IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF TENNESSEE
WESTERN DIVISION

APRIL L. RUTHERFORD-GLASS,	)	
	)	
Plaintiff,	)	
	)	
vs.	)	No. 02-2584 MaV
	)	
JO ANNE B. BARNHART, Commissioner of Social Security,	)	
	)	
Defendant.	)	

REPORT AND RECOMMENDATION

The plaintiff, April L. Rutherford-Glass, appeals from a decision of the Commissioner of Social Security ("Commissioner"), denying Glass's application for supplemental social security income and medical assistance benefits under Titles XVI and XIX of the Social Security Act, 42 U.S.C. § 401 et seq. The appeal was referred to the United States Magistrate Judge for a report and recommendation pursuant to 28 U.S.C. § 636 (b)(1)(B) and (C). For the reasons given below, it is recommended that Commissioner's decision should be remanded.

PROPOSED FINDINGS OF FACT

A. Procedural History

Glass first applied for supplemental security income and medical insurance benefits on February 3, 2000, citing disability

due to asthma, allergies, and weight problems. (R. at 77-90.) Her claimed date of onset was January 1, 2000. (R. at 77.) Her applications were denied initially and on reconsideration. Glass then filed a request for a hearing, which was duly held on July 2, 2001, before an Administrative Law Judge ("ALJ"). (R. at 28.) The ALJ denied Glass's application for benefits on February 25, 2002. (R. at 9-11.) Glass appealed the ALJ's decision to the Appeals Council. On May 30, 2002, the Appeals Council denied the request for review, leaving the ALJ's decision as the final decision.[1] (R. at 5-6.) Glass filed suit in federal district court on July 25, 2002, pursuant to 42 U.S.C. § 405(g), to review the Commissioner's final decision. Her suit alleged that the ALJ's findings were not based on substantial evidence and that the ALJ applied incorrect legal standards. After a remand so that the administrative record could be produced, the Commissioner answered on February 11, 2003.

B. The Hearing before the ALJ

At the time of the hearing before the ALJ, the plaintiff was 22 years old. (R. at 32.) She had a high school education and no additional education or vocational training. (R. at 32-33.) From seventh to twelfth grade she had been taught by in-home tutors because she could not tolerate the chalk dust and other allergens

[1] The record copy of the Action of Appeals Council is not dated, but the record's index of exhibits dates it May 30, 2002.

at school. (R. at 41-42.) At age 16, she attempted to work part-time at a clothing store but quit due to asthma and a "celo tumor" in her cerebral fluid. (R. at 33.) She has not worked since. (R. at 33-34.)

Glass's daily activities at the time of the hearing included cooking. (R. at 36.) She testified that her husband did all the household cleaning, dishwashing, bed-making, and nearly all the grocery shopping. (R. at 36, 46.) She testified to difficulty eating, swallowing, and chewing, that she could not eat meat, and that she had to crush all medications to swallow them. (R. at 48.) She did not testify to any difficulty with activities such as washing or dressing. She had a driver's license but did not drive because of panic attacks, (R. at 37), and was able to ride in a car as a passenger only with the windows up because of allergies, (*id.*). Glass denied having hobbies or recreations. She testified that going places and being around people made her physically ill. (R. at 50.) Glass's mother, Lu Nell Rutherford, testified that Glass could not visit friends' houses because of allergies. (R. at 56.)

At the time of the hearing, Glass had two children, ages ten months and three years. (R. at 44.) Her father, who lived across the street, came daily to care for the children and remained there until Glass's husband returned from work. (R. at 44-45.) Lu Nell

Rutherford testified that she also cared for the children, either in Glass's home or in the Rutherford home, on a daily basis from 3:30 p.m. to the children's bedtime. (R. at 52.) Rutherford also testified that she and her husband took care of the Glass's yard work and housework. (R. at 54.)

At the hearing, Glass testified concerning her medical problems and symptoms. She first testified to her asthma. She said her daily asthma regimen consisted of daily medication, daily inhalants, the use of a breathing machine three to four times per day, and sleeping at night with the head elevated. (R. at 49.)

As to her allergies, Glass stated that she was allergic to pollen, (R. at 35); chlorine and all cleaning products, (R. at 36); all soaps except Ivory, (R. at 46); perfume and hairspray worn by others, (R. at 41); cosmetics, (*id.*); and all animals, (R. at 45). She further testified that she was allergic to fruits, raw vegetables, lettuce, nuts, and MSG. (R. at 49.) She was able to eat noodles and bread products. (*Id.*) She had removed all stuffed animals from her home, (R. at 45), and was in the process of removing all the carpet as fast as the family could afford the renovations, (R. at 45-46).

Glass testified that she suffered from the skin disorders of eczema and/or psoriasis. She said her hands were constantly breaking out. (R. at 40.) She testified to breakouts and

continuous infections on her feet, where the skin would break, crack, and bleed. (R. at 46-47.) She treated these disorders with steroids or steroid creams, with only limited success, (R. at 46-47), and claimed that PUVA light therapy had been recommended but that, because of financial difficulty, she had not sought that treatment, (R. at 48).

Glass reported a weight of 330 pounds at a height of five feet, four inches. (R. at 43.) She claimed she could not take weight loss medication and that her steroid dependence interfered with weight loss. (R. at 35.) She noted her dependency on the anti-inflammatory/immunosuppressive drug Prednisone. (R. at 43.) She could not exercise for weight loss: she did not walk outside due to allergies in the summer and exacerbated asthma in the winter, (R. at 35), did not swim due to chlorine allergy, (R. at 36), and had been advised by doctors not to exercise at all, (*id.*).

Finally, Glass testified to the mental disorders of panic attacks, treated by medication, (R. at 37); depression, treated by medication and by monthly and weekly counseling, (R. at 50); and bipolar disorder, treated by lithium-based medication, (R. at 40). She testified that her gynecologist had treated her for depression and panic attacks since age eighteen. (R. at 38.) She discussed with the ALJ an incident in which she consumed a significant amount of tequila in response to a panic attack, but she denied other use

of alcohol or drugs. (R. at 38-39.) She testified that the medications Klonopin, Paxil, and lithium helped but did not completely control her depression, anxiety, and panic attacks. (R. at 40, 51.)

As to her functional capacities, Glass indicated that she had trouble lifting her smaller child, who was about 15 pounds, and could not lift her three-year-old child at all. (R. at 45.) She testified to a general difficulty keeping up with her children during the day and could not go outside with them. (*Id.*) Glass testified that her eczema/psoriasis outbreaks and infections limited her from putting her hands or feet in water. (R. at 47.)

C. Glass's Longitudinal Medical History According to the Records

The medical records cover Glass's treatment from John R. Austin, M.D. at the Sanders Clinic from August of 1998 to July of 2001; from Diane M. Long, M.D. at the Ruch Clinic from March of 1997 to June of 2001; and from Fred Grogan, M.D. and George Treadwell, M.D. at Allergy and Asthma Care from November of 1999 through November of 2000.[2] She had inpatient admissions in March 2000 and September 2000 at Methodist Hospitals Germantown; from April 9, 2001 to May 2, 2001, at Lakeside Behavioral Health System;

[2] Glass testified that she has been treated at the Allergy and Asthma Care Clinic for asthma since she was eleven years old. (R. at 43.)

and again at Methodist Hospitals Germantown in January of 2001 and June of 2002. She also consulted with dermatologist George Woodbury on October 19, 1999.

Glass's functional ability was assessed by three treating sources. Treating asthma/allergy physician Fred Grogan, on June 28, 2001, completed a Medical Source Assessment of Ability to do Work Related Activities (Physical). Treating psychiatrist Michael Patterson, on July 11, 2001, completed a Medical Source Assessment of Ability to do Work Related Activities (Mental). Terry Street, a certified professional counselor from Counseling and Consulting Services who was treating Glass on a weekly outpatient basis, submitted a letter assessment dated July 2, 2001.

Glass was also assessed by two non-treating physicians. In March, 2000, non-treating, non-examining physician H.T. Lavley, M.D., conducted a Residual Functional Capacity assessment (RFC). On November 15, 2001, examining but non-treating psychologist Phil M. Seyer, M.S., conducted a psychological evaluation for Tennessee Disability Determination Services.

Glass's longitudinal medical history, as reflected in the record and for purposes of her claim, begins in August of 1992, when, at age 13, Glass reported bouts of depression and crying to

her OB/GYN at the Ruch Clinic.[3] (R. at 247.) By November of 1992, the Ruch Clinic was managing Glass's severe asthma and steroid-related hair growth and weight gain. (R. at 246.) Glass continued to treat at the Ruch Clinic, and, in addition to a number of standard OB/GYN consultations, she presented with a rash in November 1993. (R. at 243.) Beginning in November 1993, clinical notes repeatedly indicate steroid dependence due to asthma and that "asthma precludes any exercise and . . . steroids increase her appetite as well as promote weight gain." (*Id.*) In November of 1996, the clinic reported that Glass's asthma was being controlled with "several medications," identifying Unisol, Proventil, Ehnale inhaler, and SloVent, (R. at 240), and also noted that Glass was taking intermittent steroids as well as Phen-Fen for weight loss, (*id.*). In the spring of 1997, at the age of 18, Glass became pregnant with her first child. (*See, e.g.,* R. at 300.) Her asthma and her use of inhalers and steroids to control asthma is continuously documented in the Ruch Clinic's records through the end of 2001. (R. at 303.)

On July 8, 1997, Glass made an initial office visit to Johnny M. Belenchia, M.D., a pulmonologist, on referral from Dr. Long, for

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[3] The Ruch clinic's records for his date indicate that Glass was already being followed by Dr. Grogan for severe asthma and was on several medications.

asthma management during her pregnancy. Dr. Belenchia diagnosed "extremely severe asthma," severe allergic rhinitis, an acute allergic reaction to chlorine from a recent swim in a pool, dysphagia which he associated with pregnancy, a pseudo-tumor of the brain with associated headaches, and nasal polyps. (R. at 308.) He also noted a history of allergic rhinitis/sinusitis in reaction to grasses, pollens, molds, and dust. (*Id.*) He stated her last emergency hospital visit due to asthma was in 1996 and indicated she was having asthma attacks every ten to fourteen days. (*Id.*) On this date, her FVC was 80%, FEV1 73%, and FVC:FEV1 ratio 86%. (*Id.*) Her muscle strength was normal but she has a rash over her lower extremities. (R. at 309.) Over the following ninety days, prenatal records from Baptist Hospital indicate an exacerbation in Glass's asthma in August of 1997. (R. at 302.)

On September 9, 1997, Glass's follow-up with Dr. Belenchia revealed "stable" pulmonary functions at FVC 82% of prediction, FEV1 at 75%, and FEV1:FVC ratio of 88%, despite her multiple problems. (R. at 306.) Rash and sinus problems were noted and a variety of asthma medications continued, including 20 mg of Prednisone daily. (*Id.*) Dr. Belenchia also noted continuing dysphagia, which he attributed to pregnancy. (*Id.*)

On October 14, 1997, Glass again reported to Dr. Belenchia. Her regimen of medications at that time included Proventil,

Flovent, Uniphyl, and nebulized Intal and Proventil. (R. at 304.) Her pulmonary functions, down from the previous visit, were FVC 67%; FEV1 59%; and FEV1:FVC ratio of 84%, after being treated with 20 mg of Prednisone daily. (*Id.*) Belenchia observed "this is the best I've actually heard her" but also observed "severe dermatitis/eczema . . . on her arms and legs" and prescribed Prednisone for it. (*Id.*) His examination of her extremities also revealed pedal edema (foot swelling). (*Id.*)

Glass gave birth to her first child on November 6, 1997. (R. at 239.) In December of 1997, the Ruch Clinic reported that Glass was off steroids and having exacerbation of eczema. (R. at 238.) Triamcinolone was prescribed, with a note that referral to a dermatologist would be in order if the medication was ineffective. (*Id.*)

On January 21, 1998, Glass called the Ruch Clinic "very depressed" and asked for assistance with depression. (R. at 237.) The clinic prescribed by telephone Prozac, 10mg daily, with one refill. (*Id.*)

On April 22, 1998, Glass was seen by John Austin, M.D., at the Sanders Clinic, who had treated her previously. He noted a history of severe asthma, and also noted "a severe rash on her hand that is cracking. Looks like eczema." (R. at 118.) Topicort, a steroid cream, was prescribed for the rash. (*Id.*) The Sanders Clinic

refilled Glass's prescriptions for Uniphyl, Proventil inhaler, and Proventil solution with Intal; Glass was also taking Flovent, Serevent, Claritin D, and Prednisone. (*Id.*) Dr. Austin noted she would be on Prednisone for three and one-half weeks, then off for two weeks. (*Id.*)

On May 12, 1998, Lu Nell Rutherford called the Ruch Clinic on Glass's behalf, reporting Glass's depression, sleep interruption, and severe mood swings. (R. at 236.) Glass apparently had discontinued the Prozac because of breastfeeding; Zoloft was prescribed as a substitute. (*Id.*)

On July 10, 1998, Glass reported to the Sanders Clinic for a fast-spreading, swollen, bruised rash on her upper arm. (R. at 118.)[4] Glass next reported to the Sanders Clinic on August 7, 1998 with psoriasis/eczema so severe her "skin [was] cracking open on her fingers." (R. at 120.) She reported hip pain and foul-smelling nasal drainage. (*Id.*) Dr. Austin noted that Glass was already on 60 mg of Prednisone daily and thought this would help her hip.

On January 13, 1999, Dr. Austin at Sanders Clinic saw Glass and observed "horrible eczema . . . it is really bad. Her fingers are bleeding and broken out. Topicort cream has not helped." (R.

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[4] **The treatment notes at the bottom of the page are not legible.**

at 117.) Glass also reported having migraine headaches daily for the previous two weeks, which she was trying to control with Tylenol because she was still breastfeeding. (*Id.*)

On February 17, 1999, Glass reported to the Ruch Clinic for her annual OB/GYN exam. The Ruch Clinic noted her eczema/psoriasis treatment, continuing asthma treatment, and current medications. (R. at 228.) Glass reported severe depression and irritability, to which Ruch Clinic responded by discontinuing the contraceptive injection Depo Provera and beginning the antidepressant Zoloft.[5] (*Id.*)

On February 26, 1999, Dr. Austin at the Sanders Clinic prescribed Vicoprofen for headaches and Phenergan for nausea. (R. at 117.) In the following month, March of 1999, he prescribed Antivert for dizziness and treated a rash on Glass's abdomen. (*Id.*) On July 16 of 1999, he diagnosed depression and prescribed Prozac, 20 mg daily. (*Id.*) He also prescribed Orlistat and Centrum to help control Glass's weight. (*Id.*) At that time, Glass was taking Slo-bid, Singulair, Claritin, Flovent, Seravent, Proventil inhaler and solution, and Atrovent solution. (*Id.*) Later that month, she received Phenergan and Vistaril after nausea, vomiting, and cramping. (R. at 117.)

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[5] It is not clear whether Glass actually began taking Zoloft in May 1998 when it was first prescribed.

On October 14, 1999, on referral from Dr. Austin, Glass consulted George R. Woodbury Jr., M.D., a dermatologist, for an assessment of whether her eczema/psoriasis would respond to PUVA, an ultraviolet light therapy.[6] (R. at 110.) Dr. Woodbury diagnosed palmoplantar psoriasis, a plaque-type psoriasis, and explained her disorder as "genetically sensitive skin that is often thickened in these areas, and at times quite itchy and dry . . . bumpy and itchy." (*Id.*) He noted papular eruption on the hands, and he twice indicated in his report that Glass had eruptions on "the bottom of the hands and feet." (*Id.*)

On October 18, 1999, Dr. Austin diagnosed Glass with arthritis in the left hip. (R. at 116.) Dr. Austin also noted Glass's continuing psoriasis, the consultation with Dr. Woodbury, and Dr. Woodbury's recommendation for PUVA light therapy to treat the psoriasis. (R. at 115.) Her asthma medications at that time included Slobid, Flovent, Severent, Singulair, Proventil, and Atrovent. (R. at 116.) Dr. Austin took Glass off Proventil and put her onto Combivent and additionally prescribed Tilade inhalant and a round of steroids. (R. at 115.) Verampil was added to control her existing migraine medications. (*Id.*)

On November 18, 1999, Glass submitted to a battery of allergy

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[6] The report in the record, R. at 110-111, is missing at least one page.

tests by George Treadwell, M.D., at Allergy and Asthma Care. Nearly every allergen of more than fifty listed is reported at a "3+" or a "4+" level of severity.[7] (R. at 139.) Examination notes indicated that Glass had been on steroids since the age of 4 at 30 mg per day and had not been able to taper off steroids for asthma treatment. (R. at 140.) On November 24, 1999, Glass called Asthma and Allergy Care with asthmatic wheezing; Dr. Treadwell instructed her to double up the steroids to 100 mg and to take three high doses of steroids and to report to the emergency room if the condition became worse. (R. at 137.) On November 30, 1999, Glass reported to the Sanders Clinic with migraines and nausea, and received Zomig for migraine and Phenergan for nausea. (R. at 115.)

Glass returned to Dr. Treadwell on December 17, 1999. At that time, Treadwell, reviewed Glass's history of hospital admissions due to asthma. (R. at 135.) He noted that she had been hospitalized for asthma approximately twice a year "for the past two years despite oral steroids" and that each time she was "sick for two to three weeks with these episodes." (*Id.*) She also reported feeling depressed, as well as continued itching and eczema/psoriasis. (R. at 136.)

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[7] Allergens are grouped into trees (13 types), grasses (11 types), weeds (10 types), molds (16 types), dusts (3 types), and miscellaneous including cat, dog, and feathers. (R. at 139.) No reference range for the scores appears on the record.

January 1, 2000, is Glass's claimed date of disability onset. In January of 2000, Glass reported to Dr. Austin at the Sanders Clinic for migraine headaches and received Amerge. (R. at 113, 199.) She was referred to Dr. Michael DeShazo for further consultation.[8] (R. at 113.) Later that month, she presented with a generalized rash and itching, as well as blurred vision accompanying severe headaches. (R. at 114.) She was then taking Zomig for migraine headaches, 40 mg of Prozac daily for depression, and 50 mg of Prednisone daily. (*Id.*) Zyrtec and Benadryl were prescribed for the skin disorder, and Fioricet had been prescribed for headaches but apparently was not helping. (*Id.*)

In early February, 2000, Glass reported to the Ruch Clinic for her annual exam. (R. at 224.) Ruch Clinic confirmed Glass was pregnant with her second child. Severe asthma and chronic steroid use were noted, as well as the daily use of Prednisone, Singulair, and inhalants. (*Id.*) She saw Dr. Treadwell at Allergy and Asthma Care on February 10, 2000, reporting a recent history of severe asthma, migraines, and hospital visits for asthma. (R. at 133.) Dr. Treadwell noted positive allergy tests for soybeans, Baker's yeast, Brewer's yeast, and haddock. (R. at 135.) She returned

[8] The record does not indicate whether Glass actually saw Dr. DeShazo.

February 28, 2000, for another visit with Dr. Treadwell. On this date he diagnosed Glass as having steroid dependent asthma "despite aggressive medical treatment and evaluation by several pulmonologists," "perennial allergic rhinitis," chronic sinusitis with nasal polyps, and esophageal motility problems (difficulty swallowing). (R. at 132.) Dr. Treadwell recommended a referral to Dr. Ward for the esophageal disorder. (*Id.*) For asthma, he prescribed Singulair, Flovent, Serevent, Atrovent as needed, Proventil as needed, EpiPen for severe attacks, Zyrtec, Flonase, Astelin, and a three-week course of Augmentin. (*Id.*) He also recommended an MRI of Glass's hip to rule out aseptic necrosis (tissue damage) due to use of steroids. (*Id.*) Pulmonary function tests on this date revealed an FEV of 69%, a VC of 70%. "Post-FEV1 increased to 101% . . . VC was down suggesting there may be some restrictive component possibly secondary to her weight." (*Id.*)

Glass was hospitalized at Methodist Healthcare from March 5 and 10, 2000, because of exacerbation of asthma and nausea and vomiting associated with pregnancy. (R. at 288.) Glenn Williams, M.D., stabilized her asthma with intravenous treatment. (*Id.*) An X-ray taken March 6, 2000 indicated left lung infiltration (fluid in the lung). (R. at 289.) She was prescribed more Prednisone on discharge. (R. at 288.) On March 29, 2000, Allergy and Asthma Care noted dyspnea (difficulty in breathing) without exertion. (R. at

148.)

As of July, 2000, Glass was still taking Prozac. (R. at 271.) She also had been visiting the Ruch Clinic for diffuse symptoms including nausea, vomiting, dizziness, loss of appetite, faintness, back pain, and diarrhea, all apparently pregnancy-related. Her asthma and use of Prednisone at levels of 30 mg to 60 mg daily for asthma are documented throughout the summer, from March 2000 through August 2000. (*See, e.g.*, R. at 274, 276, 277.)

On August 17, 2000, Glass's FVC was 87%; her FEV1 89%, and her FVC:FEV1 ratio was 111%. (R. at 141.) Dr. Grogan at Asthma and Allergy Care increased her Prednisone to attack what he characterized as "severe, unremitting, almost status-type asthma." (R. at 143.) An August 18, 2000 letter from the Ruch Clinic's Diane M. Long, M.D., discussing natal care with the insurer CIGNA, indicates pregnancy complication and risk due to severe asthma. (R. at 293.)

Glass gave birth to her second child on September 17, 2000. (R. at 158.) From September 15 to 19, 2000, she was hospitalized at Methodist Hospital for the birth. (R. at 157-58.) After a brief release, Glass was re-admitted on September 26, 2000, and held overnight for treatment of postpartum infection and pyelonephritis (kidney infection). (R. at 154-55.) A September 26, 2000 X-ray revealed a normal-sized heart and clear lungs, and the discharge

report indicates stable asthma. (R. at 156, 264.) On October 1 and 2, 2000, Glass complained of post-partum back pain and difficulty voiding; she received follow-up prescriptions for kidney infection. (R. at 219-20.)

On October 6, 2000, Glass had another pulmonary function test at Allergy and Asthma Care. Her FVC was 82%; her FEV1 was 83%, and her FVC:FEV1 ratio was 89%. (R. at 141.) As of November 1, 2000, her Prednisone dosage was up to 50 mg. (R. at 218.) Her pulmonary functions on November 3, 2000 were lower than the previous month's: FVC at 78%; FEV1 at 75%; and an FVC:FEV1 ratio at 65%. (R. at 141.)

On February 21, 2001, Glass reported to Ruch Clinic complaining of panic and anxiety attacks. Diagnostic impressions included recent anxiety and panic episodes, morbid obesity, and severe asthma. (R. at 216.) The physician recommended a medication change from Prozac to Zoloft and a possible referral to Dr. John Austin for obesity surgery. (*Id.*) Six days later, on February 27, 2001, Glass called the Ruch Clinic reporting two to three days of panic attacks after her medication was switched from Prozac to Zoloft; Xanax was prescribed to ease the transition. (R. at 215.)

On March 22, 2001, Glass's pulmonary functions tested as follows: FVC 90%; FEV1 90%; FVC:FEV1 ratio 97%. (R. at 141.) On March 27, 2001, Dr. Grogan at Allergy and Asthma Care saw Glass. He

noted that she has been maintained on 20 to 30 mg per day of Prednisone for several years. He proposed reducing Glass's steroids and attempting treatment with a new drug, Advair. (R. at 149.)

Shortly thereafter, Glass was admitted to the Partial Hospitalization Program at Lakeside Behavioral Health System. (R. at 165-67). She presented on April 9, 2001 with severe major depression and panic disorder, (R. at 167), some suicidal ideation (R. at 168, 174), and additional indications of morbid obesity, asthma, and social isolation, (R. at 167). She reported daily panic attacks lasting over an hour, (R. at 175, 176), and asthma attacks "all the time," with the most recent two or three days beforehand, (R. at 175). After an intake examination, doctors assigned her a Global Assessment of Functioning (GAF) rating of 40, (R. at 167), and recommended Glass participate in limited exercise only, (R. at 168). Psychological examination indicated anxiety and depression resulting in a significant loss of functioning, and a failure of social/occupational functioning. (R. at 173.) A needs assessment detailed symptoms of "compulsive behavior" about keeping the children and house clean, (R. at 175, 176), and an incident of drinking tequila about six weeks beforehand to "stop racing thoughts," (R. at 175, 177). She denied ever drinking before this incident; the clinical impression was a recent

behavioral change related to impulse control. (R. at 175.) The admission assessment noted, "rule out bipolar disorder." (R. at 180.)

Robert M. Serino, Ph.D., clinical psychologist at Lakeside, conducted a full psychological evaluation on April 13, 2001. He found that Glass's "attention and concentration seemed to be negatively influenced by emotional factors," but that her motor behavior was normal. (R. at 192.) Her testing revealed "a chronic pattern of interpersonal difficulties," (R. at 193), and "a chronic pattern of maladjustment with social uneasiness, introversion, depression, and emotional instability," (R. at 194). Dr. Serino noted that Glass's reality testing was "marginal under stress" but not to the point of psychosis. (R. at 193.) He diagnosed Axis I: Major Depressive Disorder and Panic Disorder with Agoraphobia, and Axis II: Personality Disorder with Avoidant, Dependent, Borderline, and Obsessive-Compulsive features. (R. at 194.)

Because Glass could "maintain a stable presentation in her external environment," she was admitted to part-time inpatient care at Lakeside. (R. at 169.) She was treated with Paxil, Trazodone, and Klonopin. (*Id.*) Paxil was increased on April 12, 2001 to 40 mg, (R. at 185), and again on April 16 to 60 mg, (R. at 186). On April 24 and 26, 2001, she reported crying spells. (R. at 189.) She was evaluated as "still not stabilized" on April 27, 2001, with

intermittent suicidal thoughts and frequent crying spells over the next few days. (R. at 191.) On May 2, 2001, Glass was able to commit to avoiding self-harm, denied suicidal thoughts, and was released to outpatient care. (R. at 169, 172.) Discharge medications included Paxil, Eskalith, Klonopin, and Trazodone. (R. at 170.) She was advised to participate in one positive leisure activity each day. (R. at 171.) Her discharge diagnosis by Michael Patterson, M.D., was Axis I: Severe Major Depression and Panic Disorder, Axis III: Obesity and Asthma, and an Axis V: current GAF of 60, with a "guarded to fair" prognosis. (R. at 167.)

On May 9, 2001, Glass entered the Lakeside Behavioral Health System Day Treatment program. (R. at 169.) On May 15, 2001, she reported to Dr. Austin at the Sanders clinic complaining of pain in the chest and difficulty breathing. (R. at 198.) The following day, May 16, 2002, she reported to psychiatrist Michael Patterson for an outpatient follow-up, reporting two panic attacks since her inpatient discharge, with symptoms of screaming and crying, mood swings, manic, and not sleeping well. (R. at 322.) Dr. Patterson increased Glass's Klonipin, prescribed Eskalith, and noted that Paxil should continue. (*Id.*) Glass reported that she was being treated weekly by certified professional counselor Terry Street.

On June 11, 2001, Glass presented at the Ruch Clinic in "acute distress" with bilateral flank tenderness, dysuria (pain in

urination), and high fever of 106°. (R. at 212.) Dr. Kennedy diagnosed her with pyelonephritis (kidney infection) and admitted to Methodist Hospital Germantown. (R. at 212, 258.) Dr. Thomas Shelton was called in on a urologic consultation and diagnosed kidney infection, and noted her history of psoriasis and severe asthma. (R. at 204.) Dr. Roy C. Fox, a pulmonologist, was called in on a pulmonary consultation. He noted that Glass had a life-long history of suffering from asthma, that she had been on 30 mg of Prednisone daily for the last four years, and that "she generally has a relapse each time attempts are made to wean" her from Prednisone. (R. at 202.) He also noted that multiple allergies contributed to her asthma, and that she had an emergency room visit approximately three weeks before. (*Id.*) A June 13, 2001 X-ray revealed normal heat and lungs, with no change since September 26, 2000. (R. at 208.) Glass was discharged on June 14, 2001. (R. at 200.)

The final entry reflecting longitudinal treatment is July 11, 2001, when Glass consulted Dr. Patterson for continuing panic attacks. Dr. Patterson continued her on Eskalith, again increased her Paxil and Klonipin, and prescribed the antihistamine Hydroxyzine. (R. at 323.)

Glass's file contains five functional capacity assessments: three from treating sources; one from an examining but non-treating

source; and one from a non-treating, non-examining source. On March 13, 2000, non-treating, non-examining physician H.T. Lavley, Jr., M.D., completed a Physical Residual Functional Capacity Assessment. (R. at 122.) Dr. Lavley opined that Glass could occasionally lift and carry twenty pounds and frequently lift and carry ten pounds; could stand, walk, or sit with normal breaks for six hours of an eight-hour workday; and had no limitations on pushing, pulling, posture, manipulation, vision, or communication. (R. at 122-26.) Dr. Lavley's handwritten notes supporting his findings are unclear but appear to read, "cl [presumably, "claimant"] . . . asthma, allergies, and weight . . . Cl has H/O treatment for asthma with multiple [illegible but possibly "exams" or "exacerbations"] from 01/00 through 02/10/00 - chest clear." (R. at 123.) He further notes "02/28/00 PFS FEV1 2.45 [illegible but possibly "improvements" or "impairments"] are SVL . . . asthma and obesity reduce lifting from 50/25 to 20/10." (R. at 124.) No other explanation is given for has assessment and there is no indication what records he reviewed.

As to environmental limitations, Dr. Lavley opined that Glass should "avoid concentrated exposure" to "fumes, odors, dusts, gases, poor ventilation, etc." (R. at 126.) He did not, however, indicate whether Glass had any limitations in the areas of cold, heat, wetness, humidity, noise, vibration, or hazards such as

machinery or heights. (*Id.*) The check-mark boxes in these areas were left blank, and Dr. Lavley's only note supporting these findings is "see [illegible]." (*Id.*) At that time, there were no treating source statements on file regarding Glass's physical capacities. (R. at 128.)

On June 28, 2001, treating physician Fred Grogan produced a Medical Source Statement of Ability to do Work-Related Activities (Physical). He reported exertional limitations on all lifting, all carrying, all standing, and all walking, stating that "breathing difficulty may prevent activity much of the time." (R. at 195.) He specifically noted "difficulty in walking, standing," but not the extent of the difficulty. (R. at 197.) He did not indicate any sitting, postural, manipulative, visual, or communicative limitations, but did not mark the boxes "unlimited" either; these check-mark boxes were blank. (R. at 196-97.) Under "environmental limitations," Dr. Grogan noted limitations on exposure to temperature extremes, dust, humidity and wetness, and fumes, odors, chemicals, and gasses. (R. at 197.) He attributed these to "severe chronic respiratory disease (asthma)." (*Id.*)

On July 2, 2001, treating counselor Terry Street, Certified Professional Counselor, of Counseling and Consulting Services, wrote a letter report indicating that Glass suffered from "repeated, random panic attacks accompanied by an excessive level

of anxiety on a daily basis." (R. at 319.) Noting that medications had little effect on Glass's condition, Street opined that Glass was "limited in her much desired roles as a wife and mother in her own home." (*Id.*)

On July 11, 2001, treating psychiatrist Michael Patterson produced a Medical Source Statement of Ability to do Work-Related Activities (Mental). In the area of carrying out instructions, he indicated Glass had "poor" ability to understand, remember, or carry out detailed instructions; "poor" ability to maintain extended concentration or attention, perform at a consistent pace, or complete a normal workday; and "poor" ability to perform activities within a schedule. (R. at 320.) He indicated "fair" abilities to remember locations and work-like procedures; to understand and carry out short simple instructions; to make simple work-related decisions; to work near others; and to sustain an ordinary routine without special supervision. (*Id.*) He did not indicate that Glass had a "good" or an "excellent" ability to perform any aspect of carrying out instructions.

Dr. Patterson also opined that Glass's impairment affected her ability to respond appropriately to supervisors, co-workers, and work pressures. Specifically, he noted that Glass had "poor" abilities to interact with the public; to accept instruction and criticism from supervisors; to get along with peers; and to create

realistic goals or plans independent of others. (R. at 321.) He opined that Glass had "fair" abilities to ask simple questions; to maintain socially appropriate standards of behavior, neatness, and cleanliness; to respond appropriately to changes and hazards in the work setting; and to use public transportation. (*Id.*) He did not indicate that Glass had a "good" or an "excellent" ability to perform any aspect of relating to others in the workplace.

On November 15, 2001, Glass was examined on a consultative basis by Phil M. Seyer, M.S., of Colonial Counseling Center, on behalf of Tennessee Disability Determination Services. At the time of that examination, she had visited Dr. Grogan four weeks previously for asthma and allergies, and Dr. Austin eight weeks previously for a checkup.[9] (R. at 325.) She was also treating weekly with counselor Terry Street and monthly with psychiatrist Michael Patterson for depression, anxiety attacks, and bipolar disorder. (R. at 326.) She reported her daily activities as "being with her children" and reported that she did not visit others, travel, or engage in any hobby or recreation except that "she will read." (*Id.*) Seyer diagnosed an Axis I: Panic Disorder without agoraphobia and bipolar disorder with recent episode unspecified; Axis II: borderline range of cognition or above; Axis

[9] Austin is written "Alston" in Sayer's report.

III: asthma and obesity; Axis IV: psychosocial environmental problems; and, Axis V: a GAF of 60 with "moderate impairment and occupational functioning due to the diagnosis." (R. at 329.) He proposed that Glass should remain under the care of her psychotherapist and asthma care providers "as long as necessary." (R. at 330.)

Seyer reported fair effort by Glass on all testing. (R. at 324.) He tested Glass's IQ on the Wechsler Adult Intelligence Scale III and reported a verbal IQ of 87; a performance IQ of 77; and a full scale score of 80, all of which "fall into a borderline range of cognition." (R. at 327.) Performance testing revealed "fair" planning and organization skills, and drawing skills in "at least the borderline range." (*Id.*)

Seyer administered a Wide Range Achievement Test, concluding that Glass read at a high school level and performed arithmetic at a fourth grade level. (R. at 328.) He administered inkblot and house-tree-person tests, and did not note features of psychosis or "significant features" of depression, but did note features of anxiety. (*Id.*) He opined that Glass's insight and judgment were weakened due to bipolar disorder and panic disorder without agoraphobia. (*Id.*)

Finally, Seyer assessed Glass's functional abilities. In the area of carrying out instructions, he opined that Glass's function

was affected by her "low to average range of cognition and bipolar disorder." (*Id.*) Glass had "impaired" abilities to understand, remember, and carry out instructions. (*Id.*) She had "moderately impaired" abilities to understand, remember, and carry out detailed instructions; "slightly impaired" abilities to understand and carry out short and simple instructions; and "slightly impaired" abilities to make simple judgments on simple work-related decisions. (R. at 328.)

In the area of relating to co-workers, Seyer opined that Glass's function was affected by "panic disorder without agoraphobia and bipolar disorder." (R. at 329.) Glass had "moderately impaired" abilities to respond appropriately to supervision and to the pressures of a work setting; "moderately impaired" abilities to interact appropriately with the public and co-workers; and a "moderately impaired" ability to respond appropriately to changes in the work setting. (*Id.*)

D. The ALJ's Decision

Using the five-step disability analysis,[10] the ALJ in this case

[10] Entitlement to Social Security benefits is determined by a five-step sequential analysis set forth in the Social Security Regulations. 20 C.F.R. §§ 404.1520, 416.920. First, the claimant must not be engaged in substantial gainful activity for a period of not less than twelve months. 20 C.F.R. § 404.1520(c). Second, a finding must be made that the claimant suffers from a severe impairment. *Id.* Third, the ALJ determines whether the impairment meets or equals the severity criteria set

found, as the first step in the evaluation, that Rutherford-Glass had not engaged in any substantial gainful activity since her claimed onset date of January 1, 2000. (R. at 13.)

At the second step in the analysis, the ALJ found that Glass's asthma, obesity, affective disorders, panic disorder, and borderline intellectual functioning all were "severe" conditions within the regulatory definition. (R. at 13.)

At the third step, the ALJ found that although Glass's impairments were severe, Glass did not have, prior to her claimed onset date of January 1, 2000, an impairment or combination of impairments that would meet or equal the level of severity described for any listed impairment set out in 20 C.F.R. Part 404, Subpart P, Appendix 1. (R. at 13, 21.) The ALJ did not state a specific basis for this conclusion. (R. at 13.)

At the fourth step in the analysis, the ALJ determined that,

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forth in the Listing of Impairments contained in the Social Security Regulations. 20 C.F.R. §§ 404.1520(d), 404.1525, 404.1526. If the impairment satisfies the criteria for a listed impairment, the claimant is considered to be disabled. If the claimant's impairment does not meet or equal a listed impairment, the ALJ must undertake the fourth step in the analysis and determine whether the claimant has the residual functional capacity to return to any past relevant work. 20 C.F.R. § 404.1520(e). If the ALJ finds the claimant unable to perform past relevant work, then, at the fifth step, the ALJ must discuss whether the claimant can perform other work which exists in significant numbers in the national economy. 20 C.F.R. § 404.1520(f).

although Glass had no past relevant work, she retained the residual functional capacity to perform light work. (R. at 19-21.) The ALJ specifically found Glass capable of lifting twenty pounds occasionally and ten pounds frequently; capable of standing, walking, and sitting for six hours in an eight-hour workday; and capable of following simple instructions, getting along adequately with co-workers and supervisors, and adapting to changes in a routine work situation. (R. at 16.)

To reach this conclusion, the ALJ evaluated Glass's physical and mental limitations. As to physical limitations, he noted that Glass suffered from asthma but concluded that the asthma did not preclude all work activity. (R. at 17.) The ALJ discredited the functional assessment of treating physician Fred Grogan, which indicated that Glass had trouble walking and standing due to asthma. (R. at 16-17.) The ALJ found Dr. Grogan's opinion inconsistent with pulmonary function tests and inconsistent with the lack of documentation as to "consistent shortness of breath or exertional causes of shortness of breath." (R. at 16.) The ALJ also discredited Dr. Grogan's opinion because, although Drs. Grogan and Treadwell were both at Allergy and Asthma Care, Dr. Grogan had not seen Glass as frequently as had Dr. Treadwell. (R. at 16.) The ALJ noted Exhibit 10F, medical records indicating that Glass suffered asthma symptoms when attempts were made to wean her from

Prednisone; "[i]t follows, then, that her symptoms are controlled when she takes her medication." (R. at 16.) The ALJ also noted that Glass's "most recent pulmonary function tests are inconsistent with debilitating symptoms . . . [b]etween August 17, 2000 and March of 2001, her functions did not fall lower than 75% and reached a high of 90%." (R. at 16.) Finally, the ALJ relied upon medical evidence indicating Glass could carry "a pregnancy almost to term and vaginally deliver the baby . . . and . . . she cares for two preschool children on a daily basis." (R. at 16.) The ALJ did not discuss any non-exertional physical limitations.

The ALJ next evaluated Glass's mental limitations. He used the two-part technique set forth in 20 C.F.R. 404.1520a(a)(3)(b)(1)-(2) (Subpart P to Rule 404):

> (1) Under the special technique, we must first evaluate your pertinent symptoms, signs, and laboratory findings to determine whether you have a medically determinable mental impairment(s). See Sec. 404.1508 for more information about what is needed to show a medically determinable impairment. If we determine that you have a medically determinable mental impairment(s), we must specify the symptoms, signs, and laboratory findings that substantiate the presence of the impairment(s) and document our findings in accordance with paragraph (e) of this section.
>
> (2) We must then rate the degree of functional limitation resulting from the impairment(s). . .

20 C.F.R. 404.1520a(a)(3)(b)(1)-(2). In this case, the ALJ first identified "affective disorders and panic attacks" with diagnostic

characteristics of "feelings of worthlessness, hopelessness, and uselessness, with crying spells, decreased energy levels, and social isolation." (R. at 18.) He identified mental functional limitations as "mild restrictions" on activities of daily living and "mild difficulties" in maintaining social functioning. The ALJ based this conclusion on his finding that Glass is "the mother and caregiver of two preschool children," that she does "some household chores," and that, despite Glass's testimony to social isolation, Social Security Ruling 85-15 holds that unskilled work involves dealing with objects rather than people. (*Id.*) He noted disorder characteristics of "moderate difficulties in maintaining concentration, persistence, or pace" due to panic attacks. He found, however, that Glass's panic attacks were neither frequent nor life altering and specifically found a "scarcity of complaints to her treating physicians." (*Id.*) The ALJ notes one episode of decompensation lasting two weeks or more but states that because Glass "rebounded" to a GAF of 60 and apparently maintained that level since the decompensation, Glass would be able to perform unskilled work. (*Id.*)

The ALJ found Glass's subjective evaluations of her physical and mental limitations only partially credible. First, he found that Glass's testimony that she could not care for her children was contradicted by Lu Nell Rutherford's testimony that Lu Nell cared

for the children only after work. (R. at 18.) Second, he found that Glass's subjective complaints were inconsistent with medical evidence because "there [was] no current evidence of debilitating psoriasis"; because her asthma complaints were inconsistent with pulmonary function tests; because her allegations of mental limitations were inconsistent with a GAF of 60; and because the reports of daily living activities given at the July 2, 2001 hearing were more restrictive than those reported on November 15, 2001 to psychological examiners. (R. at 19.) For those reasons, the ALJ found Glass's testimony credible only to the extent it was consistent with an ability to perform light unskilled work.

The ALJ then reached the fifth step and inquired whether the plaintiff was able to perform past relevant work or other work existing in significant numbers in the national economy. In this case, Glass had no past relevant work. "Once the claimant has established that she has no past relevant work," the ALJ noted, ". . . the burden shifts to the Social Security Administration to show that there are other jobs existing in significant numbers in the national economy that the claimant can perform, consistent with her residual functional capacity, age, education and work experience." (R. at 19.)

The ALJ determined that Glass could perform light unskilled and sedentary work. In doing so, the ALJ applied the Medical-

Vocational Guidelines of Appendix 2, Subpart P of the regulations. He determined that Glass was a "younger individual" based on her age of 22 at the time of the hearing. (R. at 20.) He found she had a high school education and no transferable skills. (*Id.*) He found that Glass had the exertional residual functional capacity to perform substantially all of the seven primary strength demands of both light and sedentary work: lifting up to 20 pounds; frequent lifting or carrying of objects up to ten pounds; frequent walking or standing or sitting; and some pushing and pulling of arm or leg controls. (*Id.*) The ALJ noted that when all seven exertional capacities were met, administrative notice was taken that jobs existed in significant numbers in the national economy. (*Id.*) On the basis of his finding that Glass met all exertional capacities and having taken administrative notice of jobs available in the national economy, the ALJ determined that Glass was "not under a disability." (R. at 21.) The ALJ did not consider non-exertional limitations. The Social Security Administration did not proffer any medical-vocational or other expert testimony at the hearing.

PROPOSED CONCLUSIONS OF LAW

Glass argues that the ALJ improperly failed to consider the combination of her conditions - asthma, obesity, multiple allergies, psoriasis, mental functioning, and psychological disorders - in determining that her severe impairments failed to

meet or equal a listed impairment; and that the ALJ failed to give proper weight to her treating physicians' opinions in assessing the severity of her asthma-related and mental impairments and improperly relied instead on the opinion of a non-treating consultant. Glass also contends that the ALJ erroneously found that she provided care for her children on a daily basis, when all the testimony was to the contrary, that her asthma symptoms could be controlled with medication, and that the ALJ wrongly evaluated her credibility in assessing her subjective symptoms. She further asserts that the ALJ's determination as to her residual functional capacity was not supported by substantial evidence, and that the ALJ improperly used the grids to reach a conclusion that she could perform light work in light of her non-exertional limitations.

A. Standard of Review

Judicial review of the Commissioner's decision is limited to whether there is substantial evidence to support the decision, and whether the Commissioner used the proper legal criteria in making the decision. 42 U.S.C. § 405(g); *Barker v. Shalala*, 40 F.3d 789, 794 (6th Cir. 1994); *Abbott v. Sullivan*, 905 F.2d 918, 922 (6th Cir. 1990). Substantial evidence is more than a scintilla of evidence but less than a preponderance and is such relevant evidence as a reasonable mind might accept as adequate to support a conclusion. *Kirk v. Sec'y of Health and Human Servs.*, 667 F.2d

524, 535 (6th Cir. 1981).

In determining whether substantial evidence exists, the reviewing court must examine the evidence in the record taken as a whole and must take into account whatever in the record fairly detracts from its weight. *Abbott*, 905 F.2d at 923. If substantial evidence is found to support the Commissioner's decision, however, the court must affirm that decision and "may not even inquire whether the record could support a decision the other way." *Barker*, 40 F.3d at 794 (citing *Smith v. Sec'y of Health and Human Servs.*, 893 F.2d 106, 108 (6th Cir. 1989)). If supported by substantial evidence, the Commissioner's decision must be affirmed even if the reviewing court would have decided the case differently and even if substantial evidence also supports the opposite conclusion. *See Kinsella v. Schweiker*, 708 F.2d 1058, 1059 (6th Cir. 1983). Similarly, the court may not try the case *de novo*, resolve conflicts in the evidence, or decide questions of credibility. *Cutlip v. Sec'y of Health and Human Servs.*, 25 F.3d 284, 286 (6th Cir. 1994).

B. Impairments in Combination

Glass first takes issue with the ALJ's determination at Step Three that her condition failed to meet or equal the severity criteria set forth in the Listing of Impairments contained in the Social Security Regulations. *See* 20 C.F.R. §§ 404.1520(d),

404.1525, 404.1526; 20 C.F.R. § 404, Subpt. P., App. 1. Glass claims that the ALJ erred in failing to consider the combined effect of her impairments. Glass specifically argues that the ALJ failed to consider the relationship of allergic reactions to asthmatic reactions, despite her treating physicians' documentation of allergic reactions and opinions that allergies exacerbated her asthma. (Pl.'s Brief at 12 (citing R. at 140).) Glass claims her asthma is medically equivalent in severity to Listing 3.03, *see* 20 C.F.R. 404.1256, when combined with her multiple allergies, chronic rhinitis, psoriasis, and obesity, and that the ALJ erred in not considering these symptoms in combination. (Pl.'s Brief at 12.) The Commissioner advances no counterargument to this particular point.

The ALJ must consider symptoms that in combination may constitute severe medical disability. 42 U.S.C. § 423(d)(2)(B); *see also* 20 C.F.R. 416.920(a) (requiring the Commissioner to consider the combined effect of multiple impairments). He is not required to examine every piece of evidence on the record, but his decision must set forth a rationale that is clear enough to permit judicial review. *Walker,* 834 F.2d at 643; *Gray*, 2001 U.S. Dist. LEXIS 24687 at *6.

In this case, the ALJ's opinion does not discuss the impact of Glass's allergies or weight upon the severity of her asthma

symptoms. It appears that there is substantial medical evidence in the record indicating that Glass's allergies and/or her weight may interact with her asthma and may increase the severity of her asthmatic condition. See, e.g., R. at 150 (treating doctor Treadwell's suggestion that Glass's weight may affect her flow volume); R. at 139 (results of clinical allergy testing); R. at 140 (treating doctor's opinion that asthmatic "symptoms [were] worsened by exposure to all aeroallergens, respiratory irritants, weather changes, nuts and fruits, and "some veggies."); R. at 124 (RFC physician's opinion that both asthma and obesity affected Glass's residual functional capacity).

It is submitted, therefore, that remand is appropriate for a specific finding on whether Glass's conditions, in combination, produce symptoms that equal a Listed Impairment.

C. <u>Determination as to Residual Functional Capacity</u>

Glass next argues that the ALJ erred in determining at Step Four that she could perform light-duty or sedentary unskilled work. Specifically, she contends (1) that the ALJ failed to give controlling weight to the physical and mental capacity assessments generated by treating physicians; and (2) that the ALJ improperly discredited her testimony as to her abilities to walk, lift, and care for her children.

1. <u>Weight Given to Treating Physician's Records and Findings</u>

Glass claims the ALJ put too much weight on the functional capacity assessments of non-treating, non-examining physicians, (Pl.'s Brief at 10), and incorrectly concluded that her symptoms were controlled as long as she took Prednisone, (*Id.* at 11). The Commissioner counterargues that treating physician Dr. Grogan's reports were undermined by the pulmonary function test results. (Mem. in Supp. of Comm'r's Decision at 10 (citing R. at 132, 143, 144, and 150).) The Commissioner also argues that Dr. Treadwell, not Dr. Grogan, was Glass's usual physician at Allergy and Asthma Care. (*Id.*)

The proper weight to give the opinion of a treating physician is stated in the regulations:

> Generally, we give more weight to opinions from your treating sources, since these sources are likely to be the medical professionals most able to provide a detailed, longitudinal picture of your medical impairment(s) . . . If we find that a treating source's opinion on the issue(s) of the nature and severity of your impairment(s) is well-supported by medically acceptable clinical and laboratory diagnostic techniques and is not inconsistent with the other substantial evidence in your case record, we will give it controlling weight.

20 C.F.R. § 404.1527(d)(2) (emphasis added). "It is well-settled that opinions of treating physicians should be given greater weight than those held by physicians whom the Secretary hired and who only examined the claimant once," *Farris v. Sec'y of Health and Human Servs.*, 773 F.2d 85, 90 (6th Cir. 1985), but treating physician

opinions receive controlling weight only when they are supported by clinical findings and are consistent with the evidence, 20 C.F.R. § 404.1527(d)(2); *Cutlip*, 25 F.3d at 287.

Here, by default, after discrediting Dr. Grogan, the ALJ relied on the opinion from the state agency medical consultant, a non-examining physician. As the ALJ stated, Grogan's "opinion was not given the weight generally afforded a treating physician's opinion, 20 C.F.R. 416.927 . . . That leaves the opinion from the state agency medical consultant who opined that the claimant could perform light work and considerable weight is given to that opinion." (R. at 178.)

In discrediting Grogan's opinion because Glass had not been treated by Dr. Grogan as often as she was treated by Dr. Treadwell, the ALJ failed to consider the length of time Glass had been treated by Grogan. The medical records from the Allergy and Asthma Clinic cover only the period from November 1999 to November 2000. Yet, Glass testified that she had been treated at the clinic since she was eleven years old. The Ruch Clinic records confirms Glass's treatment at the Allergy Clinic since she was young. The Ruch Clinic's records for Glass's August 1992 visit indicated that Glass was already being followed by Dr. Grogan for severe asthma and had been since she was thirteen. Moreover, an entry in the Allergy Clinic's records for November of 1999 indicate that Glass had

previously been seen by Dr. Grogan. Also, from November 1999 to November 2000, the relevant time period, Dr. Grogan saw her at least twice. Thus, based on the record, the court submits that the ALJ improperly discredited Dr. Grogan's opinion in contravention of the regulations which require a treating physician opinion to be given controlling weight.

The ALJ's conclusion that Glass's symptoms are controlled with medication is not supported by substantial evidence. The ALJ latched on to one entry in the record to support his following conclusion that Glass's asthmatic symptoms are controlled with medications:

> During the claimant's last hospitalization, her doctor indicated that relapses occurred only when an attempt was made to wean her from prednisone. (Exhibit 10F). It follows, then, that her symptoms are controlled when she takes medication.

(R. at 16.)

The entry relied upon so heavily by the ALJ was made on June 11, 2001, by Dr. Roy C. Fox, a pulmonologist, who was called in by Dr. Kennedy for a consultation when Glass was hospitalized for pyelonephritis. It was noted by Dr. Fox as part of Glass's history.

The medical record, however, is replete with entries that indicate Glass suffered asthmatic attacks despite being on medication. On November 24, 1999, Glass experienced asthmatic

wheezing despite being on steroids; she was instructed to double her steroid use and take three high doses. (R. at 137.) Dr. Treadwell noted, in December of 1997, that Glass had been hospitalized twice a year for the past two years for asthma "despite oral steroids." (R. at 135.) On March 22, 2001, Dr. Grogan noted that Glass had been maintained on 20 to 30 mg per day of Prednisone for several years, (R. at 149), during which time Glass continued to experience symptoms. All of this is in direct conflict with the ALJ's assessment that Glass only experiences asthma attacks when she is being weaned off steroids.

The ALJ also discredited the opinions of treating psychiatrist Michael Patterson and treating psychologist Terry Street and declined to give their opinions controlling weight. His stated reasons were that he de-emphasized Patterson and Street's opinions because there was an inconsistency between the two as to whether Glass suffered from bipolar disorder, and secondly, that Glass's GAF score of 60 indicated a "level of stability" that conflicted with their opinions of "devastating mental illness," particularly in light of her testimony "that has returned to rearing two small children . . . ." (R. at 17.)

As discussed in more detail below, the ALJ overlooked credible testimony by Glass's mother that Glass's father takes care of the children while her mother works. Thus, the ALJ relied on an

erroneous fact in discrediting the opinions of Patterson and Street. Also, the ALJ's rationale in discrediting Patterson and Street's opinions because one used a diagnosis of bipolar disorder and the other did not is confusing when the Commission's consultant, Dr. Cole, diagnosed bipolar disorder. The ALJ Downplays Cole's diagnosis of bipolar disorder by explaining that his diagnosis was based in part on history reported to him. Yet, it appears from Cole's detailed report that Cole made his own independent diagnosis. Thus, it is submitted that there is not substantial evidence in the record to support the ALJ's determination not to give controlling weight to Patterson and Street's opinions.

Also, contrary to the ALJ's observation of lack of documentation of constant shortness of breath, there is documented wheezing and decreased peak flow, with repeated visits to Doctors Grogan and Treadwell at Allergy and Asthma Care between November 18, 1999 and November 2, 2000. (Pl.'s Brief at 11.)

2. <u>The ALJ's Credibility Assessment</u>

Glass also argues that the ALJ's characterization of Glass's description of her child care activities is not supported by substantial evidence. Glass contends that the ALJ overlooked and ignored Lu Nell Rutherford's testimony that Lu Nell, Glass's mother, assists with the children when Lu Nell's workdays end and

her testimony that Glass's father also provides daily child care while Lu Nell is at work (Pl.'s Brief at 14-15; R. at 44-45.)

It is undisputed that the ALJ overlooked the role of Glass's father in child care. The Commissioner, however, argues that this issue is "not outcome-determinative" as to Glass's credibility, and that credibility may turn on other factors as well. (Brief in Supp. of Comm'r's Decision at 7.) Accordingly, the inquiry turns to whether there is other substantial evidence to support the finding on Glass's credibility.

The ALJ found Glass's credibility reduced because she testified to difficulty walking due to psoriasis when "there [was] no current [medical] evidence of debilitating psoriasis." (R. at 19.) The medical records indicate that Glass suffered from severe psoriasis for at least one year in duration prior to the claimed dated of onset of disability. In April of 1988, Dr. Austin noted a severe rash on Glass's hands. (R. at 118.) In August of 1988, Dr. Austin noted that Glass's psoriasis was so severe that her Skin [was] cracking open on her fingers." (R. at 120.) In October of 1999, Dr. Woodbury diagnosed palmoplantar psoriasis,[11] a plaque-type psoriasis, and twice noted eruptions on Glass's feet. (R. at 110.) In June of 2001, Dr. Kennedy noted a history of psoriasis but did

[11] "Plantar" is defined as "the sole of the feet." WEBSTER'S SECOND INTERNATIONAL DICTIONARY - UNABRIDGED.

not mention the location. (R. at 200-204.) It is submitted that there is not substantial evidence to support the ALJ's determination of diminished credibility due to Glass's testimony about the debilitating effect of her psoriasis.

The ALJ also found that Glass's testimony as to her asthma and her mental limitations was inconsistent with her pulmonary function tests and her recorded GAF score of 60.

Finally, the ALJ found Glass's daily living activities reported at the hearing on July 2, 2001 to be inconsistent with those reported to psychological examiners on November 15, 2001. (R. at 19.) At the hearing, Glass testified that her daily activities involved cooking, (R. at 36.), and denied any household cleaning, yard work, hobbies, recreation, driving, or visiting others, (R. at 36, 46). In the psychological report, she reported doing "a few things around the house" such as making herself a sandwich, cooking a family meal, doing her laundry, and taking care of her children in the morning before her father arrived. (R. at 326.) The psychological report also noted, "she will read." (R. at 326.) Glass's description of her daily living activities at the hearing is, by and large, consistent with the activities she reported to the psychologist and does not undermine her credibility.

The ALJ's failure to note Mr. Rutherford's role in child care

was a significant error in his determination of Glass's credibility. An ALJ's mistake as to a fact on the record does not justify overturning a finding that is otherwise supported by substantial evidence. *Compare Hawkins v. Secretary of Health and Human Services*, Civil Case No. 89-1438, 1989 U.S. App. LEXIS 19091, *12 at n.1 (6th Cir. 1989) (unpublished) (finding an ALJ's reference to a non-existent negative test result was harmless error when the reference was made in a list of missing medical evidence) *and Diorio v. Heckler*, 721 F.2d 726, 728-29 (11th Cir. 1983) (finding ALJ's incorrect statements about a claimant's age and work history harmless error when ALJ used correct age and history in Medical-Vocational analysis and when the Medical-Vocational guidelines were superfluous to the disability determination) *with Berryhill v. Shalala*, Civil Case No. 92-5876, 1993 U.S. App. LEXIS 23975, *20-22 (6th Cir. 1993) (finding that Appeals Council's decision that a claimant's $50 per month rent offset was unearned income was not based on substantial evidence and was not harmless error when it affected the amount of the benefit the claimant was entitled to receive). It is submitted, however, that here there is not other substantial evidence to support the ALJ's determination on Glass's credibility.

D. <u>Use of Medical-Vocational Guidelines</u>

Finally, Glass contends that the ALJ incorrectly relied on

Rule 202.20, Appx. 2, Subpart P, Regulations No. 4, (the Medical-Vocational Guidelines) in reaching his decision to deny Glass benefits. The ALJ notes in his decision:

> **The Medical-Vocational Guidelines may be used to direct an unfavorable decision only if the claimant has the exertional residual functional capacity to perform substantially all (as defined in Social Security Ruling 83-11) of the seven primary strength demands required by work at the given level of exertion (As defined by Social Security Ruling 83-10) and there are no nonexertional limitations.**

(R. at 20.) When exertional as well as non-exertional limitations are present, the Medical-Vocational Guidelines provide a framework for decision but may not be used to direct a finding of "not disabled." 20 C.F.R. 404.1569a(d) (Subpart P to Rule 4) (with mixed exertional and non-exertional limitations, "we will not directly apply the rules in appendix 2 unless there is a rule that directs a conclusion that you are disabled based upon your strength limitations; otherwise the rules provide a framework to guide our decision").

In this case, no medical-vocational expert testified at the hearing; instead, the ALJ followed the Medical-Vocational Guidelines to take administrative notice that a significant number of light-duty jobs, suitable to Glass's exertional limitations, existed in the national economy. (R. at 20.) Glass submits that there is uncontroverted evidence of both mental and environmental

non-exertional limitations, and, accordingly, that the medical-vocational guidelines should not have been used to direct an unfavorable decision without the benefit of expert testimony. (R. at 17.)

The ALJ's use of Rule 202.20 implies a finding that Glass was substantially free of non-exertional limitations. See 20 C.F.R. 404, Appx. 2, Subpt. P, Table 2 and R. at 20. The treating and RFC medical source statements, however, specify non-exertional limitations that the ALJ did not discuss, which could be outcome-dispositive.

Dr. Lavley, in the RFC, opined that Glass should "avoid concentrated exposure" to "fumes, odors, dusts, gases, poor ventilation, etc." (R. at 126.) Dr. Grogan, a treating physician, specifically placed limitations on Glass's exposure to temperature extremes, dust, humidity and wetness, and fumes, odors, chemicals, and gasses. (R. at 197.) He related these limitations to "severe chronic respiratory disease." (*Id.*) Dr. Grogan's findings appear to be supported by diagnostic testing, (R. at 139), uncontroverted by Dr. Lavley's assessment, (*see* R. at 126), and therefore at least material and potentially dispositive of limitations on the number of jobs Glass could perform in the national economy, *see* 20 C.F.R. 404.1527(d)(2) ("If we find that a treating source's opinion on the issue(s) of the nature and severity of your impairment(s) is

well-supported by medically acceptable clinical and laboratory diagnostic techniques and is not inconsistent with the other substantial evidence in your case record, we will give it controlling weight.").

In light of the complex combination of Glass's multiple conditions, her apparent lack of transferable skills, her mental limitations, and her potential environmental limitations, it is submitted that the ALJ should not have relied on the Medical-Vocational Guidelines without the benefit of expert testimony. See 20 C.F.R. 404.1566(d)(5)(E) ("If the issue in determining whether you are disabled is whether your work skills can be used in other work and the specific occupations in which they can be used, or there is a similarly complex issue, we may use the services of a vocational expert or other specialist").

CONCLUSION

For the foregoing reasons, it is submitted that the cause should be remanded.

Respectfully submitted this 3rd day of June, 2003,

DIANE K. VESCOVO
UNITED STATES MAGISTRATE JUDGE