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

TIMOTHY L. FRIEND,

Plaintiff,

Civil Action 2:13-cv-672
Magistrate Judge Elizabeth P. Deavers

v.

COMMISSIONER OF SOCIAL SECURITY,

Defendant.

OPINION AND ORDER

Plaintiff, Timothy L. Friend, 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 his applications for social security disability insurance benefits and 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. 17), Plaintiff's Reply (ECF No. 18), and the administrative record (ECF No. 11). For the reasons that follow, the Court **OVERRULES** Plaintiff's Statement of Errors and **AFFIRMS** the Commissioner's decision.

I. BACKGROUND

Plaintiff protectively filed his applications for benefits on August 20, 2010, alleging that he has been disabled since April 1, 2004, at age 36. (R. at 168-74, 175-78.) Plaintiff alleges disability as a result of asthma, emphysema, lower back pain and right hip pain. (R. at 196.) Plaintiff's applications were denied initially and upon reconsideration. Plaintiff sought a *de novo* hearing before an administrative law judge ("ALJ"). ALJ Paul E. Yerian held a hearing on February 8, 2012, at which Plaintiff, represented by counsel, appeared and testified. (R. at 32-

48.) Richard P. Oestreich, Ph.D., a vocational expert, also appeared and testified at the hearing. (R. at 48-54.) On March 27, 2012, the ALJ issued a decision finding that Plaintiff was not disabled within the meaning of the Social Security Act. (R. at 6-23.) On May 24, 2013, the Appeals Council denied Plaintiff's request for review and adopted the ALJ's decision as the Commissioner's final decision. (R. at 1-3.) Plaintiff then timely commenced the instant action.

II. HEARING TESTIMONY

A. Plaintiff's Testimony

At the February 8, 2012, hearing, Plaintiff testified that he lives in half-double with a roommate. (R. at 32.) He did not currently have a driver's licence and does not drive anyone else's car. (*Id.*) He previously had a driver's license when he was 19 years old. (R. at 34-35.) According to Plaintiff, his daughter's roommate helps with transportation. He also uses public transportation but testified that "it gets confusing sometimes." (R. at 33.) Plaintiff stated that he attended school to the ninth grade in special education classes. He denied being able to read or write at all except for writing his name. (R. at 34.)

Plaintiff testified that he is unable to work due to COPD (chronic obstructive pulmonary disease), emphysema, asthma, degenerative joint disease of his right hip, depression, and anxiety. Plaintiff testified that when walking up stairs he has to stop and "catch my breath or hit my inhaler." (R. at 36.) He has 25 steps in his house and walks to the bus stop. He cannot do either without stopping. (R. at 36-37.) He experiences shortness of breath at rest three or four times per day and uses inhalers and a home nebulizer machine. (R. at 37.)

Plaintiff next testified to experiencing constant pain in his right hip. (R. at 38.) He indicated that cold weather and lifting more than 15 pounds exacerbates his right hip pain. (R. at

38-39.) Because of pain in his side and back, Plaintiff believed he could sit between a half-hour and 45 minutes before needing to get up and move around. (R. at 39.) He would need to sit back down after about 15-20 minutes. (R. at 39-40.) Plaintiff estimated he could stand for about 10-15 minutes before needing to sit down. (R. at 40.) Plaintiff rated his pain at a level of 7 on a 0-10 scale. (R. at 43.) He denied that he is prescribed any prescription pain medication. (*Id.*)

Plaintiff experiences difficulty with sleep. According to his testimony, Plaintiff sleeps four to five hours a night. (R. at 40-41.) He does not nap during the day. Plaintiff also testified to "sometimes" having problems with memory and concentration. For example, he noted his daughter will ask him something and three hours later he would have forgotten. (R. at 41.) Plaintiff testified that he "pretty much stay to myself" and that when his kids come over, he "deal[s] with them." (R. at 41-42.) He leaves his home about twice per week. (R. at 42-43.) Plaintiff has no hobbies except for watching television. (R. at 45-46.)

At the time of the hearing, Plaintiff reported smoking a pack of cigarettes per day, down from two and a half packs per day. (R. at 45.)

B. Vocational Expert Testimony

Richard P. Oestreich, Ph.D., testified as the vocational expert ("VE") at the administrative hearing. (R. at 48-54.) The VE testified that Plaintiff's past relevant work included a forklift operator, performed at the medium exertion, semi-skilled level; truck mechanic, performed at the medium exertion, skilled level; and construction worker or blacktop worker, performed at the very heavy exertion, unskilled level. (R. at 49.)

The ALJ asked the VE to consider a hypothetical person of Plaintiff's age, education and work experience and the following capabilities and limitations:

> [L]et's assume that individual could perform the requirement of light work. . . except the individual cannot climb ladders, ropes or scaffolds. Could frequently climb stairs and ramps, balance, kneel and crawl and occasionally stoop and crouch. Also assume the individual could occasionally work around dust, fumes, gases and in poorly ventilated areas. . . . [A]ssume that the individual can perform simple, repetitive tasks in a relatively static environment that does not involve more than frequent changes in duties or processes, where the work does not require more than brief and superficial contact with others and does not involve strict time or production standards.

(R. at 50.) The VE confirmed that such an individual could not perform Plaintiff's past work. (*Id.*) The VE testified that this hypothetical individual could perform 50 percent of the total unskilled light occupational base, and approximately 20,000 total unskilled light jobs in the regional economy. Illustrative jobs that fall within the proposed hypothetical question include work such as a car wash attendant, sorter or inspector, all with 300 jobs each in the region. (*Id.*) The VE indicated that his opinion would not change if the individual was limited to work that involved oral instructions or tasks learned by demonstration. (R. at 51.)

The VE next testified that if the hypothetical individual had the same postural, manipulative and mental limitations and required oral instructions as noted above, but with the exertional capacity reduced to sedentary work, it would equate to 35 percent of all sedentary work in his region. There would be 10,000 total jobs, so about 3,000 that Plaintiff could perform, such as a hand packer, inspector, or assembler, with 150 of each. (R. at 51.)

The VE next testified that Plaintiff could not work at all if he was found to be markedly limited in his ability to tolerate work related stress, where marked is defined as a substantial loss in the ability to function. (R. at 52.)

III. MEDICAL RECORDS AND OPINIONS

A. Physical Impairments

1. Grant Medical Center

On December 26, 2008, Plaintiff presented to the emergency room with a productive cough and chest pain when coughing and taking deep breaths. (R. at 311.) A CT of the chest showed mild infiltrates in the lower-lung zones bilaterally. (R. at 312.) Plaintiff was assessed with pneumonia. (*Id.*)

Plaintiff was treated in the emergency room on August 12, 2010, for chest congestion and shortness of breath. He reported he was a long-term smoker and had tried to quit. (R. at 315.) Plaintiff was discharged with a diagnosis of bronchitis and with prescriptions for Albuterol, Norco and Zithromax. (R. at 316.)

Plaintiff presented to the emergency room on September 15, 2010, with neck and right upper chest pain following recent head-on low speed motor vehicle collision. Plaintiff was found to be mildly tender at his posterior cervical spine or upper chest. C-spine x-ray and chest x-ray displayed no acute abnormality. Plaintiff was ambulatory in the emergency room with steady gait. Plaintiff was assessed with an acute cervical strain and chest wall contusion status post recent motor vehicle crash. He was discharged home with a prescription for Vicodin and Naprosyn. (R. at 263-64.)

Plaintiff treated at the Outpatient Clinic from September 22, 2010 until at least November 2, 2011 for complaints including chest pain, back pain and hip pain, hypertension, and COPD associated with shortness of breath. Plaintiff was diagnosed with hyperlipidemia, hypertension, and COPD. Plaintiff was treated with medication. (R. at 255-62, 358-66, 369-96,

423-81.) Plaintiff's medications included Advair Diskus, Albuterol, Ipratropium Albuterol, and Ventolin. (R. at 243-45.)

2. Lynn Torello, M.D.

Dr. Torello examined Plaintiff on September 27, 2010 and completed a Basic Medical form. Dr. Torello reported that Plaintiff has COPD which causes him to easily become short of breath, especially in the heat and he is a smoker. (R. at 398.) Dr. Torello noted when Plaintiff was examined at Grant Medical Center in August 2010, the emergency room evaluation was positive for chest congestion and wheezing. (*Id.*) Dr. Torello noted that the hip x-ray was concerning for femoral acetabular impingement. (*Id.*)

Dr. Torello opined that Plaintiff was limited to lifting 6-10 pounds frequently and 20 pounds occasionally, and moderately limited in bending and in reaching with the right arm. (R. at 399.) She believed that Plaintiff's impairments would not adversely affect his ability to stand, sit or walk in an eight hour work day. On examination, Dr. Torello found limited range of motion in Plaintiff's hip, shoulder and back. Plaintiff was also found to have limitations in squatting. (R. at 401.) Dr. Torello reported that Plaintiff's straight leg extension on his right side was limited to only thirty percent, he was unable to heel walk and he could only tandem gait, where the toe of his back foot touched the heel of his front foot, when holding onto something. (R. at 400.) Dr. Torello concluded that Plaintiff is "employable." (R. at 399.)

An x-ray of Plaintiff's right hip taken on October 6, 2010, showed findings suspicious for femoral acetabular impingement. (R. at 403.)

3. Fareed R. Shaikh, M.D.

Plaintiff was initially seen in the emergency room by cardiologist, Dr. Shaikh on February 18, 2011, for evaluation of chest pain and shortness of breath with exertion. Plaintiff reported to Dr. Shaikh that his chest pain followed a physical altercation with another individual. Dr. Shaikh determined that Plaintiff's risk factors for coronary artery disease include a history of smoking, being male, and a family history of early coronary disease. Dr. Shaikh recommended an echocardiogram and a treadmill stress test. (R. at 408-09.)

On March 31, 2011, Dr. Shaikh noted Plaintiff underwent a stress test at Grant Medical Center, which revealed no signs of ischemia or infarction. Echocardiogram revealed limited study due to poor echocardiographic windows. Ejection fraction was 50% to 55%. Plaintiff indicated that his chest pain had completely resolved. (R. at 407.)

4. State Agency Evaluations

On October 30, 2010, state agency physician, Esberdado Villanueva, M.D., reviewed the record and assessed Plaintiff's physical residual functional capacity ("RFC"). (R. at 64-66.) Dr. Villanueva opined that Plaintiff could lift, carry, push and/or pull 50 pounds occasionally and 20 pounds frequently; stand and/or walk about 6 hours in a workday; and sit for about 6 hours in a workday. (R. at 64.) Plaintiff is also limited to occasionally crouch; frequently climb ramps and stairs, balance, stoop, kneel or crawl; and never climb ladders/ropes/scaffolds. (R. at 64-65.) According to Dr. Villanueva, Plaintiff should avoid concentrated exposure to fumes, odors, gases, poor ventilation based on his history of emphysema. (R. at 65-66.)

On April 12, 2011, state agency physician, Bradley J. Lewis, M.D., reviewed the record and affirmed Dr. Villanueva's assessment. (R. at 88.) He noted that Plaintiff did not allege any

worsening of his symptoms and office visits in November and December of 2010 showed no chest pain, no shortness of breath and normal respiratory and cardiovascular exams. On the one occasion Plaintiff reported shortness of breath in January 2011, it was because could not get his inhaler. (R. at 88.)

B. Mental Impairments

1. Consulting psychologist, John S. Reece, Psy.D.

On November 22, 2010, Dr. Reece evaluated Plaintiff on behalf of the state agency. (R. at 339-43.) Plaintiff reported that he had problems getting along with coworkers because they "didn't want to listen" and supervisors who were "riding him." (R. at 340.) Plaintiff reported that he had been able to travel to the evaluation by bus, and arrived at the testing center on time for the evaluation. Plaintiff also reported that he was able to reside independently, in a tent on his friend's property, make important decisions about his future, and seek appropriate community resources. He indicated that he was able to perform odd jobs independently.

Plaintiff reported that he felt hopeless, helpless, full of guilt, worthless, drained of energy, and experiences regular mood swings. (R. at 340.) He feels anxious and nervous all of the time, experiences panic attacks, and constant worry. (R. at 341.) He also reported intrusive memories. (*Id.*) Dr. Reece found that Plaintiff interacted in a cooperative manner, but that he had poor eye contact. He presented with a constricted affect and as having a mildly to moderately anxious and dysphoric mood. Plaintiff knew the purpose of the examination and he exhibited no eccentricities of manner or impulsive behaviors. There was no evidence of any flight of ideas, perseveration, or poverty of speech. His associations were well-organized. There

was no evidence of any problems with his articulation or with his receptive or expressive speech. He was described as being alert, clear, and not confused. He was alert and fully oriented with an average rate of speech and average motor activity. Dr. Reece found Plaintiff's delayed memory was poor as he was unable to recall any of the three words presented after a delayed auditory recall task. (R. at 341.) Dr. Reece estimated that Plaintiff's social insight and judgment were fair; concentration, task persistence, and pace of problem solving were all found to be satisfactory.

IQ testing revealed a verbal comprehension index (VCI) of 63, perceptual reasoning index of (PRI) 71, processing speed index (PSI) of 61, and working memory index (WMI) of 69, resulting in a full scale IQ of 61. (*Id.*)

Plaintiff was diagnosed with alcohol dependence, based on past abuse, receiving no treatment, and current daily use of alcohol in the range of 10 alcoholic drinks every night, reportedly to be able to sleep; depressive disorder, not otherwise specified, based on depression, crying spells, thoughts of death, sleep disturbance and feeling hopeless, helpless, worthless and full of guilt; an anxiety disorder, not otherwise specified, to account for panic disorder and post traumatic stress disorder symptoms that do not warrant separate diagnoses; as well as anxiety and nervousness, no times of normal mood, and constantly worrying. Although WAIS-IV results were in the range of mild cognitive impairment, Plaintiff's history does not support an impression of Mild Mental Retardation. Dr. Reece diagnosed borderline intellectual functioning

Dr. Reece assigned Plaintiff a Global Assessment of Functioning (GAF) score of 55,[1] indicative of moderate symptoms. (R. at 341.)[2]

Dr. Reece opined that Plaintiff had a moderate impairment in his ability to relate to others; a moderate impairment in his ability to understand and follow directions by his borderline intellectual functioning; and no impairment in his ability to maintain attention, concentration, persistence, and pace for repetitive tasks. Dr. Reece indicated, however, Plaintiff had marked impairment in his ability to withstand work-related stress. (R. at 342.)

2. State Agency Evaluations

On December 20, 2010, after review of Plaintiff's medical record, Douglas Pawlarczyk, Ph.D., a state agency psychologist, assessed Plaintiff's mental condition. (R. at 58-62.) Dr. Pawlarczyk opined that Plaintiff had mild restrictions in his activities of daily living; mild difficulties in maintaining social functioning; and moderate difficulties in maintaining concentration, persistence, or pace; with no episodes of decompensation of an extended duration. (R. at 62.) He further determined that the evidence did not establish the presence of the "C" criteria. (*Id.*) Upon reconsideration, Plaintiff's medical record was reviewed on April 16, 2011,

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[1]The GAF scale is used to report a clinician's judgment of an individual's overall level of functioning. Clinicians select a specific GAF score within the ten-point range by evaluating whether the individual is functioning at the higher or lower end of the range. *See Am. Psychiatric Ass'n, Diagnostic and Statistical Manual of Mental Disorders*, 4th ed., Text Revision at pp. 32–34 ("DSM–IV–TR"). A GAF score of 51–60 is indicative of moderate symptoms (e.g., flat affect and circumstantial speech, occasional panic attacks) or moderate difficulty in social, occupational, or school functioning (*e.g.*, few friends, conflicts with peers or co-workers). DSM–IV–TR at 32–34.

[2]In particular, Dr. Reece noted that Plaintiff's symptom severity "cannot have a GAF higher than 55, or moderate to significant range." (R. at 342.) "His functional GAF is also assigned at 55." (*Id.*)

by Bonnie Katz, Ph.D., who gave great weight to Dr. Reece's opinion except for the marked restriction in tolerating stress. She found that Plaintiff's activities of daily living and symptoms suggest only a moderate restriction in this area. (R. at 94.)

IV. THE ADMINISTRATIVE DECISION

On March 27, 2010, the ALJ issued his decision. (R. at 6-23.) The ALJ found that Plaintiff met the insured status requirements of the Social Security Act through March 31, 2008, but not thereafter. (R. at 11.) The ALJ noted with respect to the claim for a period of disability and disability insurance benefits, the Plaintiff's earnings record shows he had acquired sufficient quarters of coverage to remain insured through this date. Thus, the Plaintiff must establish disability on or before March 31, 2008 in order to be entitled to a period of disability and disability insurance benefits. (R. at 8.)

At step one of the sequential evaluation process,[3] the ALJ found that Plaintiff had not engaged in substantially gainful activity since April 1, 2004. (*Id.*) The ALJ found that Plaintiff had the severe impairments of (1) chronic obstructive pulmonary disease; (2) degenerative joint

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[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).

disease of the right hip; (3) a depressive disorder, not otherwise specified; (4) an anxiety disorder, not otherwise specified; (5) alcohol abuse, and (6) borderline intellectual functioning. (*Id.*) The ALJ also found that Plaintiff's chest pain is not a severe impairment because his chest pain appears to have been musculoskeletal in origin, and it had completely and spontaneously resolved within a period of less than two months. (R. at 13.) He 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. (*Id.*) At step four of the sequential process, the ALJ evaluated Plaintiff's RFC. The ALJ found as follows:

> After careful consideration of the entire record, the [ALJ] find[s] that the claimant has the residual functional capacity to lift and carry ten pounds frequently and 20 pounds occasionally, stand and/or walk (with normal breaks) for six hours total, and sit (with normal breaks) for six hours total in an eight hour work day. The claimant can frequently climb ramps and stairs, balance, kneel, amt crawl. He can occasionally stoop and crouch. The claimant is precluded from climbing ladders, ropes, and scaffolding. He must avoid concentrated exposure to respiratory irritant, such as dust, fumes, odors, and gases. The claimant retains the ability to perform simple routine tasks that are presented orally and that are performed in a relatively static work environment, which do not involve frequent changes in duties and processes, high production quotas, strict time deadlines, and more than brief and superficial contact with supervisors, coworkers, and the public.

(R. at 16.) In reaching this determination, the ALJ found the RFC is consistent with the opinions of Dr. Pawlarczyk, Dr. Lewis, and Dr. Katz. (R. at 17.) The ALJ found their assessments "consistent with and well-supported by the objective medical evidence" and "an accurate representation of the claimant's status." (R. at 20.) The ALJ assigned "very little weight" to the opinion of consultative examiner, Dr. Reece, noting he is not a treating source and therefore his opinion is not entitled to controlling weight. The ALJ also discounted Dr. Reece's opinion because the ALJ found that the opinion regarding Dr. Reece's opinion that Plaintiff was markedly impaired in his ability to handle work-related stress was not consistent with the record

or supported by the record as a whole. (*Id.*) Similar to Dr. Reece, the ALJ assigned little weight to Dr. Torello's opinion, noting she was not a treating source and "there is little objective evidence to support the specific finding as to limitations on lifting and carrying." (R. at 21.)

The ALJ further noted that Plaintiff's testimony concerning the presence of incapacitating discomfort and associated functional limitations was not credible. (R. at 18.) Relying on the VE's testimony, the ALJ determined that even though Plaintiff is unable to perform his past relevant work, other jobs exist in the national economy that Plaintiff can perform. (R. at 21-23.) He therefore concluded that Plaintiff was not disabled under the Social Security Act. (R. at 23.)

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. at 2009) (quoting *Rogers v. Comm'r of Soc. Sec.*, 486 F.3d 234, 241 (6th Cir. at 2007)); *see also* 42 U.S.C. § 405(g) ("[t]he 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 (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)).

VI. ANALYSIS

A. Disability Period

As an initial matter, Defendant contends that Plaintiff has not proven he was disabled prior to his date last insured. Plaintiff seeks Disability Insurance Benefits (DIB) under 42 U.S.C. § 423, which requires that an applicant be insured under § 423(c)(1) and be under a disability. 42 U.S.C. § 423(a). A period of disability can commence only while an applicant is fully insured. *See* 42 U.S.C. §§ 416(i)(2)(C) & (3) (setting out statutory requirements for eligibility); *see also Jones v. Comm'r of Soc. Sec.* 121 F.3d 708 (6th Cir. 1997) (recognizing "period of disability" can commence only while applicant is insured). To be entitled to DIB, Plaintiff must establish that he was disabled prior to his date last insured ("DLI"). *See* 20 C.F.R. §§ 404.315(a)(1), 404.320(b)(2); *see also Moon v. Sullivan*, 923 F.2d 1175, 1182 (6th Cir. 1990) (holding that in

order to establish entitlement to disability insurance benefits an individual must establish that he or she became disabled prior to expiration of his insured status). In this case, Plaintiff alleges that he became disabled beginning April 1, 2004. (R. at 9, 168, 175). Plaintiff's DLI was March 31, 2008. (R. at 11, 58.) Accordingly, to obtain DIB, Plaintiff must prove that he became disabled during the four-year period between April 1, 2004 and March 31, 2008.

Here, the record contains no evidence of any medical treatment at all during the four-year relevant period. Some medical records do exist predating this time from 1998, 2001, and 2002 (R. at 280-299). These documents, however, are not treatment records during the four year period from 2004 through 2008. The ALJ noted that "the record is devoid of any justification or corresponding event that coincides with the claimant's alleged onset date that would corroborate his allegations of worsening symptoms and his complete inability to engage in all types of work." (R. at 20). The lack of any medical treatment casts considerable doubt on his claims that he was disabled during the relevant period from April 2004 through March 2008. *See Strong v. Social Security Admin.*, 88 F. App'x 841, 846 (6th Cir. 2004) ("In the ordinary course, when a claimant alleges pain so severe as to be disabling, there is a reasonable expectation that the claimant will seek examination or treatment. A failure to do so may cast doubt on a claimant's assertions of disabling pain."). Moreover, state agency reviewing physician Dr. Villanueva noted that there was insufficient medical evidence prior to his DLI to determine whether he had a medically determinable impairment for DIB. (R. at 61-62).

Plaintiff offers little argument in support of his alleged onset date of April 1, 2004. He fails to cite any evidence showing any medically determinable impairment prior to his date last insured of March 31, 2008. Plaintiff merely indicates that he "disputes" the argument, and

suggests that it is important to note that he also applied for Supplemental Security Income (SSI) at the same time he applied for DIB, which does not carry an obligation to prove disability during the DLI.

"The burden of providing a complete record, defined as evidence complete and detailed enough to enable the Secretary to make a disability determination, rests with the claimant." *Landsaw v. Sec'y of Health & Human Servs*., 803 F.2d 211, 214 (6th Cir.1986); *see also Watson v. Astrue*, No. 5:11–cv–00717, 2012 WL 699788, at *5 (N.D. Ohio Mar.1, 2012) ("If anything, the dearth of opinions cuts in the Commissioner's favor, as, in the Sixth Circuit, it is well established that . . . the claimant—and not the ALJ—has the burden to produce evidence in support of a disability claim.") Here, Plaintiff tangentially suggests that the record contains some evidence of deficits in adaptive functioning that would have manifested in his developmental period, such as the fact that he did not complete high school and cannot read and write. But that assessment misses the mark. The record in this case contains nothing to show he was disabled and therefore entitled to disability insurance benefits before his DLI.

Nevertheless, in an abundance of caution and in the interests of justice, the Court turns to the arguments raised Plaintiff's Statement of Errors.

B. Statement of Errors

In his Statement of Errors, Plaintiff asserts that the ALJ mischaracterized and ignored material evidence of Plaintiff's disability. Plaintiff also maintains that ALJ erred in discrediting and disregarding the opinions and findings of physicians involved in consultative evaluations, giving more weight to those of the non-examining state agency physicians. (ECF No. 12). The Court considers each of Plaintiff's contentions of error in turn.

1. ALJ's Characterization of the Medical Evidence

Plaintiff submits that the ALJ ignored evidence that was favorable to the Plaintiff and selectively chose only evidence that supported his position. He contends that the ALJ ignored the findings of the consultive examiners regarding his impairment in social functioning and withstanding stress and misstated the GAF determination. Plaintiff also posits that the ALJ contrived or "invented" evidence in order to discredit his psychological evidence.

An ALJ is not free to ignore evidence favorable to a disability claimant. Rather, 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). An ALJ cannot "'pick and chose' only the evidence that supports his [or her] position." *Hilker v. Astrue*, No. 3:09CV0186, 2010 WL 2731344 at *10 (May 7, 2010 S.D. Ohio 2010) (quoting *Loza v. Apfel*, 219 F.3d 378, 393 (5th Cir. 2000)). Moreover, an ALJ's findings are not supported by substantial evidence if the "ALJ clearly relied on isolated notations from Plaintiff's treatment records . . . ." *Rothgeb v. Astrue*, 626 F. Supp. 2d 797, 808 (S.D. Ohio 2009).

In the instant matter, Plaintiff submits that he meets the criteria for disability under Listing 12.05 as an individual with intellectual disabilities with sub-average intellectual functioning, formerly known as mental retardation, with deficits in adaptive functioning manifested during the developmental period, that is, onset before age 22. 20 C.F.R. Pt. 404, Subpt. P., App. 1. Subparagraph C of this Listing requires "[a] valid verbal, performance, or full

scale IQ of 60 through 70 and a physical or other mental impairment imposing an additional and significant work-related limitation of function[.]" *Id*. at § 12.05C. To meet Listing 12.05C, an individual's impairment must satisfy both the diagnostic description of mental retardation in the introductory paragraph and the requirements set forth in subparagraph C. *Id.* at § 12.00A. Plaintiff maintains that the ALJ picked only portions of the consultive evaluations to use and culled out only segments of the opinions that supported his ultimate opinion that Plaintiff is not disabled.

With regard to Dr. Reece, Plaintiff faults the ALJ for acknowledging Dr. Reece's notation that Plaintiff's full scale IQ was 61 and that Dr. Reece had estimated that Plaintiff's adaptive functioning "placed his true level of intellectual functioning within the borderline range." (R. at 16.) Plaintiff maintains that the ALJ "used this one statement to completely discredit the actual testing to place [Plaintiff] in the [b]orderline range instead of in the mild mental retardation range despite the fact that he ignored every other conclusion Dr. Reece made regarding [Plaintiff's] restrictions. (Stmt. of Errors, ECF No. 12 at 11.) Likewise, he argues that the ALJ mischaracterized Dr. Reece's assessment of a GAF score of 55 and therefore erred in discounting Dr. Reece's opinion that Plaintiff was markedly limited in his ability to tolerate work stress. Plaintiff challenges that ALJ's construction of a GAF score of 55 as indicating no more than moderate limitations because Dr. Reece indicated that Plaintiff "cannot have a GAF higher than 55, or moderate to significant range." (R. at 342.)

The Court disagrees. A comprehensive reading of the ALJ's opinion as well as the medical records in this case reveals that the ALJ did not selectively choose recitations from the notes or take Dr. Reece's opinions, or any portion of them, wholly out of context. Instead,

substantial evidence supports the ALJ's conclusions. The evaluation with Dr. Reece demonstrates that Plaintiff was not diagnosed with mental retardation and that he did not have sufficient adaptive deficits. The ALJ properly noted, consistent with Dr. Reece's opinion, that Plaintiff cognitively functioned "within the borderline range" and was "able to live independently, make important decisions about his future, and seek appropriate community resources." (R. at 12, 341.) While Plaintiff scored a 61 on IQ testing, the ALJ noted that Dr. Reece specifically stated that, despite the IQ score, Plaintiff's "history does not support an impression of mild mental retardation." (R. at. 13,16, 341-342). The ALJ was well within bounds to rely on this assessment. *See Daniels v. Comm'r of Soc. Sec.*, 70 F. App'x, 868, 872 (6th Cir. 2003) ("The ALJ acknowledged Plaintiff's WAIS-R performance I.Q. of 67, but he determined that she nevertheless was not mentally retarded, pointing out [consultive examiner's] observation that she clinically appeared to function at a level exceeding her test score.").

With regard to the ALJ's interpretation of Dr. Reece's assessment of Plaintiff's GAF score of "no more than 55," the ALJ reasonably determined that a marked limitation in dealing with daily workplace stress was inconsistent. To begin, Dr. Reece did, in fact, indicate that Plaintiff's symptom severity "cannot have a GAF higher than 55, or moderate to significant range." (R. at 342.) "His functional GAF *is also assigned* at 55." (*Id.*, emphasis added.) Although it was arguably reasonable for the ALJ to interpret this passage as simply assigning a GAF of 55, the Court need not determine whether it was error. The ALJ concluded that Dr. Reece was not a treating source and his opinion that Plaintiff was markedly impaired in his ability to tolerate stress was therefore not entitled to controlling weight. He also found that the opinion regarding this limitation was not consistent with or supported by the record as a whole.

(R. at 20.) The ALJ also pointed out that Plaintiff had no formal mental health treatment and that marked impairment in handling stress was inconsistent with Plaintiff's "continuing performance of odd jobs, regular social interaction with family members, including three grandchildren, his ability to use public transportation for appointments, and his ability to live independently." (R. at 21.) Plaintiff himself indicated that he lived independently, was able to dress, make meals and take walks. (R. at 219–20.) He had no limitations with self care or hygiene, could cook, clean, shop, and count change. (R. at 222–23.) Substantial evidence supports the ALJ's conclusion that Plaintiff did not have the requisite deficits of adaptive functioning and the ALJ did not selectively "pick and choose" from the record to support this determination.[4]

Plaintiff also assails the ALJ's citation to Dr. Torello's comment that Plaintiff is "employable." (R. at 21.) The ALJ properly noted that Dr. Torello's conclusion in this regard addresses an issue reserved to the Commissioner. Because the determination of disability is reserved to the Commissioner, the ALJ "will not give any special significance to the source of an opinion" on that issue. 20 C.F.R. §§ 404.1527(d)(1)-(3) and 416.927(d)(3); *see also Vance v. Comm'r of Soc. Sec.*, 260 F. App'x 801, 804 (6th Cir.2008) (concluding that a physician's disability determination was a decision reserved for the Commissioner and therefore not entitled

[4]Plaintiff makes much of the fact that the ALJ made passing reference, apparently in error, that Dr. Reece "noted the presence of validity issues and poor motivation during the examination. Such factors therefore reduce the probative value of the examination results and the conclusions based thereon." (R. at 20–21.) The Court agrees with Plaintiff that Dr. Reece made no such reference. The Court cannot conclude, however, as Plaintiff urges, that the ALJ harbored some sort of sinister motive and actually "invented evidence" to discredit Dr. Reece. The ALJ made an error, but it was harmless. The ALJ offered numerous bases for discounting Dr. Reece's assessment and the decision is supported with substantial evidence despite this inadvertent insert.

to any special significance). The ALJ noted that "[t]he statement does, however, provide some insight into the impact of [Plaintiff's] impairments on his ability to function. Plaintiff contends again that the ALJ pulled out this "employable" finding because it supported his non-disability finding, but rejected other aspects of Dr. Torello's opinion, arguing that it distorts the physician's overall evaluation of what level of work Plaintiff could perform. The Court finds no merit to this argument that the ALJ selectively reviewed the record and chose only evidence that supported his decision that Plaintiff was not disabled. The ALJ adequately justified his conclusions by relying on all of the evidence of record.

2. Weight Assigned to Examining and Non-Examining State Agency Opinion

The parties do not dispute that treating-physician opinions are entitled to the most deference if supported by the record as a whole. Nor do the parties quarrel that in this case, Plaintiff does not rely on a treating physician's opinion. Plaintiff nonetheless contends that the ALJ erred by giving more weight to the opinions of the reviewing physicians at the Social Security Administration than to the consultive evaluators who examined him. Plaintiff insists that the opinion of a non-treating source who examines the patient is categorically entitled to more weight than an opinion of a source based solely on reviewing the records. He takes the ALJ to task for failing to follow this continuum.

As the Court of Appeals for the Sixth Circuit has described, the Court must consider a number of factors in evaluating the medical evidence in every case:

> Pursuant to 20 C.F.R. §§ 404.1527(d) and 416.927, an ALJ is to "evaluate every medical opinion" submitted in light of a variety of listed factors, which include the nature of the treatment relationship, the supporting medical basis for the opinion, and overall consistency with the larger record. The regulation also sets out a *presumptive* sliding scale of deference to be given to various types of opinions. An opinion from a treating physician is "accorded the most deference by the SSA" because of the

> "ongoing treatment relationship" between the patient and the opining physician. *Smith v. Comm'r of Soc. Sec.*, 482 F.3d 873, 875 (6th Cir. 2007) (internal quotation marks omitted). A nontreating source, who physically examines the patient "but does not have, or did not have an ongoing treatment relationship with" the patient, falls next along the continuum. *Id*. A nonexamining source, who provides an opinion based solely on review of the patient's existing medical records, is afforded the least deference. *Id*.

Norris v. Comm'r of Soc. Sec., 461 F. App'x 433, 438–39 (6th Cir. 2012) (emphasis added).

Thus, Plaintiff correctly notes that the opinions of nontreating sources are generally accorded more weight than nonexamining sources. However, "it is not a *per se* error of law . . . for the ALJ to credit a nonexamining source over a nontreating source." *Id*. at 439. The regulations and case law make clear that an ALJ may reject any opinion, even that of a treating source, if it is not well supported by the medical evidence or inconsistent with the record. *See* 20 C.F.R. §§ 404.1527, 416.927 (evaluating opinion evidence); *see also Norris*, 461 F. App'x at 439 (finding that ALJ adequately explained reasons for assigning greater weight to non-examining physicians' opinions where ALJ found the non-examining physicians' assessments to be more consistent with the record); *Ealy v. Comm'r of Soc. Sec.*, 594 F.3d 504, 515 (6th Cir. 2010) (same).

Here, the ALJ explained his rationale for the weight he assigned to each of the consultive examiner's opinions. He noted that Dr. Reece was not a treating source, and "as such his opinion is not entitled to controlling weight in any instance." (R. at 20.) The ALJ noted the inconsistencies in Dr. Reece's opinion that Plaintiff had marked limitations related to work-place stress because it was not consistent with the record. The ALJ's decision in this regard is also supported by substantial evidence. The ALJ agreed with Dr. Pawlarczyk that Dr. Reece's opinion that Plaintiff was markedly limited was not supported by the record and that Plaintiff's

activities of daily living, together with his symptoms, suggested only moderate limitations. Indeed, the record is devoid of any evidence to suggest significant difficulty in dealing with work-related stress. When Dr. Reece inquired of Plaintiff how he was able to withstand the stress and pressure associated with day to day work, Plaintiff replied merely that "he just did it." (R. at 342.) This hardly supports a finding of marked limitation.

Similarly, as to Dr. Torello's opinion, the ALJ noted again that she was not a treating source and that her opinion was not entitled to controlling weight. The ALJ assigned her opinion that Plaintiff was limited to lifting, carrying or pushing up to 10 pounds frequently and 20 pounds. (R. at 21.) The ALJ found that "little objective evidence" supported this specific finding as to the limitations on lifting and carrying. He noted that such restrictions are not supported by imaging studies of weight-bearing joints or objective pulmonary testing. The ALJ, however, in large degree, reflected or even over-compensated for most of the other physical limitations about which Dr. Torello opined into his RFC. To the extent to which the ALJ did not adopt Dr. Torello's assessment as to Plaintiff's weight limitations for lifting, carrying or pushing, he adequately explained his reasons for crediting the opinions of non-examining physicians, Dr. Villanueva and Dr. Lewis.

Ultimately, the ALJ's decision to credit the State Agency physicians' assessments over the one-time consultive evaluations reflects the fact that the non-examining physicians' opinions were more consistent with the record as a whole. Certainly, the ALJ could have provided a fuller explanation as to why the non-examining opinions were more consistent with the overall record. The ALJ, however, was under no special obligation to do so insofar as he was weighing the respective opinions of non-treating versus non-examining sources. *See Smith,* 482 F.3d at

876. If an ALJ's decision adequately explains the determination as a whole, it is sufficient. Accordingly, the Court concludes that the ALJ did not err in assigning greater weight to the opinions of the non-examining consultants.

DISPOSITION

For the foregoing reasons, the Court **OVERRULES** Plaintiff's Statement of Errors and **AFFIRMS** the Commissioner's decision.

IT IS SO ORDERED.

Date: September 30, 2014

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