Duncan v. Commissioner of Social Security Doc. 24

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

JACQUELINE S. DUNCAN,

Plaintiff,

Civil Action 2:13-cv-635
Magistrate Judge Elizabeth P. Deavers

v.

COMMISSIONER OF SOCIAL SECURITY,

Defendant.

OPINION AND ORDER

Plaintiff, Jacqueline S. Duncan, brings this action under 42 U.S.C. §§ 405(g) and 1383(c)(3) for review of a final decision of the Commissioner of Social Security ("Commissioner") denying her application for Supplemental Security Income. This matter is before the Court for consideration of Plaintiff's Statement of Errors (ECF No. 12), the Commissioner's Memorandum in Opposition (ECF No. 20), Plaintiff's Reply (ECF No. 21), and the Administrative Record (ECF No. 9). For the reasons that follow, the Court **OVERRULES** Plaintiff's Statement of Errors and **AFFIRMS** the Commissioner's decision.

I. BACKGROUND

Prior to filing the instant claim, Plaintiff had twice applied for Supplemental Social Security Income; first in November 2001 and subsequently in September 2005. (R. at 84.) On April 28, 2009, Administrative Law Judge Rita S. Eppler issued an unfavorable decision finding that Plaintiff was not disabled within the meaning of the Social Security Act. (R. at 81-94.) Plaintiff did not pursue an administrative appeal of the April 28, 2009 non-disability decision.

Plaintiff filed her current application for benefits on October 2, 2009, alleging that she has been disabled since November 1, 2001. (R. at 152-54.) Plaintiff alleges disability as a result

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of chronic obstructive pulmonary disease ("COPD") and "spine disease." (R. at 182.) Plaintiff's application was denied initially and upon reconsideration. Plaintiff sought a *de novo* hearing before an administrative law judge. Administrative Law Judge Paul E. Yerian ("ALJ") held a hearing on December 15, 2011, at which Plaintiff, represented by counsel, appeared and testified. (R. at 54-71.) Carl W. Hartung, a vocational expert, also appeared and testified. (R. at 71-79.) On February 22, 2012, the ALJ issued a decision finding that Plaintiff was not disabled within the meaning of the Social Security Act. (R. at 19-39.) On May 17, 2013, the Appeals Council denied Plaintiff's request for review and adopted the ALJ's decision as the Commissioner's final decision. (R. at 1-6.) Plaintiff then timely commenced the instant action.

II. HEARING TESTIMONY

A. Plaintiff's Testimony

At the December 15, 2011 hearing, Plaintiff testified that she is a forty-nine year old widow with an eleventh-grade education. (R. at 54-56.) She stated that she lives alone in a first-floor apartment in New Concord, Ohio. (R. at 55.) Plaintiff further testified that she does not have a driver's license and that her children drive her places when needed. (R. at 55-56.) Plaintiff stated that she receives state disability benefits, food stamps, and has a medical card. (*Id.*)

Plaintiff testified that she has not been employed since she filed her application for Supplemental Social Security Income and that she has not looked for work. (R. at 56-57.) Plaintiff said that she has difficulty breathing and that her back causes her a lot of pain. (*Id.*) Plaintiff further stated that she gets tired from walking to the bathroom and that she lays on her right side to alleviate the pain in her back. (*Id.*) She testified that her pain is in her lower back,

starting around her belt-line and radiating into her hips. (R. at 57.) She described her pain as always being present and stated that it radiates into her legs if she stands for long periods of time or is walking. (R. at 58.)

Plaintiff also testified that her breathing has worsened over the last couple of years. (R. at 58-59.) She stated that she has been on oxygen since 2009 and that she uses it at most times, including when she leaves her home. (R. at 60.) Plaintiff further testified that she still smokes approximately five cigarettes per day and that she removes her oxygen unit when she goes outside to smoke. (*Id.*) Plaintiff testified that she previously smoked four or five packs of cigarettes per day. (R. at 70.)

Plaintiff stated that she has difficulty sleeping and that she sleeps for approximately two hours per night and she takes five- or ten-minute naps throughout the day. (R. 61-62.) Plaintiff testified that she spends her days watching television and that her daughters do all of her household chores. (R. at 66.) She added that she goes to the grocery store with her daughter sometimes, but that she gets out of breath walking into the store. (*Id.*)

Plaintiff testified that Dr. Short is her primary care physician and that she sees him every three months. (R. at 63.) She indicated that her prescriptions include Ativan, Vicodin, Potassium, Prilosec, and Clovan and that she takes all of these medications as prescribed. (R. at 65.)

Upon examination by her attorney, Plaintiff testified that she gets pneumonia approximately two or three times per year. (R. at 68.) Plaintiff also stated that she quit drinking in 2006, but that she has had alcoholic beverages on at least two occasions since then. (R. at 69-

70.) Plaintiff further testified that her pain medication no longer works as well and that she gets shortness of breath even when she is just lying at home. (R. at 70.)

B. Vocational Expert Testimony

Carl Hartung testified as the vocational expert ("VE") at the administrative hearing. (R. at 71-79.) As a preliminary matter, the VE testified that he agreed with the prior vocational expert testimony that Plaintiff has no past relevant work experience. (R. at 72.)

The ALJ then asked the VE a series of questions about a hypothetical individual with Plaintiff's age, educational background, the absence of any past relevant work, and the following capabilities and limitations:

> [The] individual could perform the exertional requirements of light work as that term is defined in the Dictionary of Occupational Titles and Social Security regulations except the individual could not climb ladders, ropes, or scaffolds. Should avoid hazards such as unprotected heights and dangerous machinery, and cannot engage in commercial driving. You should also assume the individual could frequently climb stairs and ramps and occasionally stoop and crouch. You should also assume that as a result of medically determinable mental impairments the individual can perform simple repetitive tasks in a relatively static environment where changes can be explained and where independent prioritization of tasks and more than daily p[l]anning is not required. The individual can have no more than occasional[] interaction with others and cannot do work involving conflict resolution or persuading others to follow instructions.

(R. at 73.) The VE testified that the hypothetical individual could perform work at the light exertional level such as a housekeeper or cleaner (357 jobs in the regional economy), food preparation worker (177 jobs in the regional economy), dishwasher (91 jobs in the regional economy), or hand packager (92 jobs in the regional economy). (R. at 73-74.) The VE further testified that in Southeast Ohio, the total number of unskilled jobs at all physical demand levels is 28,480. (R. at 74.)

The ALJ next asked the VE to assume the hypothetical individual could not do work requiring more than occasional exposure to dust, fumes, gasses, and exposure to poorly ventilated areas. (R. at 74-75.) The VE stated that these additional limitations would not change his testimony that the hypothetical individual could perform work at the light exertional level. (*Id.*)

The VE further testified that competitive employment would be precluded if the hypothetical individual was required to use a portable oxygen unit when outside of the home. (R. at 75.) The VE explained that the only work available under these circumstances would be unskilled sedentary work, such as clerical office work, and that Plaintiff is not qualified to perform this type of work because of her education level. (R. at 75-76.) The VE also testified that competitive employment would be precluded based on treating physician Dr. Short's October 2011 assessment. (R. at 76-77.)

III. MEDICAL RECORDS[1]

A. Primary Care Physician, Philip E. Short, M.D.

Plaintiff established care with Dr. Short on May 5, 2006. (R. at 304, 323.) Dr. Short noted that Plaintiff was smoking three packs of cigarettes per day and that she had diminished breath sounds upon physical examination. (R. at 323.)

On May 26, 2006, Dr. Short treated Plaintiff for low-back pain. (R. at 321.) He noted that Plaintiff was recently hospitalized for seizures. (*Id.*) An x-ray of Plaintiff's lumbar spine

[1] Plaintiff does not dispute the ALJ's findings regarding her mental functioning limitations. (ECF No. 12.) Because Plaintiff does not assert that the ALJ erred with regard to her nonexertional limitations, the Court considers only her physical conditions and limitations.

reflected anterior spurring at her L-3, L-4, and L-5, as well as disc-space narrowing at her L5-S1, posterior spurring, posterior facet sclerosis, and hypertrophy. (R. at 299.)

In December 2006, Dr. Short treated Plaintiff for acute bronchitis. Dr. Short noted that Plaintiff was still smoking and that she exhibited no increased shortness of breath. (R. at 316-17.) Examination revealed that Plaintiff's lungs were clear with diminished breath sounds. (R. at 316.) Dr. Short indicated that he "told [Plaintiff] very strongly she needs to quit smoking." (*Id.*)

In January 2008, Dr. Short treated Plaintiff for exacerbation of chronic back pain. (R. at 311.) Plaintiff complained of low-back pain that radiated down the back of her left leg. (*Id.*) Dr. Short ordered an MRI of Plaintiff's lower back, which showed degenerative disc disease at the upper and lower aspects of her lumbar spine. (R. at 258-59.) Dr. Short noted that Plaintiff was still smoking small cigars and that her lungs were clear with diminished breath sounds. (R. at 302.)

In July and November of 2008, Dr. Short noted that Plaintiff was doing "fairly well." (R. at 309-310.) On December 17, 2008, Plaintiff was again treated for acute bronchitis. Dr. Short again noted that Plaintiff was still smoking cigarettes and still coughing, but that she had no increased shortness of breath and no wheezing. (R. at 308.)

On June 10, 2009, Plaintiff presented to Dr. Short for a follow-up from pneumonia for which she had previously been hospitalized. (R. at 307.) Dr. Short noted that she was taking Prilosec and doing better. (*Id.*) He further noted that Plaintiff denied any chest pain or shortness of breath and that her lungs were clear. Dr. Short again advised Plaintiff to stop smoking. (*Id.*)

Additionally, a June 10, 2009 letter from Dr. Short indicates that Plaintiff is to have oxygen in her home and is to be provided "two liters nasal cannula continuously." (R. at 295.)

On September 9, 2009, Dr. Short again treated Plaintiff. Her pulse oximeter reading was 95%, and examination revealed that she had no cough, hemoptysis, paroxysmal nocturnal dyspnea, orthopnea, seizures, or dizziness. (R. at 306.) Dr. Short once more strongly advised Plaintiff to quit smoking cigarettes. (*Id.*)

Dr. Short submitted a functional assessment of Plaintiff's conditions based on treatment of Plaintiff from May 5, 2006, through September 8, 2009. (R. at 304.) Dr. Short's report stated that Plaintiff had the diagnoses of COPD, seizures, and lumbar spinal stenosis. (*Id.*) He noted that Plaintiff's symptoms included chronic shortness of breath and back pain. He further noted that Plaintiff's conditions improved with medication. Dr. Short explained that Plaintiff was taking Flovent for her emphysema and potassium and Prilosec for her upset stomach. (R. at 305.) Dr. Short opined that "due to her emphysema and back pain she is unable to do sustained work because of shortness of breath. Back pain limits her ability to bend, stoop or lift." (R. at 305.)

On December 10, 2009, Dr. Short treated Plaintiff for muscular back pain. Plaintiff reported pain in her neck and in between her shoulder blades. (R. at 388.) Dr. Short told Plaintiff to take Tylenol for the pain. He also noted that Plaintiff did not have shortness of breath, cough, or hemoptysis. (*Id.*)

On June 30, 2010, Dr. Short noted that Plaintiff had no hemoptysis, shortness of breath, transient ischemic attack ("TIA") or cerebrovascular accident ("CVA") symptoms, or cough. (R. at 387.) He again told Plaintiff to stop smoking. On October 5, 2010, Dr. Short again indicated

that Plaintiff continued to smoke cigarettes and was not interested in quitting. (R. at 439.) He also noted that Plaintiff denied shortness of breath, hemoptysis, paroxysmal nocturnal dyspnea, orthopnea, or dizziness. Examination revealed that Plaintiff's lungs were clear. Dr. Short "again strongly advised her to quit smoking." (*Id.*)

In March 2011, Dr. Short treated Plaintiff for bronchitis again. (R. at 438.) Plaintiff complained of a cough that had lasted three or four days. Dr. Short noted that Plaintiff was not wearing her oxygen at the appointment and that her pulse oximeter on room air was 98%. (*Id.*) Examination showed that Plaintiff's lungs were clear with diminished breath sounds. Plaintiff was still smoking. (*Id.*)

In May 2011, Plaintiff underwent an overnight oximetry study. In this study, Plaintiff underwent three desaturations of over three-minute duration and seven desaturation events in less than three minutes. (R. at 442.) Plaintiff's lowest oximeter reading was 78%. (R. at 442.) Dr. Short signed a certificate of medical necessity for at-home oxygen for non-continuous, overnight use with a flow rate of two liters based on the results of this study. (R. at 443.)

Dr. Short completed a second functional capacity assessment in October 2011. (R. at 447-48.) Dr. Short opined that, in an eight-hour workday, Plaintiff could stand three hours for twenty minutes at one time, walk one hour for ten minutes at one time, and sit four hours for one hour at one time; lift up to ten pounds occasionally; use her hands for simple grasping, pushing and pulling, and fine manipulation; use her feet for repetitive movements; bend and squat occasionally; but could not crawl, climb steps, or climb ladders. (R. at 447-48.) Finally, Dr. Short further opined that Plaintiff would likely have full or partial unscheduled absences of five or more days a month due to her conditions. (R. at 448.) He indicated that Plaintiff's lumbar

spinal stenosis and chronic back pain are functional limitations that should be considered in evaluating her physical capabilities. (R. at 448.)

In November 2011, an x-ray showed very mild peribronchial thickening to Plaintiff's right lung base. (R. at 451.) On December 6, 2011, Dr. Short found that Plaintiff's cough was much better. He also noted that Plaintiff did not like to use her inhaler. (R. at 450.) His notes state that Plaintiff had recently used Ventolin and that it worked much better for her than Flovent. Examination revealed that Plaintiff's lungs were clear with diminished breath sounds. Dr. Short again advised Plaintiff to quit smoking. (*Id.*)

On January 4, 2012, Dr. Short prepared another letter stating that Plaintiff is prescribed continuous oxygen in her home at a flow rate of two liters. (R. at 457.)

B. Genesis Healthcare System, Bethesda Hospital

In January 2008, Plaintiff presented to Bethesda Hospital with low-back pain radiating into her hips. (R. at 258.) An MRI of Plaintiff's lumbar spine showed significant degenerative disc disease at L-5-S1 with moderate central and right paracentral disc bulge and relative canal stenosis. (R. at 258-59.)

In October 2008, Plaintiff again presented to the hospital with low-back pain. Plaintiff described the pain as a "throbbing sensation that increases with standing, sitting for extended periods of time, or trying to lie on her sides." (R. at 260-63.) Physical examination showed she had tenderness at L5-S1 and a positive straight-leg raise. (R. at 261.) Plaintiff was diagnosed with degenerative disc disease and discogenic pain and given a lumbar epidural steroid injection at her L5-S1. (R. at 262.)

In December 2008, Plaintiff presented to the emergency room complaining that she had been coughing so hard for the past two weeks that she began vomiting blood. (R. at 264-65.) Plaintiff reported consuming greater than ten alcoholic beverages per day and smoking three packs of cigarettes per day. (R. at 266.) Examination of her lungs revealed scattered wheezing and rhonchi. (R. at 267.) A chest x-ray reflected minimal atelectasis at her left lung base. (R. at 272.)

In May 2009, Plaintiff presented to the emergency room for COPD exacerbation. (R. at 288.) In the emergency room, Plaintiff's pulse oximeter reading was 90%, and she had borderline hypoxemia (abnormally low level of oxygen in the blood). (R. at 290.) She also had diminished breath sounds, wheezing, rhonchi, and crackles in her lungs. (R. at 291.) Plaintiff received intravenous antibiotics and steroids. At discharge, her pulse oximeter reading was 93% on room air. (R. at 288.) She was "strongly encouraged [ ] in somewhat graphic terms not to resume her smoking." (*Id.*) Plaintiff was given numerous medications and instructed to follow up with Dr. Short. (R. at 289.)

C. Consulting Pulmonologist, Paul Knight, M.D.

In February 2010, Dr. Knight conducted a pulmonary function study of Plaintiff on behalf of the Bureau of Disability Determination. (R. at 367-78.) Dr. Knight interpreted the study to reveal moderate obstructive ventilatory defect with mild increase in flow with bronchodilators. (R. at 369.) Plaintiff's Forced Expiratory Volume (FEV1)[2] levels were 1.12 before bronchodilator and 1.25 after. (*Id.*)

[2]FEV1 (Forced Expiratory Volume) is the maximal amount of air an individual can forcefully exhale in one second. It is then converted to a percentage of normal. FEV1 is a marker for the degree of obstruction. FEV1 greater 80% of predicted is normal; FEV1 60% to 79% of predicted reflects mild

D. Aruna Gowda, M.D.

In August 2010, hematologist Dr. Gowda evaluated Plaintiff for polycythemia (elevated red blood cell count). Dr. Gowda diagnosed Plaintiff with polycythemia secondary to smoking and macrocytosis (red blood cells are larger than normal). (R. at 426-27.) Dr. Gowda continued to track Plaintiff's completed blood count. Plaintiff was treated with phlebotomy (bloodletting) through at least August 2011. (R. at 408-35.)

E. State-Agency Evaluations

On April 5, 2010, state-agency physician W. Jerry McCloud, M.D., reviewed the record and assessed Plaintiff's physical functioning capacity. (R. at 379-86.) Dr. McCloud opined that Plaintiff could lift, carry, push, and/or pull twenty pounds occasionally and ten pounds frequently; stand and/or walk about six hours in a workday; and sit for about six hours in a workday. (R. at 380.) Dr. McCloud noted his residual functional capacity ("RFC") assessment is an adoption, under AR 98-4, of the prior ALJ's April 28, 2009 RFC assessment. (*Id.*) Dr. McCloud adopted the prior RFC, but added limitations to account for Plaintiff's degenerative disc disease and history of seizures. He further opined that Plaintiff has the following capabilities and limitations: she can occasionally stoop or crouch, frequently climb ramps and stairs, but never climb ladders, ropes, or scaffolds. (R. at 381.) Dr. McCloud found Plaintiff's statements to be only partially credible. (R. at 384.) Drs. Waddell and Morton reviewed the file and affirmed Dr. McCloud's assessment. (R. at 403-04.)

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obstruction; FEV1 40% to 59% of predicted reflects moderate obstruction; FEV1 less than 40% of predicted reflects severe obstruction. *See* Pat Bass, M.D., *Forced Expiratory Volume—What IS Forced Expiratory Volume*, About Health (August 18, 2014), http://asthma.about.com/od/glossary/g/def_fev1.htm.

IV. THE ADMINISTRATIVE DECISION

On February 22, 2012, the ALJ issued his decision. (R. at 19-39.) At step one of the sequential evaluation process,[3] the ALJ found that Plaintiff had not engaged in substantially gainful activity since October 2, 2009. (R. at 25.) At step two, the ALJ found that Plaintiff has the following combination of severe impairments best described as polycythemia, COPD, degenerative disc disease of the lumbar spine, bipolar disorder-not otherwise specified, post-traumatic stress disorder, and alcohol abuse in partial remission. (*Id.*) The ALJ also found that Plaintiff's alleged seizure or seizure type disorder is not a severe impairment because although the record contains references to seizures, it does not document the presence of any seizure or seizure-type disorder. (R. at 26.) The ALJ further found that Plaintiff did not have an impairment or combination of impairments that met or medically equaled one of the listed impairments described in 20 C.F.R. Part 404, Subpart P, Appendix 1. (R. at 27.) At step four of the sequential process, the ALJ evaluated Plaintiff's RFC. The ALJ applied *Drummond v. Comm'r of Soc. Sec.*, 126 F. 3d 837 (6th Cir. 1996), and found that new and material evidence

[3] Social Security Regulations require ALJs to resolve a disability claim through a five-step sequential evaluation of the evidence. *See* 20 C.F.R. § 416.920(a)(4). Although a dispositive finding at any step terminates the ALJ's review, *see Colvin v. Barnhart*, 475 F.3d 727, 730 (6th Cir. 2007), if fully considered, the sequential review considers and answers five questions:

1. Is the claimant engaged in substantial gainful activity?
2. Does the claimant suffer from one or more severe impairments?
3. Do the claimant's severe impairments, alone or in combination, meet or equal the criteria of an impairment set forth in the Commissioner's Listing of Impairments, 20 C.F.R. Subpart P, Appendix 1?
4. Considering the claimant's residual functional capacity, can the claimant perform his or her past relevant work?
5. Considering the claimant's age, education, past work experience, and residual functional capacity, can the claimant perform other work available in the national economy?

See 20 C.F.R. §416.920(a)(4); *see also Henley v. Astrue*, 573 F.3d 263, 264 (6th Cir. 2009); *Foster v. Halter*, 279 F.3d 348, 354 (6th Cir. 2001).

demonstrates that Plaintiff had the additional severe impairment of polycythemia beginning on October 5, 2010. He therefore concluded that he was not bound by the prior ALJ's RFC determination for the subsequent, unajudicated period of disability. (R. at 25.) The ALJ set forth the Plaintiff's RFC as follows:

> After careful consideration of the entire record, [the ALJ] find[s] that the [Plaintiff] has the residual functional capacity to perform light work as defined in 20 CFR 416.967(b) except climbing stairs and ramps frequently and stooping and crouching occasionally. She cannot climb ladders, ropes or scaffolds and is precluded from hazards such as unprotected heights and dangerous machinery and cannot engage in commercial driving. Regarding mental limitations, the [Plaintiff] retains the mental capacity for simple, repetitive tasks in a relatively static environment where changes can be explained and independent prioritization of tasks and more than daily planning is not required. Additionally, she cannot have more than occasional interaction with others and cannot perform work that involves conflict resolution or persuading others to follow instructions.

(R. at 31.) In reaching this determination, the ALJ adopted the assessments of state-agency reviewing physician Dr. McCloud, "who adopted the prior ALJ decision under AR 98-4, with the addition of no concentrated exposure to heights, hazardous machinery or commercial driving due to her history of seizures." (R. at 32.) The ALJ explained that he found Dr. McCloud's assessment "consistent with and well supported by the evidence of the record as a whole." (*Id.*) The ALJ concluded that treating physician Dr. Short's opinion was entitled to "little" weight, explaining that the opinion was "quite conclusory, providing no explanation of the evidence relied on in forming that opinion, and lacking specificity, which might otherwise make it more convincing." (R. at 33.) The ALJ added that Dr. Short appeared to rely "quite heavily on the subjective reports of symptoms and limitations reported by the claimant and seemingly accepts uncritically as true most, if not all, of what the claimant reported." (*Id.*) The also ALJ noted that Dr. Short has "no special expertise in reviewing an objective record and formulating an opinion

as to medical severity and limitations stemming from [Plaintiff's] impairments" and that he did not "have access to all of the medical evidence that is currently in the record." (*Id.*)

The ALJ next indicated that Plaintiff appears to have underlying medically determinable impairments that could reasonably cause some symptomatology. He concluded, however, that the objective evidence fails to document the presence of any impairment or combination of impairments that could reasonably be expected to result in symptoms of such a severity or frequency as to preclude the range of work described in the RFC he sent forth for Plaintiff. (R. at 35.)

Relying on the VE's testimony and following applicable regulations and case law, the ALJ adopted the prior ALJ's finding that Plaintiff has no past relevant work. He found, however, that jobs exist in the national economy that Plaintiff can perform. (R. at 37-38.) The ALJ therefore concluded that Plaintiff was not disabled under the Social Security Act. (R. at 39.)

V. STANDARD OF REVIEW

When reviewing a case under the Social Security Act, the Court "must affirm the Commissioner's decision if it 'is supported by substantial evidence and was made pursuant to proper legal standards.'" *Rabbers v. Comm'r of Soc. Sec.*, 582 F.3d 647, 651 (6th Cir. 2009) (quoting *Rogers v. Comm'r of Soc. Sec.*, 486 F.3d 234, 241 (6th Cir. 2007)); *see also* 42 U.S.C. § 405(g) ("The findings of the Commissioner of Social Security as to any fact, if supported by substantial evidence, shall be conclusive . . . ."). Under this standard, "substantial evidence is defined as 'more than a scintilla of evidence but less than a preponderance; it is such relevant evidence as a reasonable mind might accept as adequate to support a conclusion.'" *Rogers*, 486

F.3d at 241 (quoting *Cutlip v. Sec'y of Health & Human Servs.*, 25 F.3d 284, 286 (6th Cir. 1994)).

Although the substantial evidence standard is deferential, it is not trivial. The Court must "'take into account whatever in the record fairly detracts from [the] weight'" of the Commissioner's decision. *TNS, Inc. v. NLRB*, 296 F.3d 384, 395 (6th Cir. 2002) (quoting *Universal Camera Corp. v. NLRB*, 340 U.S. 474, 487 (1951)). Nevertheless, "if substantial evidence supports the ALJ's decision, this Court defers to that finding 'even if there is substantial evidence in the record that would have supported an opposite conclusion.'" *Blakley v. Comm'r of Soc. Sec.*, 581 F.3d 399, 406 (6th Cir. 2009) (quoting *Key v. Callahan*, 109 F.3d 270, 273 (6th Cir. 1997)). Finally, even if the ALJ's decision meets the substantial evidence standard, "'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 v. Comm'r of Soc. Sec.*, 478 F.3d 742, 746 (6th Cir. 2007)).

Finally, even if the ALJ's decision meets the substantial evidence standard, "'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).

VI. ANALYSIS

In her Statement of Errors, Plaintiff asserts that the ALJ erred in giving treating physician Dr. Short's opinion less than controlling weight. (ECF No. 12.) Plaintiff also posits that the ALJ improperly adopted the opinions of the non-examining state-agency physician Dr.

McCloud. More specifically, Plaintiff challenges the ALJ's adoption of Dr. McCloud's RFC assessment. The Court considers each of Plaintiff's contentions of error in turn.

A. Weight Assigned to Dr. Short

According to Plaintiff, the ALJ "assigned Dr. Short's opinions less than controlling weight without support of good reason in direct violation of 20 C.F.R. Section 416.927(c)(2)." (Pl.'s Statement of Errors 11-12, ECF No. 12.) The Court disagrees.

The ALJ must consider all medical opinions that he or she receives in evaluating a claimant's case. 20 C.F.R. § 416.927(d). The applicable regulations define medical opinions as "statements from physicians . . . that reflect judgments about the nature and severity of your impairment(s), including your symptoms, diagnosis and prognosis, what you can still do despite impairment(s), and your physical or mental restrictions." 20 C.F.R. § 416.927(a)(2).

The ALJ generally gives deference to the opinions of a treating source "since these are likely to be the medical professionals most able to provide a detailed, longitudinal picture of [a patient's] medical impairment(s) and may bring a unique prospective to the medical evidence that cannot be obtained from the objective medical filings alone . . . ." 20 C.F.R. § 416.927(d)(2); *Blakley*, 581 F.3d at 408. If the treating physician's opinion is "well-supported by medically acceptable clinical and laboratory diagnostic techniques and is not inconsistent with other substantial evidence in [the claimant's] case record, [the ALJ] will give it controlling weight." 20 C.F.R. § 404.1527(d)(2).

If the ALJ does not afford controlling weight to a treating physician's opinion, the ALJ must meet certain procedural requirements. *Wilson v. Comm'r of Soc. Sec.*, 378 F.3d 541, 544

(6th Cir. 2004). Specifically, if an ALJ does not give a treating source's opinion controlling weight:

> [A]n ALJ must apply certain factors—namely, the length of the treatment relationship and the frequency of examination, the nature and extent of the treatment relationship, supportability of the opinion, consistency of the opinion with the record as a whole, and the specialization of the treating source—in determining what weight to give the opinion.

Id. Furthermore, an ALJ must "always give good reasons in [the ALJ's] notice determination or decision for the weight [the ALJ] give[s] your treating source's opinion." 20 C.F.R. § 416.927(d)(2). Accordingly, the ALJ's reasoning "must be sufficiently specific to make clear to any subsequent reviewers the weight the adjudicator gave to the treating source's medical opinion and the reasons for that weight." *Friend v. Comm'r of Soc. Sec.*, No. 09-3889, 2010 WL 1725066, at *7 (6th Cir. Apr. 28, 2010) (internal quotation omitted). The United States Court of Appeals for the Sixth Circuit has stressed the importance of the good-reason requirement:

> "The requirement of reason-giving exists, in part, to let claimants understand the disposition of their cases," particularly in situations where a claimant knows that his physician has deemed him disabled and therefore "might be especially bewildered when told by an administrative bureaucracy that she is not, unless some reason for the agency's decision is supplied." *Snell v. Apfel*, 177 F.3d 128, 134 (2d Cir.1999). The requirement also ensures that the ALJ applies the treating physician rule and permits meaningful review of the ALJ's application of the rule. *See Halloran v. Barnhart*, 362 F.3d 28, 32–33 (2d Cir. 2004).

Wilson, 378 F.3d at 544–45. Thus, the reason-giving requirement is "particularly important when the treating physician has diagnosed the claimant as disabled." *Germany-Johnson v. Comm'r of Soc. Sec.*, 312 F. A'ppx 771, 777 (6th Cir. 2008) (citing *Rogers*, 486 F.3d at 242).

There is no requirement, however, that the ALJ "expressly" consider each of the *Wilson* factors within the written decision. *See Tilley v. Comm'r of Soc. Sec.*, No. 09-6081, 2010 WL 3521928, at *6 (6th Cir. Aug. 31, 2010) (indicating that, under *Blakley* and the good reason rule,

an ALJ is not required to explicitly address all of the six factors within 20 C.F.R. § 404.1527(d)(2) for weighing medical opinion evidence within the written decision).

In the instant case, the ALJ acknowledged that Dr. Short is a treating physician, but assigned both of his opinions "little weight." (R. at 33-34.) The ALJ explained his reasons for discounting Dr. Short's October 9, 2011 opinion as follows:

> While given some consideration, Dr. Short's opinion is entitled to no great weight for [] several reasons. First, the opinion expressed is quite conclusory, providing no explanation of the evidence relied on in forming that opinion, and lacking specificity, which might otherwise make it more convincing. The evidence of the record is absent any progress or treatment notes from the doctor, which might make otherwise support his opinion. The totality of the medical evidence *clearly* illustrates that the claimant is not as limited as indicated by this doctor. For instance, December 10, 2009 notes show the claimant reported pain in her neck and her shoulder blades for the past three to four weeks, and Dr. Short advised the [Plaintiff] to take Tylenol for the pain. It appears that the doctor relied quite heavily on the subjective reports of symptoms and limitations reported by the [Plaintiff] and seemingly accepts uncritically as true most, if not all, of what the [Plaintiff] reported. The doctor is a specialist in internal medicine, and appears to have no special expertise in reviewing an objective record and formulating an opinion as to medical severity and limitations stemming from these particular impairments. Nor did he have access to all of the medical evidence that is currently in the record. Given the foregoing, Dr. Short's opinion is entitled to very little weight.

(R. at 33 (internal citations omitted).) The ALJ explained that he afforded little weight to Dr. Short's undated opinion because Dr. Short's treatment notes and the medical evidence in the record did not support the opinion. (R. at 34.) The ALJ also noted that Dr. Short's opinion concludes that Plaintiff's impairments preclude any work activity even though such a determination is reserved to the Commissioner. (*Id.*)

The Court finds that the ALJ offered legally sufficient reasons for affording little weight to both of Dr. Short's opinions and satisfied the good-reason requirement. For example, the ALJ properly discounted Dr. Short's October 2011 opinion as conclusory and unsupported by Dr.

Short's own treatment notes and the totality of the medical evidence. *See* 20 C.F.R. § 404.1527(d)(3) (identifying "supportability" and "consistency" as a relevant considerations); *Simpson v. Comm'r of Soc. Sec.*, 344 F. App'x 181, 193 (6th Cir. 2009) (concluding that the ALJ satisfied the good-reason requirement where the ALJ noted that the opinion was inconsistent with the physician's treatment notes and with the record evidence); *Helm v. Comm'r of Soc. Sec.*, 405 F. App'x 997, 1001 (6th Cir. 2011) (same). The ALJ also did not err in discounting Dr. Short's opinion because of Dr. Short's heavy reliance on Plaintiff's subjective complaints that the ALJ found not credible and unsupported by the record. *See Ferguson v. Comm'r of Soc. Sec.*, 628 F.3d 269, 273-74 (6th Cir. 2010) (concluding that the ALJ did not err in rejecting a medical opinion based on the claimant's subjective complaints, which were not supported by objective medical evidence).

Finally, the ALJ did not err in rejecting Dr. Short's opinion that Plaintiff is unable to do sustained work given that this determination is reserved for the Commissioner. 20 C.F.R. § 404.1527(d)(1) ("[The Commissioner] is responsible for making the determination or decision about whether [the claimant] meets the statutory definition of disability . . . ."); *Bass v. McMahon*, 499 F.3d 506, 511 (6th Cir. 2007) (holding that the ALJ properly rejected a treating physician's opinion that the claimant was disabled because such a determination was reserved to the Commissioner).

The Court further finds that substantial evidence supports the ALJ's stated reasons for discounting Dr. Short's opinions. First, substantial evidence supports the ALJ's finding that Dr. Short's opinions were conclusory and unsupported. Dr. Short's undated opinion states, in a conclusory manner, that Plaintiff is unable to do sustained work because of shortness of breath

and back pain. (R. at 304-05.) Dr. Short, however, does not provide any data or laboratory findings to support this claim. (*Id.*) His October 9, 2011 opinion likewise fails to identify specific clinical data or otherwise explain why his examinations led him to opine that Plaintiff's physical capabilities are so limited. *See Buxton v. Halter*, 246 F.3d 762, 773 (6th Cir. 2001) ("[T]he ALJ "is not bound by conclusory statements of doctors, particularly where they are unsupported by detailed objective criteria and documentation.").

Second, substantial evidence supports the ALJ's finding that Dr. Short's opinions are inconsistent with his own treatment notes and the objective medical evidence in the record. For example, Dr. Short treated Plaintiff five days after submitting his October 9, 2011 Physical Capacity Evaluation and noted that Plaintiff denied any chest pain, shortness of breath, nausea, or vomiting. (R. at 452.) He also noted that Plaintiff had no TIA or CVA symptoms and that her lungs were clear upon examination. (*Id.*) Dr. Short treated Plaintiff again in December 2011 and noted that "[Plaintiff] recently used Ventolin in the past and it does much better. The Flovent does not give her near the relief that the Ventolin does." (R. at 450.) Further, in March 2011, Plaintiff's pulse and oxygenation were at 98% without the assistance of her oxygen unit. (R. at 438.) Moreover, Dr. Short's treatment notes report that Plaintiff's lungs were clear or "clear with diminished breath sounds" on examination and that she denied shortness of breath, hemoptysis, paroxysmal nocturnal dyspnea, or orthopnea. (R. at 308, 309, 310, 311, 312, 388, 438, 439, 450, 451, 452). Relatedly, the ALJ's determination that Dr. Short relied heavily on Plaintiff's subjective reports of pain and uncritically accepted them as true is also supported by substantial evidence given that his treatment notes do not support his extreme opinions. In

addition, Dr. Short's opinions are inconsistent with the opinions of Drs. McCloud, Waddell, and Morton. (R. at 380, 403-404.)

Finally, the record confirms that Plaintiff required only conservative treatment for her back pain. No doctor recommended that Plaintiff undergo surgery. Moreover, she was noted to be ambulating without assistance and with a normal gait. (R. at 261.) Plaintiff also demonstrated full range of motion of her upper and lower extremities. (*Id.*) Additionally, when Plaintiff complained of back pain to Dr. Short, he noted "I will have her just take Tylenol [] for the pain." (R. at 388.) *See LeFevers v. Comm'r of Soc. Sec.*, 476 F. App'x 608, 610-11 (6th Cir. 2012) (ALJ properly assigned only "little weight" to the treating physician's extreme opinion where the record reflected only conservative treatment).

In sum, the Court concludes that the ALJ provided good reasons for rejecting Dr. Short's opinion and that substantial evidence supports the ALJ's stated reasons. Plaintiff's contention of error relating to the ALJ's consideration of Dr. Short's opinions is therefore overruled.

B. RFC Assessment

Within this contention of error, Plaintiff asserts that "[t]he ALJ improperly adopted the opinions of the non-examining reviewer who did not review all of the evidence of the record." (ECF No. 12.) More specifically, Plaintiff challenges the ALJ's adoption of Dr. McCloud's RFC assessment. Plaintiff maintains that "[t]he ALJ erroneously adopted Dr. McCloud's physical residual capacity assessment despite it adopting the previous decision's residual functional capacity and Dr. McCloud's not having reviewed the new and material evidence that required a new residual functional capacity." (Pl.'s Statement of Errors 8, ECF No. 12.) She states that "Dr. McCloud never discussed or reviewed how [Plaintiff's] polycythemia and pulmonary

function studies [] impacted her RFC." (*Id*, at 9.) Finally, Plaintiff asserts that "the ALJ neglected to resolve inconsistencies existing between the opinion and the substantial evidence of the record that showed [Plaintiff] has new severe impairments as well as worsening in her breathing from the previous decision." (*Id*. at 11.)

Plaintiff's contention that the ALJ erred in adopting Dr. McCloud's RFC assessment because Dr. McCloud had not reviewed the new and material evidence is unavailing. Plaintiff's arguments appear to be premised upon the incorrect notion that the ALJ's determination that the new and material evidence reflected an additional, severe impairment necessarily requires inclusion of additional limitations arising from the new severe impairment. But identification of an additional impairment does not necessarily translate into additional RFC limitations. *See*, *e.g.*, *Krokus v. Colvin*, No. 13-389, 2014 WL 31360 (W.D. Pa. Jan. 2, 2014) ("Adding new impairments to an existing group of impairments would only call for additional RFC restrictions if the limitations caused by those new impairments had not already been accounted for."). Here, Plaintiff's arguments only carry weight if she met her burden to establish that her polycythemia required inclusion of limitations not already accounted for in the existing RFC. According to Plaintiff, her polycythemia impacted her pulmonary functioning and breathing.

Within his decision, the ALJ acknowledged that Plaintiff's "main problem is her breathing impairment." (R. at 35.) He then proceeded to analyze the objective evidence bearing on the severity of this impairment, including Plaintiff's pulmonary function studies and Dr. Short's treatment notes. After reviewing the record evidence and Plaintiff's testimony, the ALJ concluded that the "the record does not contain evidence of abnormal clinical and laboratory findings sufficient to document any further degree of loss of function," (R. at 31), and added that

the "evidence received into the record after the reconsideration determination concerning the [Plaintiff's] physical status did not provide any credible or objectively supported new and material information to alter the State Agency's findings concerning the [Plaintiff's] physical limitations," (R. at 32). Because the ALJ analyzed the alleged limiting effects of Plaintiff's polycythemia, namely, her breathing function, to the extent that he erred in not explicitly discussing how Plaintiff's polycythemia impacted her RFC, it was harmless error. *Cf.* 20 C.F.R. § 404.1545(e) ("[T]he pertinent inquiry is whether the ALJ considered the 'limiting effects of all [claimant's] impairment(s), even those that are not severe, in determining [the Plaintiff's] residual functional capacity.'").

Substantial evidence supports the ALJ's decision not to include additional impairments attributable to Plaintiff's polycythemia beyond those already included in the existing RFC. None of the opinions offered by Plaintiff's treating physicians linked her polycythemia to any particular limitation. Moreover, even though Dr. Short's treatment notes reflect Plaintiff's polycythemia, he did not even mention it as a condition that limited her physical capabilities in his October 9, 2011 Physical Capacity Evaluation. (R. at 447-48.)

Plaintiff maintains that the ALJ should have concluded that she required portable oxygen. The ALJ addressed the evidence upon which Plaintiff relies in support of her assertion as follows:

> I note that [Plaintiff] was issued a Certificate of Medical Necessity-Oxygen for chronic airway obstruction for a period of 12 months on May 31, 2011 after testing placed her oxygen saturation level at 78 percent. However, the doctor did not order portable oxygen, instead specifying her oxygen therapy was prescribed as "non-continuous, 8 hours sleeping." In a January 4, 2012 statement, Dr. Short indicated the [Plaintiff], "has oxygen in her home, as she is to be provided two liter nasal cannula continuously." Dr. Short's two-line letter simply states that the [Plaintiff] is to be on oxygen continuously in her *home*. As such, the doctor's

> statement cannot be extrapolated to apply anywhere outside the [Plaintiff's] home. As an aside, review of the record finds a letter from Dr. Short dated June 10, 2009 stating the very same information, verbatim. Furthermore, the January 2012 statement cannot be construed as a Certificate of Medical Necessity, as it provides no basis for extending the need of oxygen to non-sleeping hours. Understandably, Dr. Short's note was not taken into consideration in the prior April 28, 2009. It does appear, however to have been of record when the Appeals council considered, and denied, the [Plaintiff's] request for review of the prior ALJ decision of August 7, 2009.

(R. at 36 (internal citations omitted).) The Court agrees with the ALJ, that the two-line letter did not require the conclusion that Plaintiff needed portable oxygen outside of her home, especially in light of repeated notations throughout Dr. Short's notes reflecting that Plaintiff denied shortness of breath and that her lungs were clear. (*See* R. at 308, 309, 310, 311, 312, 388, 438, 438, 439, 450, 451, 452.)

In sum, substantial evidence supports the ALJ's RFC. Plaintiff's contention of error challenging the ALJ's RFC formulation is therefore overruled.

VII. DISPOSITION

From a review of the record as a whole, the Court concludes that substantial evidence supports the ALJ's decision denying benefits. Accordingly, Plaintiff's Statement of Errors is **OVERRULED**, and the Commissioner of Social Security's decision is **AFFIRMED**.

IT IS SO ORDERED.

Date: September 29, 2014

/s/ *Elizabeth A. Preston Deavers*
Elizabeth A. Preston Deavers
United States Magistrate Judge