NA 06-0127-C h/h Cunningham v. Astrue
Judge David F. Hamilton Signed on 6/15/07

NOT INTENDED FOR PUBLICATION IN PRINT

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF INDIANA
NEW ALBANY DIVISION

RANDELL B. CUNNINGHAM,	)	
	)	
Plaintiff,	)	
vs.	)	NO. 4:06-cv-00127-DFH-WGH
	)	
LINDA S. MCMAHON,	)	
	)	
Defendant.	)	

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF INDIANA
NEW ALBANY DIVISION

RANDELL B. CUNNINGHAM, Plaintiff, v. MICHAEL J. ASTRUE,[1] Commissioner of Social Security, Defendant.	)	CASE NO. 4:06-cv-0127-DFH-WGH

ENTRY ON JUDICIAL REVIEW

Plaintiff Randell B. Cunningham seeks judicial review of a final decision by the Commissioner of Social Security denying his application for disability insurance benefits and for supplemental security income under the Social Security Act. Mr. Cunningham has a long history of back problems, including four surgeries between 1988 and 1992. The surgeries and many other therapies have offered only limited relief from serious pain. After hearing conflicting evidence that might reasonably have supported a finding of total disability or a contrary finding, an Administrative Law Judge ("ALJ") determined for the Commissioner that Mr. Cunningham had a severe impairment due to his lower

[1]Michael J. Astrue took office as Commissioner of the Social Security Administration while Mr. Cunningham's case was pending before the court. Commissioner Astrue is substituted as the defendant in this action pursuant to Rule 25(d)(1) of the Federal Rules of Civil Procedure.

back pain and obesity but was still able to perform a significant range of sedentary work. As explained below, the key issue is the severity of Mr. Cunningham's pain and the credibility of his account of that pain. In weighing and discounting Mr. Cunningham's credibility, the ALJ improperly relied on Mr. Cunningham's failure to use narcotic and opiate pain medications. In fact, the record shows that Mr. Cunningham is allergic to those medicines. The ALJ also discounted his credibility because of his lack of hospitalization or emergency room visits, but the ALJ's reliance on that lack also was not reasonable. The case therefore must be remanded for further consideration.

Background

Mr. Cunningham was born in 1962 and was 44 years old when the ALJ denied benefits under the Social Security Act. He has a seventh grade education and has previously worked as a floor installer, carpenter, and construction worker. He alleges that he has been disabled since October 17, 2003, due to debilitating low back pain.

I. *Medical Evidence*

On June 30, 1988, Mr. Cunningham fell from a roof while working and injured his back. Mr. Cunningham underwent four surgeries in an attempt to correct his back problems and alleviate his pain. In his first operation on May 19, 1989, Dr. John P. Schmitz, performed an L5-S1 diskectomy. R. 154. Dr. Schmitz

discovered that Mr. Cunningham had "severe disc herniation at L 5, S 1 with part of the disc almost being a liquidly gelatinous type material." In his second operation on September 27, 1990, Dr. Schmitz and Dr. Hoblitzell performed a diskectomy and foraminotomy. R. 157. In his third operation on November 14, 1990, Dr. Schmitz performed an L5-S1 diskectomy and removed scar tissue around the nerve root. R. 161. Dr. Schmitz also performed a bilateral, lateral, and facet joint L5-S1 fusion, using right autogenous iliac bone, Steffe plates, and screws. R. 161. In his final operation on November 14, 1992, the EBI bone simulator was removed to alleviate Mr. Cunningham's pain. R. 163.

In 1997, Mr. Cunningham re-injured his back in a car accident. R. 165. On March 20, 1997, Dr. Schmitz reported that "Mr. Cunningham had multiple blunt trauma and does not have anything that should prevent him from getting better." R. 164. Dr. Schmitz reached a different conclusion when Mr. Cunningham failed to get better. Dr. Schmitz reported on May 1, 1997, that Mr. Cunningham was "going to have to live with his condition" because therapy did not help him and he could not take anti-inflammatory pain medication because of his bleeding ulcers. R. 164. Dr. Ellen Ballard reached a similar conclusion on August 8, 1997.[2] She opined that "it is unlikely, given his previous back problems that he would ever be rehabilitated to a pain free non work restricted state and

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[2]Dr. Ballard's letter indicates that Mr. Cunningham is allergic to both morphine and codeine. Subsequent medical records also indicate this allergy. R. 176, 189, 210, 233, 235, 238, 239, 240,241, 242, 252, 256, 258.

physical therapy may be contraindicated given his lower back condition." She also thought that "his best treatment may well be time." R. 179.

After Mr. Cunningham applied for Social Security disability benefits, he was examined on March 15, 2004, Dr. Mehmet Akaydin, a state agency physician. R. 181-87. Mr. Cunningham reported constant back pain that forced him to remain in his "bedroom all the time just laying [sic] in bed . . . ." Dr. Akaydin noted that Mr. Cunningham was "an alert and oriented and extremely pleasant, polite, personable and cooperative young man in no acute distress." Mr. Cunningham walked in "a somewhat slow and deliberate fashion" but without the aid of an assistive device. He was able to squat one-third of the way down and to stand back up as well as to get on and off the exam table. Dr. Akaydin examined Mr. Cunningham's back and reported that his spine was tender to palpitations but that he did not exhibit "overt willing, warmth, erythema, or spasms . . . ." After performing a neurological examination, Dr. Akaydin reported "no overt neurological/sensory abnormalities/deficits of any kind at present time."

Dr. Akaydin performed several musculoskeletal examinations and range of motion tests. He reported that Mr. Cunningham had "Normal muscle tone and bulk throughout (solid) without any evidence of muscle atrophy or spasm . . . ." R. 184. He was "easily able to pick up coins, grasp objects of various size, button and unbutton articles of clothing, open and close the exam room door, make a complete fist and touch thumb to all fingertips with both hands without any overt

difficulty whatsoever." He was also "able to pick up and hold a pen with both hands and write with his dominant hand satisfactorily." Dr. Akaydin also examined Mr. Cunningham's range of motion. Mr. Cunningham had a lumbar spine "forward flexion at 25 degrees" while his lateral flexion was "very slow and deliberate with subjective discomfort."

Dr. Akaydin concluded that Mr. Cunningham was "grossly intact for the most part in an overall general cognitive/intellectual, physical, neurological and orthopedic sense . . . ." R. 185. He indicated that Mr. Cunningham had no "overt major limiting deficits of any kind being readily appreciated except for the subjective discomfort to firm gentle palpation throughout his lower mid-line lumbar region . . . ." Dr. Akaydin believed that "Vocational Rehabilitation (or similar re-training program) would still be an excellent opportunity for this generally healthy and quite solid young man . . . ." The type of employment would need to be "relatively sedentary and 'sit-down' type nature" and "less physically strenuous and demanding than his previous work." Dr. Akaydin discouraged "employment requiring more than occasional lifting of any objects weighing more than 5-10 lbs . . . ."

On March 25, 2004, Dr. Michael Ryan examined Mr. Cunningham. Dr. Ryan described Mr. Cunningham's pain as "severe" and further explained that "all treatment modalities have been exhausted." R. 196-97. He also believed that Mr. Cunningham's condition would not improve with regular medical care such that

he could participate in gainful employment. He reported indefinite functional limitations for all activities.

On April 15, 2004, Dr. T. Crawford, a state agency physician, evaluated Mr. Cunningham. She reported that he could occasionally lift 20 pounds and frequently lift 10 pounds. R. 199. Mr. Cunningham had a "normal gait and station," "normal muscle and strength in all extremities," "decreased ROM [range of motion] in lumbar spine," and "moderate sensation diminishment . . . from hip to toes." He could sit with normal breaks for about six hours in an eight-hour workday. He had unlimited push and pull capabilities. She found no postural, manipulative, visual, communicative, or environmental limitations. R. 200-02. Dr. Crawford also found Mr. Cunningham to be credible. R. 203. Dr. R. Wenzler reviewed and approved Dr. Crawford's report. R. 205.

On June 14, 2004, Dr. Akaydin reevaluated Mr. Cunningham. R. 210-14. Mr. Cunningham reported pain in his arms, hands, hips, and knees, in addition to swelling in his legs and migraine headaches. Dr. Akaydin noted that Mr. Cunningham was "alert and oriented and extremely pleasant, polite, personable and cooperative . . . and in no acute distress." He was able to squat halfway down and to stand back up as well as to get on and off the exam table. Dr. Akaydin reported Mr. Cunningham's spine was "non-tender to firm gentle palpation . . . except for some mild to moderate lower-mid line lumbar region tenderness." His "arms and legs were generally quite healthy in overall appearance . . . ." Dr.

Akaydin noted that his range of motion was normal. Dr. Akaydin also reported that Mr. Cunningham's "lumbar spine forward flexion [was] at 35 degrees and backward extension [was] 5 degrees . . . ." Dr. Akaydin also performed a neurological and musculoskeletal examination. Mr. Cunningham had "no overt neurological/sensory abnormalities/deficits of any kind appreciated . . . ." R. 212. During his musculoskeletal evaluation, he could "make a complete fist with both hands and could touch his thumb to all his fingertips bilaterally." He could also "pick up coins, grasp objects of various size, button and unbutton articles of clothing and open and close the exam room door . . . without any difficulty whatsoever."

Dr. Akaydin concluded that Mr. Cunningham would be unable to return to "heavy construction and flooring type work" but that he would be able to perform "sedentary and 'sit-down' type" work. R. 213-14. Mr. Cunningham could perform "mildly to moderately physically strenuous employment," but his work would need to be "less physically strenuous and demanding this [sic] his previous work." Dr. Akaydin reported that the "exam was grossly unremarkable at present time for any overt major limiting deficits of any kind" but cautioned Mr. Cunningham to "be very careful with his back."

In August 2004, back x-rays showed the previous fusion at L5-S1 with "no hardware complicating signs," "mild spondylosis," and "minimal change in position of lumbar spine with flexion and extension." R. 232. The x-rays also

highlighted "longitudinal lucency in the right upper sacrum . . . [with a] benign appearance."

In September 2004, Mr. Cunningham saw Dr. Michael C. Cronen at the Pain Institute. See R. 235-36. Mr. Cunningham reported back pain. Mr. Cunningham's pulses and reflexes were "equal bilaterally in both upper and lower extremities . . . ." Dr. Cronen diagnosed postlaminectomy syndrome. To treat the pain, he recommended caudal steroid epidural blocks. Dr. Cronen also recommended that Mr. Cunningham "be seen and evaluated by physical therapy for the application of the TENS unit." On September 27, 2004, Mr. Cunningham visited the Pain Treatment Center for an epidural. R. 249.

On October 29, 2004, Mr. Cunningham saw Dr. David C. Napier for the first of several visits over the coming year. He complained of left shoulder and low back pain. R. 239. Upon examining his back, Dr. Napier noted tenderness on the right without "any significant radiation." Dr. Napier referred Mr. Cunningham to the Spine Center in Louisville. He also prescribed Daypro, Zanaflex, and Prednisone.

On December 8, 2004, Dr. Mitchell J. Campbell examined Mr. Cunningham. R. 258-59. He described Mr. Cunningham as having a "nonmyelopathic gait." Mr. Cunningham could touch "his fingertips to mid-thigh." Dr. Campbell reported Mr. Cunningham's hyperextension as 10, his motor strength as 5/5, and his DTRs

(deep tendon reflexes) as +1. Mr. Cunningham's sensation was intact, and he had "good distal pulses." Upon reviewing Mr. Cunningham's x-rays, Dr. Campbell noted the previous Steffe plate fusion and commented that he did not "see anything overly concerning . . . ." Dr. Campbell recommended a lumbar CT/myelogram.

On January 6, 2005, Dr. Napier again examined Mr. Cunningham, who complained of left shoulder and low back pain. R. 240. Mr. Cunningham explained that his knee pain made it difficult to walk. Dr. Napier reported tenderness in Mr. Cunningham's back and left shoulder. He also noted that previous pain medications, including Daypro and Zanaflex, failed to alleviate the pain. Dr. Napier continued the Daypro and Zanaflex and added Neurontin.

On February 10, 2005, Dr. Napier examined Mr. Cunningham, who complained of back, neck, knee, and shoulder pain. R. 241. Dr. Napier noted again that the previous pain medications failed to treat Mr. Cunningham's pain. Dr. Napier continued the Daypro, increased the Neurontin, and added a shot of Toradol and Depo Medrol.

On March 29, 2005, Mr. Cunningham saw Dr. Napier and complained of pain in his back, arms, and legs. R. 242. Dr. Napier noted lumbosacral tenderness. Mr. Cunningham had a "negative straight leg raise and good range of motion." Dr. Napier continued the Neurontin and added Motrin.

On August 30, 2005, Mr. Cunningham was experiencing back pain in addition to pain and swelling in his left knee. R. 312. Mr. Cunningham also had difficulty walking. Dr. Napier believed that Mr. Cunningham's knee tenderness was arthritic and gave him an injection of Kenalog and Lidocaine. Dr. Napier also noted lumbosacral tenderness in his back. Dr. Napier prescribed Mr. Cunningham Flexeril and Dayprol and gave him a shot of Toradol for his back pain. Dr. Napier discontinued the Piroxicam.

In August 2005, an x-ray of Mr. Cunningham's left knee revealed "no osseous abnormality." R. 313. His knee was not fractured or dislocated. His bone mineralization was normal.

On September 22, 2005, Mr. Cunningham visited Dr. Napier again, complaining of left knee pain, bilateral shoulder pain, and low back pain. R. 311. Dr. Napier increased his Neurontin, continued his Flexeril, and added Daypro.

On November 12, 2005, after seeing Mr. Cunningham periodically for more than a year, Dr. Napier wrote a letter evaluating his disability claim. Dr. Napier described Mr. Cunningham's previous back surgeries and chronic pain. R. 261. He explained that further surgeries were unnecessary and that Mr. Cunningham "has tried PT, medications, and epidural blocks none of which really helped." Dr. Napier explained:

> None of these modalities have really improved his chronic pain much. He continues to have significant issues with chronic pain which affect everyday of his life and are quite debilitating. He is at what appears to me to be maximal medical therapy. His current medications include Tagamet 800 mg daily, Neurontin 300 mg twice daily, Zoloft 50 mg daily, Flexeril 10 mg daily, and Feldene 20 mg daily. Unfortunately for this gentleman I see no significant avenue for improvement and suspect his problem is going to be chronic and lifelong. At this point we are no longer in a curative or even management modality. We are simply trying to palliate his symptoms as best we can.

Dr. Napier concluded that Mr. Cunningham was "permanently and totally disabled with no prospect of improvement . . . ." R. 261.

II. *Testimony at the Hearing*

Mr. Cunningham testified before the ALJ on December 8, 2005. Mr. Cunningham testified that he had arthritis, tendonitis, and fibromalygia. R. 332. He stated that holding a pencil "burns so bad through my between my [sic] fingers" that "it takes the pencil plum out of my hand." R. 332. Mr. Cunningham described his pain as being constant, allowing him only an hour and a half of sleep. R. 333. He rated his pain as a 10 out of 10. R. 333. Mr. Cunningham testified that he could sit for about ten minutes without a break and stand for about ten or fifteen minutes without a break. R. 354. He explained that pain medications, a TENS unit, and an epidural block failed to alleviated his pain. R. 336-38. Furthermore, Mr. Cunningham testified that his legs gave out often. R. 339. He was unable to drive, go grocery shopping, hunt, camp, or fish. R. 341-

42. He testified that previously he had been responsible for all the household chores but that his pain left him unable to do any chores. R. 340.

Mr. Cunningham's wife also testified about his daily life. R. 345-48. She stated that he never slept. He was unable to tie or put on his shoes and required his wife's daily assistance. Mrs. Cunningham described how she helped him bathe because he could not lift his arms to wash his hair. He required a handicap accessible shower with a built-in seat. It took Mr. Cunningham almost half an hour to shave. She also testified that she had seen his legs give out, causing him to fall.

The ALJ asked vocational expert Micha Daoud to consider a hypothetical individual of Mr. Cunningham's age, education, and work background who could lift ten pounds occasionally and five pounds frequently, sit for thirty minutes at a time during an eight hour workday, and walk or stand for thirty minutes at a time during an eight hour workday. The hypothetical individual could use ramps and stairs occasionally, stoop occasionally, and kneel occasionally. The individual would also have limitations restricting the use of ladders, ropes, and scaffolds, and should avoid concentrated vibrations, hazardous machinery, and unprotected heights. Ms. Daoud identified several jobs in the Indiana-Kentucky region that the hypothetical person could perform, including 65 inspector jobs, 65 surveillance monitor jobs, 415 unskilled information clerk jobs, and 280 general office jobs. R. 360-61. The ALJ also asked Ms. Daoud if Mr. Cunningham would

be able to perform any jobs if he and his wife were to be found credible. Ms. Daoud said he would not. R. 361.

III. *Procedural History*

On January 15, 2004, Mr. Cunningham filed an application for disability insurance benefits and supplemental security income. Mr. Cunningham initially alleged a disability onset date of November 21, 2002, but changed the onset date to October 17, 2003 because he had actually managed to work for a while after November 2002. After initial denials, he sought a hearing before an ALJ, which was held on December 8, 2005. On March 8, 2006, Administrative Law Judge Samuel A. Rodner issued a decision denying Mr. Cunningham disability benefits. The Appeals Council denied his request for review, leaving the ALJ's decision as the final decision of the Commissioner of Social Security. See *Smith v. Apfel*, 231 F.3d 433, 437 (7th Cir. 2000); *Luna v. Shalala*, 22 F.3d 687, 689 (7th Cir. 1994). Mr. Cunningham now seeks this court's review of the denial of his application under 42 U.S.C. § 405(g).

The Disability Standard

To be eligible for Social Security disability insurance benefits, Mr. Cunningham must demonstrate that he was unable to engage in any substantial gainful activity by reason of a medically determinable physical or mental impairment that could be expected to result in death or that had lasted or could

be expected to last for a continuous period of not less than 12 months. 42 U.S.C. § 423(d). Mr. Cunningham could establish disability only if his impairments were of such severity that he was unable to perform both his previous work and any other substantial work available in the national economy. 20 C.F.R. § 404.1520(f) and (g).

This eligibility standard is stringent. Unlike many private disability insurance programs, the Social Security Act does not contemplate degrees of disability and does not allow for an award based on a partial disability. *Clark v. Sullivan*, 891 F.2d 175, 177 (7th Cir. 1989). The Act provides important assistance for some of the most disadvantaged members of American society. But before tax dollars – including tax dollars paid by others who work despite serious and painful impairments – are available as disability benefits, it must be clear that the claimant has an impairment severe enough to prevent him from performing virtually any kind of work. Under the statutory standard, these benefits are available only as a matter of nearly last resort.

The implementing regulations for the Act provide the familiar five-step process to evaluate disability. The steps are:

(1) Has the claimant engaged in substantial gainful activity? If so, he was not disabled.

(2) If not, did the claimant have an impairment or combination of impairments that are severe? If not, he was not disabled.

(3) If so, did the impairment(s) meet or equal a listed impairment in the appendix to the regulations? If so, the claimant was disabled.

(4) If not, could the claimant do his past relevant work? If so, he was not disabled.

(5) If not, could the claimant perform other work given his residual functional capacity, age, education, and experience? If so, then he was not disabled. If not, he was disabled.

See generally 20 C.F.R. § 404.1520. When applying this test, the burden of proof is on the claimant for the first four steps and on the Commissioner for the fifth step. *Zurawski v. Halter*, 245 F.3d 881, 886 (7th Cir. 2001).

The ALJ found in favor of Mr. Cunningham at steps one and two. At step four, the ALJ found that Mr. Cunningham was able to perform sedentary work with certain limits. He could not lift or carry more than ten pounds occasionally or more than five pounds frequently. He would need to be able to alternate between sitting and standing every 30 minutes or so. He could engage in postural activities only occasionally and would need to avoid unprotected heights, hazardous machinery, and vibrations. R. 22. The ALJ found that these limits rendered Mr. Cunningham unable to perform any of his past relevant work. At step five, the ALJ found that Mr. Cunningham could still perform some kinds of sedentary work in the economy identified by the vocational expert, so he denied benefits.

Standard of Review

If the Commissioner's decision is both supported by substantial evidence and based on the proper legal criteria, it must be upheld by a reviewing court. 42 U.S.C. § 405(g); *Briscoe v. Barnhart*, 425 F.3d 345, 351 (7th Cir. 2005), citing *Scheck v. Barnhart*, 357 F.3d 697, 699 (7th Cir. 2004). Substantial evidence is "such relevant evidence as a reasonable mind might accept as adequate to support a conclusion." *Diaz v. Chater*, 55 F.3d 300, 305 (7th Cir. 1995), quoting *Richardson v. Perales,* 402 U.S. 389, 401 (1971). To determine whether substantial evidence exists, the court reviews the record as a whole but does not attempt to substitute its judgment for the ALJ's judgment by reweighing the evidence, resolving material conflicts, or reconsidering the facts or the credibility of the witnesses. *Cannon v. Apfel*, 213 F.3d 970, 974 (7th Cir. 2000); *Luna*, 22 F.3d at 689. The court must examine the evidence that favors the claimant as well as the evidence that supports the Commissioner's conclusion. *Zurawski*, 245 F.3d at 888. Where conflicting evidence allows reasonable minds to differ as to whether a claimant is entitled to benefits, the court must defer to the Commissioner's resolution of the conflict. *Binion v. Chater*, 108 F.3d 780, 782 (7th Cir. 1997).

A reversal or remand may be required, however, if the ALJ committed an error of law, *Nelson v. Apfel*, 131 F.3d 1228, 1238 (7th Cir. 1997), or based his decision on serious factual mistakes or omissions. *Sarchet v. Chater*, 78 F.3d 305, 309 (7th Cir. 1996). This determination by the court requires that the ALJ's decision adequately discuss the relevant issues: "In addition to relying on

substantial evidence, the ALJ must also explain his analysis of the evidence with enough detail and clarity to permit meaningful appellate review." *Briscoe*, 425 F.3d at 351, citing *Herron v. Shalala,*19 F.3d 329, 333-34 (7th Cir. 1994). Although the ALJ need not provide a complete written evaluation of every piece of testimony and evidence, *Schmidt v. Barnhart*, 395 F.3d 737, 744 (7th Cir. 2005), a remand may be required if the ALJ has failed to "build an accurate and logical bridge from the evidence to her conclusion." *Steele v. Barnhart*, 290 F.3d 936, 941 (7th Cir. 2002), quoting *Dixon v. Massanari*, 270 F.3d 1171, 1176 (7th Cir. 2001).

Discussion

The ALJ's denial of benefits was based upon his decision to discount the credibility of Mr. Cunningham's account of the severity of his pain and the opinion of his treating physician, Dr. Napier. Mr. Cunningham argues that the ALJ erred in both respects.

The ALJ examined Mr. Cunningham's medical history, pain allegations, and courtroom behavior. The ALJ considered Mr. Cunningham's four back surgeries and his "consistently severe pain" allegations. The ALJ also evaluated Mr. Cunningham's courtroom behavior and how he "frequently changed positions and showed other signs of intense pain such as grimacing, crying, and taking a 15 minute break outside the hearing room." R. 19. The ALJ contrasted Mr. Cunningham's pain allegations and courtroom behavior with his initial onset date

and his work history. The ALJ found that Mr. Cunningham initially alleged disability during a time when he had actually been working in late 2002 and early 2003. The ALJ determined that Mr. Cunningham's "ability to perform very heavy work during that period of time obviously indicates that his capacity level, even at a time when he initially claimed to have been disabled, was much higher than he described in his testimony." R. 20. The ALJ also concluded that Mr. Cunningham's poor work history failed to bolster his credibility.

The ALJ emphasized Mr. Cunningham's lack of narcotic and opiate pain medications and emergency room visits or hospitalizations. The ALJ found no reason in the medical records to account for Mr. Cunningham's lack of narcotic and opiate pain medications. The ALJ stated that "such pain medication would be consistent with his pain allegations." R. 20. He also believed that Mr. Cunningham's pain allegations were "inconceivable . . . in the absence of such emergency room visits or hospitalizations." R. 20. At the same time, the ALJ noted that none of Mr. Cunningham's doctors had ever found him to be malingering.

The ALJ also considered the opinion of the treating physician, Dr. Napier. The ALJ noted that Dr. Napier is a primary care physician, not a specialist, and he wrote that four examinations established Dr. Napier as "a marginally treating physician." R. 19. The ALJ also wrote that Dr. Napier's opinion was based primarily on Mr. Cunningham's subjective pain complaints, not objective medical

findings. The ALJ considered Mr. Cunningham's lack of radiation, negative straight leg test, and good range of motion to conclude that Dr. Napier's opinion was based on subjective pain complaints. The ALJ therefore gave Dr. Napier's opinion "limited weight." R. 19. After weighing the evidence, ALJ determined that Mr. Cunningham was only a partially credible witness and that his behavior at the hearing "was so extreme that it had to be exaggerated." R. 21.

I. *Mr. Cunningham's Credibility*

Mr. Cunningham argues that the ALJ erred in his credibility evaluation because he improperly discounted his subjective pain allegations. He argues in particular that the ALJ erred when he found no reason for Mr. Cunningham's lack of opiate or narcotic pain medications and when he emphasized the lack of emergency room visits.

Social Security Ruling 96-7p describes the two-step analysis for assessing subjective complaints of pain. See also 20 C.F.R. § 404.1529. First, the ALJ must determine whether "medically determinable physical or mental impairment(s)" exist that could "reasonably be expected to produce the individual's pain or other symptoms." § 404.1529; SSR 96-7p. If the ALJ finds that no impairment could reasonably cause the symptoms, then no symptom can be a basis for a finding of disability, no matter how genuine the complaints appear to be. SSR 96-7p. If the ALJ finds "an underlying physical or mental impairment[ ] that could reasonably

be expected to produce the individual's pain," the ALJ's next step is to "make a finding on the credibility of the individual's statements based on a consideration of the entire case record," including the objective medical evidence, daily activities, characteristics of the symptoms, aggravating factors, medications, and treatments. SSR 96-7p; see generally *Golembiewski v. Barnhart*, 322 F.3d 912, 915-16 (7th Cir. 2003).

Ordinarily a reviewing court defers to an ALJ's credibility determination. *Indoranto v. Barnhart*, 374 F.3d 470, 474 (7th Cir. 2004). Absent legal error, an ALJ's credibility finding will not be disturbed unless "patently wrong." *Powers v. Apfel*, 207 F.3d 431, 434 (7th Cir. 2000); *Diaz*, 55 F.3d at 308. Nevertheless, the ALJ must explain adequately the reasons behind a credibility finding and must provide more than a conclusory statement that a claimant's allegations are not credible. *Brindisi v. Barnhart*, 315 F.3d 783, 787 (7th Cir. 2003). The ALJ may not disregard a claimant's subjective complaints merely because they are not fully supported by objective medical evidence, *Knight v. Chater*, 55 F.3d 309, 314 (7th Cir. 1995), but the ALJ may discount subjective complaints that are inconsistent with the evidence as a whole. *Id.*; 20 C.F.R. § 404.1529.

A reviewing court must reverse where the opinion of the ALJ "contains a substantial number of illogical or erroneous statements that bear materially" on the conclusion. *Sarchet*, 78 F.3d at 307. In this case, the ALJ based a key conclusion on an incorrect reading of the medical records. One reason the ALJ

gave for discounting Mr. Cunningham's credibility was that he had "never been prescribed narcotic or opiate pain medications . . . ." R. 20. He concluded: "There is no reason given in the record for the claimant's lack of such prescription medication." R. 20. In fact, the records show an excellent reason for the lack of narcotic or opiate medications. Mr. Cunningham's medical records repeatedly note that he is allergic to morphine and codeine. R. 176, 189, 210, 233, 235, 238, 239, 240,241, 242, 252, 256, 258. The absence of such medications therefore is not a fair or reliable basis for discounting his credibility.

When the decision of an ALJ is "unreliable because of serious mistakes or omissions, the reviewing court must reverse unless satisfied that no reasonable trier of fact could have come to a different conclusion, in which event a remand would be pointless." *Sarchet*, 78 F.3d at 308-09. In this case, the ALJ found Mr. Cuningham's lack of pain medications inconsistent with his pain allegations. The ALJ relied on this inconsistency to conclude that Mr. Cunningham was only partially credible. The ALJ's error in reading the medical records undermines the credibility assessment. In light of Mr. Cunningham's allergies, a reasonable trier of fact could have reached a different conclusion.

In discounting Mr. Cunningham's credibility, the ALJ also improperly assessed Mr. Cunningham's lack of emergency room visits. The ALJ concluded that Mr. Cunningham's "allegations that his pain never goes below a 10 on a scale of 1 to 10 is inconceivable on its face in the absence of such emergency room visits

or hospitalizations." R. 20.[3] At the same time, the record shows that Mr. Cunningham has attempted to treat his pain with four back surgeries, physical therapy, an epidural, a TENS unit, and a wide range of medications that he can tolerate, all with only limited effect.[4] After so little success from all the therapies that modern medicine has to offer, Mr. Cunningham could reasonably conclude that a trip to the emergency room would be futile (and expensive), and his failure to go does not undermine his credibility. See *Ribaudo v. Barnhart*, 458 F.3d 580, 585 (7th Cir. 2006) (finding that a failure to pursue ineffective treatments does not suggest that . . . [the claimant] is not in severe pain, and therefore cannot be a sound basis for the ALJ's adverse credibility finding."). The ALJ erred by basing his credibility finding on Mr. Cunningham's lack of emergency room visits.

These errors were central to the ALJ's credibility finding, which was the decisive issue in this case. The errors were not harmless. The case must be remanded for a fresh look at the severity of Mr. Cunningham's pain.

II. *Treating Physician's Opinion*

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[3]The ALJ wrote that Mr. Cunningham had a medical card and that his financial situation would therefore not be a contributing factor to his receiving such treatment. R. 20. But Mrs. Cunningham wrote on May 17, 2004, that Mr. Cunningham lacked insurance and could not afford to see the doctor. R. 126.

[4]Mr. Cunningham's doctors have prescribed many medications in attempts to treat his pain, including Vicodin, Darvocet, Indocin, Talacen, Tylox, Neurontin, Percocet, Tylenol, and Motrin.

After seeing Mr. Cunningham at least six times over the course of one year to treat his pain, Dr. Napier wrote his letter of November 12, 2005 describing the serious back problems and all the unsuccessful efforts to treat Mr. Cunningham's pain. Dr. Napier described the pain as "quite debilitating." He offered no prospect of real improvement, and he opined that Mr. Cunningham was permanently and totally disabled. R. 261. The ALJ gave several reasons for discounting Dr. Napier's opinion. His opinion was based on Mr. Cunningham's subjective complaints; Dr. Napier is a primary care doctor rather than a specialist; and Dr. Napier was only a "marginally treating physician" because he did not have a long-term treating relationship with Mr. Cunningham. R. 19.

In evaluating medical evidence, it is the ALJ's responsibility to determine how much credence to give particular pieces of evidence. *Diaz v. Chater*, 55 F.3d 300, 309 (7th Cir. 1995). A treating physician's opinion regarding the nature and severity of a claimant's medical condition is entitled to controlling weight if well-supported by medically acceptable techniques and not inconsistent with other substantial evidence in the record. 20 C.F.R. § 404.1527(d)(2); *Skarbek v. Barnhart*, 390 F.3d 500, 503 (7th Cir. 2004). An ALJ may discount a treating source's opinion if it is inconsistent with the opinion of a consulting physician or if the treating source's opinion is internally inconsistent, as long as the ALJ "minimally articulate[s] his reasons for crediting or rejecting evidence of disability." *Clifford v. Apfel*, 227 F.3d 863, 870 (7th Cir. 2000), quoting *Scivally v. Sullivan*, 966 F.2d 1070, 1076 (7th Cir. 1992); *Knight v. Chater*, 55 F.3d 309, 314

(7th Cir. 19945 (finding physician's opinion "may be discounted if it is internally inconsistent"). An ALJ can reject a treating physician's opinion if "it appears to be based on a claimant's exaggerated subjective allegations." *Dixon v. Massanari*, 270 F.3d 1171, 1178 (7th Cir. 2001). See also *Diaz*, 55 F.3d at 308 (finding that an ALJ may give less weight to a doctor's report that is based solely on the claimant's "own statements about his functional restrictions at the time of the examination.").

In discounting Dr. Napier's opinion, the ALJ adequately discussed the record and explained his reasoning. The ALJ evaluated Dr. Napier's examination notes that indicate that Mr. Cunningham was in severe pain and concluded that Dr. Napier's examinations failed to correlate with such intense pain. The ALJ considered Mr. Cunningham's lack of radiating pain, his negative straight leg test, and his good range of motion. He also considered evidence that correlated with Dr. Napier's opinion, namely Mr. Cunningham's lumbosacral tenderness.

One problem here is that the records of Mr. Cunningham's treatment with Dr. Napier on August 30, 2005, and September 22, 2005 were not available to the ALJ. Those records were added to the record submitted to the Appeals Council. See R. 311-12. When the Appeals Council has denied review, so that the ALJ's decision is the final decision, the court may not consider the additional records. *Eads v. Secretary Dept. Of Health and Human Services*, 983 F.2d 815, 817 (7th Cir.

1993). An ALJ "cannot be faulted for having failed to weigh evidence never presented to him." *Id.*

After weighing the evidence, the ALJ concluded that Dr. Napier's evaluation was based primarily on Mr. Cunningham's subjective pain complaints. R. 19. That is a reasonable view of the record before the ALJ, apart from the errors identified above in Part I. On remand, however, it may be possible for Dr. Napier to address more directly the concerns the ALJ raised in evaluating the severity of Mr. Cunningham's pain. Also, the more complete medical records will be available for consideration on remand.

Conclusion

Perhaps Mr. Cunningham is not really disabled and just exaggerates his pain. Or perhaps this is one of those rare and difficult cases where a serious back injury causes truly debilitating pain that cannot be treated effectively. The case deserves another look based on an accurate view of the medical records. The denial of benefits is remanded for reconsideration consistent with this entry. On remand, all steps of the five-step sequential process are subject to reconsideration. Final judgment shall be entered consistent with this entry.

So ordered.

Date: June 15, 2007

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DAVID F. HAMILTON, JUDGE
United States District Court
Southern District of Indiana

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