Dixon v. Commissioner of Social Security Doc. 13

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF OHIO
WESTERN DIVISION

RUTH DIXON,	:	Case No. 3:12-cv-404
	:	
Plaintiff,	:	Judge Timothy S. Black
	:	
vs.	:	
	:	
COMMISSIONER OF SOCIAL SECURITY,	:	
	:	
Defendant.	:	

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

This is a Social Security disability benefits appeal. At issue is whether the administrative law judge ("ALJ") erred in finding the Plaintiff "not disabled" and therefore unentitled to disability insurance benefits ("DIB") and supplemental security income ("SSI"). (*See* Administrative Transcript ("PageID") (PageID 66-80) (ALJ's decision)).

I.

On November 17, 2008, Plaintiff filed applications for DIB and SSI, alleging an onset date of March 1, 2007[1] due to arthritis of her lumbar spine, bursitis[2] in her arm, problems with balance, headaches, asthma, cholesterol, and thyroid issues. (PageID 217-

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[1] Plaintiff's insured status expired on March 31, 2009. (PageID 228).

[2] Bursitis is the inflammation of one or more bursae (small sacs) of synovial fluid in the body. When bursitis occurs, movement relying upon the inflamed bursa becomes difficult and painful.

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22, 253).[3] She also alleged problems with memory and concentration. (PageID 253). Plaintiff's claims were denied initially and upon reconsideration. (PageID 153-59, 164-69). After an administrative hearing, an administrative law judge ("ALJ") issued a decision finding Plaintiff not disabled. (PageID 66-80). The Appeals Council denied Plaintiff's request for review, making the ALJ's decision the final decision of the Commissioner. (PageID 47-49). Plaintiff seeks judicial review of the decision under 42 U.S.C. §§ 405(g) and 1383(c)(3).

Plaintiff was 51 years old at the time of the hearing. (PageID 217). Plaintiff dropped out of school in the ninth grade to babysit her sister's children. (PageID 426). She received her GED in 1978. (PageID 258). Her past relevant work consisted of sales clerk, taxi driver, taxi dispatcher, head housekeeper, motel maid, and laundromat manager. (PageID 117-118). She last worked as a sales associate for two months in April 2007. (*Id.*)

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

1. The claimant met the insured status requirements of the Social Security Act through March 31, 2009.

2. The claimant has not engaged in substantial gainful activity since March 1, 2007, the alleged disability onset date (20 CFR 404.1571 *et seq.*, and 416.971 *et seq.*).

[3] Prior to her onset date, Plaintiff filed an earlier application. Specifically, there is an ALJ's decision dated 2003, in which the ALJ found that Plaintiff had the residual functional capacity to perform medium exertional work activity. (PageID 128-139, 283).

3. The claimant has the following severe impairments: 1) chronic low back pain; 2) a history of joint pain; 3) obesity; 4) a history of depression and anxiety; 5) and a history of alcohol-and cannabis-related disorders (20 CFR 404.1520(c) and 416.920(c)).

4. The claimant does not have an impairment or combination of impairments that meets or medically equals one of the listed impairments in 20 CFR Part 404, Subpart P, Appendix 1 (20 CFR 404.1520(d), 404.1525, 404.1526, 416.920(d), 416.925 and 416.926).

5. After careful consideration of the entire record, the undersigned finds that the claimant has the residual functional capacity to perform medium work as defined in 20 CFR 404.1567(c) and 416.967(c) except: 1) no climbing of ladders, ropes, or scaffolds; 2) occasional stopping and crouching; 3) no more than frequent exposure to irritants; 4) no work on uneven surfaces; and 5) simple routine tasks.

6. The claimant is unable to perform any past relevant work (20 CFR 404.1565 and 416.965).

7. The claimant was born on July 8, 1955 and was 51 years old, which is defined as an individual "closely approaching advanced age," on the alleged disability onset date. The claimant subsequently changed age category to "advanced age" (20 CFR 404.1563 and 416.963).

8. The claimant has at least a high school education and is able to communicate in English (20 CFR 404.1564 and 416.964).

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

10. Considering her age, education, work experience, and residual functional capacity, there are jobs that exist in significant numbers in the national economy that the claimant can perform (20 CFR 404.1569, 404.1569(a), 416.969, and 416.969(a)).

11. The claimant has not been under a disability, as defined in the Social Security Act, from March 1, 2007, through the date of this decision (20 CFR 404.1520(g) and 416.920(g)).

(PageID 68-79).

In sum, the ALJ concluded that Plaintiff was not under a disability as defined by the Social Security Regulations, and was therefore not entitled to DIB or SSI. (PageID 79).

On appeal, Plaintiff argues that the ALJ erred in ignoring the relevance of the results of her April 2010 lumbar MRI on her ability to perform work activity.

II.

The Court's inquiry on appeal is to determine whether the ALJ's non-disability finding is supported by substantial evidence. 42 U.S.C. § 405(g). Substantial evidence is "such relevant evidence as a reasonable mind might accept as adequate to support a conclusion." *Richardson v. Perales,* 402 U.S. 389, 401 (1971). In performing this review, the Court considers the record as a whole. *Hephner v. Mathews,* 574 F.2d 359, 362 (6th Cir. 1978). If substantial evidence supports the ALJ's denial of benefits, that finding must be affirmed, even if substantial evidence also exists in the record upon which the ALJ could have found plaintiff disabled. As the Sixth Circuit has explained:

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

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

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

A.

The record reflects that:

Plaintiff was evaluated on April 10, 2008 by Dr. William Padamadan from Tri-State Occupational Medicine, Inc., at the request of the State agency. (PageID 346). Her examination was normal. (PageID 347-348). Lumbar spine x-rays revealed some minimal narrowing at L-5 through S-1 and some right convex scoliosis of her upper spine. (PageID 353).

Plaintiff underwent a second exam on February 17, 2009 by Dr. Judith Brown, at Tri-State Occupational Medicine, Inc. On exam, Plaintiff had painful crepitus and tenderness at her knees bilaterally, trace edema of her mid-calf bilaterally, tenderness over L5, problems arising from a squat, and decreased range of motion of her dorsolumbar spine. (PageID 357-358, 361). Dr. Brown's impression was chronic lower back pain and joint pain. She opined that Plaintiff's ability to perform the physical requirements of work was mildly impaired. (PageID 358).

Plaintiff was treated at Rocking Horse Community Health Center beginning on June 28, 2006. She was treated for a thyroid condition, asthma, allergic rhinitis,

depression, and chronic low back pain. (PageID 363-364, 366, 368-371). Her treating nurse practitioner, Sue Carter, completed a Basic Medical Form on December 4, 2008. Plaintiff was treated for chronic low back pain, hypothyroidism, depression, hyperlipidemia, and nicotine addiction. She was in good and stable condition. (PageID 384). Plaintiff could stand/walk for less than one hour out of eight and uninterrupted for less than one hour and sit for one to two hours out of eight and uninterrupted for less than one hour. She could lift/carry frequently and occasionally up to five pounds. She was moderately limited in her ability to push/pull, bend, and handle. Nurse Carter opined that Plaintiff was unemployable for twelve months or more. (PageID 385).

Dr. Gerald Klyop, a non-examining physician, reviewed the record on March 31, 2009, at the request of the State agency. He opined that Plaintiff could occasionally lift/carry up to fifty pounds and frequently lift/carry up to twenty five pounds. Based on AR 98-4 (the Drummond Ruling), he adopted the previous ALJ's RFC finding. (PageID 417). Plaintiff was never to climb ladders, ropes, and scaffolds, but she could occasionally kneel and crouch. (PageID 418).

Dr. George Schulz, a psychologist, evaluated Plaintiff on June 3, 2009, at the request of the State agency. (PageID 424). Plaintiff was raised by both parents and was the youngest of ten siblings. She denied any abuse as a child. She married at age seventeen and had been married three times. Her first husband was controlling, her second husband was physically and mentally abusive, and her third husband was an alcoholic. She had five grown children. She was diagnosed with chronic back pain in

1999, asthma in 2002, and hypothyroidism in 2004. She also had complaints of vertigo. (PageID 425).

Plaintiff was seen for one session by a mental health therapist, Ms. Shelly Lopez, in January 2009, but she could not afford to return. She related that she had been struck in her head numerous times by her abusive husband but he had not allowed her to seek treatment. She was treated in the early 1990s for drug and alcohol abuse as an outpatient. She had last had alcohol the night prior to the evaluation when she had three shots of whisky and she last used marijuana two weeks prior to the evaluation. Plaintiff watched TV, read, washed dishes, cleaned the house, cooked, and did the grocery shopping. She visited with her family twice a year. She was currently living with a friend. Her gait was slow and she engaged in moderate eye contact and was cooperative. Plaintiff exhibited no speech abnormalities. (PageID 428). Her memory and concentration were adequate and her knowledge was in the low average range, as was her abstract reasoning ability. (*Id.*) Ms. Lopez diagnosed depressive disorder, anxiety disorder, alcohol-related disorder, and cannabis-related disorder. Plaintiff's GAF score was 56.[4] (PageID 429). Her ability to relate to others was mildly impaired and her ability to understand, remember, and carry out instructions was not impaired. Plaintiff's ability to maintain

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[4] The Global Assessment of Functioning ("GAF") is a numeric scale (0 through 100) used by mental health clinicians and physicians to rate subjectively the social, occupational, and psychological functioning of adults, e.g., how well or adaptively one is meeting various problems-in-living. A GAF score of 51-60 indicates 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).

attention and concentration to perform simple repetitive tasks was mildly impaired, and her ability to deal with work stress was mildly impaired. (PageID 430).

Dr. Cynthia Waggoner, a non-examining psychologist, reviewed the record on June 15, 2009, at the request of the State agency. She opined that Plaintiff did not have a severe mental impairment. (PageID 435). Dr. Leslie Green, another non-examining psychologist, reviewed the record on July 5, 2009, at the request of the State agency, and affirmed the previous assessment. (PageID 434)

Plaintiff was seen in the ER on September 10, 2009. She had acute bronchitis. (PageID 496).

Plaintiff continued treatment at Rocking Horse Community Health Center. Dr. Uddin and Ms. Hale completed a Basic Medical on February 27, 2009. Plaintiff was treated for chronic low back pain, rhinitis, hypothyroidism, depression, hyperlipidemia, and nicotine addiction. She was in good and stable condition. (PageID 488). Plaintiff could stand/walk for four hours out of eight and uninterrupted for three hours, sit for four hours out of eight and uninterrupted for three hours, and occasionally and frequently lift/carry up to five pounds. Plaintiff was moderately limited in her ability to push/pull, bend, and handle. Dr. Uddin and Ms. Hale opined that Plaintiff was unemployable for twelve months or more. (PageID 489).

Plaintiff was diagnosed with vertigo in 2009. (PageID 475). On October 14, 2009, she was diagnosed and treated for arthritis in her hips, knees, and right thumb. (PageID 474). On March 22, 2010, Ms. Carter completed another Basic Medical form.

Ms. Carter opined that Plaintiff could stand/walk for three to four hours and uninterrupted for two and one half hours, sit for three to four hours out of eight and uninterrupted for less than half an hour, and frequently and occasionally lift/carry up to five pounds. Plaintiff was moderately limited in her ability to push/pull, bend, and reach. Ms. Carter opined that Plaintiff was unemployable for twelve months or more. (PageID 472).

Ms. Carter completed interrogatories on March 11, 2010. She had treated Plaintiff since February 27, 2008. (PageID 451). Plaintiff's diagnoses were chronic low back pain, depression, B23 deficiency, nicotine addiction, hypothyroidism, and hyperlipidemia. (PageID 452). Ms. Carter stated that Plaintiff's combination of physical and mental impairments restricted her more than the sum of the parts. (*Id.*) Her psychological impairments decreased her ability to cope. (PageID 453). Plaintiff was unable to sustain attention and concentration on her work to meet normal standards of work productivity and work accuracy. (PageID 455). She had only a slight restriction in her daily activities. (PageID 459). Ms. Carter opined that Plaintiff could only lift/carry occasionally and frequently up to five pounds, stand/walk for only four hours out of eight and uninterrupted for three hours, and sit for only four hours out of eight and uninterrupted for three hours. (PageID 462). Plaintiff was never to climb, kneel, and crawl and she had restrictions in handling, fingering, and pushing/pulling. (PageID 463). She could perform sedentary work activity, but not light work activity. (PageID 465).

Treatment records show that Plaintiff had knee x-rays taken on November 18, 2005. They were normal. (PageID 550). She was treated for arthralgias and told to

exercise as tolerated. (PageID 555). Plaintiff was seen for her left knee and left hip. (PageID 566). She also had muscle spasms under her right breast. (PageID 569). She underwent a lumbar MRI on April 19, 2010, which revealed that she had "mild to moderate disc height loss and associated anterior spurring at L2-L3 and L1-L2." (PageID 563). It also revealed a small central disc protrusion at T11-T12 and a small left paracentral disc protrusion at T12-L1. (*Id.*) There was also "a broad-based disc protrusion and mild facet arthropathy" at L2-L3 and "a broad-based disc protrusion at L4-L5" that "effaces the thecal sac and nearly abuts the traversing L5 nerve roots." (PageID 562). It also showed "[a] small broad-based disc protrusion at L5-S1…." (*Id.*) An April 22, 2010 EMG of Plaintiff's hands was normal. (PageID 558).

Plaintiff underwent a mental health evaluation on January 7, 2009 at Citi Lookout. (PageID 493). The diagnosis was major depression and anxiety disorder. Plaintiff's GAF score was 61.[5] (PageID 494). On a depression questionnaire, she endorsed "a high degree of depression and anxiety which at the present time are not being treated with medication or therapy." (PageID 491). Ms. Lopez also stated, "As Ms. Dixon talked with the undersigned it was also apparent that there are many unresolved relational and emotional issues in her life." (PageID 492). It was recommended that Ms. Dixon have a psychiatric evaluation. (*Id.*)

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[5] A GAF score of 61-70 indicates some mild symptoms (*e.g.*, depressed mood and mild insomnia) or some difficulty in social, occupational, or school functioning (*e.g.*, occasional truancy, or theft within the household), but generally functioning pretty well, has some meaningful interpersonal relationships.

On February 24, 2010, Ms. Penny Zimmerman, Plaintiff's treating mental health therapist, noted that she had treated Plaintiff four times in September and November 2009. Ms. Zimmerman found that Plaintiff's chronic back pain contributed to her depression. The diagnosis was dysthymic disorder,[6] late onset. Plaintiff's GAF score was 40.[7] (PageID 450, 512). During her initial evaluation, Plaintiff had very little eye contact and took a long time to respond to questions. She had slow to retarded energy level, her facial expressions were inappropriate or incongruent, her attitude was guarded, her affect was flat and defensive, her mood was depressed, and she had an impaired memory. (PageID 503, 508). Plaintiff had missed appointments and she did not progress because of the lack of attendance. She had transportation and money problems. (PageID 450, 497-498, 500-501).

B.

Plaintiff alleges that the ALJ erred in ignoring the relevance of the results of her April 2010 lumbar MRI on her ability to perform work activity.

Plaintiff acknowledges that the ALJ mentioned the findings from her 2010 MRI, but she argues that the ALJ failed to explain why the diagnostic test did not show that Plaintiff's condition was disabling.

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[6] Dysthymic disorder is a mood disorder consisting of the same cognitive and physical problems in depression, with less severe but longer-lasting symptoms.

[7] A GAF score of 31-40 indicates some impairment in reality testing or communication (*e.g.,* speech is at times illogical, obscure, or irrelevant) or major impairment in several areas, such as work or school, family relations, judgment, thinking, or mood (*e.g.,* depressed adult avoids friends, neglects family, and is unable to work; child frequently beats up younger children, is defiant at home, and is failing at school).

The ALJ explained that Plaintiff's lumbar x-rays were described as "minimal" and "mild" (PageID 77 referring to PageID 353, 561-63). The ALJ was not interpreting raw data. Instead, the ALJ was summarizing the findings of the radiologists who interpreted the diagnostic reports. (PageID 69, citing PageID 562). For instance, the ALJ explained that Plaintiff's MRI of the lumbar spine showed that there was "mild" central narrowing, "mild" facet arthropathy, "no significant" foraminal stenosis and "mild" facet arthropathy. (PageID 69 citing PageID 562). All of these findings were contained in the radiologist's report. (PageID 562). The MRI also confirms that, although there was evidence of protrusions and discogenic changes, there was no foraminal stenosis, no acute bony abnormality, and the theca sac only "nearly" abutted the nerve root. (PageID 562). Accordingly, it was reasonable for the ALJ to conclude that Plaintiff's MRI was not *per se* evidence of disability. Contrary to Plaintiff's arguments, it was appropriate for the ALJ to summarize the findings of the radiologist that interpreted Plaintiff's MRI.

Plaintiff maintains that the ALJ "clearly" and erroneously "substituted" his opinion for that of a competent medical source by interpreting the results of the April 2010 MRI. However, the ALJ did not interpret the MRI results, he merely summarized the radiologist's findings. Even more significant, however, Plaintiff has not pointed to any medical source that endorsed her conclusion that the MRI abnormalities rendered her totally disabled. In fact, the only evidence Plaintiff provides is a citation to the online Merck Manual that explains that crepitus is an indication of worsening osteoarthritis. There is no evidence that Plaintiff was diagnosed with osteoarthritis during the relevant

period. Even if the MRI had showed that Plaintiff had osteoarthritis, the diagnosis alone would not be dispositive of whether Plaintiff was disabled. The Sixth Circuit has explained that the mere diagnosis of an impairment says nothing about the severity of the impairment. *Foster v. Bowen*, 853 F.2d 483, 489 (6th Cir. 1988). Plaintiff would still be required to show that the condition was severe enough to prevent her from working. Plaintiff's argument that her MRI abnormalities are per se evidence of disability, lacks both legal and medical support. Accordingly, the ALJ properly evaluated the record evidence, and reasonably determined that Plaintiff was capable of performing medium work. (PageID 73).

Next, Plaintiff argues that the ALJ erred in rejecting the opinion of her treating nurse practitioner, Ms. Carter. In March 2010, Ms. Carter completed forms at the request of Plaintiff's attorney. (PageID 462). Ms. Carter stated that Plaintiff could stand and walk for four hours in an eight-hour day and sit for four hours in an eight-hour say, for up to three hours without interruption. (PageID 462). She opined that Plaintiff had the ability to perform the lifting and carrying requirements of sedentary work activity. (PageID 462). Two weeks later, Ms. Carter completed another medical form. (PageID 472). On the second form, Ms. Carter indicated that Plaintiff could stand, walk, and sit for three to four hours but for only one-half hour at a time without interruption. (PageID 472). Without explaining why she changed her opinion regarding Plaintiff's ability to sit, Ms. Carter opined that Plaintiff was "unemployable." (PageID 472).

First, Ms. Carter is not an acceptable treating source, so her assessments are not entitled to any special weight. *See* 20 C.F.R. § 404.1513(d); *Shumaker v. Comm'r of Soc. Sec*., No. 1:11cv2801, 2013 U.S. Dist. LEXIS 14698, at *36 (N.D. Ohio Jan. 15, 2013)(because Nurse Rusterholz is not an acceptable medical source, the ALJ was not required to provide good reasons for the weight given to his opinion under 404.1527(c)). More importantly, Ms. Carter's assessments of Plaintiff's physical abilities varied considerably, and she did not provide any explanation for the changed findings. In March 2010, Ms. Carter opined that Plaintiff could stand, walk, and sit for up to three hours without interruption (PageID 462), but two weeks later, Ms. Carter noted that Plaintiff could only stand, walk and sit for a half hour without interruption. (PageID 472). Despite the significant differences in her opinion regarding Plaintiff's ability to stand, walk, and sit, Ms. Carter did not offer any explanation for the increased limtiations. This inconsistency alone supports the ALJ's decision to reject Ms. Carter's opinions. (PageID 70). *Stanley v. Sec'y of Health & Human Servs*., 39 F.3d 115, 118 (6th Cir. 1994) ("the ALJ did not err in declining to refer to [the treating physician's] opinion because [the treating physician] originally opined that claimant could perform sedentary work and did not provide any objective medical evidence to support his change of heart.").

However, it is clear from the record that the ALJ did not reject Ms. Carter's assessments solely because she was not an acceptable medical source, nor because there were inconsistencies in her opinion. The ALJ also noted that the medical evidence did

not support her limitations. (PageID 70). Although Ms. Carter opined that Plaintiff was "unemployable," the ALJ noted that Plaintiff's lumbar x-rays were mild, her hip x-rays were unremarkable, her EMG studies were essentially normal and her x-ray of the right knee only revealed a small suprapatellar joint effusion. (PageID 74, 77 citing PageID 353, 466, 467, 558-59). Similarly, the ALJ also noted that Plaintiff's examinations at most revealed mild findings. (PageID 69). In fact, in January 2008, consultative examiner Dr. Padamadan noted that Plaintiff's physical examination was normal. (PageID 348). Based on his findings, Dr. Padamadan concluded that there was no evidence that Plaintiff had any limitations. (PageID 348). In February 2009, consultative examiner Dr. Brown noted that Plaintiff had some tenderness, crepitus and decreased range of motion, but no significant joint effusions, rheumatoid nodules, or range of motion abnormalities. (PageID 358). Dr. Brown concluded that Plaintiff's ability to perform work-related activities was only mildly impaired. (PageID 358). Given the minimal examination findings and mild diagnostic tests, it was reasonable for the ALJ to conclude that Ms. Carter must have relied almost exclusively on the Plaintiff's unsubstantiated subjective complaints. (PageID 70).

Plaintiff further argues that the ALJ should have adopted Ms. Carter's assessment because it was supported by her MRI of the lumbar spine and Dr. Brown's findings. As previously stated, Plaintiff's MRI only noted several "mild" findings. (PageID 562). With respect to Dr. Brown, although Dr. Brown noted that Plaintiff had painful crepitus, tenderness in the knees, edema, and decreased range of motion, she explicitly concluded

that Plaintiff's ability to perform work-related activities was only mildly impaired. (PageID 358). Although Plaintiff argues that crepitus is an indication of worsening osteoarthritis, there is no evidence that she was diagnosed or treated for osteoarthritis during the relevant time. In fact, the only time that Plaintiff was examined for osteoarthritis the doctor noted that there were "no clinical indications of…nodular osteoarthritis in the distal joints." (PageID 296). While Plaintiff may believe that she has osteoarthritis, the ALJ was not permitted to find that it was a medically determinable impairment or assess functional limitations without diagnostic evidence of the impairment. 20 C.F.R. §§ 404.1508, 404.1513, 404.1528, 404.1529 (explaining that an impairment is a "medically determinable" impairment if it is proven to exist using "acceptable clinical and laboratory diagnostic techniques."). Plaintiff has not shown that she had a knee impairment that significantly limited her ability to perform the standing and walking requirements of medium work.

Plaintiff also criticizes the ALJ for crediting the opinion of the non-examining state agency physicians because they did not have access to the April 2010 MRI. However, the ALJ reviewed the entire record, including the MRI, and concluded that Plaintiff was not disabled. Based on the record evidence, including the MRI findings, the ALJ found that the opinions of Drs. Klyop and Green were still warranted to significant weight. (PageID 70).

Next, Plaintiff argues that the ALJ violated *Drummond v. Comm'r of Soc. Sec.*, 126 F.3d 837, 842 (6th Cir. 1997), because he found that the Drummond rationale did not

apply, but gave great weight to the opinions of the state agency physicians who adopted Drummond. (PageID 66). However, even though the ALJ concluded that the opinions of the state agency physicians were entitled to great weight, he explained that he was making "some minor adjustments." (PageID 70). Specifically, the ALJ concluded that Plaintiff had environment limitations that the state agency physicians did not address. (PageID 420, 434).

Finally, Plaintiff argues that the ALJ impermissibly relied on her activities, because they did not show what she could do over a sustained period. Specifically, the ALJ noted that while Plaintiff claimed that she could only sit for 30 to 45 minutes and stand and walk for 15 to 20 minutes (PageID 253), she cleaned the house, cooked, and did the grocery shopping. (PageID 427). These activities are inconsistent with Plaintiff's allegations of total disability. At the hearing Plaintiff testified that she did not cook, do laundry, or make her bed, and only rarely did household chores. (PageID 103). She further testified that she "stopped shopping about 10 years go" (PageID 104), but she told Dr. Schulz in June 2009 that she "regularly" did the grocery shopping. Plaintiff's inconsistent statements combined with the lack of objective medical evidence supports

the ALJ's adverse credibility determination.[8]

Accordingly, the ALJ properly found that Plaintiff was not disabled. *Her v. Comm'r of Soc. Sec*., 203 F.3d 388, 389-90 (6th Cir. 1999) ("Even if the evidence could also support another conclusions, the decision of the Administrative Law Judge must stand if there evidence could reasonably support the conclusion reached."). .

III.

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

IT IS THEREFORE ORDERED THAT the decision of the Commissioner, that Ruth Dixon was not entitled to disability insurance benefits or supplemental security income is found **SUPPORTED BY SUBSTANTIAL EVIDENCE**, and **AFFIRMED**; and, as no further matters remain pending for the Court's review, this case is **CLOSED**.

Date: 11/12/13

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

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[8] The ALJ also identified several additional reasons why Plaintiff was not credible. (PageID 77). Specifically, at the hearing Plaintiff testified that she stopped using alcohol 25 years ago and stopped using drugs 15 years ago. (PageID 106). However, in June 2009, she told Dr. Schulz that she smoked marijuana two times per month and drank shots of whiskey the night before her examination. (PageID 426). When reminded of these statements, Plaintiff admitted that she still drank beer occasionally. (PageID 108). Plaintiff denied telling Dr. Schulz that she smoked marijuana (PageID 106-107), but Dr. Schulz's treatment notes indicate that "[t]he last time she used marijuana was two weeks ago when she reported smoking one joint. She reported that she "normally smokes one or two joints each month." (PageID 426). Given the specificity in Dr. Schulz's treatment records, it was reasonable for the ALJ to conclude that Plaintiff was less-than-credible.