IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF OHIO
EASTERN DIVISION

Deanna Chandler,	:	
Plaintiff,	:	
v.	:	Case No. 2:13-cv-324
	:	
Commissioner of Social Security,		Magistrate Judge Kemp
Defendant.	:	

OPINION AND ORDER

I. Introduction

Plaintiff, Deanna Chandler, filed this action seeking review of a decision of the Commissioner of Social Security determining that, as of February 1, 2006, she was no longer disabled, and that she had not become disabled after that date. Plaintiff had been found disabled in a prior decision dated March 17, 1999, and had been awarded supplemental security income effective February 1, 1999.

After some delay in the administrative process due to Plaintiff's failure to attend a hearing, Plaintiff was given a hearing before an Administrative Law Judge on June 20, 2011, followed by a second hearing held on January 10, 2012. In a decision dated February 16, 2012, the ALJ upheld the termination of benefits and also decided that Plaintiff had not been disabled on any date after February 1, 2006. That became the Commissioner's final decision on March 12, 2013, when the Appeals Council denied review.

After Plaintiff filed this case, the Commissioner filed the certified administrative record on August 5, 2013. Plaintiff filed her statement of specific errors on October 15, 2013. The Commissioner filed a response on January 17, 2014. No reply

brief has been filed, and the case is now ready to decide.

II. Plaintiff's Testimony at the Administrative Hearing

Plaintiff, who was 48 years old at the time of the administrative hearings and has a GED, testified as follows. Her testimony appears at pages 1339-60 of the administrative record.

The first subject discussed at the hearing was Plaintiff's alcohol abuse. She testified that until about three years before the hearing, she drank steadily, but was able to reduce her drinking by getting back on medications for her psychological conditions and through programs she was sent to. She used cocaine during the same time that she was abusing alcohol. She also acknowledged several criminal convictions and that she spent time in prison on several occasions, and a short time in jail more recently.

Plaintiff was then asked some questions about her daily routine. She said she was able to cook, do laundry, clean her house, and listen to the radio. She did not like to be around people. In additional to psychological issues, she stated that she suffered from sleep apnea, asthma, diabetes, a thyroid condition, anemia, arthritis, carpal tunnel syndrome, and bone spurs in her heels. She had excruciating pain in her low back which prevented her from sitting, standing, or walking for prolonged periods. The pain radiated into her legs. She also had shortness of breath, cramping in her hands, and muscle spasms in her feet and legs. Lifting over five pounds hurt her back. She could not walk more than half a block and could sit for only half an hour.

Plaintiff had worked at a Subway restaurant in the past two to four years, making sandwiches and taking orders. She quit the job because she could not get along with her coworkers. She did not leave her home except for going to see the doctor or to the store, and she did not socialize with friends.

III. The Medical Records

The pertinent records - those which are most relevant to the three errors alleged in Plaintiff's statement of errors - can be summarized as follows. The Court will provide page references for these records as they are summarized.

A. Mental Health Records

Plaintiff, in her statement of errors, appears to rely on these mental health records: three evaluations done by Dr. Donaldson, one performed by Dr. Todd, several diagnostic or intake assessments made from 2005 to 2009, and progress notes from North Central Mental Health Services. They are accurately described in Plaintiff's statement of the medical evidence (Doc. 18, at 4-11), and the Court will provide only a brief recap of them here.

Dr. Donaldson first saw Plaintiff on December 12, 2005. At that appointment, she ascribed her disability to both physical and psychological concerns, including not wanting to be around people, depression, and memory problems. Her affect was agitated and she claimed not to know why she was seeing Dr. Donaldson. She described frequent mood swings and anxiety. Dr. Donaldson diagnosed a dysthymic disorder and a generalized anxiety disorder and rated her GAF at 50-60. He did not note any marked impairments in functioning. (Tr. 371-75). His second report, based on a clinical evaluation performed on March 21, 2007, was similar. He did administer the MMPI-2 but did not view the results as valid. At the end of that session, he diagnosed Plaintiff with a bipolar disorder, a generalized anxiety disorder, a bereavement disorder, and polysubstance dependence, but he rated her GAF at 60-65 and, again, while he found numerous moderate limitations on her ability to do work-related functions, found no marked limitations. (Tr. 245-48). In his third report, dated April 12, 2010, Dr. Donaldson noted that Plaintiff had no

impairment in her ability to understand, remember, and carry out simple tasks or to perform repetitive tasks (although he questioned her motivation to do so), and that she was moderately limited in her ability to get along with others and to withstand ordinary work stress. At that time, he rated her GAF at 50-55. (Tr. 666-69).

Dr. Todd saw Plaintiff on March 22, 2010, shortly before Dr. Donaldson's last report. At that time, Plaintiff had been in treatment at North Central for several years and was taking medication for psychological conditions. She had been diagnosed there with major depression and anxiety. She was attending classes, riding public transportation, and doing some household chores. Plaintiff's affect was flat and she reported some auditory hallucinations. Dr. Todd diagnosed a bipolar disorder with psychotic features and rated Plaintiff's GAF at 50. She concluded that Plaintiff was not employable and referred to a residual functional capacity evaluation form which she had completed, but that form does not appear to be part of the record. (Tr. 652-57).

The diagnostic assessments or intake reports include a report from Netcare, Inc. dated January 24, 2005, which showed that Plaintiff was attempting to resume case management following her release from prison, and that she felt her mood swings were returning. She met the criteria for a provisional diagnosis of a mood disorder. Her GAF was rated at 55 and her mental status exam was, for the most part, normal. (Tr. 376-83). She underwent another diagnostic assessment with Directions for Youth and Families on April 11, 2006 (but never returned for treatment). She reported lifelong depression and a dislike of people. The recent death of her son and a miscarriage had intensified her symptoms. Her initial and final GAF ratings were 59 and the only diagnosis made was post-traumatic stress

disorder. (Tr. 249-64). Next, North Central evaluated her on July 21, 2008. Her mood at that time was "depressed and anxious." However, she could complete activities of daily living "at an adequate level ...." She was diagnosed with severe depression with psychotic features (based on her report of hallucinations) and generalized anxiety disorder. Her GAF was rated at 54. (Tr. 594-99). That assessment was updated in December, 2009. Her only current symptom at that time was anxiety. She reported having a good relationship with her grandmother and sons but had no friends. Her mood was calm and her motor activity was within normal limits. She denied current hallucinations and she was able to perform normal activities of daily living. Her diagnoses did not change but her GAF improved to 61. (Tr. 589-94).

Finally, the two sets of progress notes cited by Plaintiff show, first, that in May, 2009, Plaintiff was not taking medication and was not depressed, but she was unable to sleep or concentrate and feared she was "headed for a crash." Prior to that, in September, 2008, she was sleeping well, her appetite was good, and she denied any depression or mood disturbances. She was taking medication at that time. (Tr. 600-09). The second set of notes, dating from 2010, show that Plaintiff had some mood disturbances when she was off her medications. (Tr. 845-48).

The Commissioner, in turn cites to other mental health records. First, Dr. Voyten, a state agency psychologist, completed a residual functional capacity assessment form on May 17, 2010. She concluded that Plaintiff was moderately (but not markedly) limited in five separate areas, most having to do with either social interaction or dealing with work stress, based on Plaintiff's history of depression. She noted that Plaintiff had not received any treatment since 2009 and she cited the findings of Dr. Donaldson concerning Plaintiff's ability to do tasks. She

also found Plaintiff only partially credible about avoiding people since she used public transportation and attended classes at Columbus State. (Tr. 673-76). Dr. Voyten also evaluated the "B" criteria and found no marked impairments. (Tr. 687). Dr. Terry, another psychologist, affirmed that assessment on October 26, 2010. (Tr. 960). The Commissioner also points to a comment made by Plaintiff to a social worker that she "was able to function in most social situations." (Tr. 597).

B. Records Concerning Asthma/COPD

Plaintiff also raises an issue about whether she met the requirements of section 3.02 of the Listing of Impairments. She cites to a number of medical records documenting her breathing difficulties. Those records show the following.

Plaintiff went to the emergency room on November 24, 2009, complaining of a cough. Examination revealed some congestion. She was given three breathing treatments and felt better. The diagnoses included acute bronchitis. (Tr. 586-87). She received similar treatment for a cough on May 27, 2010, again being diagnosed with bronchitis; a chest x-ray taken during that visit was normal. (Tr. 703-04). Her cough was improved with treatment when she was seen four days later. (Tr. 705-06). She was still wheezing when she went to the hospital two weeks later reporting chest pain and shortness of breath. She was treated with Albuterol, among other things, and hospitalized for three days while various tests were run. She was improved on discharge. (Tr. 714-34). She returned to the hospital shortly thereafter and was diagnosed with a pulmonary embolism, which was treated with heparin. (Tr. 752). Finally, spirometric tests were administered on October 6, 2010, showing an FEV1 of 1.31 before the administration of bronchodilators and 1.56 afterwards. (Tr. 950).

C. Other Pertinent Records

The only other medical records which Plaintiff refers to in her statement of errors are various emergency room records where Plaintiff reported pain in her hand, chest, abdomen or pelvis, flank, ankle, and back. She also cites to some records indicating she suffered from chronic back pain. The importance of these records to her argument is not in their precise content, but in the fact that they are part of the record and the ALJ did not (according to Plaintiff) acknowledge or properly consider them. Consequently, the Court will discuss these records when it considers Plaintiff's third statement of error below.

IV. The Medical Testimony

A medical expert, Dr. Cherdron, testified at both administrative hearings. His testimony at the first hearing begins at page 1362 of the record.

In that testimony, Dr. Cherdron concluded that the medical records established the presence of depression, bipolar disorder, a history of substance abuse, degenerative disk disease, asthma, COPD, bilateral carpal tunnel syndrome, diabetes, a pulmonary embolism, hyperthyroidism status post-thyroidectomy, status post partial vulvectomy, hepatitis, and obesity. He did not believe they were so severe as to meet or equal any impairment described in the Listing of Impairments. As far as Plaintiff's physical ability was concerned, Dr. Cherdron thought she could lift 20 pounds occasionally and ten pounds frequently, could sit for six hours in a work day and stand or walk four to six hours, with appropriate breaks, and that she could occasionally bend, crouch, crawl, stoop, and climb stairs. She should not be exposed to concentrated fumes or extremes of cold or heat or humidity, she could balance and do fine manipulation frequently, and she could neither climb ropes or ladders or work around unprotected heights. He did not think she had experienced any medical improvement since 1999, however.

At the second hearing, Dr. Cherdron confirmed that the impairments he identified at the first hearing were still present in the record, but that new evidence showed additional impairments, including cardiomegaly and gastroesophageal reflux disease. He then testified that as of October 6, 2010, Plaintiff satisfied Listing 3.02, chronic pulmonary insufficiency. He also changed his view of her residual functional capacity, adding a limit to standing or walking of four hours per day, with a five minute break every forty-five minutes, and indicating that she could grasp only frequently, whereas before he thought she could do so without limitation. Lastly, he testified that not only was there no medical improvement since 1999, but that Plaintiff had gotten worse. (Tr. 1383-91).

V. The Vocational Testimony

Dr. Oestreich also testified at the first administrative hearing, beginning on page 1370 of the record. He did not identify any past relevant work which Plaintiff had performed. He was then asked to assume that Plaintiff had the limitations identified by Dr. Cherdron, including a limitation of reaching overhead with her left arm on only a frequent (rather than continual) basis. In Dr. Oestreich's view, that would permit Plaintiff to do about 20,000 light jobs in the Columbus area, such as counter attendant, inspector, or car wash attendant. If, in addition, Plaintiff could do simple, routine tasks, was mildly limited in her ability to perform repetitive tasks, was moderately limited in her ability to attend to all but simple, routine tasks, could interact with others only occasionally, and were limited to low stress work without production quotas or time pressures, she could do the same jobs he previously identified. However, if Plaintiff were as limited as she testified, she could not work.

At the second administrative hearing, a different vocational

expert, Mr. Olsheski, was called as an expert witness. His testimony begins at page 1391 of the record. Mr. Olsheski said that the new limitations described by Dr. Cherdron would restrict Plaintiff to sedentary work and about twenty percent of the light jobs. He described three light jobs that Plaintiff could do, including hand packer, production inspector, and sewing machine operator.

VI. The Administrative Law Judge's Decision

The Administrative Law Judge's decision appears at pages 168-80 of the administrative record. The important findings in that decision are as follows.

The Administrative Law Judge found, first, that the comparison point decision date was March 17, 1999, the date on which Plaintiff was found to be disabled. As far as Plaintiff's impairments are concerned, the ALJ found that on that date Plaintiff had severe impairments including an affective disorder, polysubstance abuse, hepatitis, and a history of a fractured left elbow with related surgery. As of February 1, 2006, the date that benefits were terminated, and as of the date of the decision, Plaintiff had those impairments plus an anxiety-related disorder, a personality disorder, diabetes, COPD or asthma, obesity, cardiomegaly or congestive heart failure, thyroid disease, bilateral carpal tunnel syndrome, cervical spine degenerative disc disease, right ankle arthritis, and vulvar intraepithelial neoplasia. The ALJ also found that these impairments did not, at any time after February 1, 2006, meet or equal the requirements of any section of the Listing of Impairments (20 C.F.R. Part 404, Subpart P, Appendix 1).

Next, the ALJ found that Plaintiff had experienced medical improvement in her psychological condition as of February 1, 2006, and that she no longer met the requirements of Listing 12.04 as of that date. The ALJ then concluded that Plaintiff had the residual functional capacity to perform light work, as

described by Dr. Cherdron at the second administrative hearing, and that she was limited to the performance of simple, repetitive tasks in a low stress environment with occasional interaction with others and no strict production requirements or time quotas. The ALJ found that, with these restrictions, Plaintiff could perform the jobs identified by the two vocational experts and that such jobs existed in significant numbers in the regional and national economies. Consequently, the ALJ concluded that Plaintiff's disability ended on February 1, 2006, and that Plaintiff was not entitled to benefits.

VII. Plaintiff's Statement of Specific Errors

In her statement of specific errors, Plaintiff raises these issues: (1) substantial evidence does not support the ALJ's conclusion about medical improvement in Plaintiff's mental health condition; (2) the ALJ did not give appropriate weight to the opinions of Dr. Todd and Dr. Cherdron; and (3) the ALJ did not properly analyze Plaintiff's claim of disabling pain. The Court analyzes these claims under the following standard.

Standard of Review. Under the provisions of 42 U.S.C. Section 405(g), "[t]he findings of the Secretary [now the Commissioner] as to any fact, if supported by substantial evidence, shall be conclusive. . . ." 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) (quoting Consolidated Edison Company v. NLRB, 305 U.S. 197, 229 (1938)). It is "'more than a mere scintilla.'" Id. LeMaster v. Weinberger, 533 F.2d 337, 339 (6th Cir. 1976). The Commissioner's findings of fact must be based upon the record as a whole. Harris v. Heckler, 756 F.2d 431, 435 (6th Cir. 1985); Houston v. Secretary, 736 F.2d 365, 366 (6th Cir. 1984); Fraley v. Secretary, 733 F.2d 437, 439-440 (6th Cir. 1984). In determining whether the Commissioner's decision is supported by substantial evidence, the Court must "'take into

account whatever in the record fairly detracts from its weight.'" Beavers v. Secretary of Health, Education and Welfare, 577 F.2d 383, 387 (6th Cir. 1978) (quoting Universal Camera Corp. v. NLRB, 340 U.S. 474, 488 (1951)); Wages v. Secretary of Health and Human Services, 755 F.2d 495, 497 (6th Cir. 1985). Even if this Court would reach contrary conclusions of fact, the Commissioner's decision must be affirmed so long as that determination is supported by substantial evidence. Kinsella v. Schweiker, 708 F.2d 1058, 1059 (6th Cir. 1983).

A. Medical Improvement

Plaintiff was granted benefits as of February 1, 1999, based on a determination that her affective disorder met the requirements of Listing 12.04. That section presumes disability when a claimant suffers from a disturbance of mood with either manic or depressive symptoms, characterized by any one of a number of symptoms (such as, for a depressive disorder, loss of interest in all activities, appetite or sleep disturbances, psychomotor agitation or retardation, decreased energy, feelings of guilt or worthlessness, difficulty concentrating or thinking, thoughts of suicide, or hallucinations, delusions or paranoid thinking) and which also meets two of the four "B" criteria. The "B" criteria describe marked impairments in three areas (activities of daily living, maintaining social functioning, or maintaining concentration, persistence and pace) and also include repeated, extended episodes of decompensation. Plaintiff's first argument, phrased exactly as Plaintiff puts it in her brief, is that "substantial evidence demonstrates that Ms. Chandler does continue to meet Listing 12.04." Statement of Errors, Doc. 18, at 14. She supports this argument by recounting many of the exhibits dealing with her psychological condition and noting that they support a finding both that she still suffers from an affective disorder of some type (either depression or anxiety), still has most of the symptoms recited in Section 12.04(A), and

meets two of the "B" criteria by having a marked impairment in the areas of social functioning and maintaining concentration, persistence and pace. She does not, however, explain why the ALJ's contrary conclusion is **not** supported by substantial evidence, and does not discuss the evidence which the ALJ cited in determining that Plaintiff's condition had improved to the point where she no longer satisfied Listing 12.04.

As it relates to the precise argument made by Plaintiff, the law clearly states that "[t]he findings of the Commissioner are not subject to reversal merely because there exists in the record substantial evidence to support a different conclusion." Buxton v. Halter, 246 F.3d 762, 772 (6th Cir. 2001). However, the Court will also discuss the related question, and the one briefed by the Commissioner, which is whether the ALJ's decision on the issue of medical improvement has substantial support in the record.

The ALJ's decision on this issue begins with the observation that, at least since February 1, 2006, there is no evidence that Plaintiff had any marked or extreme functional limitations from a mental health standpoint. The ALJ cited Plaintiff's comment that she functioned adequately in most social situations and her ability to read, watch television, and attend classes where she studied accounting and had to use public transportation. She referred to observations made by Dr. Donaldson about Plaintiff's appearance and orientation and the fact that he imposed only moderate work-related limitations. The ALJ also relied on the conclusions of Drs. Voyten and Terry that Plaintiff had only mild or moderate limitations in various areas.

All of the facts cited by the ALJ are supported by the evidence of record. None of the evidence to which Plaintiff refers actually contradicts this evidence, with the possible exception of Dr. Todd's opinion that Plaintiff is not employable, although the record is not clear as to whether Dr. Todd thought

Plaintiff continued to meet the requirements of Listing 12.04. However, Dr. Todd is not a treating source, and the ALJ was entitled both to rely on the conflicting evidence from Dr. Donaldson and the two state agency psychologists and to resolve the conflicts in the medical evidence. See, e.g., Brooks v. Comm'r of Social Security, 531 Fed. Appx. 636, 642 (6th Cir. Aug. 6, 2013)(citing to Social Security Ruling 96-6p and explaining when a state agency psychologist's opinion may be given significant weight); Walters v. Comm'r of Social Security, 127 F.3d 525, 528 (6th Cir. 1997)(holding that it is not the Court's task to resolve conflicts in the evidence), citing Garner v. Heckler, 745 F.2d 383, 387 (6th Cir. 1984). Consequently, since the presence of substantial evidence to the contrary - if, in fact, that is the correct interpretation of the evidence cited by Plaintiff even though most of it does not specifically mention any marked areas of impairment - is not a sufficient basis to overturn the ALJ's decision, and since there is substantial support in the record for the ALJ's decision, Plaintiff's first statement of error is without merit.

B. The Medical Expert Opinions

In her next statement of error, Plaintiff argues that the ALJ did not give sufficient weight to either Dr. Todd's opinion or Dr. Cherdron's statement that she satisfied Listing 3.02. The Court will address each of these contentions in turn.

1. Dr. Todd

Dr. Todd's evaluation is summarized above. In brief, she concluded that Plaintiff suffered from a bipolar disorder with psychotic features and that she was not, at least for the ensuing twelve-month period, employable. Plaintiff contends that the ALJ provided "incomplete and incorrect" reasons for rejecting Dr. Todd's view (Doc. 18, at 15) and that most of the factors cited by Dr. Todd in support of her conclusion were consistent with other evidence of record, including the treatment notes from

North Central and Dr. Donaldson's various reports. The Commissioner responds that, contrary to Plaintiff's position, Dr. Donaldson concluded that Plaintiff could work with only moderate psychologically-based limitations, and that other evidence supported the ALJ's decision to reject Dr. Todd's opinion.

Dr. Todd was not, of course, a treating source. Several legal principles apply to the Court's review of an ALJ's decision to discount the opinions of a medical source who did not treat the claimant. First, "it is not a per se error of law ... for the ALJ to credit a nonexamining source over a nontreating source." Norris v. Comm'r of Social Security, 461 Fed. Appx. 433, 439 (6th Cir. Feb. 7, 2012). Second, the ALJ is not required to give "good reasons" for rejecting a nontreating source's opinions in the same way as must be done for a treating source; "an ALJ need only explain its reasons for rejecting a treating source because such an opinion carries 'controlling weight' under the SSA." Id. As this Court has noted, "[a]n ALJ is permitted to make ... resolutions of conflicting evidence, and there is no specific requirement that this type of decision be set forth in the same type of detail required when rejecting the opinion of a treating source." Jones v. Comm'r of Social Security, 2012 WL 5378850, *5 (S.D. Ohio Oct. 30, 2012), adopted and affirmed 2013 WL 556208 (S.D. Ohio Feb. 12, 2013). While the ALJ may not simply ignore the opinions of nontreating sources, as long as the record contains substantial evidence supporting the ALJ's evaluation of such an opinion, that evaluation cannot be second-guessed by a reviewing court. See, e.g., Nolan v. Comm'r of Social Security, 2013 WL 1787386, *6 (S.D. Ohio Apr. 25, 2013), adopted and affirmed 2013 WL 4831029 (S.D. Ohio Sept. 10, 2013).

Here, the ALJ specifically rejected Dr. Todd's opinion because Dr. Todd's report stated that Plaintiff was fully oriented with clear and coherent thought processes and because

Plaintiff was studying at Columbus State and using public transportation. (Tr. 177). Those two statements were both true, although, as Plaintiff notes, she subsequently stopped attending classes. Further, the ALJ's decision about Dr. Todd's opinion cannot be read in a vacuum. The ALJ did cite to Dr. Donaldson's contrary views about Plaintiff's ability to perform various work-related functions, and also to the state agency reviewers' assessments discussed in detail above. The ALJ found them more credible based on the evidence as a whole; again, Plaintiff's argument concerning Dr. Todd's opinion cites only to evidence supposedly supporting her views (although not all of it actually does so), and does not explain why any of the contrary evidence is not, on this record, substantial enough to support the ALJ's decision. The Court finds that there is substantial support for the opposite viewpoint, and does not view this issue as one justifying a remand.

2. Dr. Cherdron

As noted in the Court's review of the testimony given at the administrative hearing, Dr. Cherdron, while he identified a residual functional capacity which, from a physical standpoint, appeared to be consistent with Plaintiff's being able to work, also said, at one point, that she met Listing 3.02. The ALJ did not credit this part of his testimony. Plaintiff claims that was error, and that either the ALJ should have accepted that testimony as consistent with the record or asked Dr. Cherdron about the issue of medical equivalence.

Listing 3.02 is entitled "Chronic Pulmonary Insufficiency." It presumes disability for someone with COPD with an FEV1 equal to or less than certain values specified in a table included in the Listing. For a person of Plaintiff's height (66"), the key value is 1.35. The introduction to the Listing states that the highest test result must be used, however, and that is true "whether they were achieved pre- or post-bronchodilator."

Bomeisl v. Apfel, 1998 WL 430547, *4 (S.D.N.Y. 1998). Any test which includes both higher and lower values "must be considered as non-qualifying for purposes of the Listing criteria." Morgan v. Astrue, 2013 WL 625097, *4 (D.S.C. Jan. 30, 2013), adopted and affirmed 2013 WL 633581 (D.S.C. Feb. 20, 2013). The ALJ rejected Dr. Cherdron's testimony for exactly that reason, and Plaintiff makes no cogent argument that she was wrong to do so.

The ALJ also discussed other evidence of Plaintiff's breathing issues. She noted that the pulmonary embolism had resolved and that other testing revealed only a mild reduction in diffusing capacity, see Tr. 961. Chest x-rays were consistently normal. Although Plaintiff faults the ALJ for not asking Dr. Cherdron for an opinion about medical equivalency, Plaintiff did not ask that question either. Plaintiff has cited no legal authority for the proposition that the ALJ had to make such an inquiry under the facts of this case, and the law is clear that an ALJ has no duty to make further inquiries about medical equivalence if he or she does not believe that "the symptoms, signs, and laboratory findings reported in the case record suggest that a judgment of equivalence may be reasonable" - that is, an ALJ has "broad discretion in determining whether to consult with a medical expert" on this issue. Lance v. Astrue, 2008 WL 3200718, *4 (E.D. Tenn. Aug. 5, 2008), citing, inter alia, SSR 96-6p. The other evidence cited by both Plaintiff and by the ALJ does not suggest that a finding of medical equivalence might be reasonable here, and the ALJ did not err in her treatment of this issue.

C. Plaintiff's Pain

Plaintiff's third and final statement of error is that the ALJ did not properly evaluate her subjective complaints of pain. Citing to Rogers v. Comm'r of Social Security, 486 F.3d 234, 247 (6th Cir. 2007), she argues that the ALJ did not factor into her analysis the multiple times Plaintiff visited the emergency room

complaining of pain in her joints, abdomen and chest, nor Plaintiff's testimony about how severely her pain limited her ability to walk, stand, and sit. She essentially faults the ALJ for "cherry-picking" the record concerning the pain which Plaintiff was experiencing as well as the potential side effects of her medications, including several opiate-based pain relievers.

Taking these contentions in reverse order, Plaintiff does not point to any portion of the record where either she or a health care professional stated that her medications caused side effects inconsistent with the ability to work at the light or sedentary exertional levels. Absent such evidence, the ALJ had no reason to find that medication side effects were a significant factor in determining Plaintiff's residual functional capacity.

As to the balance of Plaintiff's argument, evaluation of a claimant's subjective reports of disabling pain is subject to a two-part analysis. First, the ALJ must determine if there is objective medical evidence which confirms the presence of disabling pain. If not (and there frequently is not, given that pain is difficult to measure or quantify, and is experienced differently even by persons with the same underlying condition), the ALJ must determine if the claimant suffers from an objectively-established medical condition of sufficient severity to permit a reasonable inference to be drawn that the disabling pain actually exists. See Duncan v. Secretary of H.H.S., 801 F.2d 847, 853 (6th Cir. 1986). This procedure is reflected in 20 C.F.R. §404.1529(a).

It is important to note that these inquiries are to be made separately, and that if there is objective evidence of a sufficiently severe underlying condition, a claimant can prove the existence of disabling pain due to that condition through other evidence even if the medical evidence is not helpful in establishing the extent of the claimant's pain. Felisky v.

Bowen, 35 F.3d 1027 (6th Cir. 1994). Thus, the Commissioner is not permitted to reject allegations of disabling symptoms, including pain, solely because objective medical evidence is lacking, but must consider other evidence, including the claimant's daily activities, the duration, frequency, and intensity of the symptoms, precipitating and aggravating factors, medication (including side effects), treatment or therapy, and any other pertinent factors. 20 C.F.R. §404.1529(c)(3). The Commissioner should also give appropriate weight to the opinion of a long-term treating physician as to whether the claimant is accurately reporting or exaggerating the extent to which disabling symptoms exist. Felisky, 35 F.3d at 1040. If the Commissioner summarily rejects the claimant's testimony concerning pain without considering these matters, reversal or remand may be warranted.

Since tolerance of pain is a highly individual matter, determination of disability based on pain also depends to some extent on the credibility of the claimant. Houston v. Secretary of H.H.S., 736 F.2d 365 (6th Cir. 1984). If the Commissioner rejects the claimant's testimony as to the extent of the claimant’s pain, there need not be an express credibility finding. Willis v. Secretary of H.H.S., No. 84-3477, slip op. at 9 (6th Cir. Apr. 30, 1985) (unpublished opinion), citing Ramirez v. Secretary HEW, 550 F.2d 1286 (1st. Cir. 1977). However, the reasons for the rejection must be apparent from the record. Id. This requirement insures that a sufficient record for review of the Commissioner’s credibility determination is made. Beavers v. Secretary of HEW, 557 F.2d 383, 386-87 (6th Cir. 1978), citing Combs v. Weinberger, 501 F.2d 1361 (4th Cir. 1974). In order to reject claimant's credibility, the Commissioner cannot rely solely on personal observation of the claimant but must base the credibility determination on "some other evidence." Weaver v. Secretary of H.H.S., 722 F.2d 310,

312 (6th Cir. 1983) (emphasis in original); see also, Persons v. Secretary of H.H.S., 526 F.Supp. 1202 (S.D. Ohio 1981). In light of the Commissioner's opportunity to observe the claimant's demeanor, the Commissioner's credibility finding is entitled to deference and should not be discarded lightly. Kirk v. Secretary of H.H.S., 667 F.2d 524, 538 (6th Cir. 1981); Beavers v. Secretary of HEW, 577 F.2d at 386-87. The evaluation of a claimant's credibility is largely committed to the discretion of the Commissioner, and the findings made in that regard are entitled to "great weight and deference." Walters v. Comm'r of Social Security, 127 F.3d 525, 531 (6th Cir. 1997). However, the Commissioner's credibility finding is not entitled to substantial deference if the medical and lay evidence supporting allegations of pain is uncontradicted and overwhelming. King v. Heckler, 742 F.2d 968 (6th Cir. 1984).

Here, the ALJ provided the following rationale for finding Plaintiff's subjective complaints of disabling symptoms less than fully credible. After reciting the proper legal standard (Tr. 175), the ALJ concluded that Plaintiff's "subjective complaints are disproportionate and not supported by the record." (Tr. 177). Her criminal history was noted as a factor in this analysis, two reviewing sources (Dr. Manos and Dr. Sagone) found her to be only partially credible, and the ALJ referred to a number of statements and testimony which indicated that Plaintiff could do more than she alleged, including evidence that she read, attended college classes, used public transportation, lived alone, functioned adequately in most social situations, and appeared fully oriented ant not confused when she was evaluated by Dr. Donaldson. These are all legitimate factors to take into account when evaluating the credibility of a social security claimant. See, e.g., Dozier v. Astrue, 2012 WL 2344163, *8 (N.D. Ohio Mar. 15, 2012), adopted and affirmed 2012 WL 2343907 (N.D. Ohio June 20, 2012)(collecting cases on use of claimant's

criminal history as a factor in evaluating credibility); see also Jernigan v. Comm'r of Social Security, 2014 WL 1328177, *10 (E.D. Mich. Mar. 28, 2014), citing, inter alia, SSR 96-7p ("One strong indication of the credibility of an individual's statements is their consistency, both internally and with other information in the case record").

The fact that the ALJ did not specifically cite to the emergency room visits mentioned in Plaintiff's statement of errors does not mean that they were not considered. The ALJ relied heavily on the assessment done by Dr. Cherdron, the medical expert, who reviewed these records. Further, "the fact an ALJ did not specifically state every piece of evidence or every symptom is not an error." Dickey-Williams v. Commissioner of Social Security, 975 F.Supp.2d 792, 807 (E.D. Mich. 2013). Given the amount of deference owed to the ALJ's resolution of credibility issues, and the fact that the ALJ's reasoning process in this case is supported by the evidence, the fact that other evidence might also have supported the opposite conclusion is not determinative. The Court finds no merit in Plaintiff's final statement of error.

VIII. Decision

Based on the above discussion, Plaintiff's statement of errors is overruled and the Clerk is directed to enter judgment in favor of the Defendant Commissioner of Social Security.

/s/ Terence P. Kemp
United States Magistrate Judge