr. 609-10).

Plaintiff was admitted to the hospital on January 5, 2011, due to progressive shortness of breath and atypical symptoms of chest pain. (Tr. 669-89). He underwent another left heart catheterization which revealed a 30% in-stent restenosis of the proximal LAD (left anterior descending) stent. (Tr. 686-87). It was recommended plaintiff continue aggressive medical

management. When seen for follow-up on January 12, 2011, plaintiff was chest pain free but reported dyspnea on exertion; his examination was normal. (Tr. 724-27).

On April 7, 2011, Muhammad Zafar, M.D., plaintiff's treating physician at the University Hospital clinic, completed a Physical RFC Questionnaire. Dr. Zafar reported treating plaintiff three times in the past six months. His diagnoses included coronary artery disease, congestive heart failure, obesity, diabetes, and sleep apnea. Dr. Zafar opined that plaintiff was capable of performing low stress jobs; could lift less than ten pounds rarely; could walk less than one city block without rest or severe pain; could sit for 45 minutes at a time and stand for 15 minutes at a time; and could stand/walk less than two hours and could sit at least six hours total in an eight-hour workday. Dr. Zafar further opined that with prolonged sitting plaintiff would need to elevate his legs one to two feet for 40% of the time. (Tr. 729-33).

While at the cardiac clinic on April 7, 2011, an echocardiogram showed ejection fraction at 25-30%. (Tr. 969). Plaintiff was sent to the emergency room for monitoring. (Tr. 943-87). Plaintiff was admitted to the hospital on April 12, 2011, for four days due to acute on chronic systolic heart failure. (Tr. 740-847). When seen for follow-up at the heart failure clinic on April 27, 2011, plaintiff denied chest pain but noted he had dizziness with rising, dyspnea on exertion, and frequent fatigue. (Tr. 874).

On December 2, 2011, Cathy Jenkins, APN, completed a Cardiac RFC Questionnaire that was co-signed by plaintiff's treating cardiologist, Stephanie Dunlap, D.O. Nurse Jenkins and Dr. Dunlap reported treating plaintiff on a monthly basis since 2008. Dr. Dunlap and Nurse Jenkins opined that plaintiff was incapable of even low stress jobs because he has heart failure, becomes short of breath easily, and needs to keep his heart rate low. They further opined that

plaintiff is able to sit, stand, and walk less than two hours total in an eight-hour workday, and would, at a minimum, need to lay down for 20 to 30 minutes every hour. Further, Nurse Jenkins and Dr. Dunlap opined that plaintiff must elevate his legs above his heart whenever he is sitting. They determined that plaintiff was unable to walk a complete city block without requiring a break and could occasionally lift ten pounds, but never more. (Tr. 735-38).

When seen for follow-up at the cardiac clinic on March 1, 2012, plaintiff reported no chest pains, palpitations, swelling or fatigue. He reported having dyspnea which lasted 1-2 minutes. Nurse Jenkins noted that plaintiff stated he was able to walk for 2 blocks and able to climb 2 flights of stairs. (Tr. 1296).

E. Specific Errors

On appeal, plaintiff asserts the following assignments of error: (1) the ALJ improperly determined that plaintiff's impairments did not meet or medically equal Listings 4.02 and 4.04; (2) the ALJ erred by not finding obesity to be a severe impairment or properly considering the impact of plaintiff's obesity in the Listings or RFC determinations; (3) the ALJ failed to take into account the side effects of plaintiff's medications in formulating the RFC; (4) the ALJ erred by not adopting specific limitations from plaintiff's treating doctors in the RFC formulation; and (5) the ALJ erroneously weighed the medical opinions of record. (Doc. 10).

1. Whether the ALJ erred in failing to find that plaintiff meets or medically equals Listings 4.02 and 4.04.

For his first assignment of error, plaintiff argues the ALJ erred in evaluating whether his heart impairments meet or medically equal Listings 4.02 and 4.04. The record documents systolic failure with ejection fraction findings between 25% and 40% and treatment notes reflect that plaintiff was unable to perform an exercise tolerance stress test due to dyspnea, which

plaintiff contends is sufficient to meet the criteria of Listing 4.02(a)(1). Plaintiff also contends that he meets Listing 4.04(C)(1)(a) due to his severe ischemic heart disease impairment because the record includes findings that he had 95% blockage of his left anterior descending coronary artery. Plaintiff further asserts the ALJ failed to sufficiently explain his findings such that reversal or remand is required. (Doc. 10 at 3-5).

Listing 4.02 pertains to chronic heart failure. *See* 20 C.F.R. Pt. 404, Subpt. P, App. 1 § 4.02. To meet or medically equal the listing, plaintiff must establish that he meets the requirements of both its "paragraph A" and "paragraph B" criteria. *Id.* In pertinent part, the "paragraph A" criteria of the listing requires a showing of "[s]ystolic failure . . . with left ventricular end diastolic dimensions greater than 6.0 cm or ejection fraction of 30 percent or less less during a period of stability (not during an episode of acute heart failure). . . ." *Id.*, § 4.02(a)(1). To meet the "paragraph B" criteria, plaintiff's must put forth evidence showing that the systolic failure results in one of the following:

> 1. Persistent symptoms of heart failure which very seriously limit the ability to independently initiate, sustain, or complete activities of daily living in an individual for whom [a medical consultant], preferably one experienced in the care of patients with cardiovascular disease, has concluded that the performance of an exercise test would present a significant risk to the individual; or . . .
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> 3. Inability to perform on an exercise tolerance test at a workload equivalent to 5 METs or less due to:
> a. Dyspnea, fatigue, palpitations, or chest discomfort. . . .

Id., § 4.02(b)(1), (3).

Listing 4.04 governs ischemic heart disease. *See* 20 C.F.R. Pt. 404, Subpt. P, App. 1 § 4.04. To meet the relevant criteria of Listing 4.04, there must be a diagnosis of ischemic heart disease "with symptoms due to myocardial ischemia, as described in 4.00E3-4.00E7, while on a

regimen of prescribed treatment . . . with[:]

> [c]oronary artery disease, demonstrated by angiography (obtained independent of Social Security disability evaluation) or other appropriate medically acceptable imaging, and in the absence of a timely exercise tolerance test or a timely normal drug-induced stress test, a [medical consultant], preferably one experienced in the care of patients with cardiovascular disease, has concluded that performance of exercise tolerance testing would present a significant risk to the individual, with both 1 and 2:
>
> 1. Angiographic evidence showing:
>   a. 50 percent or more narrowing of a nonbypassed left main coronary artery; [and]
> 2. Resulting in very serious limitations in the ability to independently initiate, sustain, or complete activities of daily living.

Id., § 4.04(C).

The following represents the entirety of the ALJ's discussion on whether plaintiff's heart impairments meet or medically equal Listings 4.02 and 4.04: "The [plaintiff]'s heart disease, although severe, does not satisfy the criteria of the cardiac listings at section 4.02 (chronic heart failure) or section 4.04 (ischemic heart disease)." (Tr. 14). The undersigned agrees with plaintiff that the ALJ failed to properly evaluate whether his severe heart impairments meet or equal a listed impairment.

The ALJ's cursory conclusion that plaintiff's impairments do not meet or equal Listing 4.02 or 4.04 prevents the Court from engaging in meaningful judicial review of whether the ALJ's decision is supported by substantial evidence. *See Reynolds v. Comm'r of Soc. Sec.*, 424 F. App's 411, 414-16 (6th Cir. 2011) (citing *Clifton v. Chater*, 79 F.3d 1007, 1009 (10th Cir. 1996); *Senne v. Apfel*, 198 F. 3d 1065, 1067 (8th Cir. 1999); *Burnett v. Comm'r of Soc. Sec.*, 220 F.3d 112, 120 (3d Cir. 2000)) (an ALJ "must actually evaluate the evidence, compare it to [the relevant listing], and give an explained conclusion, in order to facilitate meaningful judicial

review. Without it, it is impossible to say that the ALJ's decision at Step Three was supported by substantial evidence."). *See also Risner v. Comm'r of Soc. Sec.*, No. 1:11-cv-36, 2012 WL 893882, at *4-5 (S.D. Ohio Mar. 15, 2012) (remanding case where the ALJ failed to provide any reasoning in support of his finding that the listing was not met and holding that "a reasoned and explained conclusion is not merely a formalistic requirement [but] a necessary component for this Court to ascertain whether the ALJ's decision was supported by substantial evidence."). The Commissioner defends the ALJ's brief conclusion, citing to the ALJ's discussion of the medical evidence relating to plaintiff's heart impairments in other portions of the decision which the Commissioner contends "provides adequate rationale for a reasonable person to conclude that [plaintiff]'s impairments do not meet the medical severity of Listings 4.02 and 4.04." (Doc. 17 at 5, citing Tr. 15-17). The undersigned acknowledges that there is no "*per se* rule that every ALJ must discuss in detail any section of the Listing which might conceivably be implicated by the claimant's severe impairments." *Reiser v. Comm'r of Soc. Sec.*, No. 11-cv-1010, 2012 WL 6138987, at *7 (S.D. Ohio Dec. 11, 2012) (Report and Recommendation), *adopted*, 2013 WL 139890 (S.D. Ohio Jan. 10, 2013). However, here, plaintiff has put forth evidence showing the requirements of Listings 4.02 and 4.04 may be satisfied, yet the ALJ's decision does not include a discussion of this evidence in the context of the listings.

The record evidence establishes that plaintiff suffered systolic failure and had decreased ejection fractions ranging from 25% to 40%, which are relevant to Listing 4.02's "paragraph A" criteria. *See* Tr. 350, 358, 380, 439, 513, 694, 696, 697, 740, 752, 754-55, 969, 1117-20. Further, plaintiff testified to and put forth medical opinion evidence supporting his claims that his heart impairment causes severe limitations in his ability to engage in activities of daily living

due to, *inter alia*, shortness of breath and fatigue. *See* Tr. 35-46 (plaintiff testified that he is able to walk no more than two blocks, requires naps due to fatigue, and spends most of his day sitting); Tr. 728-33 (plaintiff's treating primary care physician, Dr. Zafar., opined that plaintiff was able to walk less than one city block, was limited to standing for 15 minutes at a time, and would miss more than four days of work monthly due to his impairments); Tr. 735-38 (plaintiff's treating cardiologist, Dr. Dunlap, endorsed Nurse Jenkins' opinion that plaintiff's heart impairments caused fatigue, weakness, and shortness of breath which markedly limited his ability to do physical activity and would result in plaintiff requiring multiple 20 minute breaks daily and missing more than four days of work monthly). This evidence is pertinent to the "paragraph B" criteria of Listing 4.02. Because the record includes evidence relating directly to Listing 4.02's elements, the ALJ should have provided a reasoned explanation for his finding that plaintiff did not meet or medically equal the listing.

Likewise, the record includes evidence significant to the Listing 4.04 criteria. The ALJ determined that plaintiff has severe ischemic heart disease. (Tr. 13). Further, the record includes angiographic evidence that plaintiff had 95% stenosis at the left anterior descending artery in September 2009. (Tr. 439). A stent was placed that month (Tr. 438), but during another left heart catheterization in 2011, it was revealed that plaintiff had 30% in-stent restenosis of the stent and aggressive medical management was recommended. (Tr. 686-87). Again, the ALJ's decision fails to discuss this evidence in relation to the Listing 4.04 criteria.

Given the above evidence relating directly to the Listing 4.02 and Listing 4.04 criteria, it was not sufficient for the ALJ to conclude in one sentence that plaintiff's heart disease did not meet these listings. Without some discussion as to why this evidence fails to meet or equal the

criteria of Listings 4.02 and 4.04, the Court cannot conclude that the ALJ's determination is supported by substantial evidence. It is the ALJ's duty to credit the evidence relating to Listings 4.02 and 4.04. "[T]he Court's role in the decisional process is simply to review such a determination under the 'substantial evidence' standard. That cannot be done here because there is no determination to review." *Reiser*, 2012 WL 6138987, at *7.

Accordingly, plaintiff's first assignment of error is sustained and this matter is reversed and remanded with instructions to the ALJ to provide a reasoned analysis regarding his Listings 4.02 and 4.04 findings.

2. Whether the ALJ erred by not finding plaintiff's obesity to be a severe impairment or by failing to properly consider the impact of obesity in his Listings and RFC determinations.

For his second assignment of error, plaintiff argues the ALJ erred in assessing his obesity because he did not find it to be a severe impairment; the ALJ failed to consider the effects of plaintiff's obesity in evaluating the cardiac listings; and the ALJ failed to consider the impact of obesity on plaintiff's sleep apnea impairment and RFC. Plaintiff asserts that the medical evidence supports a finding that he suffers functional limitations due to obesity, such as shortness of breath and fatigue due to sleep apnea. Plaintiff concludes that the ALJ's RFC formulation fails to adequately portray his functional limitations due, in part, to this failure to classify obesity as a severe impairment or consider its impact as required by Social Security Ruling 02-1p. (Doc. 10 at 5-9).

The Commissioner agrees that the ALJ erred by not classifying plaintiff's obesity as a severe impairment, but maintains that the error was harmless because the ALJ considered the effects of plaintiff's obesity in assessing his RFC. The Commissioner asserts that because the ALJ noted that plaintiff was obese, *see* Tr. 14 (the ALJ recounted that plaintiff's echocardiogram

"was limited because of his obesity [the claimant is 5'9" tall and weighs over 330 lbs"]), and relied on opinions of doctors who noted plaintiff's obesity, he did all that was required in considering the impact of plaintiff's obesity in formulating his RFC. Further, the Commissioner notes that plaintiff does not cite to any evidence establishing that he has functional limitations due to obesity beyond those contained in the ALJ's RFC formulation. (Doc. 17 at 6-8).

a. *Obesity and Listings 4.02 and 4.04*

Social Security Ruling 02-1p provides that "the combined effects of obesity with other impairments can be greater than the effects of each of the impairments considered separately." SSR 02–1p, 2000 WL 628049, at *1 (2002). Adjudicators must "consider the effects of obesity not only under the listings but also when assessing a claim at other steps of the sequential evaluation process, including when assessing an individual's residual functional capacity." *Id.* "[O]besity may increase the severity of a coexisting or related impairment to the extent that the combination of impairments meets the requirements of a listing. This is especially true of . . . cardiovascular impairments." SSR 02–1p, 2000 WL 628049, at *5. *Id.* In addition, the signs, symptoms, and laboratory findings from the combination of a cardiovascular impairment and obesity may equal a cardiovascular listing. *Id.*

In this case, the ALJ erred by failing to consider plaintiff's obesity in determining whether plaintiff meets or medically equals Listing 4.02 or 4.04 and by failing to explain his conclusions in this regard. Plaintiff's Body Mass Index is 49.9 (Tr. 31, 217), which is categorized as "extreme" obesity, representing the greatest risk for developing obesity-related impairments. *Id.* at *2 (citing the National Institutes of Health Clinical Guidelines on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults). Despite the

evidence documenting the extreme nature of plaintiff's obesity, the ALJ's decision is silent on the impact of obesity on whether plaintiff's cardiovascular impairments meet or equal Listing 4.02 or 4.04. The ALJ's cursory Listings discussion is deficient for the reasons stated above. Given that Social Security Ruling 02-1p recognizes the adverse impact of obesity on cardiovascular impairments and that obesity may support a finding of medical equivalency to a listed impairment, the ALJ should have addressed the impact of plaintiff's obesity in determining whether plaintiff meets or equals the relevant listings. Therefore, on remand the ALJ must specifically consider the impact of plaintiff's obesity in combination with his cardiac and other impairments in determining whether plaintiff meets or equals a listed impairment.

b. *Obesity as a severe impairment and the RFC formulation*

The record contains ample notations from treating, examining, and reviewing medical sources documenting the significance of plaintiff's obesity in relation to his health. *See*, *e.g.*, Tr. 358-61 (consultative examining physician Dr. Bailey noted that plaintiff was morbidly obese and complained of shortness of breath, and reported that she was unable to palpate the underlying viscera of his abdomen as it was massive and protuberant); Tr. 614-16 (February 2010 treatment notes from plaintiff's primary care physician include diagnosis of morbid obesity and notations that he will likely need extra diabetes medication as a result of obesity); Tr. 719 (December 2010 treatment notes include plaintiff's complaints of difficulty walking due to shortness of breath, findings that plaintiff is obese, and notations that the doctor could not auscultate to check for heart murmur "due to body habitus"); Tr. 729-33 (Dr. Zafar opined that plaintiff's morbid obesity was one impairment that caused shortness of breath and other functional limitations); Tr. 735-38 (Nurse Jenkins and Dr. Dunlap opined that plaintiff's obesity and other impairments caused

physical functional limitations). Plaintiff's obesity is clearly a "severe" impairment as it is more than a "slight abnormality which has such minimal effect on [plaintiff] that it would not be expected to interfere with the [plaintiff]'s ability to work, irrespective of age, education, and work experience." *Farris v. Sec'y of H.H.S.*, 773 F.2d 85, 90 (6th Cir. 1985) (citing *Brady v. Heckler,* 724 F.2d 914, 920 (11th Cir. 1984)). As the Commissioner concedes, the above evidence supports the conclusion that plaintiff's obesity is a severe impairment and the ALJ erred by finding otherwise. However, the undersigned finds that the ALJ's error is harmless because he determined that plaintiff has severe impairments, continued with the sequential evaluation process, and formulated plaintiff's RFC by relying, in part, on the opinions of doctors who accounted for plaintiff's obesity.

Social Security regulations require that if one "severe" impairment exists, all impairments - severe or otherwise - must be considered in the remaining steps of the sequential evaluation process. 20 C.F.R. §§ 404.1523, 404.1545(e). Where an ALJ errs in finding a particular impairment "non-severe" in Step Two of the analysis, the error is harmless if the ALJ finds at least one severe impairment and continues to address each impairment in determining the claimant's RFC. *See Meadows v. Comm'r of Soc. Sec.*, No. 1:07-cv-1010, 2008 WL 4911243, at *13 (S.D. Ohio Nov. 13, 2008) (citing *Maziarz v. Sec'y of H.H.S.* 837 F.2d 240, 244 (6th Cir. 1987)). Here, the ALJ determined at Step Two of the sequential evaluation process that plaintiff has severe impairments of ischemic heart disease, chronic heart failure secondary to dilated cardiomyopathy with reduced ejection fraction, hypertension, diabetes mellitus, and sleep apnea. (Tr. 13). The ALJ then went on to assess plaintiff's residual functional capacity. The ALJ considered the opinions of Drs. Bailey, Zafar, and Dunlap (Tr. 16-18), who all accounted for

plaintiff's obesity in opining on plaintiff's functional capacity. Because the ALJ took these physicians' opinions into account in fashioning plaintiff's RFC, he thereby incorporated the effect that obesity has on plaintiff's ability to work. *See Coldiron v. Comm'r of Soc. Sec.*, 391 F. App'x 435, 443 (6th Cir. 2010) (by utilizing opinions of physicians who explicitly accounted for the claimant's obesity when fashioning the RFC, the ALJ incorporated into the RFC the effect obesity has on the claimant's ability to work). *See also Bledsoe,* 165 F. App'x at 412 ("[T]he ALJ does not need to make specific mention of obesity if he credits an expert's report that considers obesity."). Given the absence of any specific evidence on how plaintiff's obesity, as opposed to his other impairments, impacts his functional limitations, the Court concludes that the ALJ accounted for the effect of plaintiff's obesity on his residual functional capacity. Plaintiff's second assignment of error is overruled in this regard.

For the above reasons, plaintiff's second assignment of error is sustained in part and overruled in part.

3. Whether the ALJ erred by not accounting for the side effects of plaintiff's medication.

For his third assignment of error, plaintiff asserts the ALJ erred by not considering the side effects of his medication in contravention of Social Security regulations. (Doc. 10 at 9) (citing 20 C.F.R. § 404.1529) (providing that ALJs are to consider side effects of medications in assessing a claimant's functional limitations). Plaintiff argues that the ALJ improperly evaluated the side effects caused by Lasix, a diuretic he is prescribed to prevent fluid buildup around his heart. Plaintiff testified that the Lasix causes him to urinate frequently, up to 15 times a day (Tr. 54-55), and contends that the ALJ's finding that plaintiff "can adjust his fluid intake, and there is no reason to believe that he could not function in the workplace with normal

bathroom breaks" (Tr. 15) ignores this testimony and medical opinion evidence from his treating cardiologist who noted that frequent urination was a medication side effect. *See* Tr. 736 (Nurse Jenkins and Dr. Dunlap noted that frequent urination and fatigue were side effects from plaintiff's medications). Plaintiff argues that the ALJ's determination that plaintiff's frequent urination can be controlled simply by regulating his fluid intake amounts to an improper medical opinion and the ALJ's RFC is not supported because it fails to accommodate plaintiff's need for restroom breaks. Plaintiff concludes by noting that per the VE's testimony, his need for frequent restroom breaks would preclude him from employment and render him disabled. (Doc. 10 at 11, citing Tr. 60-61) (the VE testified that hourly restroom breaks would likely preclude employment).

The ALJ did not account for plaintiff's urinary frequency in formulating the RFC. The ALJ acknowledged plaintiff's reports of urinary frequency to medical providers, but determined that no accommodation was necessary because "[plaintiff] did not complain of a need to urinate so frequently that it disrupted his daily activities" and "[plaintiff] can adjust his fluid intake, and there is no reason to believe he could not function in the workplace with normal bathroom breaks." (Tr. 15). The ALJ's finding in this respect is not substantially supported by the record.

The ALJ's rationale ignores the fact that one of the established side effects of plaintiff's medication is frequent urination, which is supported by the opinion of plaintiff's treating cardiologist. The RFC assessment completed by Nurse Jenkins and Dr. Dunlap, plaintiff's treating cardiologist, identifies that plaintiff's medication causes the side effect of "frequent urination." (Tr. 736). Plaintiff testified that he takes water pills to "take water away from [his]

heart" and that, as a result, he urinates 15 or more times a day. (Tr. 54). In February 2012, plaintiff reported to his primary care physician that this medication, Lasix,[4] caused urinary frequency. (Tr. 1316). Because plaintiff has put forth evidence establishing that he suffers from urinary frequency, the ALJ should have included an accommodation in formulating the RFC.

Moreover, there is no medical opinion or treatment note reflecting that plaintiff's need to urinate may be managed with adjustments in his fluid intake. "ALJs must not succumb to the temptation to play doctor and make their own independent medical findings." *Simpson v. Comm'r of Soc. Sec.*, 344 F. App'x 181, 194 (6th Cir. 2009) (internal quotations omitted). Given the absence of any medical evidence supporting the ALJ's finding that plaintiff's urinary frequency is controllable by managing fluid intake, the Court concludes that the ALJ impermissibly created his own lay medical opinion. Accordingly, the ALJ's finding in this regard lacks substantial support in the record and must be remanded. On remand, the ALJ should formulate a new RFC that accommodates plaintiff's need for bathroom breaks.

For the above reasons, plaintiff's third assignment of error is sustained.

4. <u>Whether the ALJ erred in weighing the medical opinions of record.</u>[5]

Plaintiff asserts the ALJ erred in weighing the medical opinions of record by giving

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[4]Lasix (furosemide) is "a 'water pill' . . . used to reduce the swelling and fluid retention caused by various medical problems, including heart or liver disease. . . . It causes the kidneys to get rid of unneeded water and salt from the body into the urine." *See* www.nlm.nih.gov/medlineplus/druginfo/meds/a682858.html (last visited August 4, 2014). Frequent urination is listed as a side effect. *Id.*

[5]Plaintiff's fourth and fifth assignments of error assert, respectively, that the ALJ erred by not adopting limitations put forth by Drs. Zafar and Dunlap regarding plaintiff's need to elevate his legs while sitting and by giving more weight to the consultative examining physician than to his treating physicians. *See* Doc. 10 at 11-16. Because these two assignments of error relate to how the ALJ weighed the medical opinion evidence of record, they are addressed together.

greater weight to the opinion of Dr. Bailey, the one-time consultative examining physician, while giving reduced weight to the opinions of his treating physicians. Plaintiff contends the reasons given by the ALJ for not giving controlling weight to the treating source opinions "do not stand the scrutiny of review." Specifically, plaintiff contends the ALJ erred by not including a limitation in the RFC that plaintiff must elevate his legs while seated consistent with the opinions of his treating physicians. Plaintiff also argues the ALJ erred by relying on Dr. Bailey's opinion in formulating the RFC because the vagueness of her opinion renders it worthless for purposes of determining plaintiff's functional limitations. (Doc. 10 at 11-16).

It is well-established that the findings and opinions of treating physicians are entitled to substantial weight. "In general, the opinions of treating physicians are accorded greater weight than those of physicians who examine claimants only once." *Walters v. Comm'r of Soc. Sec'y*, 127 F.3d 525, 530-31 (6th Cir. 1997). *See also Harris v. Heckler*, 756 F.2d 431, 435 (6th Cir. 1985) ("The medical opinions and diagnoses of treating physicians are generally accorded substantial deference, and if the opinions are uncontradicted, complete deference."). "The treating physician doctrine is based on the assumption that a medical professional who has dealt with a claimant and his maladies over a long period of time will have a deeper insight into the medical condition of the claimant than will a person who has examined a claimant but once, or who has only seen the claimant's medical records." *Barker v. Shalala*, 40 F.3d 789, 794 (6th Cir. 1994).

"Treating-source opinions must be given 'controlling weight' if two conditions are met: (1) the opinion 'is well-supported by medically acceptable clinical and laboratory diagnostic techniques'; and (2) the opinion 'is not inconsistent with the other substantial evidence in [the]

case record.'" *Gayheart v. Comm'r of Soc. Sec'y*, 710 F.3d 365, 376 (6th Cir. 2013) (citing former 20 C.F.R. § 404.1527(d)(2)[6]). *See also Cole v. Astrue*, 661 F.3d 931, 937 (6th Cir. 2011). If the ALJ declines to give a treating source's opinion controlling weight, the ALJ must balance the factors set forth in 20 C.F.R. § 404.1527(c)(2)-(6) in determining what weight to give the opinion. *See Gayheart,* 710 F.3d at 376; *Wilson*, 378 F.3d at 544. These factors include the length, nature and extent of the treatment relationship and the frequency of examination. 20 C.F.R. §§ 404.1527(c)(2)(i)(ii), 416.927(c)(2)(i)(ii); *Wilson*, 378 F.3d at 544. In addition, the ALJ must consider the medical specialty of the source, how well-supported by evidence the opinion is, how consistent the opinion is with the record as a whole, and other factors which tend to support or contradict the opinion. 20 C.F.R. §§ 404.1527(c)(3)-(6), 416.927(c)(3)-(6); *Gayheart,* 710 F.3d at 376; *Wilson*, 378 F.3d at 544. The ALJ must give "good reasons" for not according controlling weight to a treating physician's opinion. *Wilson*, 378 F.3d at 544. The ALJ must likewise apply the factors set forth in §§ 404.1527(c)(3)-(6) and 416.927(c)(3)-(6) when considering the weight to give a medical opinion rendered by a non-treating source. 20 C.F.R. § 404.1527(c). When considering the medical specialty of a source, the ALJ must generally give "more weight to the opinion of a specialist about medical issues related to his or her area of specialty than to the opinion of a source who is not a specialist." 20 C.F.R. §§ 404.1527(c)(5), 416.927(c)(5).

The ALJ gave "little weight" to Dr. Zafar's opinion, finding that it was not well-explained; was inconsistent with other record evidence; and was not supported by his own

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[6]Titles 20 C.F.R. §§ 404.1527 and 416.927 were amended effective March 26, 2012. The provisions governing the weight to be afforded a medical opinion that were previously found at §§ 404.1527(d) and 416.927(d) are now found at §§ 404.1527(c) and 416.927(c).

treatment notes. The ALJ found that Dr. Zafar's determination that plaintiff could walk less than one block was inconsistent with plaintiff's testimony. The ALJ also found that Dr. Zafar's proposed leg-elevation limitation was not supported by the objective or clinical findings as plaintiff often presented with no edema, though he occasionally presented with minor +1 edema in his lower extremity. The ALJ further determined that the leg elevation limitation was not supported by Dr. Zafar's treatment notes because there was no discussion of such a limitation in any of the progress notes. The ALJ also noted that Dr. Zafar had a limited treatment history with plaintiff. (Tr. 17) (internal citations omitted).

Likewise, the ALJ gave "little weight" to the opinion of Nurse Jenkins and Dr. Dunlap based on the inconsistencies between their walking, sitting, and standing limitations and the record evidence of plaintiff's activities of daily living. The ALJ also determined that the limitation regarding plaintiff's need to elevate his legs was similarly unsupported by the medical evidence and the relevant treatment notes. The ALJ further noted that progress notes from Nurse Jenkins reflected that plaintiff reported greater physical abilities than those found in the opinion. (*Id.*).

In contrast, the ALJ gave "greater weight" to consultative examiner Dr. Bailey's assessment. The ALJ noted that Dr. Bailey's examination findings were largely normal and supported her opinion that plaintiff could perform a mild amount of sitting, ambulating, and standing and, further, that more recent examination findings from Nurse Jenkins were substantially similar. The ALJ determined that Dr. Bailey's opinion supported a finding that plaintiff was capable of performing sedentary work. (Tr. 17-18) (internal citations omitted).

For the following reasons, the undersigned finds that the ALJ did not err in weighing these medical opinions or in declining to adopt the leg elevation limitations prescribed by plaintiff's treating sources.

First, the ALJ was not required to credit Dr. Zafar's or Nurse Jenkins and Dr. Dunlap's opinions that plaintiff must elevate his legs when sitting or provide such an accommodation in the RFC formulation. The ALJ thoroughly discussed his rationale for rejecting this limitation and those reasons are supported by substantial evidence. (Tr. 17).

There is no mention whatsoever in any of plaintiff's treatment records regarding an instruction that plaintiff must elevate his legs for all or a portion of the time he spends sitting. Further, as the ALJ noted, most of the treatment records from the treating sources reflect that plaintiff had no swelling or edema in his extremities. (Tr. 17, citing Tr. 719, 852, 876, 1144, 1158). The ALJ acknowledged that in April 2011, plaintiff had 3+ pitting edema which required him to be diuresed with IV Lasix, but aside from this instance findings of extremity swelling or edema were minor and health providers' notations reflect a connection to plaintiff's diet as opposed to a failure to elevate his legs. (Tr. 17, citing 740, 754). *See also* Tr. 1081 (plaintiff had 1+ pitting edema in September 2011 and reported a goal to reduce salt and soda intake); Tr. 1209 (plaintiff had 1+ lower extremity edema in November 2011 and was advised to reduce his salt intake). In any event, the existence of minor edema does not necessarily require an accommodating limitation. *See Howard v. Comm'r of Soc. Sec.*, 276 F.3d 235, 240 (6th Cir. 2002) ("[T]he RFC is meant to describe the claimant's residual abilities or what a claimant can do, no what maladies a claimant suffers from . . . ."). The absence of any documentation in the record supporting a leg-elevation limitation supports the ALJ's determination to not credit

plaintiff's treating sources' opinions on this issue. *See also Adams v. Astrue*, No. 1:07-cv-2543, 2008 WL 9485485, at *9 (N.D. Ohio July 15, 2008) (Report and Recommendation), *adopted*, 2008 WL 9396450 (N.D. Ohio Sept. 25, 2008) (declining to adopt treating source's leg-elevation limitation where there was no indication in any treatment records that the source advised plaintiff, who had consistent lower extremity edemas, to elevate her legs). Because the evidence reflects that edema is generally absent and, when present, is minor and there are no treatment records containing a leg elevation instruction from any source, the ALJ's refusal to include a limitation for leg elevation in the RFC is substantially supported.

Second, the ALJ's decision to give reduced weight to the treating source opinions is otherwise substantially supported by the record evidence.[7] The ALJ gave "little weight" to Dr. Zafar's opinion because: (1) he had a minimal treatment history with plaintiff at the time of rendering his opinion; (2) he failed to adequately explain his proposed limitations; (3) his opinion on plaintiff's ability to walk was inconsistent with the record evidence; and (4) his leg-elevation restriction was not supported by examination findings or notations in the treatment records. Review of the record supports the ALJ's determinations. The record clearly establishes that Dr. Zafar's opinion was rendered after having examined plaintiff on three occasions. *See* Tr. 729. The ALJ was entitled to discount his opinion given the minimal treatment history with plaintiff. *See* 20 C.F.R. §§ 404.1527(c)(2)(i), 416.927(c)(2)(i) ("Generally, the longer a treating source has treated you and the more times you have been seen by a treating source, the more weight [the ALJ] will give to the source's medical opinion."). *See also Helm v. Comm'r of Soc. Sec.*, 405 F.

[7]The Court notes that plaintiff's argument is limited to the ALJ's refusal to adopt his treating sources' leg elevation limitations. While plaintiff has arguably waived his challenge to the ALJ's decision by failing to set forth a developed argument addressing the reasons provided for discounting these opinions, *see McClellan*, 804 F. Supp.2d at 688, the above analysis is included for the sake of completeness.

App'x 997, 1000-01 n.3 (6th Cir. 2011) (finding that ALJ properly cited to short treatment relationship in discounting medical source's opinion and noting that "it is questionable whether a physician who examines a patient only three times over a four month period is a treating source. . . .").

Further, review of the evidence supports the ALJ's determination that Dr. Zafar's proposed limitations are inconsistent with his examination findings and other record evidence. While Dr. Zafar opined that plaintiff was able to walk less than one city block (Tr. 730), his treatment notes and other treatment notes from University Hospital reflect that plaintiff consistently reported a greater walking ability. *See*, *e.g.*, Tr. 873-74 (in April 2011, plaintiff reported to Nurse Jenkins that he walked for exercise and was walking two to three blocks); Tr. 1073 (in September 2011, plaintiff told Nurse Jenkins he was able to walk 2-3 blocks and climb 2-3 flights of stairs); Tr. 1177, 1263 (October and December 2011 reports to Nurse Jenkins and Dr. Dunlap reflect the same). Plaintiff also testified that he was able to walk two to three blocks. (Tr. 38). Further, cardiac clinic records from October 3, 2011, document that plaintiff was able to walk 1030 feet without experiencing any symptoms, including shortness of breath. *See* Tr. 1268-69 (plaintiff completed 6 laps, walked 1030 feet, and his O2 saturation remained between 94% and 96%, his heart rate went from 77 bpm to 80 bpm, and his blood pressure elevated slightly from 136/68 mmHg to 154/74 mmHg). Given the inconsistencies between Dr. Zafar's opinion on plaintiff's physical abilities and the medical and clinical evidence and plaintiff's own reports, the ALJ's decision to give this opinion "little weight" is substantially supported.

While the length and frequency of Dr. Dunlap and Nurse Jenkins' treatment relationship with plaintiff clearly establishes them as treating sources, their opinion regarding plaintiff's functional abilities is similarly inconsistent with the record evidence such that the ALJ was not required to adopt their restrictions. Like Dr. Zafar, Dr. Dunlap and Nurse Jenkins opined that plaintiff was incapable of walking more than one city block due to weakness and shortness of breath. *See* Tr. 735-37. However, as noted above, plaintiff consistently reported to these sources that he was capable of three times this amount and Dr. Dunlap's records include a walking test showing that plaintiff walked over 1000 feet without experiencing any significant fatigue or shortness of breath. *See* Tr. 1268-69. These inconsistencies substantially support the ALJ's decision to discount Dr. Dunlap and Nurse Jenkins' limitations. *See* 20 C.F.R. §§ 404.1527(c)(3-4), 416.927(c)(3-4) (an opinion's lack of support by and inconsistency with record evidence are factors the ALJ may consider in weighing the opinion).

Third, to the extent plaintiff argues that consultative examiner Dr. Bailey's opinion was so vague that it was impermissible for the ALJ to rely on it in formulating the RFC, the Court finds that any error in this regard is harmless as there is other substantial evidence of record which supports the ALJ's RFC formulation.

After a physical examination revealing no significant findings aside from obesity, Dr. Bailey opined that plaintiff retained the functional capacity to perform "at least a mild amount of sitting, ambulating, [and] standing. . . ." (Tr. 361). Plaintiff argues that this opinion "is so broad that it is essentially worthless." (Doc. 10 at 14). The ALJ interpreted Dr. Bailey's finding of a "mild amount" of sitting, walking, and standing as suggesting "a capacity for

sedentary work." (Tr. 18).[8] The ALJ thus appears to have relied on Dr. Bailey's opinion to support his RFC finding that plaintiff was capable of sitting for a minimum of six hours and standing or walking for two hours in an eight-hour work day. (Tr. 14).

In the absence of any other record evidence, the ALJ's reliance on Dr. Bailey's opinion would not substantially support his finding that plaintiff can sit for six hours a day. *See Moeller v. Comm'r of Soc. Sec.*, 489 F. App'x 868, 870 (6th Cir. 2012) (finding that ALJ erred by formulating RFC allowing for six hours of sitting in a day where consultative examining physician opined that plaintiff was capable of a "mild amount" of sitting). However, other opinion evidence and plaintiff's own reports substantially support the ALJ's finding that plaintiff is capable of sitting for six hours in an eight-hour workday. Dr. Zafar opined that plaintiff was capable of sitting for six hours and plaintiff testified that he spends eight to ten hours a day watching television and that he spends his free time sitting on the porch. (Tr. 43, 45-46, 51-53, 731). In a June 2010 Function Report, plaintiff did not report that his ability to sit was affected by his impairments. (Tr. 285). Further, agency reviewing physician Rebecca R. Neiger, M.D., reviewed plaintiff's file in April 2009 and opined that plaintiff was capable of sitting for six hours in an eight hour workday.[9] (Tr. 362-69). Taken as a whole, the above-cited evidence provides substantial support for the ALJ's finding that plaintiff is capable of sitting for six hours in an eight-hour workday.

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[8]"Sedentary work involves lifting no more than 10 pounds at a time. . . . Although a sedentary job is defined as one which involves sitting, a certain amount of walking and standing is often necessary in carrying out job duties. Jobs are sedentary if walking and standing are required occasionally and other sedentary criteria are met." 20 C.F.R. §§ 404.1567, 416.967.

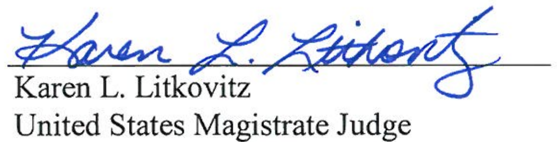
[9]Notably, the ALJ gave reduced weight to Dr. Neiger's opinion because "subsequent evidence (a chronically low ejection fraction)" did not support her opinion that plaintiff was capable of light work. (Tr. 18).

For these reasons, the Court concludes the ALJ did not err in weighing the medical opinions of record and the ALJ's RFC formulation is supported by substantial evidence. Accordingly, plaintiff's fourth and fifth assignments of error are overruled.

IV. Conclusion

For the reasons stated herein, the ALJ's decision is **REVERSED** and **REMANDED** for further proceedings. On remand, the ALJ is instructed to: (1) provide a detailed discussion as to whether the evidence establishes that plaintiff meets or medically equals Listing 4.02 or 4.04; (2) consider the impact of plaintiff's obesity in the Listings determination; and (3) formulate a new RFC which accounts for the side effects of plaintiff's medications, namely, urinary frequency.

Date: 8/5/14



Karen L. Litkovitz
United States Magistrate Judge