IP 01-1220-C T/F Cline v. Barnhart
Judge John D. Tinder Signed on 8/16/02

NOT INTENDED FOR PUBLICATION IN PRINT

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF INDIANA
INDIANAPOLIS DIVISION

CLINE, CHARLES A,	)	
	)	
Plaintiff,	)	
vs.	)	
	)	
BARNHART, JO ANNE B	)	CAUSE NO. IP01-1220-C-T/F
COMMISSIONER OF SSA,	)	
	)	
Defendant.	)	

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UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF INDIANA
INDIANAPOLIS DIVISION

CHARLES A. CLINE,	)	
	)	
Plaintiff,	)	IP 01-1220-C-T/F
	)	
vs.	)	
	)	
JO ANNE B. BARNHART,	)	
Commissioner of Social Security,	)	
	)	
Defendant.	)	

ENTRY REVIEWING COMMISSIONER'S DECISION[1]

Plaintiff requests judicial review of the final decision of the Commissioner of Social Security ("Commissioner") denying his application for Disability Insurance Benefits ("DIB") under Title II of the Social Security Act (the "Act"). The court rules as follows.

I. BACKGROUND

Plaintiff, Charles A. Cline, applied for DIB on May 6, 1998, alleging disability since December 22, 1997. (R. at 206-08.) The Agency denied Plaintiff's application initially (R. at 181), and again on reconsideration. (R. at 182-91.) The Administrative Law Judge ("ALJ"), James Norris, held a hearing on December 14, 1999 (R. at 45-73), and, on

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[1]This Entry is a matter of public record and is being made available to the public on the court's website, but it is not intended for commercial publication either electronically or in paper form. Although the ruling or rulings in this Entry will govern the case presently before this court, this court does not consider the discussion in this Entry to be sufficiently novel or instructive to justify commercial publication or the subsequent citation of it in other proceedings

January 5, 2000, the ALJ found that, despite his impairments, Plaintiff was capable of performing a significant number of jobs in the economy at the light level. (R. at 35-36.) Therefore, the ALJ denied Plaintiff's DIB claim. (R. at 32-40.) The Appeals Council denied Plaintiff's request for review and the ALJ's decision became the final decision of the Commissioner. (R. at 6-7.)

A. Plaintiff's Testimony

Plaintiff was born on December 3, 1949, and was fifty years old at the time of the ALJ's decision. He completed the tenth grade, and his past relevant work consisted of being a pipe-fitter and city superintendent. (R. at 48-49.)

Plaintiff stated that he last worked as a pipe-fitter on December 22, 1997. (R. at 48.) He testified that he was no longer able to work because of leg and back pain. (R. at 48-49.) He further stated that bending and climbing stairs were painful, and he was having trouble with his balance. (R. at 57.) Plaintiff testified that he could stand for ten minutes, but walk for a longer period of time. (R. at 58.) He also stated that he experienced diarrhea and stomach cramps. (R. at 65.)

Plaintiff stated that Dr. Subareddy Puchalapalli, his treating physician, limited him to lifting five pounds, and prohibited him from bending, pushing or pulling. (R. at 59.) According to Plaintiff, Dr. Puchalapalli did not limit his walking or standing. (R. at 60.)

Plaintiff testified that he was taking Coumadin (a blood thinner) for his heart condition. He stated that he used to get epidural injections that would negate is back pain for six to eight months at a time, but that he could no longer get them after he started taking the blood thinner. (R. at 55.) Plaintiff testified that this was because the blood thinner adversely interacted with the injections, and that if he stopped taking the blood thinner, he would have another heart attack. (*Id*.) He further testified that he was taking the narcotic OxyContin, the anti-depressant Celexa, a tincture[2] of opium for pain, the sleeping aid Vistaril, the muscle relaxer Soma, the diuretic Lasix to prevent swelling in the legs, and Zantac for his stomach problems. (R. at 63.)

B. Medical Evidence

Six months prior to Plaintiff's onset of disability, on June 27, 1997, Dr. James A. Trippi examined Plaintiff in a follow-up examination to Plaintiff's May 1997 heart attack and angioplasty. (R. at 359-62.) Plaintiff told the doctor that he felt fine, and in addition, had returned to work less than one week after having a stent[3] placed in one of his arteries in order to improve blood flow to his heart. (R. at 360.) Plaintiff reported no signs of pain or shortness of breath, although his stamina was not what it used to be. He had resumed

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[2]"An alcoholic or hydroalcoholic solution prepared from vegetable materials or from chemical substances; most tinctures are prepared by percolation or by maceration." Stedman's Medical Dictionary (hereinafter "Stedman's") 1815 (26th ed. 1995).

[3]"Slender thread, rod, or catheter, lying within the lumen of tubular structures, used to provide support during or after their anastomosis, or to assure patency of an intact but contracted lumen." Stedman's 1674.

smoking ten cigarettes per day. (*Id*.) Dr. Trippi noted that Plaintiff took Prozac, Lasix, Zantac, Aspirin, and Zocor. The doctor also recommended that Plaintiff refrain from greater than ordinary activity. (R. at 361.)

Upon examination, Dr. Trippi reported that Plaintiff was obese, but appeared to be in no acute distress. (R. at 361.) He also reported no spinal tenderness, and no abnormality in the rate or rhythm of Plaintiff's heart. (R. at 360.) Plaintiff's abdomen was non-tender, and his bowel sounds were normal. (R. at 361.) Examination of Plaintiff's arms and legs revealed normal peripheral pulses and gait, and no clubbing, edema,[4] or cyanosis.[5] (*Id*.) The doctor's assessment was coronary artery disease, tobacco habituation, history of probable hypercoagulability,[6] history of deep vein thrombosis,[7] obesity, gastroesophageal reflux, and depression. (R. at 362.)

Dr. Michael F. Coscia, an orthopedic specialist, examined Plaintiff on August 29, 1997. (R. at 368-73.) First, he noted Plaintiff's complaint of intermittent back pain that began in 1972, but became unbearable in March 1996, causing him to undergo an L4-5 left -sided microdiscectomy for disc herniation. Plaintiff stated that he felt relief for three

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[4]"An accumulation of an excessive amount of watery fluid in cells, tissues, or serous cavities." Stedman's 544.

[5]"A dark bluish or purplish coloration of the skin and mucous membrane due to deficient oxygenation of the blood, evident when reduced hemoglobin in the blood exceeds 5 g per 100 ml." Stedman's 425.

[6]"Abnormally increased coagulation." Stedman's 823.

[7]"Formation or presence of a thrombus; clotting within a blood vessel which may cause infarction of tissues supplied by the vessel." Stedman's 1809.

months after the surgery, but complained that he had again been experiencing incapacitating lower back pain, but no leg pain. Dr. Coscia noted that Plaintiff had been taking Coumadin for many years for his chronic deep venous thrombosis. (R. at 368.) The doctor also noted that Plaintiff had a heart attack when he was taken off the blood thinner in order to undergo epidural injections for his back pain. (*Id*.)

Dr. Coscia stated that Plaintiff's medical problems were apparent hypercoagulopathy with two previous heart attacks, bilateral lower extremity deep venous thrombosis, chronic severe lower back pain, gastrointestinal sensitivity, and depression. (R. at 369.) His review of Plaintiff's gastrointestinal system was negative for nausea, vomiting, and diarrhea. (R. at 370.) The doctor also reviewed Plaintiff's cardiovascular system and found it negative for chest pain, palpitations, or tachycardia.[8] (*Id*.) His review of Plaintiff's neuromuscular system was negative for seizures, headaches, tingling, joint pain, and motor weakness. (*Id*.) The doctor further reported that Plaintiff had a slow, shuffling gait, and that Plaintiff could forward flex to thirty-five degrees before experiencing exacerbation of low back pain. (*Id*.) Straight leg raising was negative bilaterally to sixty degrees, at which point Plaintiff experienced low back discomfort.

Dr. Coscia further stated that x-rays of Plaintiff's lower back revealed moderate loss of intervertebral disc space height at L3-L4, L4-L5, and L5-S1. (R. at 371.) His diagnosis

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[8]"Rapid beating of the heart, conventionally applied to rates over 100 per minute." Stedman's 1758.

was L5-S1 grade one spondylolisthesis,[9] secondary to bilateral spondylolysis[10] with probable accompanying lateral recess spinal stenosis, L3-L4, L-L5, and L5-S1 marked disc dehydration, degenerative change with possible discogenic back pain, status post two heart attacks, chronic coagulopathy on long term Coumadin, and long term cigarette smoking history. (*Id*.) He recommended that Plaintiff not have back surgery, which would require Plaintiff to discontinue his use of blood thinners, and Plaintiff had experienced a heart attack when he had previously done so. (R. at 372.) The doctor also recommended that Plaintiff pursue disability and vocational retraining rather than return to working as a pipe-fitter. He also prescribed Tylox and a back brace to help alleviate Plaintiff's pain. (*Id*.)

On September 12, 1997, Plaintiff had a follow-up examination with Dr. Anna Zimmerman. (R. at 376.) She reported that Plaintiff was discouraged about his health conditions, but was not clinically depressed and denied needing Prozac. Dr. Zimmerman refilled Plaintiff's Tylox prescription. (*Id*.)

On April 22, 1998, Plaintiff underwent a neurological evaluation. (R. at 428.) Dr. Petronio M. Illagan noted Plaintiff's complaints of dizziness and visual disturbance. However, the doctor reported that Plaintiff had no problems with articulation, swallowing,

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[9]"Forward movement of the body of one of the lower lumbar vertebrae on the vertebra below it, or upon the sacrum." Stedman's 1656.

[10]"Degeneration or deficient development of the articulating prat of a vertebra." *Id.* 1656.

facial movements, or proprioception,[11] and denied bowel incontinence. Dr. Illagan reported that Plaintiff had a wide-based gait, and exhibited difficulty and clumsiness with rapid alternating movements. The doctor's impression was of brain stem infarct.

Dr. Illagan examined Plaintiff again on May 12, 1998, and reported that Plaintiff had his first onset of a seizure disorder. (R. at 427.) Plaintiff was admitted to the emergency room after having generalized tonic clonic[12] convulsion. He stated that his right hand began shaking, and that he began breathing hard while watching television. Dr. Illagan prescribed Tegretol and recommended further testing. In accordance with Dr. Illagan's recommendation, Plaintiff underwent an electroencephalogram ("EEG") on May 15, 1998. (R. at 409.) The test revealed no slowing or epileptiform discharge. There was also no focal or generalized abnormality. Dr. Illagan's impression was of a normal EEG.

Plaintiff had a follow-up examination with Dr. Illagan on June 18, 1998. (R. at 427.) The doctor noted that Plaintiff had not had a seizure since his last examination. Dr. Illagan stated that Plaintiff was taking Tegretol because his brain infarct placed him at a higher risk for seizure activity. One month later, on July 16, 1998, Dr. Illagan noted that Plaintiff

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[11]"A sense of perception, usually at a subconscious level, of the movements and position of the body and especially its limbs, independent of vision; this sense is gained primarily from input from sensory nerve terminals in muscles and tendons (muscle spindles) and the fibrous capsule of joints combined with input from this vestibular apparatus." Stedman's 1439.

[12]"A form of movement marked by contractions and relaxations of a muscle, occurring in rapid succession seen with, among other conditions, spasticity and some seizure disorders." Stedman's 354.

was not having headaches, still had not had another seizure, and his dizziness seemed to be resolved. (R. at 452.)

Dr. Joseph Grady, a consultive examiner, examined Plaintiff on August 11, 1998. (R. at 428-433.) He first noted Plaintiff's history of low back pain and heart trouble. Plaintiff also stated that he had one possible episode of seizure activity in May 1998. The doctor then made note of Plaintiff's current complaints of occasional chest pain and lower back pain that did not radiate to his legs. Plaintiff also told Dr. Grady that he had a history of nausea, constipation, headaches, and knee pain. Dr. Grady then conducted a physical examination and noted that Plaintiff neither limped nor exhibited instability in his gait when walking without a cane. (R. at 430.) Plaintiff could stand on his heels and tiptoes, but could not tandem gait or squat. Plaintiff's heart had a regular rhythm, and his abdomen was soft and non-tender to palpation. Forward flexion of Plaintiff's spine was 50/90 degrees, with pain occurring upon flexion beyond fifty degrees. (R. at 431.) Plaintiff's arm and leg strength were normal, and there was no atrophy, tremor, or fasiculations. A straight leg rasing test in the supine and sitting positions produced no radicular symptoms. Dr. Grady also detected no obvious neurological deficits. He further stated that Plaintiff did describe some generalized tonic clonic movement, which Dr. Grady felt may have been seizure activity. His impression was a history of coronary artery disease with recurrent chest pain, which could possibly be angina, a history of reported stroke, a history of chronic lower back pain, and a history of deep venous thrombosis. (R. at 433.)

Dr. Howard E. Wooden, Ph.D., a consultive psychologist, evaluated Plaintiff's mental status on January 12, 1999. (R. at 462-64.) The doctor noted Plaintiff complained that he was frustrated, angry, and depressed because of his physical problems. (R. at 462.) Plaintiff also stated that his primary limitations and impediments to working were physical. Upon examination, Dr. Wooden determined that Plaintiff's depression was situational, but that it had existed long enough to satisfy the criteria for mild to moderate dysthymia.[13] (R. at 462.) The doctor's diagnostic impression also included a global assessment of functioning score of seventy.

On January 22, 1999, a State Agency reviewing physician reviewed the medical records to that date and assessed Plaintiff's functioning. (R. at 474-81.) The physician determined that Plaintiff could occasionally lift/carry twenty pounds, frequently lift/carry ten pounds, and stand/walk, and sit with normal breaks for six hours each in an eight-hour workday. The physician further determined that Plaintiff's ability to work at heights and around machinery was unlimited, and that Plaintiff needed to avoid concentrated exposure to extreme cold, heat, wetness and humidity.

On August 6, 1999, Dr. Michael M. Manbeck examined Plaintiff regarding his complaints of diarrhea and abdominal cramping. (R. at 166-67.) The doctor noted Plaintiff's claim that his symptoms had begun in January 1999, and a colonoscopy was

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[13]"A chronic mood disorder manifested as depression for most of the day, more days than not, accompanied by some fo the following symptoms: poor appetite or over-eating, insomnia or hypersomnia, low energy or fatigue, low self-esteem, poor concentration, difficulty making decisions, and feelings of hopelessness." Stedman's 536.

very unremarkable. The doctor also noted Plaintiff's assertion that he was having ten to twenty bowel movements per day, along with abdominal cramping. According to Dr. Manbeck, the lab findings showed that Plaintiff was positive for clostridium difficile.[14] Plaintiff also told Dr. Manbeck that he had been treated with medication for two weeks, which resolved his symptoms, but that the symptoms returned five days after he ended his medication. Upon completing a physical examination, Dr. Manbeck reported that Plaintiff's abdomen was soft and diffusely tender to light palpation, his extremities were without edema, and that he was neurologically intact. (R. at 167.) The doctor recommended that Plaintiff be treated with oral medication (Vancomycin) for one month. His impression was abdominal complaints and diarrhea secondary to clostridium difficile. (R. at 168.)

II. ARGUMENT

A. Standard of Review

The Social Security Act requires the reviewing court to accept the ALJ's findings of fact as conclusive, "so long as substantial evidence supports them and no error of law has occurred." *Dixon v. Massanari*, 270 F.3d 1171,1176 (7th Cir. 2001). Substantial evidence in this instance refers to such relevant evidence that a reasonable mind could

[14]"A species found in the feces of newborn infants; pathogenic for human beings, guinea pigs, and rabbits; frequent cause of colitis and diarrhea following antibiotic usage. Found to be a cause of pseudomembranous colitis and associated with a number of intestinal diseases that are linked to antibiotic therapy. It is also the chief cause of nosocomial diarrhea." Stedman's 354-55.

accept as adequate to support a conclusion. *Zurawski v. Halter*, 245 F.3d 881, 887 (7th Cir. 2001). Also, although the ALJ is not required to address every piece of evidence, he must clearly express a legitimate and logical reason for his decision. The ALJ must "build an accurate and logical bridge from the evidence to his conclusion." *Clifford v. Apfel*, 227 F.3d 863, 872 (7th Cir. 2000), *as amended*.

In addition, the court grants special deference to the credibility determinations made by the ALJ because he is in the best position to assess the credibility of witnesses. *Nelson v. Apfel*, 131 F.3d 1228, 1237 (7th Cir. 1997). Therefore, the court will reverse these determinations only if the claimant can show that they were "patently wrong." *Powers v. Apfel*, 207 F.3d 431, 435 (7th Cir. 2000). Finally, although the reviewing court is at liberty to review the record in its entirety, it does not re-weigh evidence, substitute its judgment for that of the ALJ, or decide the facts anew. *Butera v. Apfel*, 173 F.3d 1049, 1055 (7th Cir. 1999).

B. Analysis

A claimant must prove that he suffers from a "disability",[15] as it is defined by the Act, in order to qualify for disability benefits. The ALJ performs a five-step inquiry in order to determine whether a claimant is disabled. This inquiry includes determining: (1) whether a

[15]Disability is defined as "the inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than twelve months." 42 U.S.C. § 423(d)(1)(A).

claimant is engaged in work activity which is both substantial and gainful within the past twelve months; (2) whether a claimant's impairment significantly limits his/her physical or mental ability to do basic work activities, thus constituting a severe impairment; (3) whether a claimant has an impairment which meets or equals those listed in the Listing of Impairments; (4) whether a claimant is unable to perform past relevant work; and (5) whether a claimant is able to engage in other work existing in significant numbers in the economy. 20 C.F.R. § 404.1520(b)(c)(d)(e)(f).

The ALJ first determined that Plaintiff had not engaged in any substantial gainful activity since his onset date. Next, the ALJ determined that Plaintiff had "severe" impairments consisting of coronary artery disease with a history of myocardial infarctions which required angioplasty and a stent, a history of deep venous thrombosis, lumbar disc disease with a history of surgery, lumbar spondylolisthesis, and a history of a seizure disorder. He determined that Plaintiff's chronic diarrhea was not severe because it did not have a medically determinable etiology. He also determined that Plaintiff's depression was not severe under the Act. (R. at 30.) At step three, the ALJ determined that none of the claimant's impairments, singly or in combination, met or equaled the criteria of any of the impairments listed in the Listing of Impairments. (R. at 31.) At step four, the ALJ determined that Plaintiff had a residual functional capacity ("RFC") to perform light work, which involves frequently lifting or carrying objects up to ten pounds maximum weight with occasional lifting of twenty pounds. 20 C.F.R. § 404.1567(b). The ALJ also imposed some environmental restrictions on Plaintiff's RFC. (R. at 31-32.) The ALJ found that

Plaintiff's past relevant work was classified as heavy to very heavy work, and light skilled work with no transferable skills. Since Plaintiff was restricted to light work and did not have a high school education, the ALJ found that he could not return to his past relevant work. (R. at 20.) Finally, the ALJ determined that there were a significant number of jobs in the economy available to the Plaintiff. (R. at 33-34.)

Plaintiff appeals this decision on several grounds, contending that: (1) the ALJ erred in evaluating Plaintiff's seizure disorder; (2) the ALJ erred in not recognizing Plaintiff's medications as evidence of severe pain; (3) the ALJ erred when evaluating Plaintiff's non-medicinal treatments; (4) the ALJ erred in playing doctor when deciding whether or not Plaintiff suffered from muscle atrophy; (5) the ALJ erred in not re-contacting Plaintiff's treating physician, Dr. Puchalapalli; (6) the ALJ erred when evaluating Plaintiff's ability to stand and walk; (7) the ALJ erred when evaluating Plaintiff's ability to stoop; (8) the ALJ erred in neglecting to obtain testimony from a medical expert, specifically citing Social Security Ruling ("SSR") 96-6p; (9) the ALJ erred in neglecting to mention Plaintiff's obesity; (10) the ALJ erroneously evaluated Plaintiff's diarrhea; and (11) the ALJ erred when evaluating Plaintiff's mental condition. The court will now address these issues.

1. The ALJ Erred In Evaluating Plaintiff's Seizure Disorder

As previously stated, it is not the job of the reviewing court to decide the facts anew, but it must be able to say that the evidence is such that a reasonable mind would find the evidence substantial enough to reach the ALJ's conclusion. The reviewing court is unable

to do so when it cannot be certain whether the ALJ considered all the relevant evidence. *See Zblewski v. Schweiker*, 732 F.2d 75, 78-79 (7th Cir. 1984) (""In the absence of an explicit and reasoned rejection of an entire line of evidence, the remaining evidence is 'substantial' only when considered in isolation.").

Plaintiff contends that the ALJ erroneously evaluated his seizure disorder. In his report, the ALJ's sole recognition of Plaintiff's seizure disorder was to state that it qualified as a "severe" impairment as defined under the Act.[16] The functional restrictions placed on Plaintiff's ability to perform light work do not take into account this severe impairment. For example, the ALJ in no way limits Plaintiff's access or exposure to heights or machinery.

The Commissioner argues that Plaintiff's use of Tegretol to control the seizures, the fact that he had not experienced any seizures after his initial episode, and the fact that an EEG showed normal results, indicate that the ALJ sufficiently considered the Plaintiff's seizures when rendering his decision and calculating the RFC. However, as previously stated, the ALJ's only mention of Plaintiff's seizure disorder was in classifying it as a severe restriction. He did not refer to the disorder again in his report, nor did he articulate why he felt that the seizures were no longer a concern. Therefore, the court cannot say that the ALJ built a logical bridge between the evidence and his conclusion that Plaintiff has an

[16]That is, of course, assuming that the ALJ did not simply ignore the MRI and the findings of Dr. Campbell. This court has no way of determining if either were even considered. The ALJ, however, deserves the benefit of the doubt, and the court assumes that the evidence was diligently reviewed, but that a discussion of it was mistakenly left out of the decision.

RFC to perform light work with the only restrictions being an avoidance of extreme heat, cold, and humidity and in addition, whether there was substantial evidence supporting the ALJ's decision.

2. The ALJ Erred In Not Recognizing Plaintiff's Medications As Evidence Of Severe Pain

Plaintiff next contends that the ALJ erroneously evaluated his use of medication. An ALJ should consider medications when determining the extent and severity of a claimant's pain and disability. 20 C.F.R. § 404.1529. The only reference to Plaintiff's pain medications in the ALJ's report states that, "the claimant does not take the kind nor quantity of medication associated with a severe pain syndrome." (R. at 33.) However, in this case, Plaintiff used a variety of narcotics (including Oxycontin, Darvocet, Duragesic, Tylenol with codeine, Tylox, and Vicodin)[17] to control his pain.

The Commissioner argues that the fact that Plaintiff's pain was alleviated by these narcotics proves that his pain was not a severe impairment. However, this argument fails to recognize the fact that the necessity of powerful pain relievers in order to obtain pain relief is a strong indicator that the claimant experiences severe, debilitating pain. It is

[17]All of these medications are habit forming and produce many side effects. In addition, OxyContin carries the same addiction risks as morphine, Darvocet also carries a warning of addiction, and Duragesic is restricted to use for acute pain that cannot be managed by other medications. Physician's Desk Reference 517, 1786, 1907, 2595, 2597, 2912 (56th ed. 2002).

imperative for the ALJ to cite valid reasons for his opinion that Plaintiff's multiple pain medications do not infer a severe pain disorder.

3. The ALJ Erred When Evaluating Plaintiff's Non-Medicinal Treatments

Plaintiff next contends that the ALJ erred in not recognizing that, due to his conditions and medications, Plaintiff's other treatment options were limited. When evaluating Plaintiff's medical condition, the ALJ should consider treatment other than medication when making a disability determination. 20 C.F.R. § 404.1529(c)(3)(v). The only indication that the ALJ considered alternative treatments is the vague phrase, "As to treatment, the claimant has received appropriate treatment for his impairments and his condition has responded to treatment." (R. at 33.) The ALJ does not recognize that the other appropriate treatment for Plaintiff's back problems, epidural injections and spinal fusion, were not available as a result of Plaintiff's use of the blood thinner Coumadin to control his deep vein thrombosis. In order to utilize these treatments, Plaintiff would have had to discontinue his use of Coumadin, which was not a feasible option because without the drug, Plaintiff was very likely to suffer another heart attack. Consequently, the only alternative was pain management by prescription narcotics. As stated before, though the ALJ need not address every piece of evidence, he should, nonetheless, articulate his reasons for discounting a major line of evidence such as Plaintiff's inability to explore avenues of treatment which did not include pain medicines. *See Garfield v. Schweiker*, 732 F.2d 605, 610 (7th Cir. 1984).

4. The ALJ Erred in Playing Doctor When Deciding Whether Or Not Plaintiff Suffered From Muscle Atrophy

Plaintiff also asserts that the ALJ did not rely on any medical authority when determining whether or not Plaintiff suffered from muscle atrophy. An ALJ may not play doctor and substitute his own opinion for that of a physician, or make judgements that are not substantiated by objective medical evidence. *Rohan v. Chater*, 98 F.3d 966, 970-71 (7th Cir. 1996). The ALJ needs to articulate why he feels that Plaintiff does not suffer or show signs of muscle atrophy so the court may properly review this decision.

5. The ALJ Erred In Not Re-Contacting Plaintiff's Treating Physician

20 C.F.R. § 404.1512(e)(1) provides that when the evidence received from a treating physician or psychologist or other medical source is inadequate to determine whether a claimant is disabled, the ALJ should re-contact a claimant's treating physician. In this case, there was discrepancy between Dr. Puchalapalli's reports submitted to the ALJ and the recommendations that the doctor made to the Plaintiff. Additionally, Dr. Puchalapalli did not complete an RFC assessment. The method of adjudicating social security claims requires the ALJ to order additional tests if necessary to render an informed disability determination. *Steele v. Barnhart*, 290 F.3d 936, 941 (7th Cir. 2002).

The Commissioner argues that it is the Plaintiff's duty to ask the treating physician for additional records. Defendant cites *Glenn v. Secretary of Health and Human*

Services, 14 F.2d 387, 391 (7th Cir. 1987), for the proposition that a "claimant who is represented by counsel is assumed to have presented his strongest case for benefits." (Def.'s Br. at 15.) However, it is the ALJ's duty to fully develop the record. *Chapman v. Barnhart*, 189 F. Supp. 2d 795, 803 (N.D. Ill. 2002) (describing as a well-settled proposition that "[i]t is a basic obligation of the ALJ to develop a full and fair record.") (quotation omitted). In this case, that duty extends to re-contacting the treating physician if more information is needed. The Commissioner also argues that there is a need to re-contact a treating physician only if "the source's evidence is inadequate to make a determination as to disability." (Def.'s Br. at 15.) However, Dr. Puchalapalli's report did not include an RFC finding, nor did he mention the limitations on lifting about which Plaintiff testified. In order for the ALJ to make an informed decision regarding Plaintiff's RFC and the extent of his physical limitations, the ALJ should re-contact Dr. Puchalapalli and request a more complete report as to Plaintiff's impairments and limitations.

6. The ALJ Erred When Evaluating Plaintiff's Ability To Stand And Walk

Plaintiff next asserts that the ALJ erroneously evaluated Plaintiff's ability to stand and walk. In his report, the ALJ states that there are "no significant objective findings to justify the imposing of any marked restrictions upon the claimant's activities." (R. at 33.) Consequently, the ALJ did not impose any restrictions on Plaintiff's ability to stand and walk when he calculated Plaintiff's RFC. However, there is objective medical evidence in the record that indicates that Plaintiff was limited in his ability to stand and walk. Plaintiff's

treating physician, Dr. Puchalapalli, reported that Plaintiff's ability to walk was limited, and also reported that Plaintiff had severe ataxia,[18] including an unsteady gait. (R. at 413-14, 420.) In addition, Dr. Illagan noted that Plaintiff had a wide based gait and positive Romberg's signs.[19] (R. at 428.)

The Commissioner cites contrary evidence that states that reviewing physicians opined that Plaintiff was able to stand/walk for six hours in an eight-hour workday, and that Dr. Grady noted Plaintiff did not limp, exhibit instability in his gait, and that his legs appeared normal. Similarly, the Commissioner notes that Dr. Puchapalli stated Plaintiff's muscle strength and deep tendon reflexes in his legs were normal and he had no need of assistive devices. (Def.'s Br. at 17.) Though this might be true, it is up to the ALJ to weigh the conflicting evidence and determine the weight to impart on each side. The ALJ should articulate his reasons for dismissing a line of evidence and stating that there were no significant medical findings justify any restrictions upon Plaintiff's ability to stand or walk.

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[18]"An inability to coordinate muscle activity during voluntary movement, so that smooth movements occur. Most often due to disorders of the cerebellum or the posterior columns of the spinal cord; may involve the limbs, head, or trunk." Stedman's 161.

[19]"A swaying of the body or falling when standing with feet close together and the eyes closed. . .." Dorland's Illustrated Medical Dictionary 1526 (28th ed. 1994).

7. The ALJ Erred When Evaluating Plaintiff's Ability To Stoop

Plaintiff next contends that the ALJ erroneously evaluated his ability to stoop. Light work involves stooping occasionally. In his RFC calculation, the ALJ placed no limitations on Plaintiff's ability to stoop, even though Dr. Grady found that Plaintiff was limited to bending forward 50/90 degrees. Full range of motion is 90/90. (R. at 433.) The ALJ deserves the benefit of the doubt, and the court assumes that Dr. Grady's report was reviewed, but that a discussion of it was mistakenly left out of the decision. Again, an ALJ is not required to address every piece of evidence, but he is required to articulate his reasons for not addressing an important line of evidence. *Clifford v. Apfel*, 227 F.3d 863, 872 (7th Cir. 2000), *as amended*.

The Commissioner argues that Plaintiff should not be restricted in stooping because "even if Plaintiff experienced pain with stooping beyond 50 degrees, Plaintiff's medication helped control pain, and light work requires only occasional stooping." (Def.'s Br. at 17.) Even though light work involves only occasional stooping, if Plaintiff is unable to stoop at all, Plaintiff will be unable to perform light work. In this case, the ALJ should articulate his reasons for ignoring Dr. Grady's report and imposing no restrictions on Plaintiff's stooping.

8. The ALJ Erred In Not Obtaining Testimony From A Medical Expert

Plaintiff contends that the ALJ erred when he did not obtain testimony from a medical expert. Plaintiff cites SSR 96-6p, which states that an ALJ is required to obtain an updated medical opinion from a medical expert if it appears that the Plaintiff may medically equal one of the Listings.

At the hearing, the ALJ stated: "Well, I agree with you, I think that he, Mr. Cline probably meets or equals any of the Listings. I know he can't, well, he can equal, but you don't have the medical opinion, but I, I have a little problem with meeting the listing, but I will certainly look at everything." (R. at 73.) This statement is confusing and unclear, but the Commissioner interpreted it to mean that the ALJ was informing the Plaintiff of the possibility that his impairments "could" equal a listed impairment, not that he thought it was reasonable in light of the medical evidence. (Def.'s Br. at 11.) The court assumes that the Commissioner interpreted the statement in a light most favorable to the defense, so the court will adopt the Commissioner's interpretation. In its context, the statement by the ALJ that the Plaintiff "could" equal a listed impairment raises a reasonable inference that the ALJ was of the opinion that a finding of equivalence was reasonable. Thus, the ALJ should consult a medical expert to determine if Plaintiff's impairments, do in fact equal a Listing. This will allow the ALJ to make an informed decision of Plaintiff's disability. *See Green v. Apfel*, 204 F.3d 780, 781 (7th Cir. 2000) ("the procedure for adjudicating social security disability claims departs from the adversary model to the extent of requiring the administrative law judge to summon a medical expert if that is necessary to provide an informed basis for determining whether the claimant is disabled.").

9. The ALJ Erred In Not Mentioning Plaintiff's Obesity

Plaintiff next contends that the ALJ failed to take into account Plaintiff's obesity when he determined that Plaintiff's impairments did not meet or equal any of the Listings of Impairments, and when calculating Plaintiff's RFC. More specifically, Plaintiff cites SSR 00-3p and *Clifford v. Apfel*, 227 F. 3d 863, 873 (7th Cir. 2000), for the contention that the ALJ must evaluate whether obesity intensifies the severity of a claimant's impairments. "[T]he provisions [of SSR 00-3p] also remind adjudicators that the combined effects of obesity with other impairments can be greater than the effects of each of the impairments considered separately." *Castrejon v. Apfel*, 131 F. Supp. 2d 1053, 1057 (E.D. Wis. 2001) (quoting SSR 00-3p). Thus, the ALJ needs to articulate that he considered the evidence in the record regarding Plaintiff's obesity and the combined effects of his obesity with his other impairments.

10. The ALJ Erred In Not Addressing Plaintiff's Diarrhea

Plaintiff also contends that the ALJ erroneously evaluated Plaintiff's diarrhea. The ALJ states in his ruling that, "The claimant also complained of chronic diarrhea, but since this condition has no medically determinable etiology, it may not be considered a 'severe' impairment under the authority of SSR 96-3p." (R. at 30.) But Dr. Manbeck reported that Plaintiff's diarrhea was due to clostridium difficile, so the ALJ's conclusion is unsupported by the record. The Commissioner argued that since the diarrhea was not expected to last for at least twelve months, it did not meet the statutory duration requirement in any event.

(Def.'s Br. at 19-20.) Though this may be true, the ALJ himself needs to address this evidence in his decision.

11. The ALJ Erroneously Evaluated Plaintiff's Mental Disorder

Finally, Plaintiff contends that the ALJ did not acknowledge and evaluate his treating physician's diagnosis of "severe" depression. Though the ALJ addressed Plaintiff's mental disorder, he only mentions the testimony of two state agency physicians who determined that Plaintiff had mild to moderate dysthymia and did not have a severe mental impairment. (R. at 30.) Generally, treating physicians' opinions are given more weight since, "they are likely to be the medical professionals most able to provide a detailed, longitudinal picture of the claimant's medical impairment(s)." 20 C.F.R. 404.1527(d)(2). Dr. Puchalapalli stated that Plaintiff suffers "severe depression due to chronic back pain," and is "unable to resume work." (R. at 450.) He also prescribed Plaintiff Zoloft, an anti-depressant. (*Id*.) The ALJ needs to articulate why he apparently discounted the treating physician's diagnosis of severe depression.

III. CONCLUSION

For the foregoing reasons, the final decision of the Commissioner of Social Security in this case is **REVERSED** and this case is **REMANDED** pursuant to sentence

four of 42 U.S.C. § 405(g) for proceedings consistent with this Entry to allow the ALJ to evaluate the evidence and articulate how this evidence affects the disability determination.

ALL OF WHICH IS ORDERED this 16th day of August 2002.

_____
John Daniel Tinder, Judge
United States District Court

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